



Adults, Wellbeing and Health Overview and Scrutiny Committee

Date **Friday 6 September 2019**
Time **9.30 am**
Venue **Committee Room 2 - County Hall, Durham**

Business

Part A

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

1. Apologies for Absence
2. Substitute Members
3. Minutes of the meeting held on 4 July 2019 and of the special meeting held on 30 July 2019 (Pages 3 - 14)
4. Declarations of Interest, if any
5. Media Issues (Pages 15 - 16)
6. Any Items from Co-opted Members or Interested Parties
7. Future of Ward Six, Bishop Auckland Hospital - Report of the Director of Transformation and Partnerships and report and presentation by representatives of County Durham and Darlington NHS Foundation Trust (Pages 17 - 120)
8. Review of Stroke Rehabilitation Services in County Durham - Report of the Director of Transformation and Partnerships and presentation by representatives of County Durham Clinical Commissioning Groups and County Durham and Darlington NHS Foundation Trust (Pages 121 - 232)

9. Crisis Service Improvements - Report by Levi Buckley, Director of Operations, Durham and Darlington, Tees Esk and Wear Valleys NHS Foundation Trust (Pages 233 - 256)
10. Right Care, Right Place Programme - Report and presentation by Jo Murray, Right Care Right Place Delivery Lead (Durham and Darlington), Tees Esk and Wear Valleys NHS Foundation Trust (Pages 257 - 268)
11. Peterlee Urgent Treatment Centre - Update report of Durham Dales, Easington and Sedgefield Clinical Commissioning Group (Pages 269 - 298)
12. Path to Excellence Phase 2 - Report of the Director of Transformation and Partnerships (Pages 299 - 314)
13. 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
29 August 2019

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

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

Councillors A Batey, R Bell, L Brown, P Crathorne, R Crute, J Grant, T Henderson, E Huntington, P Jopling, C Kay, K Liddell, S Quinn, A Reed, A Savory, M Simmons, H Smith, J Stephenson, O Temple and C Wilson

Co-opted Members: Mrs R Hassoon

Co-opted Employees/Officers: Mr C Cunnington-Shore

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DURHAM COUNTY COUNCIL

**ADULTS, WELLBEING AND HEALTH OVERVIEW AND SCRUTINY
COMMITTEE**

At a meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in Committee Room 2 - County Hall, Durham on **Thursday 4 July 2019 at 9.30 am**

Present

Councillor J Robinson (Chair)

Members of the Committee

Councillors R Bell, L Brown, P Crathorne, R Crute, J Grant, T Henderson, P Jopling, S Quinn, A Reed, M Simmons, H Smith, J Stephenson, O Temple and C Wilson

Co-opted Members

Mrs R Hassoon

Also Present

L Hovvels

1 Apologies

Apologies for absence were received from Councillors A Batey, J Chaplow, E Huntington, K Liddell, S Quinn, A Savory and Mr Cunnington-Shore.

2 Substitute Members

There were no substitute members in attendance.

3 Minutes

The minutes of the meeting held on 1 April 2019 and of the special meeting held on 11 June 2019 were agreed as a correct record and signed by the Chair.

Councillor Temple referred to the minutes of the meeting held on 1 April 2019 and with reference to the question he asked in relation to the number of reactive positive tests returned from online STI Pack Requests compared with the number of positive tests returned at the STI clinics, he had not yet received a response.

The Chair confirmed that a petition had been received from Helen Goodman MP, in opposition to the closure of the out of hours provision at the Richardson Hospital.

In response to Councillor Bell, the Director of Commissioning, DDES CCG confirmed the receipt of the petition and indicated that whilst a decision had been made, the implementation of the proposed changes was not until September and should there be anything further to report, Members would receive an update at the special meeting in July.

4 Declarations of Interest, if any

There were no declarations of interest.

5 Media Issues

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

- Concerns raised over changes to extended access to GP services in County Durham – Northern Echo 20 June 2019
- What changes to out of hours GP care means for patients needing a doctor – Sunderland Echo 14 June 2019
- New vision for Sunderland Royal Hospital ‘could prevent cancelled operations’, say health chiefs – Sunderland Echo 8 March 2019
- Residents in care homes ‘missing out on dental care’ – BBC Website 24 June 2019

6 Any Items from Co-opted Members or Interested Parties

There were no items from Co-opted Members or Interested Parties.

7 Skerne Medical Group

The Committee received a report of the Director of Transformation and Partnerships which provided an update in relation to the proposals for consultation/engagement by Skerne Medical Practice in respect of the development of options for future service provision across the practice locality (for copy see file of minutes).

The Committee received a presentation from Dr Hearmon, Partner of Skerne Medical Group, which detailed the reasons behind reducing services to three sites and put forward five options for public consultation.

Councillor Grant confirmed that the closure of the Trimdon Village practice had left vulnerable patients unable to travel. She referred to the merging of East Durham

Medical Group, a group which contained six sites with a full complement of GP's and asked how this had materialised with such difficulty recruiting salaried GP's. She asked whether decisions were taken in light of financial pressures or patient needs. She referred to the consultation which included unrealistic scenarios and asked for comments on whether they were possible due to the financial implications.

With regards to finance, the Director of Primary Care, North Durham CCG, confirmed that all options were realistic. Although funding would need to be sought in order for building work to take place, it was possible to find developers willing to invest. This was a private business and the biggest issue was the reducing number of Partners as it created issues in terms of the longevity of a new lease and the ability of a reducing number of partners to commit to long term financial demands. A normal lease was for a minimum of 5 years.

In response to Councillor Grant's concerns about private business decisions, the Director of Primary Care, North Durham CCG, confirmed that a GP partnership review conducted by the government had concluded that compared to the salaried model, the partnership model was the only model that could take GPs to the next level. The review was critical of the culture of non-private practice and it found that partners went over and above for patients.

Councillor Temple suggested that if any of the scenarios were financially unviable, they should be removed before being released for public consultation. It was important to only include those that were deliverable.

Dr Hearmon recognised that some were more realistic than others, however they were asked to consider a number of options from the Primary Care Committee. All options were realistic as although some did not yet have the financial investment required, investors could still come forward.

Mrs Hassoon had concerns that the cheapest option, due to leases held, was not necessarily the best.

Councillor Bell confirmed that he would not support a single site, due to the geographical area covered and suggested that people were likely to base their consultation response on prioritising a surgery in, or closest to the area they lived. It was crucial that the practice increased the number of partner GPs but he agreed that before the consultation was opened to the public, the options should be reduced to include only those that were financially achievable.

Councillor Hovvels, Portfolio Holder for Adult and Health Services and Local Member, confirmed that it was essential to deliver the best option and repair the damage that had been done in the community. They were quite rightly discontent at the loss of local services. She considered it would be beneficial to have more financial information in order to fully consider the scenarios. Members had heard

about the issues of having split sites over a large geographical area but also about access issues for patients with reduced sites, but the outcome had to be based on retaining the best level of service.

Dr Hearmon confirmed that the purpose of the review was to ensure long term, sustainable medical care and clarified that it would take some time before new GP's became Partners. As had been alluded to earlier, the government were still of the opinion that the partnership model was the preferred continuing way for GP services to be provided.

Councillor Bell was grateful for the information provided and was delighted that four GP's had been recruited. He also showed appreciation to Skerne Medical Group for actively seeking comments from the Committee and the Chair thanked them for the presentation.

Resolved:

That the report and presentation be received, and Committee's comments on proposals for consultation/engagement in respect of the development of options for future service provision across the practice locality be communicated in writing to the Skerne Group and DDES CCG.

8 Path to Excellence Programme Phase 2

The Committee received a report of the Director of Transformation and Partnerships which provided background information on proposals for pre - engagement activity by South Tyneside and Sunderland NHS Partnership in respect of the development of options for future service provision in respect of the Phase 2 of the Path to Excellence Programme (for copy see file of minutes).

Councillor Grant advised that Trimdon and Thornley were electoral divisions affected by the proposals as users of Sunderland services and as such should be included within the list of wards affected by the programme.

In response to a question from Councillor Bell, the Medical Director for South Tyneside and Sunderland NHS FT and clinical director Path to Excellence programme, advised that the Integrated Care System had been consulted as well as CCGs and hospitals. The proposals particularly affected North East Ambulance Service and therefore it had also been considered at a higher level.

The Chair advised that with regards to the vascular service review, NEAS had still to receive confirmation of what additional resources would be available to meet the demands of those service changes and asked for assurance that they had been included in the pre-consultation activity for the Path to Excellence programme. He was advised that NEAS had been involved in the first phase and no service change

would be implemented without prior agreement with NEAS as they would be directly affected.

The Principal Overview and Scrutiny Officer added that in relation to the vascular surgery review, NEAS had identified potential resource requirements which was then escalated to NHS England. A decision followed which implemented a service change and NEAS were advised to report any issues to NHS England who would review if necessary.

The Principal Overview and Scrutiny Officer reminded Members that as with any major service reconfiguration, a joint overview and scrutiny committee had been set up during phase 1 of the programme, however due to the negated impact on Durham, this Committee had not been included. One of the proposed recommendations going forward was that this Committee appointed representatives to any such Joint Health Overview and Scrutiny Committee that may be established between South Tyneside Borough Council, Sunderland City Council and Durham County Council, for the purposes of considering the Path to Excellence Programme Phase 2 and any associated statutory consultation.

Resolved:

That the Committee;

- a) receive the report
- b) consider and comment on the information detailed within the Path to Excellence Phase 2 case for change documentation and the presentation by the Path to Excellence programme team representatives
- c) Agree to the appointment of representatives to such Joint Health Overview and Scrutiny Committee that may be established between South Tyneside Borough Council, Sunderland City Council and Durham County Council for the purposes of considering the Path to Excellence Programme Phase 2 and any associated statutory consultation.

9 County Durham Oral Health Strategy Update

The Committee received a report of the Deputy Director of Public Health, County Durham and Public Health Strategic Manager, which provided an update on the progress which was being made with the County Durham oral health strategy and an overview of activity to tackle oral health inequalities across County Durham (for copy see file of minutes).

Councillor Brown was formerly employed in a role with direct care of adults with mental health issues and she referred to the difficulties with regards to oral health. She advised that some people were terrified of going to see a dentist, yet she had enquired as to whether anyone could visit the premises to discuss oral health with patients, to no avail. The Deputy Director of Public Health confirmed that CDDFT

had a Specialist Dental Service providing dental care for children and adults with treatment needs that could be met by a general dental practitioner, and an Oral Health Promotion team which provided training and education in oral care to health care professionals.

Councillor Bell was sceptical with regards to fluoridated water and queried whether any research had been done with regards to what children were drinking as many drank bottled water or soft drinks. The Deputy Director of Public Health confirmed that there were huge disparities in oral health across the County, associated with areas of deprivation and it was those who would benefit most from fluoridated water.

Councillor Crute confirmed that the Oral Health Strategy had proven benefits of fluoridated water with evidence-based research. There were also benefits associated which could offset the cost of poor oral health in children.

The Deputy Director of Public Health confirmed that every four years a review was undertaken by Public Health England and water fluoridation caused no harm to health, only benefits. It had also been recognised that there was a huge financial benefit - after 10 years there would be a £21 return, whereas toothbrush schemes only had a return of £3.

Councillor Temple welcomed the debate on water fluoridation but having lived in an area that had benefitted for a number of years, there had been extensive research proving oral health benefits – it had been in every oral health report over the years, and it was time to press on with introducing the scheme to the rest of the County.

The Principal Overview and Scrutiny Officer confirmed that a further joint meeting would be held with Environment and Sustainable Communities and Children and Young Peoples Overview and Scrutiny Committees, later in the year to debate water fluoridation.

Resolved:

That the report be noted and a further joint meeting to review oral health be held late December 2019/early January 2020.

10 Adults and Health Services Update

The Committee considered a report of the Corporate Director of Adults and Health Services which provided a summary of developments across Adult and Health Services (for copy see file of minutes).

Councillor Crute commented on the financial crisis in the South West which exemplified what could go wrong with a combined budget.

There had been recent discussions with regards to scrapping the green paper on social care and he suggested keeping a close eye on developing plans.

The Corporate Director of Adults and Health Services confirmed that there was an element of uncertainty around the green paper and the NHS long-term plan which had been published in January had been criticised as a “missed opportunity” in relation to the government’s plans on the future of adult social care.

The government had shifted the onus of adult care component to local authorities and there was a concern that providing the right level of care was having a financial impact. Funding was complicated with regards to care packages and there had been a significant increase in the provision of complex care packages which came at a significantly higher cost. She advised that 20-30 years ago people did not have the life expectancy as they did today and this was another fact which increased the need and complexity of adult social care.

A report would be presented to Cabinet in March looking at the principles on how to develop a model to be finalised in Autumn.

Members were reminded by the Principal Overview and Scrutiny Officer that there were CQC Local Health and Social Care System Reviews being undertaken and the Committee would respond following any outcome. He advised that some work had been done by the Children and Young Peoples Overview and Scrutiny Committee in response to the JTAI, undertaken in July 2018 by Ofsted, the Care Quality Commission, HMICFRS and HMI Probation.

Resolved:

That the content of the report be noted and the Committee agreed to receive further updates in relation to Adult and Health Service developments on a six monthly basis.

11 Quarter Four 2018/19 Performance Management Report

The Committee considered a report of the Director of Transformation and Partnerships which presented progress towards achieving the key outcomes of the council’s corporate performance framework for the Altogether Healthier priority theme (for copy see file of minutes).

Councillor Temple was concerned by the tracked participation in sport and physical activity data and he asked if there was anything that the Council could do with regards to sport and leisure, which would assist in tackling this problem. The Finance Manager, CYPS, confirmed that the data was collected from the Active People Survey and allowances could be made for margin of error, however due to different trends year on year comparisons were not always significant.

Councillor Crute asked how data was measured with regards to the self-reported well-being – people with a low level of happiness. He referred to employment statistics which masked the issue of low income and this could potentially hide the true statistics. The Finance Manager, CYPS, confirmed that this was a survey indicator and agreed that it was entirely subjective as it was based on how an individual was feeling on one particular day however he would see if any more in depth data was retrievable.

Resolved:

That the report be noted.

12 NHS Quality Accounts 2018-19

The Committee considered a report of the Director of Transformation and Partnerships which provided responses made on behalf of the Committee in respect of NHS Foundation Trust Draft Quality Accounts 2018/19 (for copy see file of minutes).

Resolved:

That the report be noted.

13 Refresh of the Work Programme 2019/20

The Committee received a report of the Director of Transformation and Partnerships which provided a suggested work programme for the Adults Wellbeing and Health Overview and Scrutiny Committee for 2019/20 (for copy see file of minutes).

Resolved:

That the report be noted.

DURHAM COUNTY COUNCIL

At a meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in Committee Room 2 - County Hall, Durham on **Tuesday 30 July 2019 at 12.00 pm**

Present

Councillor J Robinson (Chair)

Members of the Committee

Councillors A Batey, R Bell, R Crute, T Henderson, P Jopling, S Quinn, A Savory, M Simmons, J Stephenson, O Temple and A Hopgood

Co-opted Members

Mrs R Hassoon

1 Apologies

Apologies for absence were received from Councillors J Chaplow, P Crathorne, J Grant, E Huntington, C Kay, K Liddell, A Reed, H Smith, C Wilson and Mr C Cunnington Shore (Healthwatch County Durham)

2 Substitute Members

Councillor A Hopgood for Councillor L Brown

3 Declarations of Interest

There were no declarations of interest.

4 Any Items from Co-opted Members or Interested Parties

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

5 Clinical Commissioning Group merger proposal

The Committee received a report and presentation from the Chief Officer, North Durham and Durham Dales, Easington and Sedgefield Clinical Commissioning Groups that advised of a Clinical Commissioning Group (CCG) merger proposal (for copy see file of Minutes).

The presentation highlighted the following:-

- Current arrangements – 5 CCGs covering Teesside, Darlington & Durham
- Plan, buy and monitor NHS services for over 1.2 million people

- What CCGs do
- Why do we want to make the changes?
- Proposals – 4 options
- What was not covered by the change
- Principles
- Expected benefits
- Option 4 preferred
- What this would mean for patients and the public
- What happens next
- Opportunity to feedback and further engagement

The Chief Officer added that the CCGs were a good organisation carrying out fantastic work locally but that it was important for everyone to work together, and he thanked Healthwatch for their continued support and involvement with the engagement.

Mrs Hassoon asked if the patient reference groups would continue and was advised that the CCG would not want to change any of these arrangements as they worked well.

Councillor Hopgood was concerned that this was another re-organisation in the past 20 years, and she asked how much it would cost. She queried that the savings of 20% would surely be spent on the re-organisation and there was a chance that arrangements could change again with a further merger. The Chief Officer said that there would also be a cost with re-organisation but not necessarily in financial terms but in staff time and the disruption to staff. He assured members that the CCG were not expecting to see a bill following this re-organisation.

As the consultation was due to close, Councillor Bell recommended that the committee support option 4 for the shared management structure and then look at options for a further merger when they were proposed.

Councillor Crute commented that the correct governance arrangements needed to be in place with the feedback given from the patient reference groups. However, he was concerned how scrutiny would fit in to these new arrangements especially with the Integrated Care Partnerships (ICP) and the Integrated Care System (ICS) to ensure that the organisations were subject to accountability. The Chief Officer assured members that they would ensure the governance arrangements were in place.

The Corporate Director of Adult and Health Services said that Durham should be looked at as a place and should be protected especially in terms of the local authority and social care perspective. She added that it would make more sense to have one CCG and that the relationship was already in place so she would support the merger. In terms of the wider ICP/ICS issue this would be monitored

closely. The Chair agreed that having one CCG would add value and may be beneficial to protect the acute trust in Durham.

Councillor Temple asked for some assurance that the merger would not affect the proposals for Shotley Bridge Hospital. He also asked if there were any plans to merge Durham and Darlington CCGs as thought this would make more sense in terms of the foundation trust. He referred to the likelihood future merger with Sunderland and South Tyneside and felt that that the geography would not be helped by a single Durham CCG. The Chair said that some services had already started merging care with Sunderland and South Tyneside.

In response the Chief Officer said that the CCG would continue to support the Shotley Bridge proposals however there was some concerns around the capital funding. They were seeking assurances from NHS England regarding the short-term funding. In terms of Durham and Darlington he advised that a merger was considered as the CCG work closely with Darlington as they shared a border and some patients were just as likely to go to Darlington as they were Durham for their care needs. However, GPs in the Darlington area felt that they worked more closely with Tees and they were aligned to the southern ICP. There needed to be a greater understanding of what would work in each ICP area as hospitals could not provide a service alone. He advised that there would be a need for some staff to work together as one team serving different areas under the ICP.

The Chair of the North Durham Clinical Commissioning Group explained that representatives from GPs in North Durham CCG consulted on the proposed merger and that no concerns were raised. The shared management operation may cause some difficulties for future financial sustainability, but assurance had been given that funding for Durham CCGs would be used for practices in the Durham area.

The Chief Officer confirmed that the function of the governing body that resources allocated for Durham would be distributed in Durham. The two Durham CCGs managed their finances well and would continue to use the resources as best as they could for the population of Durham abiding by the formula for the funding criteria.

Resolved:

That the report be received and that option 4 be supported.

6 Any other business - Sunderland and South Tyneside Path to Excellence Programme - Durham Representatives

The Principal Overview and Scrutiny Officer informed the Committee that at the last meeting the proposal for phase 2 of the Sunderland and South Tyneside Path to Excellence Programme was discussed. He indicated that at that time, the Committee had resolved to seek representation on any Joint OSC arrangements

established for Phase 2 of the programme. The Principal Overview and Scrutiny Officer reported that the Joint Overview and Scrutiny Committee established by South Tyneside BC and Sunderland City Council to consider Phase 1 of the programme had met on 29 July 2019 and it had been agreed that joint scrutiny arrangements would now include three representatives from Durham County Council and nominations would be sought from the respective groups.

Adults Wellbeing and Health OSC

6 September 2019 – Media Slide

20 NHS building projects given
green light – BBC Website 5
August 2019

Major health projects are at risk despite
spending pledge – Northern Echo 7 August
2019

Middlesbrough: West Lane Hospital rated
'Inadequate' by CQC – Northern Echo 21
August 2019

Review of mental health services under
scrutiny by Darlington councillors – Northern
Echo 26 August 2019

Why Durham health chiefs have been asked
to join 'Path to Excellence' efforts for
Sunderland and South Tyneside hospitals –
Sunderland Echo 2 August 2019

Altogether better



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

6 September 2019

**Future of Ward 6 Bishop Auckland
Hospital**



Report of Corporate Management Team

Lorraine O'Donnell, Director of Transformation and Partnerships

Electoral division(s) affected:

Countywide

Purpose of the Report

- 1 To update the Adults Wellbeing and Health Overview and Scrutiny Committee on proposals for consultation/engagement by County Durham and Darlington NHS Foundation Trust and County Durham CCGs in respect of the future of ward 6, Bishop Auckland Hospital.

Executive summary

- 2 The Adults Wellbeing and Health Overview and Scrutiny Committee has previously met to consider proposals for the future of ward 6, Bishop Auckland Hospital following initial concerns reported within media that the ward was planned for closure.
- 3 The Committee has received previous reports and presentations on work being done by the Foundation Trust to examine the services being provided at ward 6 to ensure that it is the "right care" being provided in the "right place" by the "right person" and that it is the best possible care that it could be.
- 4 At its meeting on 18 January 2019, the Committee considered staff consultation feedback in respect of the services currently provided at ward 6 Bishop Auckland Hospital and staff thoughts on what future service provision might look like. Members also received the results of a service evaluation exercise undertaken with ward 6 patients which asked for patients to describe their experience on the ward. This information included admission information, home address, length of stay on ward 6, care ratings, patient involvement in their care and also post discharge support.

- 5 The Committee considered the outcomes of “Rapid Process Improvement Workshops” undertaken by the Trust during November 2018 which examined current care pathways against best practice models of care. Members were also advised of the outline timetable to support the development of an associated communications and engagement plan which would feed into the development of options for a future model of care.
- 6 In accordance with the recommendations agreed by the Committee at its meeting on 18 January 2019, representatives of County Durham CCGs and County Durham and Darlington NHS Foundation Trust will be in attendance to provide members with a presentation setting out the proposed plans for patient and stakeholder consultation together with the options for future service models that are planned to be consulted upon in respect of ward 6 Bishop Auckland Hospital.

Recommendation

- 7 The Committee is asked to receive this report and presentation and comment on proposals for consultation/engagement in respect of options for future service models that are planned to be consulted upon in respect of ward 6 Bishop Auckland Hospital.

Background

- 8 At its meeting held on 15 November 2018 the Adults Wellbeing and Health Overview and Scrutiny Committee, following initial concerns reported within media that ward 6 was planned for closure, received a report and presentation by County Durham and Darlington NHS Foundation Trust which provided an overview on the current usage of ward 6; the national and local policy context which highlighted a need to review the current model of care and information regarding ongoing staff consultation in respect of ward 6.
- 9 At its meeting on 18 January 2019, the Committee considered staff consultation feedback in respect of the services currently provided at ward 6 Bishop Auckland Hospital and staff thoughts on what future service provision might look like. Members also received the results of a service evaluation exercise undertaken with ward 6 patients which asked for patients to describe their experience on the ward. This information included admission information, home address, length of stay on ward 6, care ratings, patient involvement in their care and also post discharge support.
- 10 At that meeting, the Committee also considered the outcomes of “Rapid Process Improvement Workshops” (RPIWs) undertaken by the Trust during November 2018 which examined current care pathways against

best practice models of care. Members were also advised of the outline timetable to support the development of an associated communications and engagement plan which would feed into the development of options for a future model of care.

- 11 The RPIWs and staff consultation identified a number of considerations namely:
 - (a) A continued need for care in Bishop Auckland Hospital;
 - (b) A need for therapy input for the patient cohort currently using Ward 6
 - (c) The need to standardise the model of care in line with the other community hospitals in County Durham;
 - (d) Areas of service provision that are not operating in line with best practice
- 12 The RPIWs have provided real patient scenarios that the Foundation Trust planned, with partners, to use to engage with patients, carers and the public. CDDFT submitted a workplan request to Healthwatch County Durham for support in undertaking this work which would seek wider patient and public views and opinions to help shape options for the future model of care which would deliver the best possible patient experience and outcomes for our local populations.
- 13 In accordance with the recommendations agreed by the Committee at its meeting on 18 January 2019, representatives of County Durham CCGs and County Durham and Darlington NHS Foundation Trust will be in attendance to provide members with a presentation setting out the proposed plans for patient and stakeholder consultation together with the options for future service model that are planned to be consulted upon in respect of ward 6 Bishop Auckland Hospital.
- 14 Supplementary reports and presentation slides from County Durham and Darlington Foundation Trust and County Durham Healthwatch are included with this report at Appendices 2,3,4 and 5.

Considerations

- 15 Members are asked to consider the future service model options and associated consultation and engagement plans for ward 6, Bishop Auckland Hospital.

Main implications

Consultation

- 16 County Durham and Darlington NHS Foundation Trust and Durham CCGs will report upon their proposals for formal patient and stakeholder consultation on the future service model options in respect of ward 6 Bishop Auckland Hospital.

Legal

- 17 This report has been produced in accordance with the Local Authority (Public Health, Health and wellbeing boards and Health Scrutiny) Regulations 2013 as they relate to the National Health Service Act 2006 governing the local authority health scrutiny function.

Conclusion

- 18 The initial media articles and subsequent patient and stakeholder consultation and engagement have raised concerns amongst local residents and Durham County Councillors regarding the future of ward 6 Bishop Auckland Hospital.
- 19 The Committee has previously asked that County Durham CCGs and County Durham and Darlington NHS Foundation Trust provide members with a presentation setting out the proposed plans for patient and stakeholder consultation together with the options for future service model that are planned to be consulted upon in respect of ward 6 Bishop Auckland Hospital
- 20 In light of representations made by the Adults Wellbeing and Health Overview and Scrutiny Committee, members are asked to receive this report and consider proposals for patient and stakeholder consultation and engagement as well as the future service model options being consulted upon in respect of ward 6, Bishop Auckland Hospital.

Background papers

- Agenda, Minutes and Reports to the Adults Wellbeing and Health Overview and Scrutiny Committee meetings held on 15 November 2018 and 18 January 2019.

Contact: Stephen Gwilym

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Appendix 1: Implications

Legal Implications

This report has been produced in accordance with the Local Authority (Public Health, Health and wellbeing boards and Health Scrutiny) Regulations 2013 as they relate to the National Health Service Act 2006 governing the local authority health scrutiny function.

Finance

Not applicable

Consultation

The proposals for patient and stakeholder engagement by County Durham and Darlington NHS Foundation Trust and County Durham CCGs are detailed within the attached presentation.

Equality and Diversity / Public Sector Equality Duty

An Equality Impact Assessment has been undertaken in respect of the proposals and is included within this report.

Human Rights

Not applicable

Crime and Disorder

Not applicable

Staffing

Not applicable

Accommodation

Not applicable

Risk

Not applicable

Procurement

Not applicable

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North Durham Clinical Commissioning Group
Durham Dales, Easington and Sedgefield Clinical Commissioning Group
Darlington Clinical Commissioning Group

Review of Inpatient Rehabilitation in County Durham and Darlington

A review of ward 6 within Bishop Auckland Hospital

Pre-Consultation Business Case

Contents

1.0	Executive Summary	2
2.0	Vision	3
2.1	Scope	3
2.2	Aims and Objectives	3
3.0	Background and Introduction	4
3.1	Demographics and Prevalence	5
3.2	National Context and Evidence Base	6
4.0	Local Context	8
4.1	Quality and Performance	10
5.0	Patient Experience and Feedback	12
6.0	Staff Engagement	14
7.0	Current State	14
8.0	Case for Change	18
8.1	Workforce challenges	20
8.2	Financial challenges	20
9.0	Options Criteria and Process	20
9.1	Options Appraisal	22
9.2	Preferred Option	27
10.0	Benefits Realisation	28
11.0	Risks	29
12.0	Testing out the Preferred Option	29
13.0	Proposed Future State	32
13.1	Service Model	32
13.2	Specific Measurable Outcomes	33
13.3	Performance Management	33
14.0	Project Plan	34

1.0 Executive Summary

The following report outlines the commitment from the local health system within County Durham and Darlington to develop inpatient and community rehabilitation services. As part of this transformation programme ward 6 was identified as an area for review. The outcome of this project is detailed within this pre-consultation business case (PCBC).

Although the scope of the project relates to the current ward 6 at Bishop Auckland Hospital (BAH) the work also took into account the wider strategy on bed utilisation and the development of community based services.

The aim of the project focused on the current utilisation of ward 6 against national and local best practice and clinical standards. Patients (and their families) who have been cared for on ward 6 in the last two years were asked about their experiences and had an opportunity to feedback on any areas for development. County Durham Healthwatch led this engagement work on behalf of the CCGs and Trust.

Ward 6 is currently a 24-bedded, nurse-led step down facility based in BAH with no therapy/rehabilitation support.

The review was clinically led and as a result there were four options which were agreed for consideration. An options appraisal process was undertaken with standardised criteria used to score each option against. Again this was a clinically led process.

The outcome of this appraisal was the determination that the preferred option was to change the functionality of the current ward 6 into a dedicated rehabilitation facility and to relocate this elsewhere within BAH to ensure effective use of resources. Specifically it is proposed that ward 6 would relocate to be adjacent to ward 16 (so in effect be ward 17) to ensure therapy resource could be further strengthened and used across the two wards. Ward 17 is currently not used as an inpatient facility.

Further to this, following extensive service improvement work within CDDFT, the service is confident that the capacity available could be reduced by eight beds as patients would be more effectively managed and discharged. This recommendation is a result of the implementation of a range of ongoing initiatives within the acute setting to manage patient flow and use the most appropriate care setting to manage people's conditions.

A new model for community services was introduced in 2018 which strives to deliver more care closer to home. The proposed model of care outlined within this business case for inpatient rehabilitation takes account and is aligned to the ethos of #homefirst (in County Durham, with the intention of rolling out in Darlington also) and care closer to home.

The following PCBC outlines the current services delivered, the gaps against best practice and national clinical standards. The review details the options appraisal process and the preferred option to be put forward for formal consultation. The final section of the PCBC demonstrates the potential impact of implementing the preferred model and how the local system would know if the change had made a positive impact on patient care.

2.0 Vision

Our vision and commitment is:

- To develop a person-centred model of care that delivers care closer to home
- To minimise variation and maximise the health outcomes of our local population
- To ensure that patients (and their families) achieve their rehabilitation goals in conducive environments staffed by multi-disciplinary teams
- To ensure care is accessible and responsive to people's needs
- To ensure timely and supportive discharge is achieved consistently

2.1 Scope

To present a robust evidence based business case to review the model of care for inpatient rehabilitation across County Durham and Darlington, with a particular focus on ward 6 at BAH.

The scope of this project relates to ward 6 at BAH which is a 24 bedded, nurse-led unit which currently delivers step down care. The service has no therapy input and is therefore not a rehabilitation facility. Although the project is specifically reviewing this ward at BAH, this is set within the context of the wider local health system and the ongoing work programmes aimed at ensuring care is delivered closer to home and hospital usage is optimised.

2.2 Aims and Objectives

To present a robust evidence based business case, which describes the model of inpatient rehabilitation care for the population of County Durham and Darlington, with a particular focus on rehabilitation care at Ward 6 BAH.

- To review the current usage of rehabilitation beds across County Durham and Darlington
- To understand the effectiveness of care provided currently and to review appropriateness in line with new community based services
- To engage with patients and carers who have used services within Ward 6 at BAH to gain an understanding of their experiences and their views on a different approach to their care
- To outline for the future provision of rehabilitation inpatient care with a specific focus on Ward 6 at BAH
- To outline a preferred option for a new model of care which assesses impact on the system and individual patient care

3.0 Background and Introduction

Ward 6 is currently a 24-bedded, nurse-led step down facility based in BAH with no therapy/rehabilitation support. The ward currently accepts patients who are:

- orthopaedic non-weight bearing patients, irrespective of post code
- Medically fit and stable or patients that require step-down nursing support, patients that are unable to be discharged home
- patients requiring complex discharge planning and who are then inpatients awaiting a Decision Support Tool
- patients deemed to be homeless who don't require health care

The CCGs and Trust are working in partnership to understand the current use of ward 6 at BAH, the review of this service has highlighted that patients on this ward could have been potentially cared for in a more optimal way. There is a concern that following a review of best practice and up to date clinical standards that rehabilitation is not being delivered to this cohort of patients.

As a local health system we believe that people should be given the opportunity to achieve their rehabilitation goals within environments that are conducive to recovery. Section 3.2 describes what good rehabilitation looks like and the current model of care in this instance does not deliver against this set of standards.

There have been a number of improvement projects which have been implemented over recent years to ensure that our local population receives care that is appropriate, timely and where possible delivered closer to home. As part of this longer term vision a new community contract was put in place in 2018. CCGs and CDDFT have a major emphasis on community services focusing on;

- Prevention and maintaining independence
- Supporting patients with long term conditions
- Managing crisis and supporting a return to independence

Since the contract was awarded in 2018 the CCGs and provider (CDDFT) are working together on a period of transformation. Reviewing services to ensure they meet best practice and clinical standards. The review of ward 6 sits within the wider context of this work ensuring that community bed provision is utilised to best effect and in line with the care closer to home agenda.

It is important to ensure that people are cared for in the most appropriate setting whether that be in an inpatient or community setting. Unnecessary lengthy stays in a hospital bed is not good for patients; this is due to contributing factors of sleep deprivation, increased risk of falls and fracture and risk of catching healthcare inquired infections.

The "home first" mindset across health and social care systems is more than good practice it is the right thing to do. When patients are medically optimised they should be supported to return to their own home / place of residence.¹ Health and social care professionals should work together to do everything possible to

¹ National Service Framework for NHS continuing health care and NHS funded nursing care)
www.gov.uk

discharge the patient home, especially older people so they can enjoy their lives in their home environments.

For those patients who require inpatient based rehabilitation it is important to ensure that care is delivered where possible closer to home and in the most appropriate setting. The health and care system understands that there is a potential need for robust inpatient rehabilitation services however we need to ensure best use of this resource. Within County Durham there are a range of community hospitals available for use from County Durham and Darlington residents. Figure seven outlines the current usage of those facilities.

Bed provision needs to be aligned with the community services model of care with robust criteria for referrals and discharge. Whilst people are in these settings, care needs to be planned and managed effectively to ensure people achieve their optimum rehabilitation goals.

A review of the current arrangements for inpatient rehabilitation care is a key initiative for CDDFT and CCGs to be compliant with national and best practice rehabilitation care. In consideration of the PCBC, the following key points should be taken into account;

- Integrated Care Partnership (ICP)/Integrated Care System (ICS) Alignment
- CCG strategic aims
- Local and National Evidence
- Best use of public funds
- Care closer to home
- Reducing length of stay in acute NHS beds
- NHS Long Term Plan

3.1 Demographics and Prevalence

County Durham and Darlington have an ageing population, the Joint Strategic Needs Assessment (JSNA) 2015 estimates the overall population of County Durham is projected to grow by 4.2% between 2014 and 2024. This projected growth is higher than the growth expected in the North East (2.5%), but lower than in England (7.2%).

The number of people aged 65 and over has increased by 26.4% between 2001 and 2015. This increase in the county was higher than that across the region (19.1%) and nationally (23.9%). By 2024 the number of people aged 65 will increase by 19.3% and by 47.5% by 2039. ²

In the period 2004 to 2014 the population of Darlington has increased to 105,396, an increase of 6.1% which uses ONS mid-year estimates for this period. The number of people aged 65 and over is expected to increase from 21,000 in 2016 to 24,000 in 2025, which is an increase of 12.5%. The life expectancy for males and females is also lower than the national average.

The increase in the older population creates a demand for services, requiring organisations to focus on managing demand and prevention, therefore a change to

² County Durham Joint Strategic Needs Assessment
County Durham Council
www.durham.gov.uk

the model of rehabilitation care delivered is a priority for County Durham and Darlington NHS Foundation Trust (CDDFT) and County Durham and Darlington Clinical Commissioning Groups (CCGs) in order to meet patients' needs and be compliant with national evidence and best practice.

3.2 National Context and Evidence Base

The World Health Organisation³ states that rehabilitation intervention should be aimed at achieving the following broad objectives:

- Preventing the loss of function
- Slowing the rate of loss of function
- Improving or restoring function
- Compensating for lost function

Rehabilitation is a philosophy of care that focuses on the impact of health conditions on a person's life to maximise their potential and independence. It helps ensure people are included in their communities, employment and education rather than feeling isolated from the mainstream and pushed through a system with ever-dwindling hopes of leading a fulfilling life.

It is increasingly acknowledged that effective rehabilitation delivers better outcomes and improved quality of life and has the potential to reduce health inequalities and make significant cost savings across the health and care system.⁴ There is strong evidence that people see rehabilitation as vital; this was highlighted during NHS England's stakeholder engagement project to determine "what good looks like" from an individual's perspective, which led to the development of the document *Rehabilitation is Everyone's Business: Principles and Expectations for Good Adult Rehabilitation*.⁵

The 10 principles of good rehabilitation services:

1. Optimise physical, mental and social wellbeing and have a close working partnership with people to support their needs
2. Recognise people and those who are important to them, including carers, as a critical part of the interdisciplinary team
3. Instil hope, support ambition and balance risk to maximise outcome and independence
4. Use an individualised, goal-based approach, informed by evidence and best practice which focuses on people's role in society
5. Require early and ongoing assessment and identification of rehabilitation needs to support timely planning and interventions to improve outcomes and ensure seamless transition
6. Support self-management through education and information to maintain health and wellbeing to achieve maximum potential
7. Make use of a wide variety of new and established interventions to improve outcomes e.g. exercise, technology, Cognitive Behavioural Therapy

³ World Health Organisation (2012)
Concept paper: WHO guidelines on health-related rehabilitation (Rehabilitation Guidelines)
http://www.who.int/disabilities/media/news/2014/15_01/en

⁴ NHS England: Commissioning Guidance for Rehabilitation (2016)
www.nhs.uk

⁵ Rehabilitation is everyone's business: Principles and expectations for good adult rehabilitation NHS (2014)
Wessex Strategic Clinical Networks.
www.networks.nhs.uk/nhs-networks/clinical-commissioning-community/improving-adult-rehabilitation-services/principles-expectation

8. Deliver efficient and effective rehabilitation using integrated multi-agency pathways including, where appropriate, seven days a week
9. Have strong leadership and accountability at all levels – with effective communication
10. Share good practice, collect data and contribute to the evidence base by undertaking evaluation/audit/research

These expectations and principles reflect the aims of a future health and care system and are drawn directly from the comments of service users and are underpinned by peer-reviewed evidence.^{6 7}

County Durham and Darlington Commissioners have reviewed the current provision of rehabilitation services using the NHS England “ten top tips for commissioning local rehabilitation services” guidance. In the case of ward 6 the review has highlighted that although rehabilitation should be provided for this cohort of patients it currently isn’t due to the lack of therapy provision.

National best practice suggests that people should be actively supported in their discharge at the earliest opportunity and indeed where possible patients should be “discharged to assess”. Implementing a ‘discharge to assess’ or ‘home first’ model is more than good practice, it is the right thing to do (NHS England Quick Guide to Discharge to Assess / Publications Gateway Reference 05871 2015).

Where appropriate, people should be assessed for their needs once in their “usual place of residence”. Assessments would be carried out by a trusted assessor in the patient’s own home to understand better their needs and to plan longer term care. People should be supported to return to their home for assessment of longer-term care and support needs (NICE guideline, Transition between hospital settings and community or care home settings for adults with social care needs 2015.)

There needs to be the ability to meet the needs of individuals and there needs to be a standardised approach to the provision of care such that it is not influenced by where a patient lives.

The Long Term Plan (LTP) sets out the ambition of having more intensive community based rehabilitation in place in order to reduce length of stay and hospital admissions in order to plough any cost efficiencies to improving direct patient care.

⁶ The Five Year Forward View
NHS England (2014)
www.england.nhs.uk/

⁷ Hard truths: The journey to putting patients first Vol 2
Department of Health (2014)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/270103/35810_Cm_8777_Vol_2_accessible_v0.2.pdf

4.0 Local Context

There are three CCGs leading this review across County Durham and Darlington, they are North Durham, Durham Dales, Easington and Sedgfield (DDES) and Darlington. The main provider for both acute and community services is County Durham and Darlington NHS Foundation Trust (CDDFT) who are key partners/experts in this review. They operate out of three main sites with a range of community hospitals and services delivered in local settings.

	Acute Sites	Community Hospitals
County Durham and Darlington NHS Foundation Trust	University Hospital of North Durham	Chester-le-Street Hospital
	Bishop Auckland Hospital	Shotley Bridge Hospital
	Darlington Memorial Hospital	Sedgfield Hospital
		Weardale Hospital
		Richardson Hospital

The overall population of County Durham and Darlington is just less than 650,000.



Figure 1 – geography of three CCGs within County Durham and Darlington

There is an opportunity to improve both the quality and efficiency of the care we commission and provide. If we are to have safe, sustainable services that are set up to facilitate greater advances in care and outcomes we need to address three key factors:

- Changing patterns of need;
- Improving clinical standards of care;
- Making the best use of an expert workforce

A change to the model of delivery for rehabilitation care is a key initiative for Commissioners and CDDFT and supports the #Next Step Home agenda. In line with CCG strategic aims and priorities, the revised model will:

Manage resources effectively - through reducing lengthy stays within an inpatient setting providing better value for money for the health system and workforce efficiencies.

Invest in primary care and community services – provide a standard, equitable and appropriate rehabilitation pathway.

Secure the right services in the right place - the model will ensure patients are treated in the right place, at the right time, by the right clinician.

Make services more accessible and responsive to the needs of our communities – the model will be accessible for our local population.

Any service review outcomes need to contribute towards CCG priorities to provide high quality care closer to home.

CDDFT has been involved with a series of hospital-based improvement programmes including SAFER and PJ Paralysis. Both of these transformation programmes focus on the time spent during an acute episode ensures the benefits of hospital based care are maximised and that patients have a focus of recovery.

SAFER is a tool used to aid patient flow – that is the transition of care within a system, from the time a patient enters the hospital to the point at which they are discharged. The toolkit is designed to reduce unwarranted variation and to ensure care is delivered in a seamless way. The key elements of SAFER include

- Patients receiving a senior review before midday to ensure robust decision making and action
- All patients will have an expected discharge date at the earliest point in their care episode
- Early (supported) discharge will be delivered
- Where patients are in hospital longer than 7 days, a multi-disciplinary team will review patients with a clear 'home first' mindset

PJ Paralysis (figure two) is an initiative aimed at getting patients out of bed and into a chair with their own clothes on wherever possible. This is proven to aid recovery, reduce length of stay, promote wellbeing and enable people to feel dignified. Staff on all wards throughout CDDFT were engaged in this work to ensure patients have the opportunity to gain the best possible outcomes from their care in hospital and to be discharged home at the earliest point.

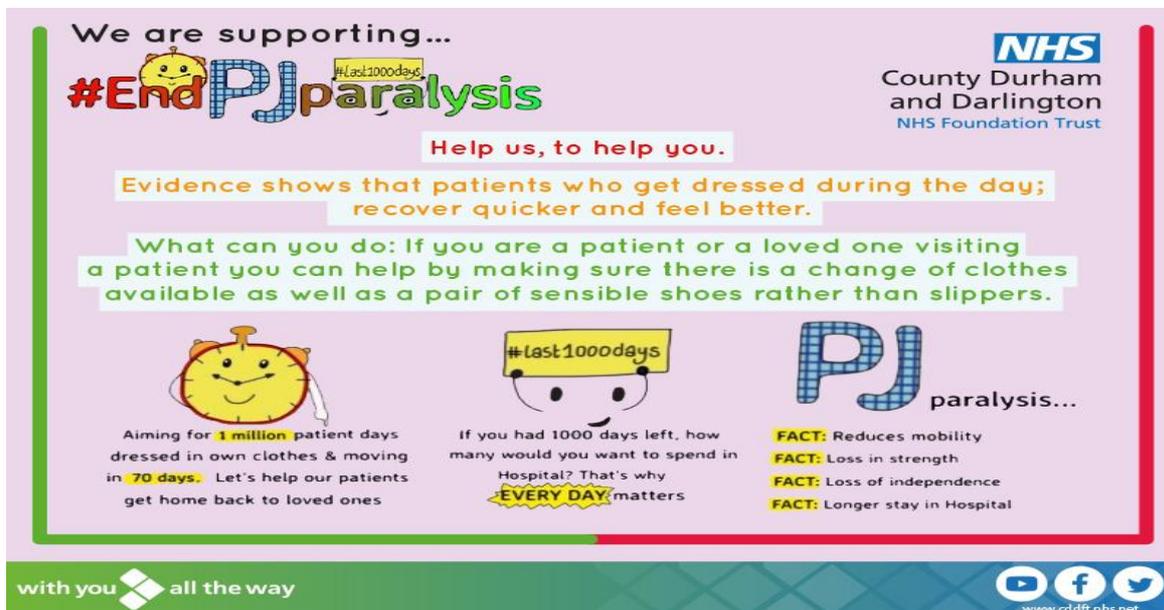


Figure 2 – PJ Paralysis campaign

4.1 Quality and Performance

Figure three demonstrates there has been a reduction in Length of Stay (LoS) over the two year time period; however figure four shows there has been a higher rate of admissions over all.

As the data shows the main cohort of patients are over the age of 65 and although admissions have increased there is also a larger number accessing community care as part of their care pathway (408 referrals into community care in 2017/18 compared to 732 in 2018/19) and LoS has reduced to accommodate this greater flow of patients.

Bed occupancy rates have also decreased although it must be noted that a proportion of that reduction can be attributed to the inclusion of escalation beds in the total figures. However the system recognises that overall the bed occupancy has reduced over time and there is an opportunity to review how resources are being utilised to best effect.

	2017/18	2018/19
Average LOS	22.12	12.34
Bed occupancy	95.25%	79.43%

Figure 3 total average LoS and bed occupancy on ward 6 at BAH

Range	2017/18	2018/19
15-19	1	
20-24		1
30-34	1	1
35-39	3	
40-44	1	3
45-49	10	6
50-54	10	14
55-59	10	13
60-64	24	30
65-69	28	31
70-74	35	71
75-79	58	86
80-84	73	118
85+	137	219
	391	593

Figure 4 admissions onto ward 6 BAH by age range (2017/18 and 2018/19)

Figure five shows LoS by locality. There has been significant progress made in terms of integrated working with the local authorities within County Durham and Darlington which has had a positive impact on LoS. Included in this is the aim to manage non-weight bearing (NWB) patients in a non-hospital setting. This is another example of where the system is working to ensure only those who need it are seen in a hospital setting, freeing up capacity to manage those who need it most.

Further work is required with Local Authorities and other partners outside of the area to replicate this good practice in terms of timely discharge and seamless transition into the community. There are plans in place to develop this, to ensure that people receive the same level of care and access to pathways. The implementation of the new community contract places an emphasis on prevention.

The data suggests that 81% of all admissions (2018/19) were as a result of an emergency attendance via the Emergency Department at one of the acute hospitals. It is anticipated that more is being done in recent years to prevent the more frail and elderly population from being admitted into hospital by proactive management in the community. The transformation of community services over the last year will hopefully demonstrate the management of this vulnerable population cohort and will reflect in the coming years' worth of data.

Ward Hospital	2018/19			
	DDES	Dton	Durham	Other
B06	12.22	11.77	12.56	14.42

Figure 5 Average LoS on ward 6 at BAH (2018/19)

Figure six shows the increase in admissions year on year by locality. Only 20% of the increase is from the Durham Dales area, the immediate catchment area for BAH. Looking at the information it shows that many people are admitted to ward 6 from outside of the BAH vicinity and therefore there is an opportunity to understand

if people could be managed within a community hospital closer to home. See section 12 for further details.

Locality	Sum of 2017/18	Sum of 2018/19	change year on year	% change	% of increase by area
Chester le Street	24	37	13	54%	6%
Dales	105	147	42	40%	21%
Darlington	66	100	34	52%	17%
Derwentside	28	50	22	79%	11%
Durham	62	90	28	45%	14%
Easington	4	10	6	150%	3%
HRW	4	12	8	200%	4%
M'boro	1	1	0	0%	0%
OOA	3	5	2	67%	1%
Sedgefield	91	135	44	48%	22%
Sunderland	2	6	4	200%	2%
(blank)	1	0	-1	-100%	0%
Grand Total	391	593	202	52%	100%

Figure 6 change in admissions year on year by locality

Figure seven shows the current use of community hospitals across County Durham and Darlington, as highlighted there is scope to use these more in any future model of care.

Admitting Hospital	2018/19					
	Easington	Durham Dales	Sedgefield	Dton	Durham	Other
Weardale	2	209	26	20	87	2
Sedgefield	61	57	233	104	87	15
Richardson	1	291	58	216	8	32
Shotley Bridge	15	67	9	5	2294	81
Chester le Street	2	2	3		36	4
B16	2	20	21	9	19	3

Figure 7 current admissions into community hospitals by locality

5.0 Patient Experience and Feedback

CCGs and provider organisations have a duty to engage and consult on any potential major service change as described within the NHS Act 2006.⁸

As part of the review an initial patient experience exercise was undertaken by CDDFT with the patients residing on the ward during a period of time in 2018. The feedback received was, as expected, complimentary in terms of the quality of nursing care provided.

A further engagement exercise was commissioned by the CCGs and CDDFT in early 2019. County Durham Healthwatch agreed to capture the views of the patients and their families residing on the ward during May and June 2019. They

⁸ NHS Act 2006
www.legislation.gov.uk

also, with help from CDDFT were able to contact patients (and their families) who had been in the care of ward 6 at some point over a two year period.

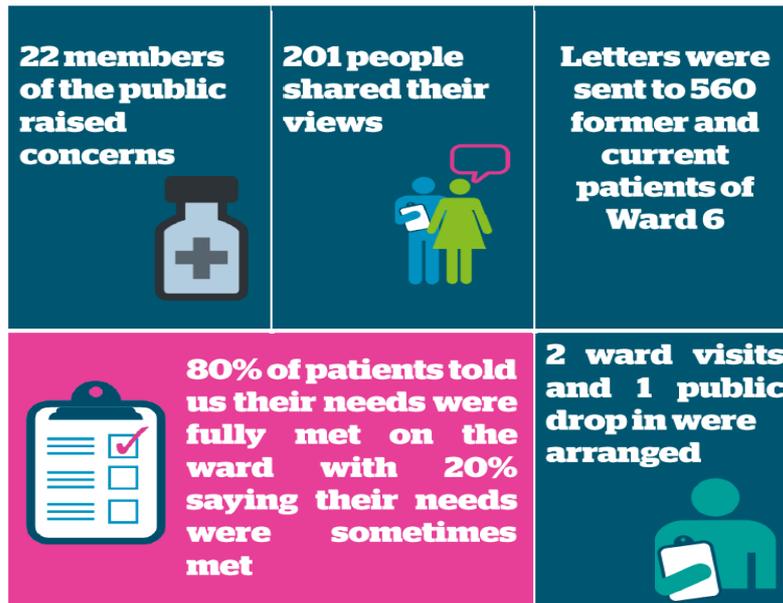


Figure 8 Overview of patient and carer engagement activity

The report from County Durham Healthwatch is available in appendix one, however some of the key characteristics included:

- 49% of respondents were transferred from UHND
- 45% of respondents were transferred from DMH
- 6% of respondents were transferred from another ward at BAH
- The majority of those surveyed (70%) returned to their usual place of residence

The key recommendations from the report included:

- The need to retain step down facilities, particularly for those more complex discharges. In particular it was felt that patients (and their families) needed to be supported through this discharge process and involved in any decision making.
- Therapeutic intervention should be offered (where appropriate) to all both within an inpatient and community setting
- To continue delivering holistic support - to coordinate support from a number of sources including families, charities and health and social care agencies
- The review needs to take into account the extended length of time some patients are staying on the ward to see if there are steps they could take to reduce this, where appropriate
- Using the comments made by patients completing the survey to help shape future services

6.0 Staff Engagement

Staff and wider stakeholder engagement has taken place with clinical and non-clinical staff throughout this review process, to gain their ideas and suggestions for improved models of care. This engagement was supported by a Human Resources (HR) Process.

We have had ongoing dialogue with teams across health and social care to understand the challenges faced and working with them to understand how inpatient services could be maximised and improved for patients and their families.

During November 2018, staff from ward 6 and the wider system were involved in reviewing patient scenarios – real life examples of patient journeys which involved a care episode on ward 6 at BAH. The attendees analysed by the workshop teams, with a view to determining the best possible pathway, which included;

- Identifying care needs
- Patient /carer expectations and process issues impacting length of stay
- What could have been done differently to improve the patient pathway
- Highlighting any issues/barriers that may need addressing

The highly skilled staff have been using their knowledge and expertise to outline where within the current service there maybe some gaps in terms of achieving the very best possible clinical outcomes. We have listened and involved them throughout this process (see options appraisal process section nine) and will continue to communicate and engage as we continue with this project.

7.0 Current State

Ward 6 at BAH provides nurse-led step down care with 24 beds, it was initially set up nine years ago for stranded patients aged 18 years and over. Stranded patients are those deemed to be both medically and therapy fit with a hospital stay of over seven days. Super stranded patients have a length of stay of 20+ days.

The ward has evolved over time to include non-weight bearing patients, homeless people, patients with complex care needs and those waiting for packages of care or social work assessment. The ward is managed by Advanced Nurse Practitioners with limited or no access to therapy teams. No dedicated rehabilitation support is available.

Figure nine shows where people who access ward 6 have been transferred from during 2018/19. The majority of people are being transferred from University Hospital North Durham (UHND) and Darlington Memorial hospital (DMH).

Once on ward 6 the average length of stay in 2017/18 was 22.12 days, due to the ongoing transformation work within the Trust this decreased to 12.34 days during 2018/19. More detailed information is available in section 4.1.

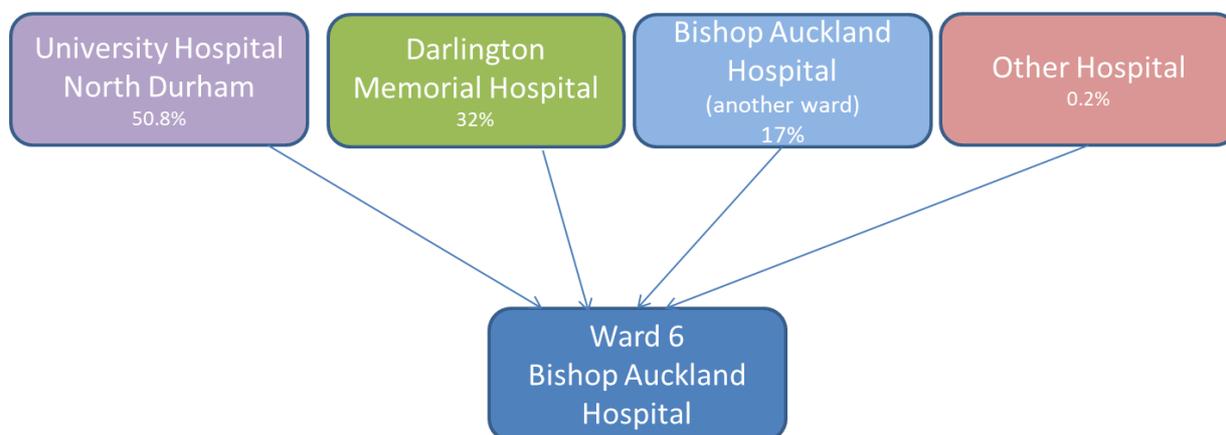


Figure 9

CDDFT Strategy ‘Our Patients Matter’ sets out the purpose to provide safe, compassionate and joined-up care to the local populations with the aim of achieving the vision – to get care right, first time, every time for all of our patients.

In striving to deliver the safest, quality care for patients, the CCGs and Trust have reviewed the services provided for the groups of patients who have been transferred to Ward 6 to ensure they have received the ‘right care’ in the ‘right place’ by the ‘right person’ and that it was the best possible care that it could be comparing to national evidence and best practice.

Patients appear to be inappropriately transferred to Ward 6 due to acute bed pressures and often holistic considerations of patient’s needs are not always a priority. With robust discharge planning, proactive management and timely consideration, “home first” could have better patient outcomes.

Figure ten demonstrates that the majority of those discharged went back to their usual place of residence (prior to admission into hospital). The work carried out with clinical staff looking at typical patient scenarios explored the opportunity of people being discharged home at an earlier point in their pathway. Systems and processes are now in place to ensure that clinicians set expected discharge dates at the point of admission in the acute ward i.e. UHND or DMH with a view to planning for that discharge at the earliest opportunity.

Discharge Destination Description	2018/19			
	DDES	Dton	Durham	Other
Usual Place Of Residence	158	41	83	8
Temporary Place Of Residence	23	13	26	2
Nhs Provider (General/Young Phys. Disab)	11	4	1	2
Nhs Provider (Mentally Ill/Learning Dis)			1	
Nhs Nursing/Residential Care/Group Home	1	3	8	
Local Authority Part 3 Residential Accom				
Not Applicable - Patient Died/Stillbirth	17	5	9	
Non-Nhs Residential Care Home (Not La)	28	20	10	3
Non-Nhs Nursing Home (Not La)	54	14	39	9

Figure 10

The points of interest raised with the current model will be explored further in the business case within the options appraisal and preferred options sections (nine and ten).

In Darlington, there are two week step down nursing beds for those who require 24 hour nursing, but are awaiting a complex package of care to be established, or DST to be undertaken are commissioned. There is an opportunity for this commissioned facility to be further utilised.

Rehabilitation provision in the community in Darlington is delivered via RIACT which is made up of a workforce which supports falls, stroke/neuro rehab and domiciliary rehab services including crisis response 8am-8pm, 7 days a week.

The service is made up of the following roles and WTE:

Role	WTE
Community Charge Nurse	1
Community Staff Nurse	4.5 (2 of these people are due to come into post) (3 of these roles rotate with DNs)
Associate Practitioner	3.8
Care and Support Worker	4.34
Clinical Lead Physiotherapist	0.56
Specialist Physiotherapist	2.2
Physiotherapist	1.45
Occupational Therapist	1
Specialist Occupational Therapist	1.45 (1 of these people are due to come into post)
Total	20.3

Figure 11

Overall activity for RIACT is as follows and demonstrates a 9% increase in referrals between 2017/18, and if activity continues as is in year, will see a further increase of at least 2% by the end of 2019.

	Total referrals to RIACT
2017	3302
2018	3605
2019 (upto 4th July 2019)	1837

Figure 12

The service acts as the first point of contact for RIACT and reablement service (DBC) and also manages access to the CCG fourteen commissioned rehabilitation beds also providing the rehabilitation support into these beds and additionally to those eligible for community RIACT services as part of an intermediate care model of care, for upto a period of 6 weeks.

Eligibility and exclusion criteria's for the fourteen rehabilitation beds is as follows:

Eligibility:

- Are aged 18 or over, with an identified rehabilitation need
- Do not require the involvement of a secondary care medical consultant
- Are medically optimised to be managed in the community by primary care (GP)
- Registered with a Darlington GP
- Is recovering from an acute health episode which no longer requires hospital care and can be safely managed in a rehabilitation bed
- Would benefit from a period of rehabilitation to enable onward discharge to home
- Are prepared to engage in a programme of rehabilitation
- Palliative patients with rehabilitation potential
- Cannot be supported by health domiciliary care or other community health services (continuing health care residents are excluded as the district nursing service now can commission independent sector placements/ domiciliary care)

This service will exclude the following: (not intended to be exhaustive or exclusive)

- Adults whose primary need is for specialist mental health care.
- Children under 18 years of age.
- Residents who require 24 hour nursing care.
- Residents who are not registered to a GP practice in Darlington.
- Individuals at high risk of self-harm to themselves or who may pose a risk of harm to others or who have behaviours that cannot be safely risk assessed and managed in Ventress Hall.
- People with End of Life Care needs.
- Residents who are able to be cared for in their own home.
- Residents where the sole reason for admitting is dementia or deterioration in Cognitive functioning. (Physical Care needs must outweigh any mental health needs and must be the primary reason for admission. Increasing confusion due to a physical problem should not be excluded.)
- Carer crisis - these residents should be referred to Social Services
- Residents who require medical intervention other than that which can be provided by a GP/community services.
- Residents who are unable to participate in a rehabilitation programme due to an acute state of confusion such as delusion.
- Residents who refuse to engage in a rehabilitation programme

Capacity and Demand for current bed based rehabilitation beds is highlighted below and demonstrates that the usage is consistently in the region of 80% which means that the beds are not being used to capacity. However, in 2018/19 there is a pattern emerging of increased breaches, identifying a challenge in either discharging people from services in a timely manner, or being able to meet the needs of those within the service to meet their rehab potential within the allotted six weeks as part of the current intermediate care service:

Figure 13

	Total Number of Admissions	Percentage Occupancy (Average)	Number of Breaches (exceeding 6 weeks stay)
2017/18	211	83%	0
2018/19	190 ¹	81% ²	19

¹ March Admission figures for Eastbourne were not provided and are not included.

² Excludes March 2019 as Eastbourne LOS information was not provided.

8.0 Case for Change

The current model of inpatient rehabilitation care is not standardised and is not always compliant with national evidence and best practice. The current model is not fit for purpose to address the needs of the local population; services are often developed based around estate as opposed to the demand required. Patients residing in inpatient based rehabilitation care have considerable therapy and social needs, resulting in long length of stays.

As described earlier we know that it is best for patients to be discharged home at the earliest opportunity to maximise their rehabilitation goals. Another consequence of prolonged length of stay is the impact on financial resource and the best use of public money and inappropriate use of limited inpatient facilities and skilled workforce.

Ward 6 currently accepts patients who are;

- Orthopaedic non-weight bearing
- Medically fit and stable
- Requiring step-down nursing support
- Unable to be discharged home for example where a change in package of care is required
- Requiring complex discharge planning awaiting a Decision Support Tool (DST)
- Deemed to be homeless who don't require healthcare

CDDFT has drawn upon national recommendations and best practice to carry out quality improvement initiatives over the last year which has been enhanced by the evolving work of the Teams Around Patients (TAPs) through the community contract and has seen an increase in the number of patients receiving appropriate care as detailed below:

- An increase of Non weight bearing patients being supported at home with temporary home modifications and the utilisation of therapy support The patient's rehabilitation is expedited in their own home. If the patient does require inpatient care then they are supported at a facility close to their home.
- Implementing the SAFER⁹ bundle, has enabled earlier discharge planning which has reduced the number of medically fit and stable patients being transferred to Ward 6. Now they are supported by the local authorities and partner agencies to return to their home by implementing enhanced care packages, where required.
- Using the Discharge to Assess methodology and "home first" philosophy more in-patients waiting for a Decision Support Tool (DST) are supported with involvement of Trusted Assessors to return home while these discussions take place.
- The use of The Homelessness Reduction Act, 2017- Duty to Refer Guidance 2018 is helping to ensure that services are working together effectively to prevent homelessness by ensuring that peoples' housing needs are considered when they come into contact with public authorities.¹⁰
- A Non-Weight Bearing four month pilot was commissioned from February 2019 – June 2019 by County Durham Local Authority, 10 beds were commissioned from two residential care homes on a "Time to Heal" basis to avoid potential lengthy hospital stays. The pilot proved to be a useful exercise with valuable learning. Although activity was lower than expected. It was thought this was due to CDDFT becoming more adept to move non-weight bearing patients into community settings with appropriate support from partner agencies. There is a plan to explore whether this model could be rolled out further.

There is much evidence to support the need for appropriate rehabilitation services for the local population, it is widely recognised that longer stays in hospital can lead to worse health outcomes and can increase care needs. One week in bed equates to 10% loss of strength and in an older person that 10% can make the difference between dependence and independence.¹¹

Appropriate rehabilitation services:

- Focus on good outcomes for patients, driven by the goals patients set increasing patient independence
- Centred around patients' needs, not their diagnosis
- Relies upon multidisciplinary team working
- Deliver cost savings, by unnecessary bed occupancy
- Increase collaborative working between social care, secondary care and community care to provide a safe sustainable service

⁹ Emergency Care Improvement Programme
The SAFER Patient Flow Bundle
NHS Improvement
<https://improvement.nhs.uk/documents/633/the-safer-patient-flow-bundle.pdf>

¹⁰ Homelessness: duty to refer

www.gov.uk

¹¹ Functional Impact of 10 Days of Bed Rest in
Healthy Older Adults
The Gerontological Society of America 2008
www.bgs.org.uk/blog/

8.1 Workforce challenges

Within the current service there is no therapy input onto ward 6. The service is nurse-led with senior clinical leadership from Advanced Nurse Practitioners (ANPs).

CDDFT want to promote their model of care for inpatient rehabilitation and there seamless links into the community to demonstrate that it is a great place to work; to retain and attract the very best in terms of highly skilled and competent staff.

8.2 Financial challenges

- Inefficient care models are driving up costs. Insufficient focus on prevention and treating people in the wrong care setting both push up the cost of care. This is most obvious in the occupation of acute beds by patients who could have been better treated in community settings, discharged sooner, or whose admission could have been avoided in the first place.
- The cost of bank and agency staff has an impact on all services. Any initiative implemented to improve the recruitment and retention of staff, means that limited resources can be used to provide high quality direct patient care.
- Unwarranted variation in clinical practice is increasing the cost of care, increasing opportunity cost through increased claims on clinical time, or both.
- A robust community model of care is required to prevent people requiring inpatient care. Where community services are provided seamlessly there is a timely transition from hospital to home. Inpatient beds are used where required and discharge is delivered in an efficient way.

9.0 Options Criteria and Process

A clinically led group was set up to develop options for the future model for the cohort of patients currently utilising ward 6 at BAH. Representation on the group included consultants, matron, ward sister, therapy leads, operational managers and commissioners. Alongside this the group had access throughout to the feedback received from the engagement work which was carried out by County Durham Healthwatch.

The criteria, which was used to measure options against were chosen to help ensure high quality, long term inpatient rehabilitation services are sustainable longer term for County Durham and Darlington.

Clinical quality	Maintains or improves clinical outcomes; timely and appropriate services; minimises clinical risk	Patient, Public and carer Engagement – Experience and Feedback
Sustainability/flexibility	Ability to meet current and future demands in activity; ability to respond to local/regional/national service changes	
Equity of access	Reasonable access for urban and rural populations	
Efficiency	Delivers patient pathways that are evidence based; supports the delivery though access to resources	
Workforce	Provides environments which support the recruitment/retention of staff; supports clinical staffing arrangements	
Functional suitability	Provides environments suitable for delivery of care; clinical adjacencies with other relevant services/dependencies e.g. imaging	
Acceptability	Acceptable to service users, carers, relatives, other significant partners	
Cost effectiveness	Provides value for money	

Figure 14 options appraisal criteria

Each option was assessed against the range of criteria identified by the multi-disciplinary group with supporting information used from the patient engagement exercise carried out.

9.1 Options Appraisal

The table below (figure 15) outlines the options that were assessed. On this basis there are four options to consider, one of which includes continuing to deliver the current model of service.

Option	Description
1	Do nothing and remain as is
2	Re-purpose into an inpatient rehabilitation ward with a reduction of eight beds – co-locate with ward 16
3	Re-purposing ward 6 facility as a care home model
4	Close all ward 6 beds

Figure 15 Options for future service delivery

The options appraisal process was undertaken and each option was assessed against the criteria and given a score out of 10 for each component. The table below summarises some of the key points raised and outlines the scores for each element.

Option one – do nothing

Criteria	Score (out of 10)	Narrative
Clinical quality	5	<ul style="list-style-type: none"> Ward is currently utilised by those deemed medically fit There are more appropriate uses for the inpatient provision The quality of nursing care provided is extremely good
Sustainability/flexibility	5	<ul style="list-style-type: none"> The ward currently manages people who could be managed in the community There is a need to flex the beds to ensure they meet the needs of the local population The ward does provide additional capacity at times of high demand
Equity of access	5	<ul style="list-style-type: none"> People from across County Durham and Darlington as well as out of area utilise the ward BAH is closer for those who live in the South of County Durham and Darlington

Criteria	Score (out of 10)	Narrative
Efficiency	4	<ul style="list-style-type: none"> The inpatient facility is not efficient in terms of managing patients to a point of discharge due to the model of care available, mainly due to lack of therapies Increased length of stay, which could be improved by more effective discharge processes and community provision
Workforce	6	<ul style="list-style-type: none"> Seen as stand-alone unit in terms of pathways and interfaces
Functional suitability	7	<ul style="list-style-type: none"> BAH provides a suitable environment to deliver care Unable to access therapy input in current location due to limited resource
Acceptability	8	<ul style="list-style-type: none"> The level of care experienced by patients and their families is good overall People in the south of the county and in Darlington benefit from the location
Cost effectiveness	3	<ul style="list-style-type: none"> Current model is not cost effective Resource could be better utilised to provide rehabilitation offer
Total	43	

Option two - Re-purpose into an inpatient rehabilitation ward with a reduction of eight beds – co-locate with ward 16

Criteria	Score (out of 10)	Narrative
Clinical quality	7	<ul style="list-style-type: none"> • Criteria for these beds would need to be developed • Rehab service with therapy input to promote rehabilitation • The quality of nursing care provided would be retained
Sustainability/flexibility	7	<ul style="list-style-type: none"> • The ward could provide additional capacity at times of high demand • Model with fit with new ways of working re: bed optimisation and community services
Equity of access	9	<ul style="list-style-type: none"> • Support in the community • LoS will be reduced so access issues will be limited • Use of all inpatient rehabilitation beds can be utilised to deliver care closer to home
Efficiency	8	<ul style="list-style-type: none"> • Opportunity to use optimum number of beds to ensure rehab input is provided for those who need it • Co-location of ward 17 to make best use of therapy provision
Workforce	8	<ul style="list-style-type: none"> • Using economies of scale of existing therapy provision to deliver • Therapy input required at this stage would be based upon <ul style="list-style-type: none"> ○ Physiotherapy – 5 days a week ○ Occupational Therapy – 5 days a week ○ SALT and dietetics according to need
Functional suitability	7	<ul style="list-style-type: none"> • There are appropriate number of beds and facilities available on ward 17
Acceptability	7	<ul style="list-style-type: none"> • Resources will be re-purposed to ensure a more sustainable model is in place • The level of care experienced by patients and their families is good overall • A slight reduction in beds may create concern, however the PCBC demonstrates better use of resource
Cost effectiveness	8	<ul style="list-style-type: none"> • Better use of resources to manage the demand • Changes to bed configuration will result in therapy input to inpatients
Total	61	

Option three – Re-purposing ward 6 facility as a care home model

Criteria	Score (out of 10)	Narrative
Clinical quality	3	<ul style="list-style-type: none"> Criteria for patients accessing this would need to be developed in line with service model Ratio of nursing staff per patient will be reduced
Sustainability/flexibility	3	<ul style="list-style-type: none"> Flexibility to use when system in high demand Sustainability risk re workforce retainment
Equity of access	3	<ul style="list-style-type: none"> The model could be offered to all in the CDD area Travel implications for those out of the Bishop Auckland vicinity i.e. family
Efficiency	4	<ul style="list-style-type: none"> Efficient in terms of staff costs Low efficiency in relation to cost of facilities
Workforce	4	<ul style="list-style-type: none"> Working on a care home based staffing model Potential ratio of: <ul style="list-style-type: none"> 1 qualified nurse (band 5/6) per 24 beds 1 HCA per eight beds Local GPs would be aligned to ward (used as and when required) Potential to require band 7/8a Monday-Friday to manage Existing community infrastructure i.e. district nursing would be utilised NHS staff would not want to work within this model Risk of de-skilling
Functional suitability	4	<ul style="list-style-type: none"> Retaining all 26 beds on ward 6 Hospital facilities are used to deliver services which don't require that level of estate
Acceptability	4	<ul style="list-style-type: none"> Retaining all 24 beds on ward 6 Unacceptable use of NHS estate and workforce
Cost effectiveness	7	<ul style="list-style-type: none"> The model would be more financially viable The ongoing cost of NHS estate and equipment would be costly for the level of service provided
Total	32	

Option four - Close all ward 6 beds

Criteria	Score (out of 10)	Narrative
Clinical quality	3	<ul style="list-style-type: none"> Criteria for patients accessing this would need to be developed in line with service model Ratio of nursing staff per patient will be reduced
Sustainability/flexibility	3	<ul style="list-style-type: none"> Flexibility to use when system in high demand Sustainability risk re workforce retainment
Equity of access	3	<ul style="list-style-type: none"> The model could be offered to all in the CDD area Travel implications for those out of the Bishop Auckland vicinity i.e. family
Efficiency	4	<ul style="list-style-type: none"> Efficient in terms of staff costs Low efficiency in relation to cost of facilities
Workforce	4	<ul style="list-style-type: none"> Working on a care home based staffing model Potential ratio of: <ul style="list-style-type: none"> 1 qualified nurse (band 5/6) per 24 beds 1 HCA per eight beds Local GPs would be aligned to ward (used as and when required) Potential to require band 7/8a Monday-Friday to manage Existing community infrastructure i.e. district nursing would be utilised NHS staff would not want to work within this model Risk of de-skilling
Functional suitability	4	<ul style="list-style-type: none"> Retaining all 26 beds on ward 6 Hospital facilities are used to deliver services which don't require that level of estate
Acceptability	4	<ul style="list-style-type: none"> Retaining all 24 beds on ward 6 Unacceptable use of NHS estate and workforce
Cost effectiveness	7	<ul style="list-style-type: none"> The model would be more financially viable The ongoing cost of NHS estate and equipment would be costly for the level of service provided
Total	32	

9.2 Preferred Option

Following consideration of the necessary risks and challenges for each option, option two is the preferred model, enabling this to be implemented quickly and efficiently.

The preferred model will be assessed using NHS England's four key tests in relation to major service change which is fundamental to any proposed transformation.¹²

1. Strong public and patient engagement
2. Consistency with current prospective need for patient choice
3. Clear clinical evidence base
4. Support for proposals from clinical commissioners

The preferred model will need to provide assurance against the fifth test affecting bed reconfiguration:

- 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 new workforce will be there to deliver it.
- Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions.
- Where a hospital has been using beds less efficiently than the national average, it has a credible plan to improve performance without affecting patient care for example Getting it Right First Time Programme (GIRFT)

The preferred option following the appraisal for a new model of care is to move the physical location of the ward to ward 17, co-located with ward 16.

This will be a rehabilitation facility with dedicated therapy input and nursing care. Patients will access the service following an episode on an acute or other community inpatient facility for rehabilitation. This recommendation follows a process of evaluation on a range of options based on the information available at that time. The service will deliver better care, value and quality for our local population and wider neighbouring geographical areas.

This service will be aligned to the community model of care to ensure that patients are supported in terms of their discharge and that the transition is seamless.

Currently there are 24 beds on ward 6. The preferred option would include a reduction in beds by eight so the total number which would be located on ward 17 would be 16 beds. Ward 17 is currently utilised as a paediatric dental clinic (one day a week) this would be relocated elsewhere in BAH. The reduction in beds accounts for the decreased overall length of stay and throughput of patients due to the nature of the rehabilitation available and indeed the transformation of community services to ensure people are discharged home at the most appropriate time.

The net reduction in inpatient beds is eight as compared to the current model. However there has been a review of current bed utilisation across all CDDFT estate to ensure that all acute and community bed provision is optimised and care is delivered closer to home wherever possible. The better value calculation (of 20%) is

¹² Planning, assuring and delivering service change for patients
NHS England
www.england.nhs.uk

based on innovation and improvements to productivity, of which the Trust is currently implementing several initiatives for example SAFER (explained in section four); which has been rolled out across all care of the elderly and medical wards.

CDDFT has increased the trusted assessor resource to facilitate “Discharge to Assess”, and “Assess to Admit”, along with recent improvements to internal discharge facilities to allow an increase in the daily usage of discharge lounges.

The Trust have given assurance that through these new ways of working which includes greater use of bed provision within all community hospitals as well as more smarter processes for discharge planning that the reduction of eight beds will provide the optimum level of capacity.

The service will deliver better care, value and quality for our local population and wider neighbouring geographical areas.

10.0 Benefits Realisation

What are the benefits to patients of changing ward 6 into a rehabilitation ward and ensuring care closer to home wherever possible?

The main aim of the proposal is to deliver best practice and service provision which ensures that services are delivered at the right time and in the right environment for the people of County Durham and Darlington. This includes delivering hospital based care when required with a view to ensuring patients and their families are involved and supported in their discharge back into the community.

The benefits of delivering a robust inpatient and community rehabilitation model include:

- The ethos of recovery with a focus on targeted rehabilitation
- Supporting an earlier discharge from hospital
- Delivering care closer to home in community hospitals and at home
- Providing continuity of care from hospital to home
- Delivering a more equitable service for all patients
- More integrated working with the whole health and social care system to ensure care is delivered seamlessly for patients and their families
- Ensuring patients maintain their independence wherever possible

Better use of resources

- Ensuring a multi-disciplinary team is in place with dedicated therapy input and workforce contingency
- Further integration of acute and community teams to ensure greater use of staff resource and to reduce any delays in discharge
- Dedicated therapy input would potentially reduce length of stay and therefore beds would be used in a more efficient and appropriate way
- Best practice standards for rehabilitation would be met
- A better of funding for the whole system ensuring that individuals are seen and managed in the most appropriate way
- Greater ability to ensure a reduction in delayed discharges

- A reduction in multiple handovers to clinical teams as the need for step-down beds is lessened due to improved community based provision

11.0 Risks

The associated risks with the preferred option have been reviewed and mitigations would be actioned if it was agreed to commission the proposed model of care. Figure 16 details these risks and accompanying mitigations.

Figure 16

Risks Associated with Preferred Model	
1	Risk – The inability to realise the efficiencies such as reduced length of stay to enable an investment in therapy provision
	Mitigation – Ongoing management of key quality performance indicators to ensure services continue to deliver new model of care To ensure the SAFER way of working continues to be implemented across all wards within CDDFT
2	Risk – Discharges are not managed as effectively as they could be resulting in delays
	Mitigation – To ensure that ward 6 staff are supported and involved in ongoing improvement work to ensure effective discharge management. To ensure staff on all wards (particularly acute) are supported to begin discharge planning in line with best practice at the earliest opportunity.

12.0 Testing out the Preferred Option

In addition, the PCBC seeks to demonstrate compliance with the NHS England four tests of service reconfiguration:

- strong public and patient engagement;
- appropriate availability of choice;
- clear, clinical evidence based; and
- clinical support.

What this means for patients

In terms of the current admissions into ward 6 at BAH, figure 17 shows the percentage usage by locality. From this information it is evident that admissions are fairly distributed across the area except for Easington.

Locality	% Total Admissions
North Durham	25.5%
Durham Dales	24.7%
Easington	2.65%
Sedgefield	26%
Darlington	20.7%
Other	1.6%

Figure 17 – usage of ward 6 by locality

If we break this down by postcode area it becomes clearer in terms of where patients flow into ward 6 currently.

As highlighted in figure 18 currently the main cohorts of patients utilising ward 6 are from Bishop Auckland, Darlington, Crook and Durham. What is also evident is there are people utilising these services from more widespread locations including Stanley and Consett.

Postal area	2017/18	2018/19
Unknown	1	0
Durham	32	34
Chester Le Street	26	35
Houghton Le Spring	2	9
Durham	27	58
Consett	10	24
Stanley	17	25
Darlington	31	59
Richmond	0	7
Barnard Castle	3	6
Bishop Auckland	85	83
Crook	21	55
Spennymoor	12	40
Ferryhill	21	36
Darlington	35	46
Sildon	11	23
Newton Aycliffe	47	34
Northallerton	2	1
Bedale, Hawes, Leyburn	1	2
Catterick Garrison	2	2
Newcastle Upon Tyne	1	6
Blaydon On Tyne	0	1
Sunderland	0	1
Middlesbrough	1	0
Stockton On Tees	1	0
Wingate	0	1
Trimdon Station	0	2
Middlesbrough	0	1
York	1	0
Out of Area	1	2

Figure 18 – usage of ward 6 by area

For people in postcode areas near to BAH this maybe the closest/most convenient hospital for them to use and therefore would continue to use the facility. Where patients choose to go to another community hospital closer to home, this new model of service would accommodate that. CDDFT do have a Choice Policy in place which sets out very clear expectations in terms of options available to patients following discharge from an acute site.

In terms of utilisation of other community hospital sites there are some key headlines for consideration. The information below shows that the majority percentage of people do access their local community hospital. However it identifies that there is still scope to develop processes and systems to ensure wherever possible people are managed closer to home.

- **60% of admissions into Weardale Community Hospital are from Durham Dales locality**
- **41.8% from Sedgefield and 18.7% from Darlington are admitted into Sedgefield Community Hospital**
- **48% of people from Durham Dales and 35.6% from Darlington access the Richardson hospital**
- **92.8% of admissions into Shotley Bridge Community Hospital are from North Durham patients**
- **76.5% of admissions into Chester-le-Street Community Hospital are from North Durham patients**

In terms of the proposed model of care it is envisaged that patients who need ongoing inpatient rehabilitation would be admitted onto a community hospital close to where they live where possible. It is important to recognise that ward 6 is part of a wider model of care relating to community hospitals across County Durham as well as intermediate care provision and community based care. The proposed model for inpatient rehabilitation at BAH is aligned to this wider network of care provision.

There is also work ongoing with County Durham Local Authority to manage non-weight bearing patients within a care home setting on a 'time to heal' basis. This will support the effective use of inpatient based bed provision, ensuring only those who have a clinical need are using this limited resource.

Patients admitted onto this particular ward will experience a standardised approach to inpatient rehabilitation as is in place across the Trust. This will include robust care plans with key recovery goals identified and management in place to achieve these

goals. Discharge planning will be a core function of the ward utilising the principles of SAFER to ensure high quality, effective care is given to all patients.

13.0 Proposed Future State

The CCGs and CDDFT are proposing to improve the availability of rehabilitation to those people who require inpatient based care at BAH. The ward will remain (in a slightly different location on the BAH site) with a reduction of eight beds but with a guarantee of therapy input. This proposed service change will ensure that all hospital sites have appropriate rehabilitation provision in place so that inpatient facilities are utilised effectively.

Patients' value therapy and the effect it can have on their recovery. There is strong evidence to show that skilled therapy provided at the right intensity can greatly improve outcomes. The proposed model contributes towards the CCG's priorities to provide high quality care closer to home.

13.1 Service Model

It is increasingly acknowledged that effective rehabilitation delivers better outcomes and improved quality of life and has the potential to reduce health inequalities and make significant cost savings across the health and care system.

A person-centred approach is fundamental to ensure that rehabilitation is as an active and enabling process for each individual. It ensures that support is built around a person's own circumstances and responds to the diversity of needs that will be present. This includes consideration of mental and physical health, and the relationship between these which is critical to planning effective care.

The 'Home first' model aims to stop patients being stranded on hospital ward and results in fewer people going into residential care.¹³ With all of the above in mind our focus is to ensure people are discharged home at the most appropriate point in their pathway, with a robust care plan and comprehensive community service offer.

Using the data available to us and understanding our population needs we have determined that there will be a need for inpatient based rehabilitation at BAH. Within the current model we know that the lack of therapeutic intervention is a major issue for patients and their families. Therefore we propose that the future inpatient model needs to include a multidisciplinary workforce to best meet therapy need of our population.

We propose based on the data available that we could reduce the bed base by eight beds whilst improving the level of care and rehabilitation available for patients. This would ensure that whilst patients are in an inpatient setting that they receive the best available rehabilitation to enable them to go home at an earlier stage and with a better level of functionality the programme of work regarding community based services has ensured a better more integrated delivery model to ensure that patients are seen in their own home where possible by a range of professionals to aid their recovery.

¹³ NHS England Quick Guide To Discharge to Assess / Publications Gateway Reference 05871 2015
www.nhs.uk/NHSENGLAND

13.2 Specific Measurable Outcomes

Focusing on outcomes is one way of enabling the transformational change required in the healthcare system. Outcomes need to be meaningful to people who use rehabilitation services and enable them to maximise their potential, manage their healthcare themselves and promote independence. The Government's Mandate to NHS England for 2016-17¹⁴ has an expectation that improvements will be demonstrated against the NHS Outcomes Framework¹⁵ so as to provide evidence of progress and enable comparison of services locally.

Consideration will be given to the level of outcome data to collect which demonstrates a patient centred approach and impact upon their individual rehabilitation goals.

Outcome measurement tools need to be appropriate for the client group, health condition and method of service delivery.

Data collection should allow for benchmarking against other services and show how existing inequalities have been reduced in terms of access to services, experiences of services and if outcomes have been achieved.

The following key areas will be covered:

- Key performance indicators
- Monitoring of service and patient outcomes (quarterly meetings and evaluation metrics)
- Patient waiting times (assessment and treatment)
- Patient satisfaction
- Clinical governance

Continuous improvement of the service and impact upon the length of stay and will be reviewed through existing governance arrangements and mechanisms.

13.3 Performance Management

The performance management framework will be implemented through existing contract management arrangements.

The following key areas will be covered:

- Key performance indicators
- Monitoring of service and patient outcomes (quarterly meetings and evaluation metrics)
- Patient waiting times (assessment and treatment)
- Patient satisfaction
- Clinical governance

Continuous improvement of the inpatient rehabilitation model and the impact upon patient length of stay will be monitored through existing governance arrangements and mechanisms.

¹⁴ The Government's Mandate to NHS England for 2016-17
www.gov.uk/government/publications/nhs-mandate-2016-to-2017

¹⁵ NHS Outcomes Framework
Department of Health (2014) The NHS outcomes framework 2015/16
www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015

14.0 Project Plan

The Director of Commissioning Strategy and Delivery for Durham Dales, Easington and Sedgefield and North Durham CCGs will sponsor this project with the support of colleagues from the CDDFT, Local Authorities and Commissioning and Delivery Team to implement the preferred model.

High Level Milestones:

- Public Consultation October 2019
- Implementation Plan February 2020
- Launch April 2020

The Patient Engagement Report prepared by County Durham Healthwatch and Consultation and Engagement plan to accompany this business case can be found as appendix one and two.

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Ward 6

Bishop Auckland Hospital

Consultation and communications plan

Final Version

Updated 08.08.19

Contents

Introduction and background	3
The context for this consultation	Error! Bookmark not defined.
Policy and legislation.....	4
Aims and Objectives.....	6
Scope of the consultation	7
Pre-Engagement.....	8
Stakeholders	8
Methodology - Outline.....	10
Standard formats of information	13
Key messages for consultation	14
Questions for consultation	14
Timeline.....	16
Equality Impact Assessment	17

Introduction

The three Clinical Commissioning Groups (CCGs) in County Durham (Durham Dales, Easington and Sedgfield CCG and North Durham CCG) and Darlington have been working with County Durham and Darlington NHS Foundation Trust (CDDFT) as part of their commitment to review the provision of services on Ward 6 at Bishop Auckland Hospital (BAH).

These organisations recognise that there is a need for appropriate inpatient care and services provided locally for our patients. The CCGs also seek to ensure that these services provide the best opportunities for individuals to recover from periods of illness or injury, so that they can live the fullest possible lives as independently as possible.

This consultation and communications plan outlines the steps we intend to take to ensure that Darlington CCG (DCCG), Durham Dales, Easington and Sedgfield CCG (DDES CCG) and North Durham CCG (ND CCG) run an appropriate and inclusive public consultation on the proposals regarding the provision of inpatient rehabilitation services within Bishop Auckland Hospital, and more specifically Ward 6.

A consultation summary document which explains the proposals for consultation and includes a questionnaire/ feedback form will be available as part of how the CCGs will obtain local views and feedback.

In addition, the aims of this consultation and communication plan are to;

- Set out the background and context to the current services provided within Ward 6 at Bishop Auckland Hospital (also see pre-consultation business case)
- Provide patients, public and stakeholders with clear information about the rationale behind any proposals being suggested
- Set out the legal framework within which this consultation is undertaken
- Outline the range of methods to be used for consultation and communication

Context

Ward 6 at Bishop Auckland Hospital provides nurse-led step down care with 24 beds, which was initially set up nine years ago for patients (aged 18 years and over) who may be medically fit but were unable to return home immediately.

Unnecessary lengthy stays in a hospital bed are not good for patients; this is due to sleep deprivation, increased risk of falls and fracture and risk of catching healthcare acquired infections. Every day in hospital is a precious day away from home; the “home first” mindset across health and social care systems is more than good practice, it is the right thing to do. When patients are medically well they should be

supported to return to their own home / place of residence.¹ Health and social care professionals want to work together to do everything possible to discharge the patient home, especially older people so they can enjoy their lives in their home environments.

In 2018 local commissioners within County Durham and Darlington procured a new community services contract aimed at ensuring equity of access, care closer to home and offering a seamless transition between acute and community based care. CDDFT have also undergone major transformation in terms of the effective use of their inpatient provision, ensuring that beds are used effectively and efficiently. Ultimately to ensure that those who most need inpatient care are able to access it and to ensure timely discharge into the community to aid recovery.

Policy and Legislation

In the development of this consultation and communications plan, the CCGs in County Durham and Darlington have referenced national guidance setting out their legal duty to involve patients and the public in the planning of service provision. Included below is a summary of the various legislation, guidance and principles relevant to this consultation, such as, the requirements set out in the Health Act 2006 as amended to Health and Social Care Act 2012:

- Section 242, of the Health Act 2006
 - *Places a duty on the NHS to make arrangements to involve patients and the public in planning services, developing and considering proposals for changes in the way services are provided and decisions to be made that affect how those services operate.*
- Section 244, of the Health Act 2006
 - *Requires NHS bodies to consult relevant OSCs on any proposals for substantial variations or substantial developments of health services. This duty is additional to the duty of involvement under section 242 (which applies to patients and the public rather than to OSCs).*
- Section 14Z2 of The Health and Social Care Act 2012,
Places a duty on CCGs to make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways):
 - *in the planning of the commissioning arrangements by the group,*
 - *in the development and consideration or proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them,*

¹ National Service Framework for NHS continuing health care and NHS funded nursing care)
www.gov.uk

- *in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.*

Other specific considerations have related to:

The 'four tests':

The 2014/15 mandate from the Government to NHS England outlines that proposed service changes should be able to demonstrate evidence to meet four tests:

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

NHS England introduced a new test applicable from 1 April 2017. This requires that in any proposal including plans to significantly reduce hospital bed numbers NHS England will expect commissioners to be able to evidence that they can meet one of the following three conditions:

- I. 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
- II. Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
- III. 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).

The Gunning Principles

- I. Consultation must take place when the proposal is still at a formative stage
- II. Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response
- III. Adequate time must be given for consideration and response and
- IV. The feedback from consultation must be conscientiously taken into account

The Equality Act 2010

The Equality Act 2010 unifies and extends previous equality legislation. Nine characteristics are protected by the Act, age, disability, gender reassignment,

marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

The NHS Constitution

The NHS Constitution came into force in January 2010 following the Health Act 2009. The constitution places a statutory duty on NHS bodies in England and explains a number of patient rights which are a legal entitlement protected by law. One of these rights is the right to be involved directly or through representatives:

- In the planning of healthcare services
- The development and consideration of proposals for changes in the way those services are provided, and
- In the decisions to be made affecting the operation of those services.

Aims and Objectives

The aim of our consultation is to create meaningful engagement with local people and stakeholders to inform them about our proposals for change, actively listen to their feedback, and ensure their feedback impacts the final decision. Our approach to consultation will be responsive and proportionate to those it will affect the most.

To achieve our aim, we will:

- Inform people about our proposals and how they have been developed
- Be clear about who will be affected and how
- Ensure a diverse range of voices are involved, reflecting communities most likely to be affected
- Make sure our methods and approaches are tailored to specific audiences as required.
- Engage with people and stakeholders in multiple ways to enable them to make an informed response to our proposals
- Provide accessible documentation, including easy read and word documents suitable for screen readers.
- Work transparently to show the journey so far and how the final decision will be made
- Ensure compliance with legal requirements (consultation and equalities duties)
- To create a thorough audit trail and evidence base of feedback.
- Listen, respond and adapt our processes and approach throughout our consultation period where required
- Use the information gathered during the Equalities Analysis and pre-consultation to inform our approach.
- Collate, analyse and consider the feedback we receive to make an informed decision.

Our work is guided by the seven best practice principles from The Consultation Institute (<https://www.consultationinstitute.org/about/>) - integrity, visibility, accessibility, confidentiality, full disclosure, fair interpretation and publication.

No decisions about the future provision of services currently delivered from ward 6 will be made prior to the consultation. Our plans are not set in stone and we are consulting on them so that we can get a deeper understanding of the views of local people. The Durham Health Overview and Scrutiny Committee and Darlington Overview and Scrutiny Committee has recommended that the proposals should be consulted on in their role of holding the local health and Care providers / commissioners to account for the population they serve.

It is important to note that a consultation is not a local referendum or vote. The Governing bodies of the three CCGs will carefully consider the views expressed by local people but our legal duty is to consider the quality of the arguments set out, rather than to count numbers for or against our proposals. After the consultation has ended, the Committee in Common will consider its outputs, including all responses and the independent Equalities Analysis, before making a decision on whether to proceed with the proposals.

Scope of the consultation

A focus on rehabilitation

It is increasingly acknowledged that effective rehabilitation delivers better outcomes and improved quality of life and has the potential to reduce health inequalities and make significant cost savings across the health and care system.

A person-centred approach is fundamental to ensure that rehabilitation is as an active and enabling process for each individual. It ensures that support is built around a person's own circumstances and responds to the diversity of needs that will be present. This includes consideration of mental and physical health, and the relationship between these which is critical to planning effective care.

For those who require inpatient based rehabilitation it is important to ensure that care is delivered where possible closer to home and in the most appropriate setting. The health and care system understands that there is a potential need for robust inpatient rehab services however we need to ensure best use of this resource. The bed provision needs to be aligned with the community services model of care with robust criteria for referrals and discharge. Whilst people are in these settings care needs to be planned and managed effectively to ensure people achieve their optimum rehab goals

A review of the current arrangements for inpatient rehabilitation is a key initiative for CDDFT and CCGs to be compliant with national and best practice rehabilitation care.

The increase in the older population creates a demand for services, requiring organisations to focus on managing demand and prevention, therefore a change to the model of rehabilitation care delivered is a priority for CDDFT and County Durham and Darlington CCGs to meet patients' needs and be compliant with national evidence and best practice.

With robust discharge planning, proactive management and timely consideration, home first could have better patient outcomes.

The 'Home first' model aims to stop patients being stranded on hospital ward and results in fewer people going into residential care (NHS England Quick Guide To Discharge to Assess / Publications Gateway Reference 05871 2015)

Following a review of the service currently delivered from ward 6 at BAH, a clinical proposal has been put forward to repurpose the unit into an inpatient rehabilitation facility. This forms the scope of the public consultation.

With all of the above in mind our focus is to ensure people are discharged home at the most appropriate point in their pathway, with a robust care plan and comprehensive community service offer. During their time in hospital it is important that patients have access to a wide range of professions to help them in achieving their rehabilitation goals.

Pre-Engagement

A period of public engagement was undertaken through Healthwatch County Durham during May – June 2019. This provided direct opportunities for patients who had been in Ward 6 (from both County Durham and Darlington catchment areas) over the previous two years to provide comments and feedback about their care and experiences. This was through a questionnaire sent out directly to those individuals who had been a patient on the ward.

In addition, Healthwatch staff had the opportunity to attend Ward 6 and engage in conversations with current patients, as well as some family members and members of the public while they were there too.

As part of this work 560 responses were gathered. All of this information has been collated and analysed by Healthwatch County Durham and presented to the CCGs (see appendix one). Included in the report was a summary of the observations that Healthwatch County Durham was able to make from the feedback gathered, as well as their own recommendations.

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.

Patients and the public	Healthcare professionals / providers	Partner organisations and Voluntary and Community Groups	Political / Governance
Patients who access these services	CDDFT staff teams at Bishop Auckland Hospital	Local Authority directors of Social Care / Adults services	Local MPs
Family members and carers	CDDFT staff teams at other hospital sites	Healthwatch	Health Overview and Scrutiny
Patient, Public and Carer Engagement Committee (PPCE)	Community staff and teams	Voluntary and Community sector providers	Local Councillors and elected members
Patient Reference Groups (PRGs)	Physiotherapists / Orthopaedic staff	Area Action Partnerships	Health and well-being boards
	Ambulance Service / Patient Transport	Durham County Carers Support	CCG Governing Body
	GPs and Primary Care	Housing organisations	
	Primary Care Networks	Health networks	
	CCG Staff	Neighbouring CCGs	
	NHS Improvement		
	Staff Unions		
	Local Medical Committee		

The consultation and communications processes will also include 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 County Durham and Darlington areas 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) will be key partners in supporting 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.

Considering the example list of stakeholders above, we can see the relevance to the consultation and its conversations through a graphical representation below. This grid outlines, as an example, the levels of interest identified stakeholders have alongside the scope to influence as part of this process.



Methodology - Outline

Included below is an outline of the intended approaches that will be used to enable the CCGs to deliver effective and meaningful consultation with the previously identified stakeholders. Activities may be altered to help us achieve these aims depending on feedback and suggestions received.

There will be a small number of public events at which people will be able to hear information presented by staff from the CCGs and CDDFT. There will then be opportunities for attendees to share their thoughts and experiences to help inform the decision making process.

Alongside this there will be information (documentation and an animation) available online for people to access. This will cover the same information that will be used at the public events. To enable individuals the opportunity to feedback outside of the public events, an online questionnaire will also be available.

In recognition of the need to help provide opportunities to contribute to where people are, the CCGs will also be working with local groups and community organisation to enable us to hear from people where they are as much as is practically possible.

Pre-Consultation activity

Activity / action	What's included	Additional information
Design and produce consultation document	Production, editing and proof reading. Work with PRG / Healthwatch members to help review content and language	Needs to ensure it clearly enables stakeholders to understand the issues and proposed solutions being presented.
Development and design of easy ready and summary documents	Work with expert partners to ensure documents meet best practices requirements and communication needs	
Produce any relevant stakeholder briefings		Needs to ensure it clearly enables stakeholders to understand the issues and proposed solutions being presented.
Development and design of any summary information / infographics	Relevant 'branding' or associated design for the consultation is agreed	Need to ensure all materials can be used across printed and online communication channels
Development of survey questions	Conformation of the agreed questions and key feedback that is required	
Confirm freepost address responses and identified information collection points		Work with partners to help ensure a variety of methods and locations are available for stakeholders to share feedback
Devise programme of public events and activities to attend	Research appropriate locations of publically accessible sites for engagement events	Ensure that materials for capturing feedback mirror survey questions and that information can be directly comparable between formats / audiences
Advertising of events	Promotional materials for events	Registration opportunities to help manage events appropriate and health and safety requirements Consider budget for paid

		advertising where possible
Liaise with partner organisations for targeted outreach sessions	Identify key audiences and groups to liaise with directly	
Development of required video / animations for communication	Summary of key information and issues to help inform people with feedback. Work with PRG / Healthwatch members to help review content and language	Needs to ensure it clearly enables stakeholders to understand the issues and proposed solutions being presented.
Website page development	Content and key materials prepared as above	Work with Communications team to develop
Schedule of social media posts	Regular information required to keep people updated and informed. Signpost to survey, events and work undertaken	Work with Communications team to develop
Press release	Agreed press release prepared for circulation at launch of consultation	

Consultation activity

Activity / action	What's included	Additional information
Public events	Deliver the public events, likely to include presentation to set out scenario and proposals, table discussions for participants to share comments and gather group feedback. Open opportunities for questions	
Presentations	Attend AAPs, Parish councils or other local groups requesting presentations on issues and consultation options	Devise appropriate methods for collating and collecting comments and feedback from these events
Targeted outreach sessions	Meetings with specific and identified audiences from stakeholder list Visit open public events and space; farmers markets, community events etc.	Add in any further groups as identified
Continue social media schedule of posts	Updates on events and activities.	

	Continued promotion of ways to respond and contribute	
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Post Consultations activity

Activity / action	What's included	Additional information
Data input and collection	Ensure all feedback gathered in all formats is appropriately compiled and record for analysis	
Analysis of feedback for key themes and preferred options	Analysis and coding of feedback	
Consultation summary briefing	Provide stakeholders with	Work with Communications team to develop
Update website pages	Ensure all information on the website is up to date and reflects the fact the consultation period had completed	Work with Communications team to develop
Draft full consultation report		
Consultation report published	Share document with all required audiences including Governing body, OSC, and public through CCG websites	

Standard formats of information

We will ensure that all information produced as part of the consultation will be in language that can be easily understood. Technical phrases and acronyms will be avoided, and information will be produced in a range of formats as required (for example, large print, braille, different languages), to reflect the needs of the diverse County Durham and Darlington populations.

These include;

- Consultation document, both printed and digital, including versions: full; summary; easy read. Other languages will be available on request.
- Freepost feedback forms
- Dedicated webpage with content and information on the CCGs websites
- Presentations for staff, public and patients, stakeholders, including Easy Read version
- Posters for GP surgeries, pharmacies, hospital departments and other public sites
- Postcard including space for short feedback and respondents' names and addresses
- Infographics – printed and digital

- Short animation – covering case for change, patient journey, and call to action
- Video of clinicians describing how the new service model will work and describing the changes from current services
- Pull-up banners
- Targeted advertising to extend reach – e.g. Facebook, promoted Twitter posts, and local media

Key messages for consultation

As part of the documentation and information available throughout the consultation process there are a number of central messages. Included below for reference is an outline of the overarching messages;

- Local NHS commissioners and providers want to improve and increase the rehabilitation and therapeutic input patients receive to aid their recovery
- Local NHS commissioners and providers want to enable patients to only stay in hospital for as long as is necessary and have care available to support them once discharged
- Due to local developments in the community and to patient flow processes in hospital we can slightly reduce the number of beds needed and invest that resource into direct patient care, in particular to ensure dedicated therapy support
- Investments in County Durham and Darlington Community Services provide a greater offer to people which is available closer to their homes, enabling them to get the right support when they are back home
- Inpatient beds are not always the best place for patients to be as part of their recovery back to living their fullest and functional life for them
- Local NHS commissioners and providers want to make best use of the workforce that is available and the extended range of skilled professionals within hospitals and community teams
- Developments in local delivery and the successes of the Teams Around Patients model (integrating Community services and Primary Care) provides greater infrastructure for staff and patients outside hospitals
- Local NHS commissioners and providers need services that can be staffed and delivered effectively to ensure that services are meeting all of the national requirements and clinical standards

Questions for Consultation

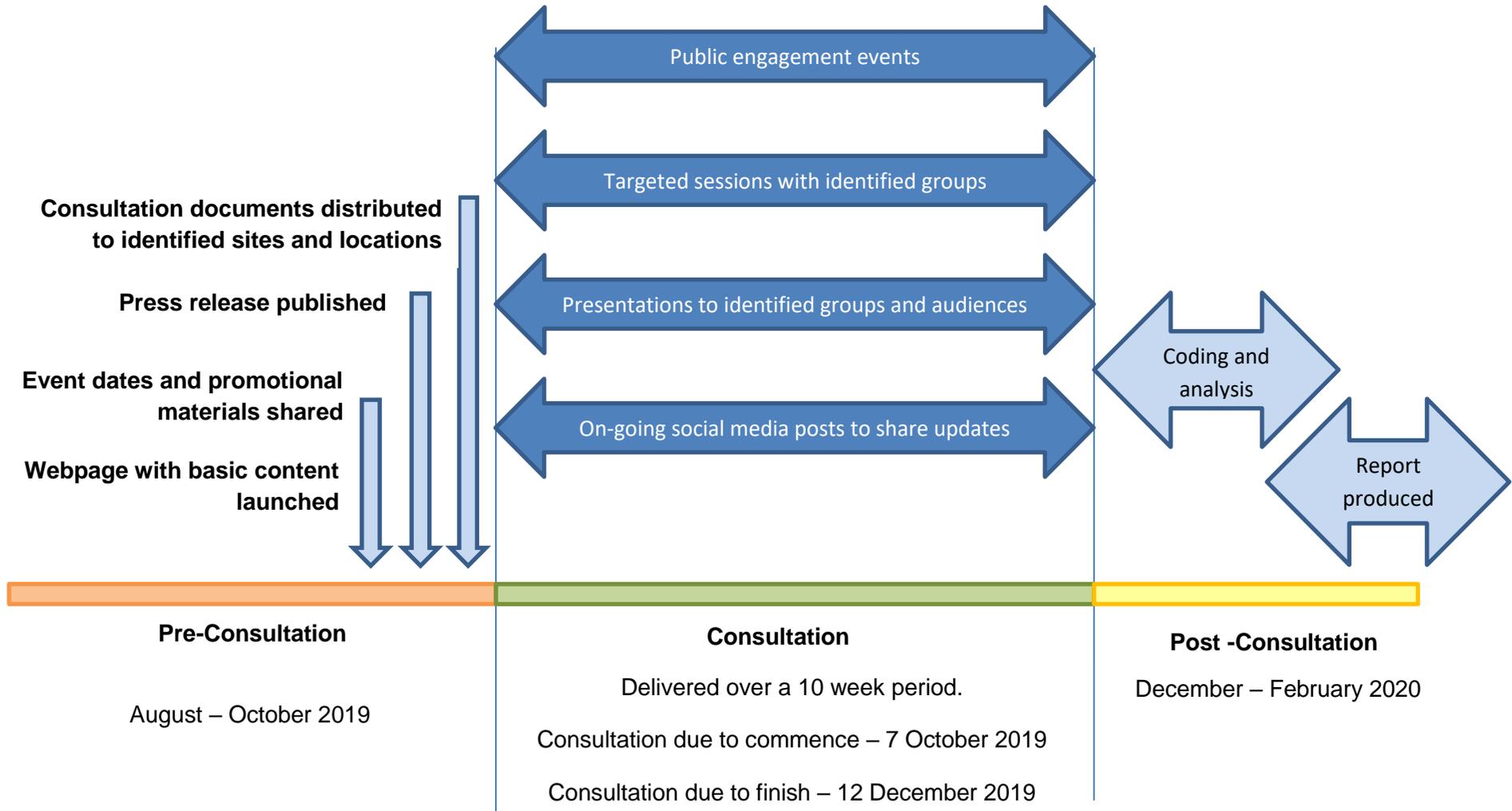
As a structure for the conversations that will take place, the following questions will be included as part of all of the conversations undertaken during the consultation process. To enable appropriate analysis of the feedback from the information provided, these are a mixture of closed and open-ended questions. This format enables analysis to include direct measurement of responses as well as

- *Have you been a patient on Ward 6?*
- *Have you had a family member experience services / stay on Ward 6?*
- *Do you understand the proposals?*
- *Based on the information available, what is your preferred option?*
- *What do you think the benefits of the preferred option are?*
- *Are there any barriers associated with the preferred option?*
- *Is there anything else that we haven't considered? / you want to suggest?*
- *What is the first part of your postcode?*

There will also be further equal opportunity questions to help us understand more about the range of people who have been able to respond.

Timeline

Included below is an overview of some of the key activities and at what points in the process these will be completed.



Equality Impact Assessment

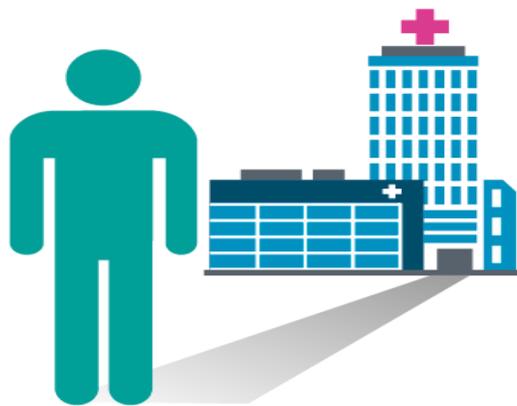
Included below is an Equality Impact Assessment (EIA) in relation to the activities planned to be conducted as part of the consultation and communication processes. A separate EIA process will be undertaken for any outcomes of the consultation in relation to future plans and provisions of services in due course.

STEP 3 - FULL EQUALITY IMPACT ASSESSMENT	
<p>The Equality Act 2010 covers nine 'protected characteristics' on the grounds upon which discrimination and barriers to access is unlawful. Outline what impact (or potential impact) the project/service review outcomes will have on the following protected groups:</p>	
<p>Age A person belonging to a particular age</p>	<p>We will make sure that information and the opportunity are available in arrange of formats including face to face, written and online. Where appropriate the CCG / Trust will seek to work collaboratively with relevant voluntary and community sector organisations who can help ensure we are hearing from all age ranges in our community</p>
<p>Disability A person who has a physical or mental impairment, which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities</p>	<p>We will make sure that information and the opportunity are available in arrange of formats including easy read and videos. Where appropriate the CCG / Trust will seek to work collaboratively with relevant voluntary and community sector organisations who can help ensure we are hearing from all age ranges in our community</p>
<p>Gender reassignment (including transgender) Medical term for what transgender people often call gender-confirmation surgery; surgery to bring the primary and secondary sex characteristics of a transgender person's body into alignment with his or her internal self-perception.</p>	<p>The consultation will be open to all of the local population of the County Durham and Darlington CCGs. There are no foreseen negative consequences for people accessing the services due to gender reassignment. .</p>
<p>Marriage and civil partnership Marriage is defined as a union of a man and a woman (or, in some jurisdictions, two people of the same sex) as partners in a relationship. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must be treated the same as married couples on a wide range of legal matters</p>	<p>The consultation will be open to all of the local population of the County Durham and Darlington CCGs. There are no foreseen negative consequences for people accessing the services due to gender reassignment.</p>
<p>Pregnancy and maternity Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context.</p>	<p>The consultation will be open to all of the local population of the County Durham and Darlington CCGs. There are no foreseen negative consequences for people accessing the services due to gender reassignment.</p>

Race It refers to a group of people defined by their race, colour, and nationality, ethnic or national origins, including travelling communities.
The consultation will be open to all of the local population of the County Durham and Darlington CCGs. Where appropriate the CCG / Trust will seek to work collaboratively with relevant voluntary and community sector organisations who can help ensure we are hearing from all age ranges in our community
Religion or belief Religion is defined as a particular system of faith and worship but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.
The consultation will be open to all of the local population of the County Durham and Darlington CCGs. There are no foreseen negative consequences for people accessing the services due to gender reassignment.
Sex/Gender A man or a woman.
The consultation will be open to all of the local population of the County Durham and Darlington CCGs. There are no foreseen negative consequences for people accessing the services due to gender reassignment.
Sexual orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes
The consultation will be open to all of the local population of the County Durham and Darlington CCGs. There are no foreseen negative consequences for people accessing the services due to gender reassignment. .
Carers A family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person
The consultation will be open to all of the local population of the County Durham and Darlington CCGs. Where appropriate the CCG / Trust will seek to work collaboratively with relevant voluntary and community sector organisations who can help ensure we are hearing from all age ranges in our community
Other identified groups relating to Health Inequalities such as deprived socio-economic groups, substance/alcohol abuse and sex workers
The consultation will be open to all of the local population of the County Durham and Darlington CCGs. Where appropriate the CCG / Trust will seek to work collaboratively with relevant voluntary and community sector organisations who can help ensure we are hearing from all age ranges in our community

Bishop Auckland Hospital - Ward 6

Capturing the views of patients about the care they have received



Bishop Auckland Hospital Ward 6 Report

Contents

Executive Summary	4
Observations	5
Recommendations	6
Background to this work	7
What we did and what we found	9
Recommendations	13
Appendix 1: NHS briefing paper	15
Appendix 2: HWCD survey	22
Appendix 3: comments and feedback	25



Healthwatch County Durham

Healthwatch County Durham is the county's consumer champion for health and social care, representing the voices of current and future users to decision makers.



We listen

We listen to patients of health services and users of social care services, along with their family members or carers, to find out what they think of the services they receive.



We advise

We advise people how to get the best health and social care for themselves and their family. We provide help and information about all aspects of health and social care provided in County Durham.



We speak up

We make sure that consumers views are heard by those who provide health and social care. Wherever possible we try to work in partnership with providers to influence how they make improvements.

Executive Summary

In early October 2018 Healthwatch County Durham (HWCD) was approached by Local MP for Bishop Auckland, Ms Helen Goodman and by 22 members of the public, regarding concerns they had regarding Ward 6 at Bishop Auckland Hospital (BAH). They told HWCD they believed the ward was going to be closed and that in the future County Durham and Darlington NHS Foundation Trust (the Trust) wanted to treat more people at home via the district nursing teams rather than in the existing hospital ward environment.

Ward 6 at BAH is a nurse led step down ward consisting of 24 beds for patients across the county. It supports:

- patients who do not require any further medical intervention or therapy, but some on-going nursing care
- patients waiting for more assessments about their continual healthcare
- patients waiting for specialist equipment

Consultation had taken place with staff on Ward 6, however Healthwatch was concerned that there did not appear to be plans to engage with patients or stakeholders.

After the escalation of the concerns raised by the public there was an exchange of letters between Healthwatch and the Trust, public meetings and representation by the Trust at Overview and Scrutiny Committee (OSC). This resulted in Healthwatch meeting with the Trust and CCGs to offer advice about meaningful engagement. As a result the CCGs and the Trust submitted a work plan request to Healthwatch to undertake some independent patient engagement and produce a report of their findings, regarding experiences of Ward 6.

In March 2019 it was agreed that Healthwatch would work with patients and the public during May/June 2019 to determine what was important to them about the care they had received and if there were other support mechanisms that might have helped them with their recuperation.

Observations

Letters were sent out to 560 former and current patients of Ward 6 from the last 2 years, giving them the opportunity to complete a questionnaire and listening events were also held at BAH.

In total 180 questionnaires were completed and Healthwatch spoke to 18 patients and public on ward 6 at BAH and to three members of the public in the hospital café.

The majority of patients told us they had received good care and support on the ward which was valued and had helped their recovery. Many had received therapies which had helped in their recuperation and where no therapy had been given, a significant number of patients felt other therapies might have helped them in their recovery.

Speaking to both patients, families and staff on the ward it was apparent that this model of care was an important component in the patient's journey of recovery. Having patients transferred to this ward enabled staff to "assess their needs" to ensure that the plans in place were appropriate for patients when they left hospital, giving time for any adjustments to be made.

In some cases it took a considerable amount of time to get a patient ready for discharge and there may be an opportunity for the Trust to undertake some specific work to understand why this is happening and if there are opportunities to reduce the time spent on this ward.

Staff work holistically with patients, families, therapists, housing providers and social care to make discharge from hospital safe for patients. Staff have skills and knowledge to be able to liaise with many different agencies to be able to facilitate a safe discharge.

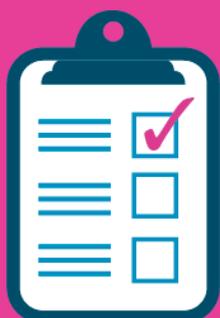
22 members of the public raised concerns



201 people shared their views



Letters were sent to 560 former and current patients of Ward 6



80% of patients told us their needs were fully met on the ward with 20% saying their needs were sometimes met

2 ward visits and 1 public drop in were arranged



Recommendations

Based on what patients told us we have the following recommendations for the Trust to consider

- We recommend the step-down model of care is retained as it enables nursing staff to ensure the assessments of patient needs are appropriate and allows for any adjustments to be made before discharge ensuring patients are safe when they return home or to other residential settings
- That as part of the recuperation process the Trust takes the opportunity to offer all appropriate therapeutic support to patients both as inpatients and within the community

- To continue delivering holistic support - to coordinate support from a number of sources including families, charities and health and social care agencies
- The Trust should look at the extended length of time some patients are staying on the ward to see if there are steps they could take to reduce this, where appropriate
- Using the comments made by patients completing the survey to help shape future services

Background to this work

In early October 2018 Healthwatch County Durham (HWCD) was approached by 22 members of the public and the Local MP for Bishop Auckland, Ms Helen Goodman, in relation to concerns they had regarding Ward 6 at Bishop Auckland Hospital (BAH). They told Healthwatch they believed the ward was going to be closed and that in the future the County Durham and Darlington NHS Foundation Trust (the Trust) wanted to treat more people at home via the district nursing teams rather than in the existing hospital ward environment.

Consultation with staff on Ward 6 had commenced on 1st October 2018 to explore the proposals and was due to finish on 31st October 2018. The feedback was to be collated and used to inform the decision making processes. Healthwatch was concerned that there did not appear to be plans to engage with patients or stakeholders.

Ward 6 at BAH is a nurse led step-down ward consisting of 24 beds for patients across the county. It supports patients:

- who do not require any further medical intervention or therapy, but some on-going nursing care or
- patients waiting for more assessments about their continual healthcare or
- patients waiting for specialist equipment

In response to the concerns raised, HWCD wrote to Sue Jacques, Chief Executive Officer of the Trust on 11th October 2018, asking for the following information

- the timeline for appropriate consultation with the public and patients for any proposed revision in services
- confirmation of the completion and evaluation of an impact assessment
- details of the Trust's communication and engagement strategy

Healthwatch also attended a public meeting about the proposals on 18th October 2018, it was confirmed at the meeting that due to the concerns raised any proposals for Ward 6 had been paused whilst the Trust considered their position.

In her letter of 29th October, to Healthwatch, Sue Jacques, outlined the rationale behind the proposals, stating the number of patients needing to access the care model on Ward 6 had been reducing because the teams were doing some really good work to implement national best practice, which includes shorter stays in hospital and patients being cared for closer to home. The new Community Service Contract commenced on 1st October 2019 and there was an expectation that some resources would transfer to the new service, including ensuring the Trust appropriately funded local provision. There was also confirmation the impact assessment would be reviewed once the consultation was complete.

The future of the ward was discussed at length by the Overview and Scrutiny Committee (OSC) at Durham County Council, which HWCD attends, on the 15th November. Ms Carole Langrick Deputy CEO of the Trust presented a paper (*see appendix 1*) to OSC outlining the Trust's actions to date in relation to Ward 6. She first of all offered an apology regarding the way in which the information had been received by OSC and how the staff consultation had been conducted. She spoke at length around the Trust's commitment to Bishop Auckland Hospital and to providing 'safe quality care'. There was considerable discussion raised by Elected Members - some very impassioned about the long-term future of Bishop Auckland Hospital but specifically around the care provided to patients by this ward and the staff. She shared that a number of staff had sought employment elsewhere as a consequence of the consultation. It was agreed that the consultation would be extended and that the ward would remain open. She also agreed to public engagement and where appropriate consultation and that the Trust would make further presentations to the OSC in the New Year. Following the November meeting, HWCD offered to meet with CDDFT to offer advice on meaningful engagement with patients. This offer was accepted and meetings took place in December 2018 and January 2019, with the CCGs in attendance.

At the OSC in January 2019, Sue Jacques presented and reported on progress since November 2018. She confirmed that Healthwatch had been approached by the CCGs and Trust and the workplan request was being considered by Board the following week. She stated that engagement would be based on feedback from staff, members of the public, patients and carers. It would include clinical guidance and opinion.

There were a number of questions raised by the committee as they wanted to be assured that the process would be robust. Sue Jacques agreed the Business Case would be brought back to the OSC later in the year. She confirmed the Trust does

have the option to keep Ward 6 open and the OSC can count on a thorough and comprehensive engagement process.

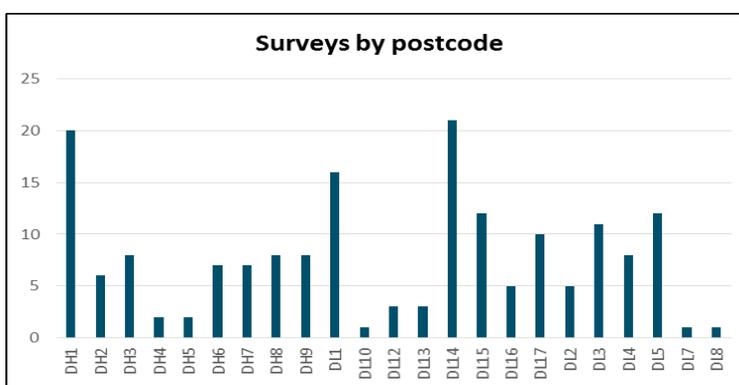
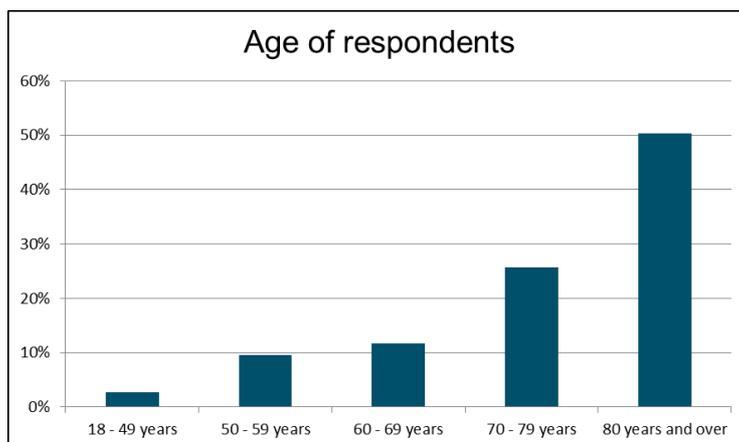
As a result of the ongoing communication by letter and meetings between Healthwatch, the Trust and CCGs over the period from November 2018-March 2019 and also taking into account the views of the public, the local MP and OSC, the CCGs and Trust did submit a workplan request to the Healthwatch board. This outlined the request for independent patient engagement to be undertaken regarding the review of Ward 6.

In March 2019 it was agreed that Healthwatch would work with patients during May/June 2019 to determine what was important to them about the care they had received and if there were other support mechanisms that might have helped them with their recuperation. Healthwatch would produce a report outlining patient views which would be presented to the Board, Trust and stakeholders in July 2019 and this would be used to help shape options for the future model of care which would deliver the best patient experience and outcomes.

What we did and what we found

Healthwatch worked with the CCGs and Trust to produce a questionnaire (see appendix 2) and 560 patients who were cared for by ward 6 between April 2017 and February 2019 were sent a letter from the Trust inviting them to complete a survey about their care. Healthwatch also publicised the questionnaire on the website and in the e-bulletin. In total 180 responses were received, 53 from male patients and 127 from female patients. Two listening events were arranged on the ward at BAH and also in the café on the ground floor of the hospital. We spoke to a total of 18 patients and 3 members of the public at these events.

The two graphs below show the age range of the patients completing the survey and the geographical spread of responses. A large proportion of patients did not live in the Bishop Auckland area.

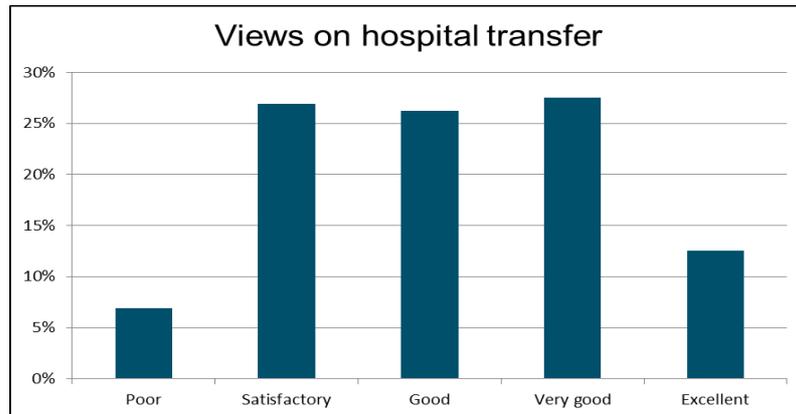


Based on the survey responses and the individual conversations we had at BAH, we have the following observations about what is important to patients about their recovery and where they are cared for.

Patients on Ward 6 generally are transferred there from different hospitals or wards. In our survey 168 patients provided information about their transfer:

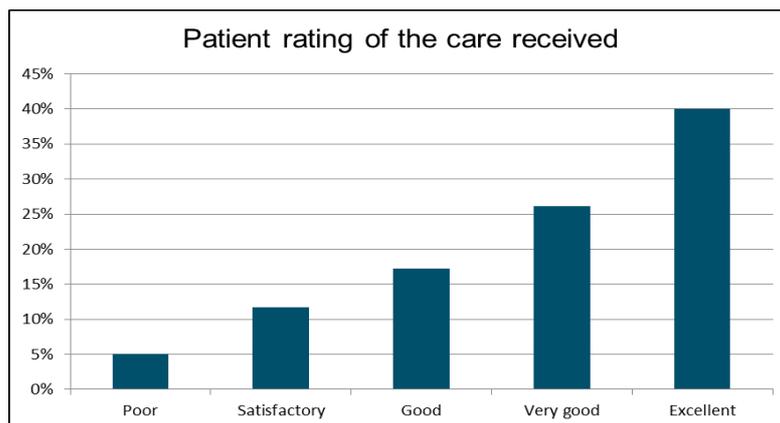
- 49% (82) of patients transferred from University Hospital North Durham
- 45% (75) of patients transferred from Darlington Memorial Hospital
- 6% (11) of patients transferred from another ward at Bishop Auckland Hospital

The graph below shows the experience of patients when they transferred from one hospital to another. The majority of patients found this process good to excellent.



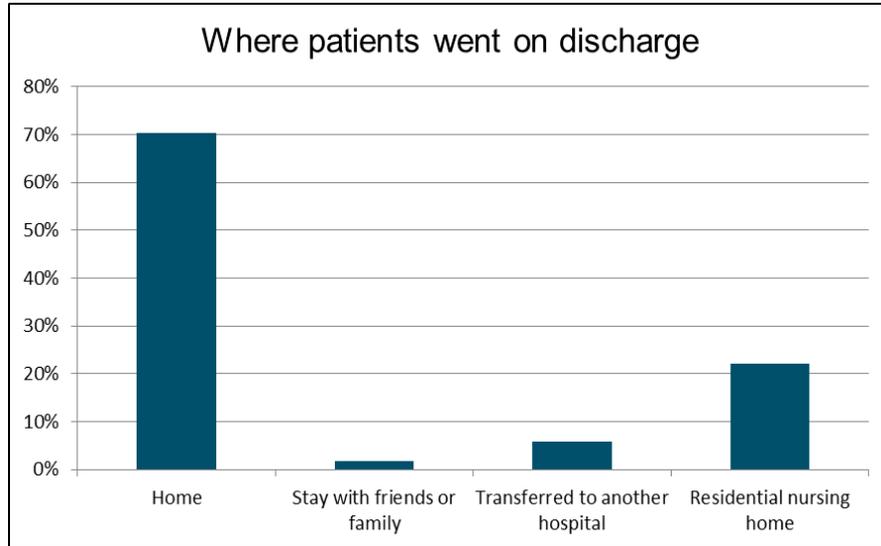
The time patients spend on the ward varies, 27% stayed on the ward up to 1 week, 28% stayed up to 2 weeks and 45% stayed over 2 weeks. The majority of patients (57%) did not receive any therapy services whilst on the ward. Of those that did receive therapy, this rated from 5% poor to 13% excellent. Of those receiving therapy 71% thought that the therapy they received ranged from good to excellent. We asked the patients in our survey if they did not receive therapy, do they think it would have helped them and 34% of those patients said it would.

We asked patients to rate the care they had received and the graph below shows their responses. It was reassuring to see that 83% of patients thought their care had been good to excellent, with only 5% of patients telling us their care had been poor. The majority of patients (80%) told us their needs were fully met while they were on the ward with 20% of patients telling us their needs were met sometimes.

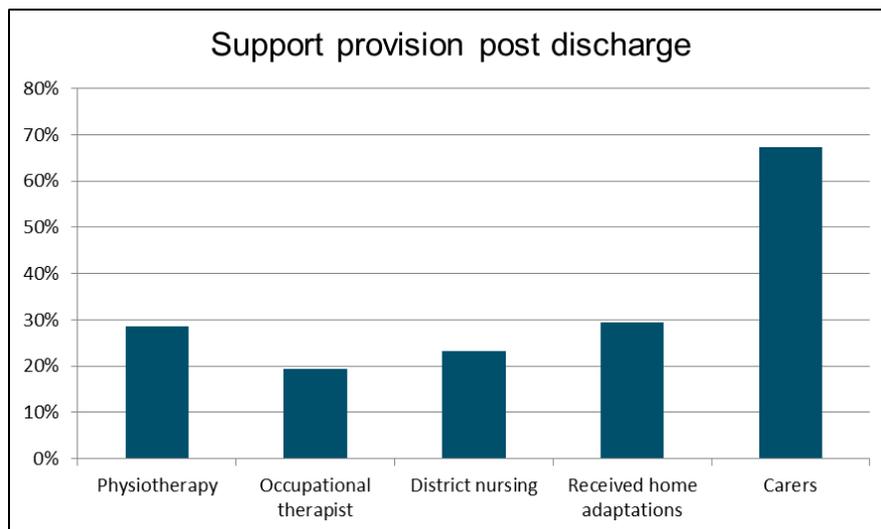


“All members of staff were excellent, so kind and caring”

The majority of patients wanted to be involved in the planning for their discharge and the graph below shows where patients went when they were discharged from hospital, with the majority returning home



We asked patients about the support they had or expected to receive to help them settle in at home and 129 people provided information about this, the graph below indicates the range of support received.



“I felt rushed into making a decision on where I would live as I was not able to return home with a broken arm”

The majority of patients, 72%, told us they received the care and support they expected when they left hospital, with 19% feeling the support was delivered to some extent and 9% who felt the support was not provided.

We also gave the opportunity for patients completing the survey to tell us anything else about their experiences of the ward that they wanted to share and the table at appendix 3 contains their individual comments.

It's interesting to note how many patients value the care and support they have received on the ward, although not everyone who completed the survey felt they had a positive experience on the ward. We will recommend that the Trust takes time to reflect on the comments made, to determine if there is an opportunity to improve services and patient experience.

We have made a number of recommendations based on what we were told both in the surveys and our listening events and these can be found below.

Recommendations

Based on what patients told us we have the following recommendations for the Trust to consider

- We recommend the step-down model of care is retained as it enables nursing staff to ensure the assessments of patient needs are appropriate and allows for any adjustments to be made before discharge ensuring patients are safe when they return home or to other residential settings
- That as part of the recuperation process the Trust takes the opportunity to offer all appropriate therapeutic support to patients both as inpatients and within the community
- To continue delivering holistic support - to coordinate support from a number of sources including families, charities and health and social care agencies
- The Trust should look at the extended length of time some patients are staying on the ward to see if there are steps they could take to reduce this, where appropriate
- Using the comments made by patients completing the survey to help shape future services

Healthwatch believes there are important lessons to be learnt from the way in which the Trust initiated its' engagement process and we continue to be committed to work with the CCGs and Trust to ensure that patients and the public in County Durham (and Darlington) are given every opportunity to share their valuable views and experience.

Thank You

We would like to thank everyone who took the time to complete our survey and talk to us at Bishop Auckland Hospital

Appendices

1. Copy of the report from the Trust to OSC
2. Copy of survey
3. Table of comments made in the survey

Appendix 1: NHS briefing paper



County Durham
and Darlington
NHS Foundation Trust

**Briefing Paper to Durham County Council Adults Health and Wellbeing
Overview and Scrutiny Committee
15th November 2018
on the
Ongoing quality improvement work on Ward 6 at Bishop Auckland Hospital
(BAH)**

Introduction

The objectives of this paper are to inform members and provide the committee with:

- An outline of the Trust's overarching commitment to delivering safe, quality care for patients across County Durham and Darlington,
- details of the service provision at Bishop Auckland Hospital (BAH),
- a description of the services being delivered on ward 6 within the context of nationally recognised best practice,
- information which evidences the changes in demand and utilisation of Ward 6,
- details of the dialogue taking place with staff about the different model of care for the cohort of patients using Ward 6.
- Assurance that we will bring any future proposals back to partners and stakeholders for discussion.

Background

Bishop Auckland Hospital has a vibrant future. It provides a range of planned services which the Trust continues to invest in and develop. These include:

- a new state-of-the-art MRI scanner at the hospital - cutting edge technology delivering the highest quality images for clinicians to diagnose a range of conditions including cancers and an improved experience for our patients
- diagnostic care including a CT scanner and x-ray department – and 8,000 endoscopies were carried out there in 2017/18
- It is the Trust's centre for bowel screening for the whole of County Durham and Darlington

- It is a centre of excellence for orthopaedic surgery – 5,000 operations took place in 2017/18 and there are plans to increase this activity over the winter period
- Over 100,000 outpatient appointments took place at the hospital during the last financial year as well as 10,000 day cases
- There are 5 inpatient wards at BAH providing inpatient care:
 - wards 3 & 4 provide stroke rehabilitation
 - Ward 6
 - Ward 16 providing dedicated orthopaedic, general, and neuro-rehabilitation care
 - Ward 18 orthopaedic surgery

Ward 6

Ward 6 at Bishop Auckland Hospital provides nurse-led step down care from 24 beds which is supported by Advanced Nurse Practitioners. There is no rehabilitation support provided on the ward. The ward currently accepts patients who are:

- orthopaedic non-weight bearing patients, irrespective of post code
- Medically fit and stable or patients that require step-down nursing support, patients that are unable to be discharged home
- patients requiring complex discharge planning and who are then inpatients awaiting a Decision Support Tool
- patients deemed to be homeless who don't require health care

The Trust's Strategy 'Our Patients Matter' sets out our purpose to provide safe, compassionate and joined-up care to the local populations we serve with the aim of achieving our vision – to get care right, first time, every time for all of our patients.

Therefore, we have been looking at the services we are providing for these groups of patients who are transferred to ward 6 to ensure that it is the 'right care' being proved in the 'right place' by the 'right person' and that it is the best possible care that it could be. The evidence that we have drawn upon and considered includes national recommendations and best practice. This evidence shows:

- Longer stays in hospital can lead to worse health outcomes and can increase long-term care needs. Research has identified that 10 days in a hospital bed leads to 10 years' worth of lost muscle mass in people over the age of 80 and reconditioning takes twice as long as this deconditioning (Gerontol.J, 2008).
- One week in bed equates to 10% loss of strength and in an older person that 10% can make the difference between dependence and independence.

-
- The deconditioning caused by days in bed for patients over 80 means that some people go into hospital never to see their own home again. (Gerontol.J, 2008).
 - When patients are medically optimised – they should be supported to return to their own home / place of residence (National Service Framework for NHS continuing health care and NHS funded nursing care)
 - People should be supported to return to their home for assessment of longer-term care and support needs (NICE guideline, Transition between inpatient hospital settings and community or care home settings for adults with social care needs 2015.)
 - Implementing a 'discharge to assess' or 'home first' model is more than good practice, it is the right thing to do (NHS England Quick Guide To Discharge to Assess / Publications Gateway Reference 05871 2015)
 - 'Home First' results in fewer people going into residential care (NHS England Quick Guide To Discharge to Assess / Publications Gateway Reference 05871 2015)
 - The 'Home first' model aims to stop patients being stranded on hospital ward (NHS England Quick Guide To Discharge to Assess / Publications Gateway Reference 05871 2015)
 - The use of The Homelessness Reduction Act, 2017- Duty to Refer Guidance 2018 supports identifying service users when they are threatened with homelessness, and what the procedures are for referring someone to a local authority to support a more streamlined approach. (Duty to Refer Guidance /Gov.uk/Publications 2018)

In striving to deliver the safest, quality care for our patients, the Trust over the past year has acted upon this national evidence and best practice. We identified that on Ward 6 whilst the nursing care was highly regarded and of a good standard, the model of service was not compliant with the above national evidence. We therefore began to undertake some quality improvements as follows:

- A whole system strategic review of the use and function of community hospitals was carried out in 2017 led by Lesley Jeavons, Director of Integrated Community Services. This review confirmed the current discharge practice of using all community hospitals as an interim, additional step to promote a speedier discharge from the acute settings instead of utilising the 'Home First' philosophy. Subsequently joint working commenced at an operational level to manage admissions and discharges to community hospitals more effectively which allowed for community hospital capacity including BAH to be used more flexibly (Update report submitted to OSC September 2018)

- In 2017, we identified that ward 6 had a length of stay longer than 35 days. The ward staff, Lead Nurse for Discharge and Matrons commenced Plan Do Study Act (PDSA) cycles to promote a reduction in the average length of stay.
- Changing the culture and practice around discharges. By implementing SAFER ([NHS Improvement](#), published 2017) a practical tool to help reduce delays for patients in adult inpatient wards. When followed it reduces length of stay and improves patient flow and safety. The SAFER bundle blends five elements of best practice:
 - S – Senior review
 - A – All patients
 - F – Flow
 - E – Early discharge
 - R – Review
- In 2017, the local health system implemented ‘Discharge to Assess’ by utilising the multi-agency and multi-disciplinary Trusted Assessors in TAPs. This facilitates joint decision making in the patient’s best interest; to avoid delays in returning to their home or normal place of residence rather than being transferred to Ward 6 inappropriately.

The quality improvement work outlined above, further enhanced by the evolving work of the Teams Around Patients through the community contract, has resulted in an increase in the number of patients receiving appropriate care. This can be seen in the qualitative changes to care as detailed below

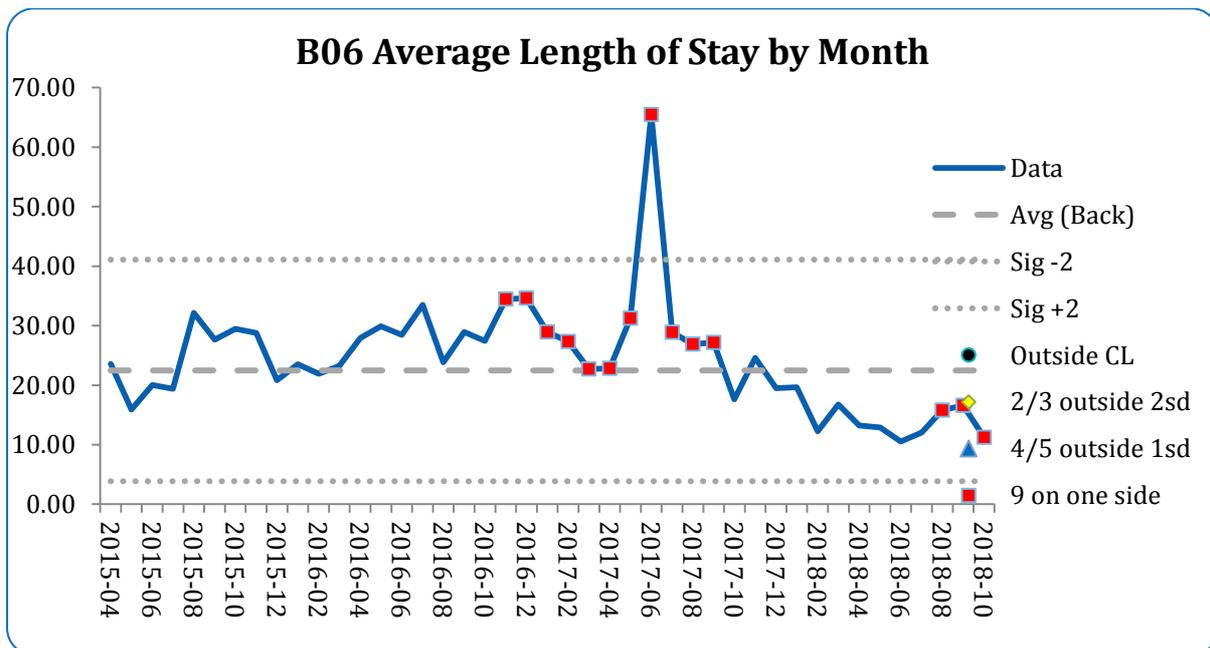
- An increase of Non weight bearing patients being supported at home with temporary home modifications and the utilisation of therapy support which is now coordinated through the Teams Around Patients (TAPs). The patient’s rehabilitation is expedited in their own home. If the patient does require inpatient care then they are supported at a facility close to their home.
- Implementing the SAFER bundle has enabled earlier discharge planning which has reduced the number of medically fit and stable patients being transferred to ward 6. Now they are supported by the local authorities and partner agencies to return to their home by implementing enhanced care packages, where required.
- Using the Discharge to Assess methodology and Home First philosophy more inpatients waiting for a DST are supported with involvement of Trusted Assessors to return home while these discussions take place.

- The Duty to Refer Guidance is helping to ensure that services are working together effectively to prevent homelessness by ensuring that peoples' housing needs are considered when they come into contact with public authorities.

These qualitative changes to care have resulted in demonstrable changes in;

- **Average Length of Stay** The average length of stay on Ward 6 has reduced from:
 - 28.41 days in 16/17 to
 - 25.26 days in 17/18 and to
 - 13.10 days in 18/19 (to end October).

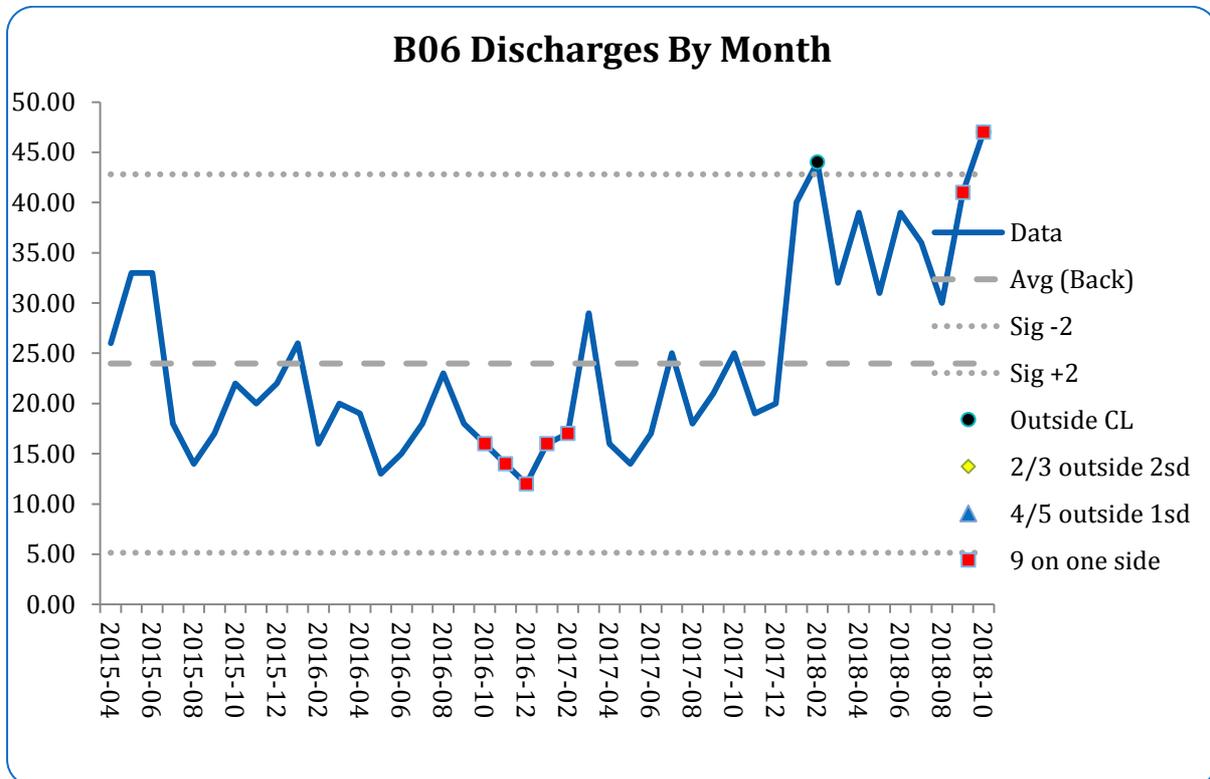
This is a 54% reduction in 2 years.



Outlier month above (Jun 2017) caused by one patient ending a ward stay on ward 6 of 250+ days

- **Discharges** The discharges from Ward 6 have increased from;
 - 210 discharges in 16/17 to
 - 291 discharges in 17/18 to

- 263 discharges in 18/19 to end October only with a forecast 451 at year end from the year to date figures



This quality improvement work, which has led to a fall in demand on ward 6, meant that when the Trust identified an infection risk at University Hospital of North Durham (UHND), ward 6 could be used to support a deep clean exercise. A deep clean programme was established across all of the in-patient wards at UHND. This resulted in ward 6 at BAH becoming a sub-acute medical ward between 29th May and 5th October 2018 to accommodate elderly care, medical admissions from UHND.

Ward 5 at UHND was then used as the de-cant ward enabling all UHND wards to be deep cleaned. This required additional medical consultant and therapy cover for ward 6 at BAH on a temporary basis. The deep clean programme was completed on 5th October 2018.

The ability to be able to use ward 6 in such a way led the Trust to start considering different models of care and therefore, different use of the facilities at Bishop Auckland Hospital.

This prompted the beginning of engagement work with staff on ward 6. We wanted to engage and involve clinical and non-clinical colleagues in a dialogue to gain ideas and

suggestions about what different models of care might look like and how facilities might be used differently.

We undertook this dialogue as a staff consultation so that it was supported by an HR process and as part of this process we prepared a briefing to outline what is also described in this paper. We acknowledge that this process was not managed as well as it could have been and that some of the language used in the briefing to set the context for the staff dialogue caused concern. We have taken this into consideration and have learnt from it.

At the time of writing this report, the staff consultation process has yet to conclude and the dialogue continues. We are collating all of the ideas and suggestions about how to make best use of the excellent facilities Bishop Auckland Hospital has to offer. Once we have reviewed all of this information we intend to bring it together into a proposal for moving forward, which we will discuss with stakeholders and partners.

Recommendation

Overview and Scrutiny Members are asked to:

- i. receive the report
- ii. note the data, actions taken and progress to date;
- iii. Consider and comment on the actions taken to date in order to meet patient needs and improve patient outcomes, the care closer to home agenda and Home First philosophy.

Appendix 2: HWCD survey

Bishop Auckland Hospital Ward 6 Survey

We want to hear about your most recent experience of being a patient on Ward 6 at Bishop Auckland Hospital. Please can you complete this survey by 31 May 2019.

1. Which hospital were you originally admitted to before moving to Ward 6 at Bishop Auckland Hospital?

- University Hospital North Durham
- Darlington Memorial Hospital
- Another ward at Bishop Auckland Hospital
- Other, please specify

2. How long have you been/were you on Ward 6 during your most recent stay?

- up to 1 week
- up to 2 weeks
- more than 2 weeks

3. Did you receive therapy in hospital?

- no
- yes

What type of therapy was it?.....

4. How would you rate your therapy?

- poor
- satisfactory
- good
- very good
- excellent

5. If no, do you think it would have helped you?

- yes
- no

6. How would you rate the care that you have received?

- poor
- satisfactory
- good
- very good
- excellent

7. Did you feel/or did you want to be involved in decisions about your discharge from hospital?

- yes definitely yes to some extent no
 I did not want to be involved not applicable at this stage

8. Where did you go or where will you go after leaving hospital?

- home stay with friends or family
 transferred to another hospital residential nursing home
 somewhere else, please specify.....

9. What support would be/will be provided when you leave/left hospital to help you settle in at home?

- Physiotherapy Occupational therapist
 District nursing Received home adaptations Carers
 Other support, please specify.....

10. Was the care and support you expected available when you needed it?

- yes no to some extent
 I did/do not expect any further care or support after I am discharged

11. Overall, were your needs met on Ward 6?

- yes always yes, sometimes
 no, please explain why.....

12. If you transferred from one hospital to another, how did you find this?

- poor satisfactory good very good excellent

It would help us to understand your answers better if we knew a little bit about you. These questions are completely optional, but we hope you will complete them. The information is collected anonymously and cannot be used to identify you personally.

13. Are you?

- male female

14. What is your age?

- 18 - 49 years 50 - 59 years 60 - 69 years
 70 - 79 years 80 years and over

15. What is the first part of your postcode? ie DH1

16. Any other comments about your experiences that you would like to share?

Thank you for taking the time to complete this survey.

Appendix 3: comments and feedback

One nurse been particularly nice - brought me eggs to eat when menu no good for me (I have coeliac disease so this was important). Menu repeats after 2 weeks so monotonous for me (been in 8 weeks +)
Vegetarian, so have had mushroom soup and veg sandwiches. Need handrails on my bed when I go home, which I don't have. Bedroom needs to be downstairs if I move.
Electric wheelchair at home as I have bottom of legs removed. Fiancé is at home. I can normally drive as I can use my false legs.
Sometimes too much food (amount). Lost my slippers. Woman keeps talking about her mam (disturbs my sleep) so struggling to rest.
This was a very noisy ward at night which meant I did not get sufficient sleep
I was better able to look after myself after a week on ward 6. After breaking first hip a year earlier I came home earlier as was not able to go for rehab due to my dementia. I felt that by going to ward 6 for a week rather than a care home I was given the same opportunity to walk again as the people who don't have dementia (and in an environment where I was encouraged to walk again with the safety of hospital back up).
Thought I had died and gone to heaven when I arrived on ward 6. It was a wrench to leave
I was taken to ward 6 for rehabilitation after fallen and broke my hip. The care was excellent from all staff. Nothing was a bother. I would not be afraid if I ever had to go back.
Excellent ward - so glad it stayed open
BAH - started on ward 18 then got moved to ward 6. Staff were excellent but no physiotherapy which was a let-down. Tried to do my own - physiotherapist did not want to know. When I got the restriction released it took 3-5 days for physio to reassess me. They think they are above everybody. The staff in ward 6 were outstanding.
I went to Weardale because there was no beds on ward 6. After a place became open I came to ward 6 and was very happy for my family because it was near to them for visits.
Could not be more pleased with the help and support I received. The staff were brilliant. Thank you all for all your help.
If this ward had not been available, my dad would have probably ended up in long term care. His stay gave him back some independence and allowed him to recover following a bad fall and surgery. The staff encouraged him to be involved in his own care and helped him to socialise again. If he had gone into long term care he would not have recovered to the level he is now with his continued independence with family support in his own home.
The staff at Bishop Auckland were great and enabled a quick move to a suitable care home.
The staff were excellent. We would have been lost without ward 6. Keep up the good work.

I was greatly supported from the hospital social worker, Lesley Walton, in my request to be allowed a place in West Lodge Care Home. I am a widow (93) and knew that I could no longer live on my own as I was very frightened to be alone at night. I will always be grateful to Lesley and love living at West Lodge.
Very professional, caring and compassionate. They did everything they could to help me.
I had very good care at ward 6. The staff were very kind and caring. I couldn't have asked for better care.
Care and caring received was very good. Always helpful with family when asked questions.
Looked after really well on ward 6. Amazing staff.
I completed this form on behalf of my father as his health prevented him from doing so. We would like to have been given more notice of his discharge from ward 6. We were given 48hrs to find a residential home. My father had previously lived independently at home, so this was a huge move for him and a difficult time for me as his next of kin. While we have always been very supportive of health care staff, we were very disappointed with the social worker who became involved at the hospital. An earlier case conference to discuss my father's needs would have eased this process.
Staff on ward 6 were very caring and friendly, and always on hand to help.
I was in ward 6 for 6 weeks and the care and attention I received was excellent. Everyone was professional, caring and friendly. Although no one wants a spell in hospital, I cannot think of a better ward I would like to be in. It cannot close.
We were very happy with the care my mam was given.
Wife filled in form. Husband can't remember.
My wife was only there for a short stay. Staff were very helpful and friendly both to her and me. Great hospital, very clean and tidy. Would definitely give it a five star rating. (Shame it's bad to get to from Annfield Plain)
Very good food. Excellent staff.
Thankfully ward 6 was still open. I've been going as a patient for years and never a wrong word or anything bad to say about the staff from the nurses to the auxiliaries - even the cleaners are polite and have time for you. It means a lot when you are ill. Very good ward. Thank you for your service ward 6.
On my stay at ward 6 staff were fantastic, couldn't do enough for me and were always asking me if I needed anything. I was there for around 8 weeks and if staff had time they were always there to have a chat with me and help me to do my jigsaws. They did all my personal care with the utmost dignity and respect.
It is just over a year since my wife was admitted to ward 6. We were given to understand that the purpose of the transfer to Bishop Auckland was for rehabilitation. In practice she was admitted to what could only be described as a dementia unit - God's waiting room! Whilst on ward 6 her health deteriorated and she was sent to Durham A&E with a serious infection presumably picked up on the ward.

My stay in hospital was excellent. The staff were really good and really looked after me. Kindest regards to all.
Ward 6 is a ward that gives support and preparation for returning home. They did a fabulous job.
Hope I've given you right information as this all happened last year.
I was in Bishop ward 6 for 3 weeks and 4 days, and can honestly say I was treated excellently. The staff were so nice. (...) Daughter visited every day - for most days 8 hours - and found everyone so kind, friendly and professional. I have spoken to many people about the way this ward was run and all praise.
Nursing staff gave 150% - they are wonderful. Could not get better care if I paid thousands of pounds for it.
Some staff were very good towards/with me, however some not.
Whilst the nurses were perfectly pleasant in their day to day duties the senior nurses/therapists were dismissive of our requests for physiotherapy. No attempt was made at upper body conditioning and as a result my mother is ill prepared for life in a wheelchair and her independence has been compromised. When the lack of action to address this was raised directly to them the nurses responses were rude and not at all patient-centred. We were bitterly disappointed with their attitude and absolutely no plans for physiotherapy in the future have been forthcoming.
I can't praise the staff from ward 6 Bishop Auckland Hospital enough. They were all kind, caring and very professional. Should I ever need to stay in hospital again, I hope I will be fortunate to stay in a ward such as ward 6.
My stay in ward 6 was peaceful. Care and attention from all nurses at all times. Doctor Paul and his staff looked after me with care. Many thanks to all.
The care I received in hospital was satisfactory but the fact I received no physiotherapy and was discharged with a broken hip and arm was very unsatisfactory. I felt rushed into making a decision on where I would live as I was not able to return home with a broken arm.
Some staff were very caring, others could not care at all. We had to complain to the ward sister several times about rough and poor treatment, e.g. the nurse that took away my painkiller med because I had to wipe my nose before swallowing it, and said that she would write in my notes that I had refused it.
The care I received on ward 6 over the 10 weeks that I was there was second to none, most of the staff couldn't do enough for you.
This survey was filled in by myself (husband) as my wife has dementia.
Ward 6 were unable to help me further so I was discharged to a care home as I needed 24hr care
Nursing staff ward 6 were very kind and helpful and pleasant.
Compared to the old days, 1960's, the NHS care and information is marvellous. So much information given, too much sometimes with photos! All the nurses are so friendly and caring. It's almost like a private hospital. Thank you very much. The consultant cannot

be faulted, explains fully the whole procedure, actually talks to you instead of about you.
The care I received from all the staff on ward 6 at BGH was excellent. The physio team got me walking again. The only let down was not given my discharge papers on leaving - had to ring back and chase this. Also great help from doctors to fill in my insurance claim for two lost holidays due to falling ill. overall I would thoroughly recommend a stay on ward 6. Thank you.
As a consequence of seven weeks without physio my recovery was affected. I signed myself out as I was expected to stay in bed for a further four weeks and my husband took over the hospital appointments at Darlington Memorial and general care. My body weight went down from 8 stones to 6 stones during the period in ward 6!!
All members of staff were excellent, so kind and caring.
I found the staff and care on ward 6 BAH on the whole good, but there is always room for improvement.
Insufficient time spent on physiotherapy when moved from ward 6 to ward 16 (2 weeks only)
No problems at all. Nurses were excellent
Came for rehab and feels that there was no other ward to put him on. Would have been better in a MH hospital but needed rehab. Tried to take own life and cut his wrist resulting in a number of operations to save his hand. Rehab needed to strengthen his fingers.
Everybody does their best can't always expect to be top of the list
Cannot praise staff enough Food ok. Nothing but praise. Lack of GP's coming round
Well looked after meals are good. Nurses will help when needed
Cannot find enough blankets and the pillows are thin. Great care from nurses that makes it better for family. Nurses are very approachable
Want to go to bed at 9. Nurses are wonderful. Need to discuss where I'm going after hospital talk to my daughter. Neighbours and friends but they are old.
Ward 6 is a very friendly environment. Staff always very caring.
I was cared for very well during my stay, the staff were excellent.
Staff were friendly and caring
Very poor help/advice from social worker.
I'm old, they don't have time for you.
Staff are so lovely and dedicated.
It was very good staying there.
Just like to say, Darlington and Bishop Auckland, could not fault these two hospitals.
Very satisfied with care received on ward 6 at Bishop Auckland. Superb staff.
All round experience excellent.

Always felt safe.
Thank you for excellent care.
Without the care I received from the staff on ward 6 and 16, I would not have been able to walk from a broken ankle
Ward 6 - can't thank them enough for the care and attention given to me on my stay there. Thank you very much.
Lots I can't write (I have severe Parkinson's)
I am fine and still going strong.
When being transferred from Durham Hospital to Bishop, paramedic (after I asked her if brakes were on the chair) said yes. But they were not. Chair tipped and sent me flying on to floor. With having plaster on I could not get up, she just stood there and left my grandson to pick me up. That is why I arrived at 12 o'clock at the other hospital.
Yes I had my hearing aid in, just as I was turning over, a nurse came to my bed at the same time my hearing aid dropped on floor, exact timing. She stood on it leading to terrible stress. Daughter wanted me to sign some forms to help me but she had to shout as I could not hear - terribly embarrassing.
Staff at Darlington Hospital were very good, but the transfer day, mam was ready early morning and did not arrive to Bishop Auckland until late evening. The service mam received at Bishop Auckland Ward 6 was first class. We would have struggled if we had not received this service. Bishop Auckland ward 6 is needed.
The staff were all good.
The staff in ward 6 provided my husband with excellent care. He was admitted to ward 6 on leaving Darlington, recovering from a UTI. If ward 6 were to close it would be detrimental to the patients who cannot go straight home after they have been ill.
If ward 6 wasn't available I don't know what I or my family would have done. I was well enough but not fit enough to go home on my own. I felt this ward helped and supported me to get on my feet quickly.
All treatment very satisfactory.
I found my stay at Bishop most helpful at the time, the staff were extremely helpful in every way and anything I needed was provided by the nursing staff, I found their help to be there when needed and was very grateful for all the help they provided me with. (5 star care)
I was transferred to Bishop Auckland from the D'ton Memorial Hospital after my operation because it was felt that I would get better physiotherapy. After being put on Ward 6, I found it to be very disturbing and noisy because of the 2 ladies with dementia; I was moved to a 4-bedded room where 3 of the ladies had dementia, none of them spoke and they were bedridden. The physiotherapist couldn't think what would be appropriate or any help to me so for the following 6 days there was no change. I was told that I couldn't be discharged because there was no care plan in place. My sister finally sorted it by saying I was ok in my warden-controlled flat. It was a very stressful and upsetting (time?) that I would not wish to repeat.

I would say that the treatment I received whilst in Ward 6 was second to none , the staff were all kind to me and I was treated with respect , my medication was always on time , especially the I.V. antibiotic I had 3 times a day .
Meals: choices poor, not enough variety, diabetic menu poor, and not always clearly indicated on menu
I wouldn't like to go into Bishop again. I hope carers are checked when they take up a position on one of the wards.
I have nothing but praise for the medical nursing staff at both wards 6 and 16 in Bishop Auckland Hospital. Despite working long hours they were always hardworking, cheerful, respectful and sensitive to patients' needs. In my long life this was the first time ever I have had to stay in hospital. It was a new experience but I was never worried or confused by what was done to me. I am so grateful to all of them.
No, it is all on this what you want me to fill in.
I found the care in ward 6 was excellent and the need for this ward should be looked into. I think it is disgraceful that they are talking about closing it.
Satisfactory.
Sat in chair 5 hours, meds not given, controlled drugs not transferred. Never want to go to Bishop Hospital again - very distressing. Spent Christmas in hospital in Darlington because needs weren't met on Ward 6
The communication between both hospitals was poor. I had an injury that was overlooked. Falls on Ward 6.
Mobility was hindered due to knee brace and weight bearing ability in first 4 weeks
Whilst I stayed on ward 6 there was a nurse who was quite awful to me. When I transferred from Darlington Hospital I had a lot of medication to which I was accused of overdosing, even though meds are locked away. I went shopping for bedding as I was being discharged in a couple of days. I was cold and tired. The same nurse said I was slurring my words so she got a pen torch and shone it in my eyes and accused me of taking something whilst I was out. This is untrue. On discharge I found out that the same nurse destroyed some of my prescribed meds, which I had to order more, there was no discharge letter or cardex so district nurses couldn't give my injections.
The four times I have been in hospital over the last two years has been an entertaining and pleasant experience - that is after one recovers from the initial surgery. Most of the staff are incredible - but there's always one who upsets the illusion. One of the best things, apart from the super staff, is the puddings for lunch/dinner (or dinner/tea) as the staff refer to the meals. Thank you so much.
Staff were lovely, very kind and helpful. It is a very busy ward but despite that they were always there, with a smile, to help. I was a long stay patient, non-weight-bearing for up to 8 weeks. The care and attention I got was just fantastic. Thanks to all the staff on ward 6, I am now at home leading an independent life.
I was in Ward 6 after heart attack so there was (no) treatment and I was happy there. Previously had two bad falls and went to D'ton Hosp and then Richardson at Barnard Castle and had therapy, but my sister was placed in Ward 6 after a bad fall and she was very well taken care of by everyone - but she died later. I am very sorry to think you

might change Ward 6 and I do not want you to close it. I am nearly unable to cope so sometime if I had to anywhere I would choose Ward 6.

I was perfectly happy with the care I got while on ward 6

The treatment I received during my stay was excellent

I have completed this on behalf of my sister in law as she is unable to do this herself following a stroke. The discharge experience was appalling. Discharge was discussed by hospital with family and social worker, and care home visited to make assessment; at this point no firm date was set. On 16/01/2019 we were out when hospital phoned to say that discharge was to be that day. We were only out for two hours but by the time we got the message, patient had been discharged and was on her way to care home. We immediately went to the care home who were unaware that she was on her way, they were unprepared for her. No paperwork or care plan was in place. The social worker was also unaware of the situation. The patient arrived by patient transport shortly after us. Her wheelchair and zimmer frame were not sent with her. Family contacted Ward 6 and these were later sent by taxi. The whole experience was a nightmare, more to the family than the patient herself as family & care staff protected her as much as possible as she was and still is very vulnerable following a stroke at the end of October 2018. Follow up support has also been poor and has taken several weeks of phone calls by family to put it in place. Despite us being told by hospital this had been done.

The carer came for six weeks to wash me and she is a great person. Now my husband is my full time carer. The meeting of nurses and carers took place when I was there to close ward 6 someone took that meeting, and those who worked there were crying and really upset. So after that day when patients went home no one else came into the ward. I feel really sorry for who didn't know what was going to happen to them. I hope God has blessed them - then, now, and always.

No complaints at all. Nurses were lovely.

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Review of Inpatient Rehabilitation in County Durham and Darlington

A review of ward 6 at Bishop Auckland Hospital

Adults, Wellbeing and Health Scrutiny Committee
6 September 2019



Background

- The local health system is reviewing models of care to ensure that inpatient facilities are used as effectively as possible
- Ward 6 at Bishop Auckland Hospital (BAH) was identified for review as part of this work programme
- It is important to ensure that any future models of care give people the greatest opportunity for recovery
- The local health system is committed to delivering care closer to home

Vision

To develop a person-centred model of care that delivers care closer to home

To minimise variation and maximise the health outcomes of our local population

To ensure that patients (and their families) achieve their rehabilitation goals in conducive environments staffed by multi-disciplinary teams

To ensure care is accessible and responsive to people's needs

To ensure timely and supportive discharge is achieved consistently

Scope of Review

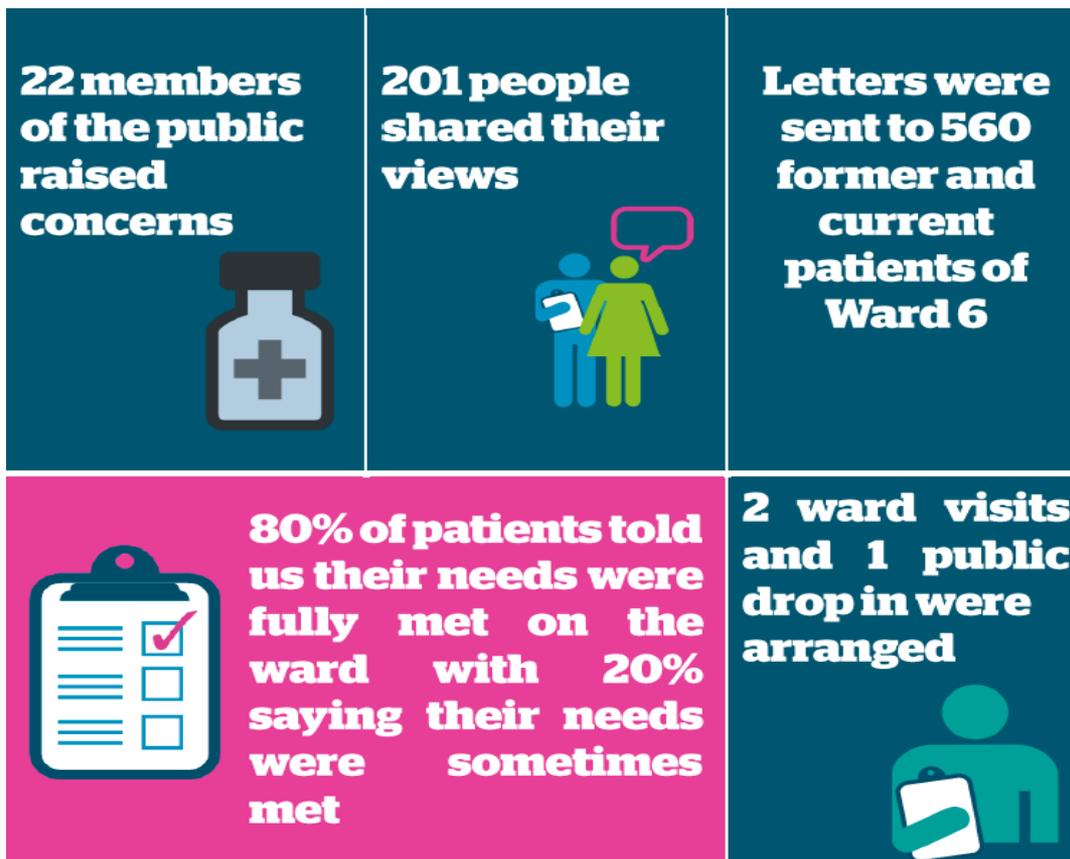
- The scope of this project relates to ward 6 at Bishop Auckland Hospital (BAH) which is a 24 bedded, nurse-led unit which currently delivers step down care.
- Although the project is specifically reviewing this ward at BAH, the wider context of delivering care closer to home has been taken into account

Current Service

- Ward 6 provides nurse-led step down care
- There are 24 beds
- There is currently no dedicated therapy support
- On ward 6 the average length of stay was 22 days in 17/18 in 18/19 this has reduced to 12 days

Patient and Carer Feedback

- Healthwatch County Durham carried out engagement with patients (and their families) across CDD



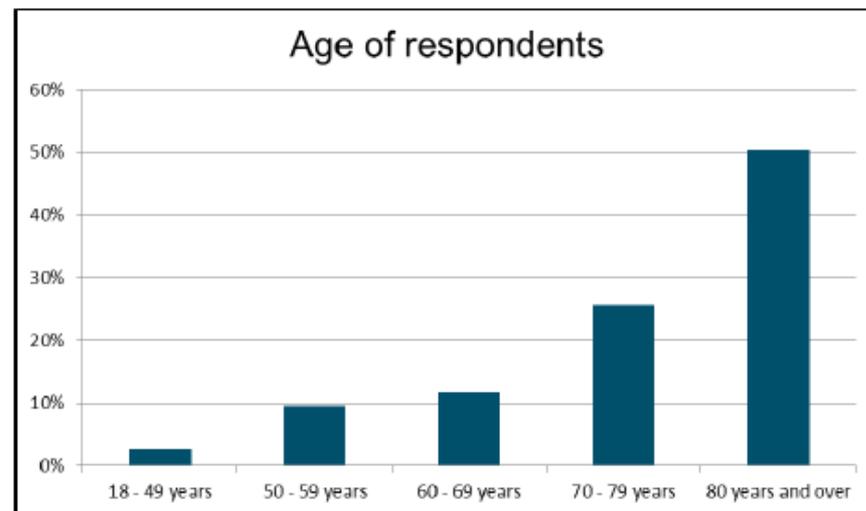
Patient and Carer Themes

The Trust should look at the extended length of time some patients are staying on the ward to see if there are steps they could take to reduce this, where appropriate

The majority of patients (57%) did not receive any therapy services whilst on the ward.

83% of patients thought their care had been good to excellent

The majority of patients (80%) told us their needs were fully met



Case for Change

- The current model of inpatient rehabilitation care is not standardised and is not always compliant with national evidence and best practice.
- We know that it is best for patients to be discharged home at the earliest opportunity to maximise their rehabilitation goals.

Options Appraisal

Clinical quality	Maintains or improves clinical outcomes; timely and appropriate services; minimises clinical risk	Patient, Public and carer Engagement – Experience and Feedback
Sustainability/flexibility	Ability to meet current and future demands in activity; ability to respond to local/regional/national service changes	
Equity of access	Reasonable access for urban and rural populations	
Efficiency	Delivers patient pathways that are evidence based; supports the delivery though access to resources	
Workforce	Provides environments which support the recruitment/retention of staff; supports clinical staffing arrangements	
Functional suitability	Provides environments suitable for delivery of care; clinical adjacencies with other relevant services/dependencies e.g. imaging	
Acceptability	Acceptable to service users, carers, relatives, other significant partners	
Cost effectiveness	Provides value for money	

Preferred Option

- The ward to become an inpatient rehabilitation unit
- Therapists to be part of the model of care
- Care to be delivered on the BAH site with a reduction of eight beds overall
- Patients will access the service following an episode on an acute or other community inpatient facility for rehabilitation.

What this means for patients in County Durham

- Discharge planning will be start at the beginning of the patients inpatient pathway
- Robust inpatient rehabilitation will be provided from BAH
- Further inpatient rehabilitation will be available across community hospitals
- Enhanced utilisation of intermediate care
- Community based services which are responsive to need
- Health and social care will continue to work in an integrated way to avoid delayed discharges

Next Steps

- The proposals have been ratified by executive and governing body committees in CCGs and Trust
- Public document on proposals to be developed
- Public consultation planned – 7 October 2019 for 10 week
- NHSE assurance process to be followed
- Outcome of consultation to be considered by CCGs and Trust in the new year
- Ongoing communication with OSCs on progress

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

6 September 2019



**Review of Stroke Rehabilitation
Services in County Durham**

Report of Corporate Management Team

Lorraine O'Donnell, Director of Transformation and Partnerships

Electoral division(s) affected:

Countywide

Purpose of the Report

- 1 To present to the Adults Wellbeing and Health Overview and Scrutiny Committee a range of future service model options in respect of stroke rehabilitation services for public consultation and the associated communications and engagement plan from North Durham CCG and Durham Dales, Easington and Sedgefield CCG CCGs and County Durham and Darlington NHS Foundation Trust.

Executive summary

- 2 The Adults Wellbeing and Health Overview and Scrutiny Committee has previously met to consider plans and proposals by County Durham and Darlington Foundation Trust in conjunction with North Durham CCG and Durham Dales, Easington and Sedgefield CCG to undertake a review of stroke rehabilitation services across County Durham.
- 3 Reports and presentations have been considered by the Adults Wellbeing and Health Overview and Scrutiny Committee at previous meetings which has set out the key rationale for the review of stroke rehabilitation services; plans for patient and stakeholder engagement to ascertain experiences with the current service model; the results of that engagement activity and how this was to be used to formulate future service model options which could be subject to public consultation.
- 4 This report and the attached supplementary reports and presentation slides from North Durham CCG and Durham Dales, Easington and Sedgefield CCG and County Durham and Darlington NHS Foundation

Trust set out a range of future service model options for public consultation and the associated communications and engagement plan.

Recommendations

- 5 Members of the Adults Wellbeing and Health Overview and Scrutiny Committee are requested to:-
 - a) Receive this report;
 - b) Consider and comment on the reports and presentation slides from North Durham CCG and Durham Dales, Easington and Sedgefield CCG and County Durham and Darlington NHS Foundation Trust on the range of future service model options for public consultation and the associated communications and engagement plan.

Background

- 6 At its meeting held on 2 May 2018, the Adults Wellbeing and Health Overview and Scrutiny Committee received a presentation which set out the rationale for a review of stroke rehabilitation services. The presentation set the context of stroke rehabilitation within the previous review undertaken of acute stroke services which led to the centralisation of acute stroke services at University Hospital North Durham (UHND).
- 7 At that meeting members were advised that a major driver to review services was below target performance in respect of the number of patients treated by a stroke skilled early supported discharge team – 2.6% for North Durham CCG and 3.5% for DDES CCG against a national average of 35%.
- 8 There were also concerns that the average length of stay for stroke rehabilitation patients at Bishop Auckland Hospital was far in excess of best practice. There was also evidence of a limited availability of healthcare professional input as part of the stroke pathway particularly in respect of occupational therapy; speech and language therapy and physiotherapy.
- 9 CCGs and County Durham and Darlington NHS Foundation trust reported upon plans to undertake patient and stakeholder engagement as part of the review and committed to bringing details of the proposed engagement activity back to the Adults Wellbeing and Health OSC.
- 10 A further report was considered by the Committee on 6 July 2019 which set out details of the proposed engagement activity which included discussions with patient reference groups across County Durham; bespoke engagement led by Healthwatch County Durham with stroke

patients and their carers and families; specialist health networks; established stroke groups and the County Council's Area Action Partnerships.

- 11 The activity would include a call for evidence to review best practice in respect of stroke rehabilitation services and understand where improvements could be made. This would also require gathering the experiences of local people and those established stroke support groups which would inform a service improvement project.
- 12 It was anticipated at the time that this work would be completed within 12 weeks and a report brought back to the Committee.
- 13 At the Adults Wellbeing and Health Overview and Scrutiny Committee held on 15 November 2018, an update presentation was given to members which set out the emerging themes from the engagement process and also advised that the engagement activity was to be extended to ensure that as many patients and stakeholders as possible from across County Durham and Darlington were given the opportunity to respond to the process.
- 14 Key emerging themes were that patients had positive experiences of the acute hospital stroke service; there was limited dedicated community-based stroke provision; patients felt too many people were involved in their care; care closer to home would be valued along with peer support.
- 15 The engagement activity had also identified gaps within existing stroke rehabilitation services which included that the current pathway promoted multiple transfers of care; therapy assessment takes place within a hospital setting rather than in the person's home setting; community-based rehab services are inequitable across County Durham; rehabilitation within the community does not provide the intensity required as detailed in national guidance and that patient based outcomes could be improved upon e.g. time for therapy-based interventions.
- 16 The final report detailing the findings from the engagement activity was considered by the Committee at its meeting held on 18 January 2019. In addition to the issues previously identified, members were informed that there were communication challenges at various points of the current stroke pathway. Patients wanted emotional wellbeing and support particularly after discharge from hospital with a more consistent community rehabilitation service provided which would include a longer period of therapy once discharged from hospital.
- 17 At the meeting, the Committee were informed that the findings of the engagement activity would be discussed at a meeting with a range of

clinical staff to further develop options and appraise these against standard criteria which includes clinical evidence base, accessibility and financial sustainability. This exercise would include representation from both community and hospital-based clinicians, primary care, regional clinical network and the Stroke Association and the views of patients and carers will also be included.

- 18 Following this meeting, a preferred option will be formed as a result of this appraisal and a business case will be developed on that basis. The business case was to be presented back to the Adults Wellbeing and Health Overview and Scrutiny Committee and would include costings for any preferred option across County Durham and Darlington.
- 19 It was noted that any potential service changes may be subject to staff engagement, which will be carried out as part of the ongoing process with staff helping to shape any future model of care. Assurance from NHS England on any proposed future service change and on the process to date and going forward would also be sought.
- 20 This report and the attached supplementary reports and presentation slides from North Durham CCG and Durham Dales, Easington and Sedgefield CCG CCGs and County Durham and Darlington NHS Foundation Trust set out a range of future service model options in respect of stroke rehabilitation services for public consultation and the associated communications and engagement plan.
- 21 Representatives of North Durham CCG and Durham Dales, Easington and Sedgefield CCG CCGs and County Durham and Darlington NHS Foundation Trust will be in attendance to present the reports and proposals for public consultation in respect of the review of stroke rehabilitation service in County Durham.

Considerations

- 22 Members are asked to consider and comment on the reports and presentation slides from North Durham CCG and Durham Dales, Easington and Sedgefield CCG and County Durham and Darlington NHS Foundation Trust on the range of future service model options for public consultation and the associated communications and engagement plan.

Main implications

Legal

- 23 This report has been produced in accordance with the Local Authority (Public Health, Health and wellbeing boards and Health Scrutiny) Regulations 2013 as they relate to the National Health Service Act 2006 governing the local authority health scrutiny function.

Consultation

- 24 Reports and presentations have been considered by the Adults Wellbeing and Health Overview and Scrutiny Committee at previous meetings which set out plans for patient and stakeholder engagement to ascertain experiences with the current service model and the results of that engagement activity and how this was to be used to formulate future service model options.
- 25 This report and the attached supplementary reports and presentation slides from North Durham CCG and Durham Dales, Easington and Sedgefield CCG CCGs, County Durham Healthwatch and County Durham and Darlington NHS Foundation Trust set out a range of future service model options for public consultation and the associated communications and engagement plan.

Conclusion

- 26 The Committee has previously considered reports and presentations by County Durham CCGs and County Durham and Darlington NHS Foundation Trust setting out the proposed plans for patient and stakeholder engagement which would inform the development of options for the future service model for stroke rehabilitation services across County Durham and associated consultation, communications and engagement plans.
- 27 Members are asked to receive this report and presentation and consider proposals for patient and stakeholder consultation and engagement as well as the future service model options being consulted upon in respect of stroke rehabilitation services across County Durham.

Background papers

- Agenda, Minutes and Reports to the Adults Wellbeing and Health Overview and Scrutiny Committee meetings held on 2 May 2018, 6 July 2018, 15 November 2018 and 18 January 2019.

Contact: Stephen Gwilym

Tel: 03000 268140

Appendix 1: Implications

Legal Implications

This report has been produced in accordance with the Local Authority (Public Health, Health and wellbeing boards and Health Scrutiny) Regulations 2013 as they relate to the National Health Service Act 2006 governing the local authority health scrutiny function.

Finance

Not applicable

Consultation

The report and presentations set out proposals for statutory consultation in respect of future service model options for stroke rehabilitation services in County Durham.

Equality and Diversity / Public Sector Equality Duty

An Equality Impact Assessment has been undertaken in respect of the proposals and is included within this report.

Human Rights

Not applicable

Crime and Disorder

Not applicable

Staffing

Not applicable

Accommodation

Not applicable

Risk

Not applicable

Procurement

Not applicable

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North Durham Clinical Commissioning Group
Durham Dales, Easington and Sedgfield Clinical Commissioning Group
Darlington Clinical Commissioning Group

**Improving Stroke Rehabilitation
For the People of County
Durham and Darlington**

*A review of stroke rehabilitation services within County
Durham and Darlington*

**Pre-Consultation Business Case
County Durham**

Contents

1.0 Executive Summary	4
2.0 Vision.....	5
2.1 Scope.....	5
2.2 Aims and Objectives	5
3.0 Introduction and Background	6
3.1 Demographics and Prevalence	6
3.2 National Context & Evidence Base	9
3.3 Best Practice and National Guidelines	10
4.0 Local Context.....	10
4.1 Quality and Performance	14
5.0 Patient Experience and feedback	18
6.0 Staff Engagement.....	21
7.0 Current State.....	22
7.1 Stroke prevention	22
7.2 Hyperacute Model of Care	23
7.3 Stroke Rehabilitation.....	23
7.4 Psychological Support.....	24
7.5 Stroke Six Month Review	24
8.0 Case for change – Stroke Rehabilitation.....	25
8.1 Acute based rehabilitation.....	25
8.2 Community based rehabilitation	26
8.3 Gaps within current state vs. best practice	26
8.4 Workforce challenges	27
8.5 Financial challenges	28
9.0 Options Criteria & Process.....	28
9.1 Options Appraisal.....	30
9.2 Preferred Option	33
9.2.1 Community Specialist Stroke Rehabilitation	35
10.0 Benefits Realisation	36
11.0 Risks	39
12.0 Testing out the Preferred Option	40
13.0 Proposed Future State	42

13.1	Service Model	42
13.2	Referral and Access	43
13.3	Specific Measurable Outcomes	43
13.4	Performance Management	45
14.0	Project Plan.....	45

1.0 Executive Summary

The following report outlines the commitment from the local health system within County Durham and Darlington to develop inpatient and community stroke rehabilitation services. In 2011 County Durham and Darlington stroke services were transformed in terms of the hyperacute (early stage of the pathway) model, where the outcome was a single site service based at University Hospital North Durham (UHND).

The quality and performance of this part of the stroke pathway have improved significantly, however it is recognised that the rehabilitation elements could be better. We have continued to talk to our patients and their families to understand their experiences and the feedback reflects the need to review and improve rehabilitation for this cohort of our local population. Therefore there is a commitment from the local health system to improve both inpatient and community rehabilitation for those who have had a stroke.

The scope of the project relates to the care currently delivered within the stroke rehabilitation ward at Bishop Auckland Hospital (BAH) and services within the community for this particular cohort of the local population. The project focuses on national and local clinical standards and best practice and assesses the gaps within the current service. The following business case outlines some of the challenges locally in terms of the limited specialist workforce as well as constraints within the current model which prevent more optimum care. The review then seeks to address these gaps in provision with proposals on how care could be delivered in the future.

The review was clinically led and as a result there are two options for consideration. An options appraisal process was undertaken with standardised criteria used to score each option against; this criteria is the same as that used during the hyperacute stroke review in 2011. Again this was a clinically led appraisal process. The outcome of the appraisal was the presentation of the preferred option - to consolidate acute rehabilitation onto one site at UHND with robust and effective community based rehabilitation in place. A major driver is to ensure care closer to home and effective use of resources.

Further to this, following extensive service improvement work within CDDFT, the service is confident that the capacity available could be reduced by eight beds as patients would be more effectively managed and discharged. This recommendation is a result of the implementation of a range of ongoing initiatives within the acute setting to manage patient flow and use the most appropriate care setting to manage people's conditions. A new model for community services was introduced in 2018 which strives to deliver more care closer to home. A significant amount of investment has also been targeted for community stroke rehabilitation within County Durham.

The aim is to deliver the best possible care to gain the greatest opportunity to improve patient outcomes within the resource available and to deliver this care closer to home wherever possible. The following business case outlines the proposals for consultation and highlights any impacts, benefits and risks (with mitigations) of the preferred option. It demonstrates the impact on patients and their families, outlining what will be different if the proposed model of care was to be implemented.

2.0 Vision

Our vision and commitment is:

- To develop a person-centred model of care that delivers care closer to home
- To minimise variation and maximise the health outcomes of our local population
- To develop a service which retains and attracts an excellent workforce
- To ensure care is accessible and responsive to people's needs

2.1 Scope

To present a robust evidence based business case to review the model of care for acute and community based stroke rehabilitation across County Durham and Darlington.

The scope of this project relates to the rehabilitation elements following an acute episode due to stroke, whilst also highlighting developments across the whole stroke pathway. This includes prevention through to longer term assessment and care. CCGs and CDDFT have a major emphasis on community services focusing on;

- Prevention and maintaining independence
- Supporting patients with long term conditions
- Managing crisis and supporting a return to independence

2.2 Aims and Objectives

- To review the model of care across County Durham and Darlington
- To understand the effectiveness of care provided currently and to review appropriateness in line with national policy, standards and best practice
- To commission services which fully support patients through the stroke pathway, using the resource available to achieve the best possible outcomes
- To engage with patients and carers who have used stroke services to gain an understanding of their experiences and their views on a different approach to their care
- To outline a range of options for the provision of stroke rehabilitation within a hospital setting as well as the community
- To outline a preferred option for a new model of care which assesses impact on the system and individual patient care
- To reduce avoidable admissions into hospital and ensure care is delivered closer to home where possible
- To ensure care is planned, integrated and seamless
- To ensure people are given the opportunity to reach their full potential and their rehabilitation goals

3.0 Introduction and Background

Stroke, a preventable disease, is the fourth single leading cause of death in the UK and the single largest cause of complex disability (Stroke Association (2018) State of the nation: Stroke statistics). The number of stroke survivors living with disability will increase by a third by 2035 (Patel, A., Berdunov, V., King, D., Quayyum, Z., Wittenberg, R. & Knapp, M. (2017)).

Strokes are a blood clot or bleed in the brain which can leave lasting damage, affecting mobility, cognition, sight and/or communication.

The Stroke Association State of the Nation report, February 2018 key statistics show:

- There are more than 100,000 strokes in the UK each year. That is around one stroke every five minutes.
- There are over 1.2 million stroke survivors in the UK.
- Stroke is the fourth biggest killer in the UK.
- A third of stroke survivors experience depression after having a stroke.
- Almost two thirds of stroke survivors leave hospital with a disability.
- People of working age are two to three times more likely to be unemployed eight years after their stroke.
- The cost to society is around £26 billion a year.

The following pre-consultation business case (PCBC) outlines the stroke specific services currently being delivered across County Durham and Darlington. It demonstrates current performance and the drivers for the proposed change. Throughout the report there will be references to national and local policy and initiatives which have demonstrated a step change in the effectiveness of care delivered for those who suffer a stroke in our region.

A significant amount of work has been done on ensuring patients are seen as quickly as possible once a stroke is suspected. However it is recognised that there needs to be a continuation of that transformation in order to give people in our area the best possible outcomes longer term.

The following section demonstrates the level of need in County Durham and Darlington for robust stroke prevention, hospital based care, community rehabilitation and long term care.

3.1 Demographics and Prevalence

Stroke remains a major cause of death and disability across County Durham and Darlington with around 1,000 people suffering a stroke each year. These patients need access to high quality, specialist hospital and community based care to give them every opportunity to reach their very best recovery goals.

County Durham

The overall population of County Durham is growing and ageing, with an increase in population for those more vulnerable groups – children and older people. The 65+ age group is projected to rise by 36.8% (n37, 300) between 2014-2030 and overall life expectancy for males and females is lower than the national average.

Stroke Specific prevalence – County Durham

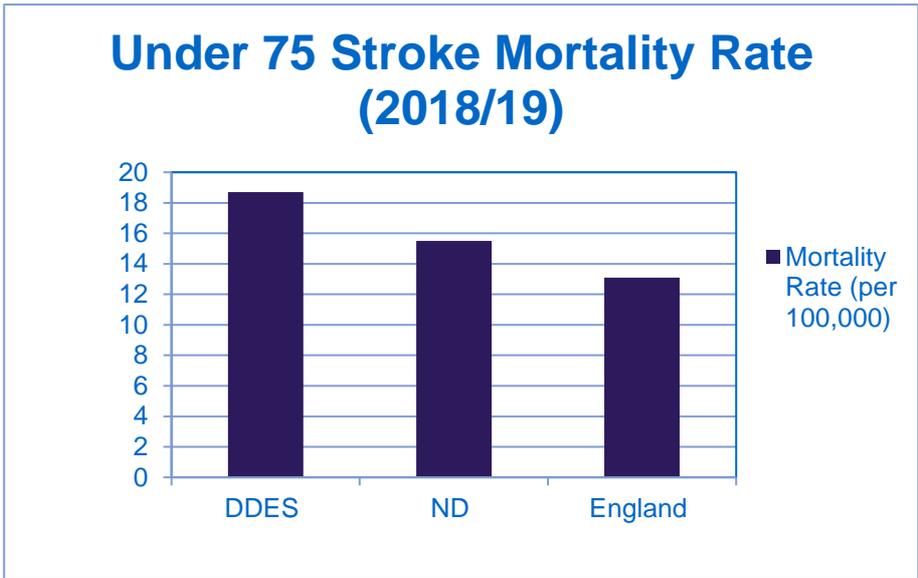


Figure 1 demonstrates that in both County Durham CCGs the under 75 mortality rate due to stroke is higher than the national average.

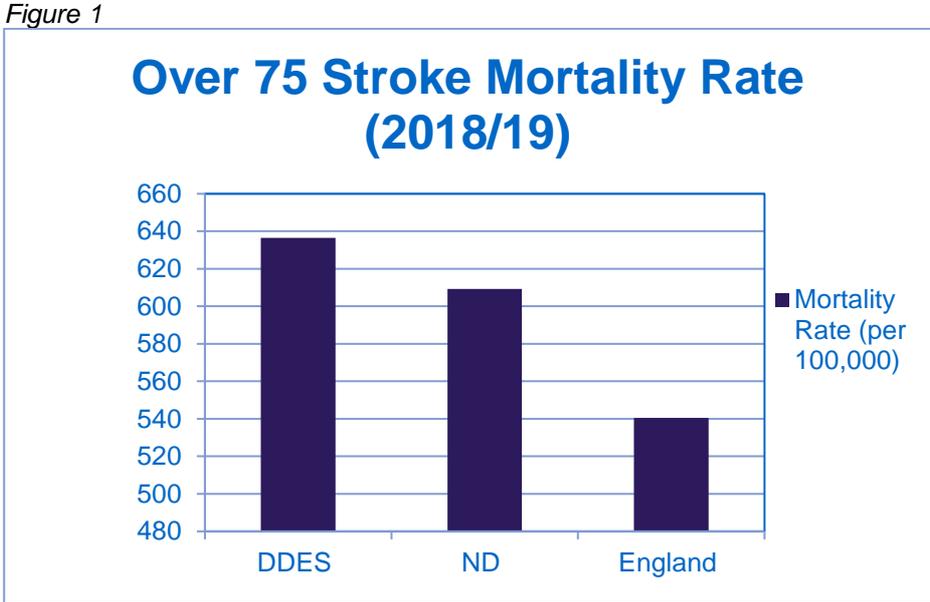


Figure 2 demonstrates that in both County Durham CCGs the over 75 mortality rate due to stroke is higher than the national average.

Figure 2

Both County Durham CCGs have a higher prevalence of stroke. The North Durham population has 2.2% prevalence whilst Durham Dales, Easington and Sedgfield (DDES) CCG have an average of 2.5% compared nationally to 1.8%.

CCG	Admission Rate (actual) (per 100,000)	Admission Rate- National Average (per 100,000)
DDES	174.5	169.1
North Durham	198.1	

Figure 3

Darlington

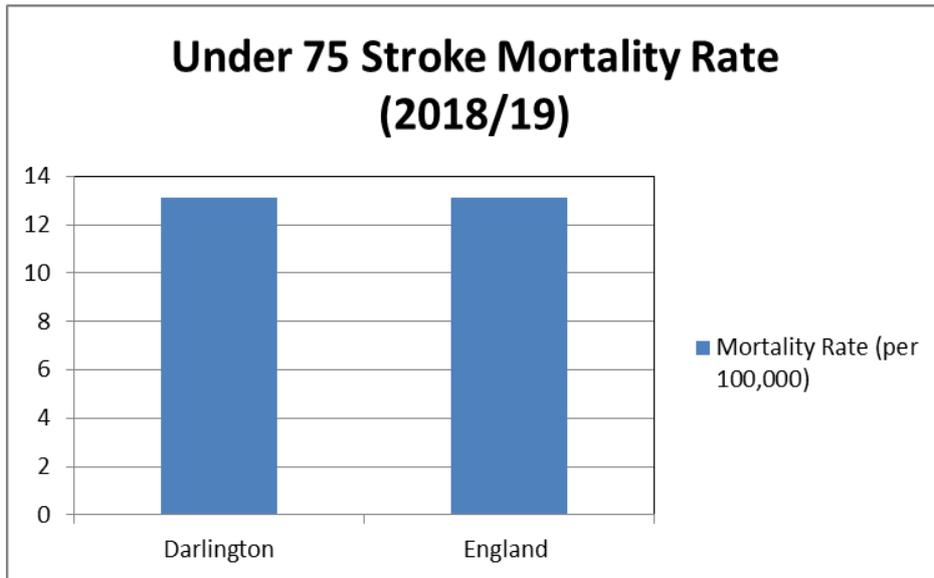


Figure 4 demonstrates that in Darlington the under 75 mortality rate due to stroke is the same at the national average (13.1)

Figure 4

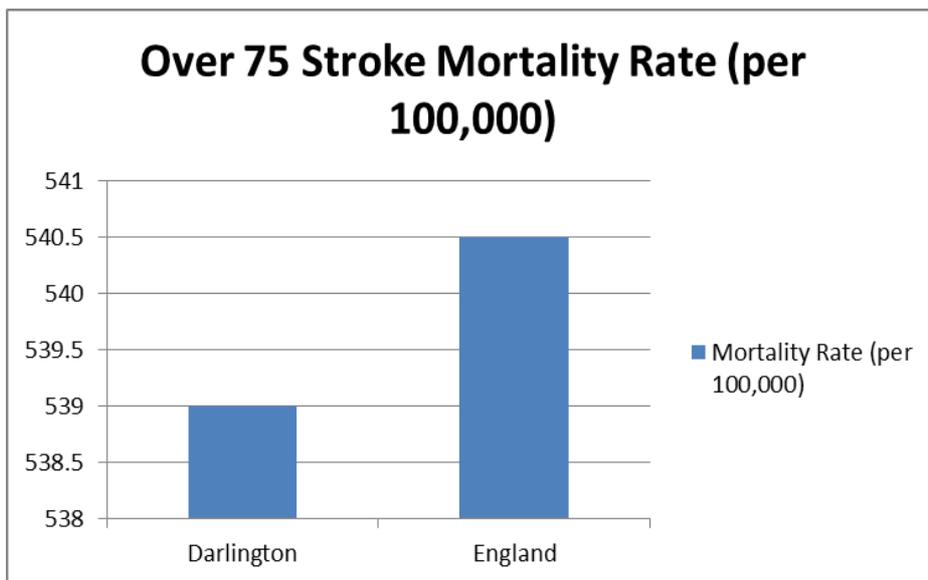


Figure 5 demonstrates that in Darlington the over 75 mortality rate due to stroke is slightly lower than the national average (539.0 vs 540.5))

Figure 5

Darlington has a higher prevalence of stroke (2.2%) compared to the national average of 1.8%.

CCG	Admission Rate (actual) (per 100,000)	Admission Rate- National Average (per 100,000)
Darlington	156	169.1

Figure 6

3.2 National Context & Evidence Base

NHS England's Long Term Plan (LTP) published in 2019, outlines the importance of access to specialist hyperacute stroke intervention, with availability 24/7. The changes made in 2011 to consolidate hyperacute stroke services at UHND secured this local provision, and locally this has had an impact on patient outcomes (please see section 4.1).

The LTP also highlights the aim of local systems to commission and deliver early supported discharge into the community. It is recognised that in order to improve patient outcomes and experience that specialist teams should provide seamless care from acute and into the community. There is also a commitment to delivering seven day services for stroke care in the next five years.

During the hyperacute phase there is also a commitment to ensure that patients receive the very latest in advanced techniques delivered by highly skilled specialist staff at the earliest opportunity. This in effect means that the local workforce need to be recruited and retained, developing clinical competencies and ensuring effective and efficient use of staff.

Longer term rehabilitation is a key area for improvement in the LTP. It is recognised nationally that currently patients are unable to access sufficient therapy to maximise recovery and it is particularly difficult to obtain vocational rehabilitation to help people get back to work. Not all longer term rehabilitation needs to be delivered by teams only treating stroke patients and not all patients will benefit from long periods of rehabilitation but there needs to be greater flexibility in provision. There needs to be the ability to meet the needs of individuals and there needs to be a standardised approach to the provision of care such that it is not influenced by where a patient lives.

The LTP sets out the ambition of having more intensive community based rehabilitation in place in order to reduce length of stay and hospital admissions in order to plough any cost efficiencies to improving direct patient care.

There is a strong commitment to improving rehabilitation services and in order to monitor the impact of this transformation the national dataset Sentinel Stroke National Audit Programme (SSNAP) will be modified to ensure measurement of outcomes across the whole pathway. Currently much of the focus is on the period of time shortly following a stroke, the move is to ensure performance drives quality throughout the patient pathway.

Stroke is a complex and devastating condition, the time needed for rehabilitation varies between people but will often need to continue long after leaving hospital, ideally in a person's own home.

For some people it can take months or even years to make a full recovery, while others have to live the rest of their lives with disability regardless of the quality of care provided. Evidence shows that rehabilitation at home is cost effective when delivered by specialist teams in the community as soon as the patient returns home.
(Reference SSNAP)

Length of stay has dropped considerably since the first national stroke audits began with many patients being discharged after less than a week. (Section 4.1 shows the average length of stay for stroke patients on ward 2 at UHND and ward 4 at BAH) Whilst this is encouraging it is widely recognised that most patients would prefer to continue their care at home if possible. However this also means that early supported discharge services and

wider community services need to be effectively organised to ensure smooth transitions of patient care from the hospital to the community. Community teams are best staffed with specialists in stroke care.

3.3 Best Practice and National Guidelines



There are various national best practice guidelines and clinical standards which promote the transformation of stroke services. Some of the key messages from the National Stroke Strategy (2007) and NICE guidance on stroke rehabilitation (2013) include:

- Intensive rehabilitation should occur in the community at the earliest opportunity
- Assessment should be ongoing and should happen at the earliest opportunity in the pathway to improve outcomes and ensure seamless transition
- The first two weeks following stroke should include short and frequent therapy in a community based setting
- Patients should have as few “hand offs” of care as possible
- Transfers of care from hospital to community should be seamless with a single multi-disciplinary team
- Discharge to assess is the best model to meet people’s needs, using the home first philosophy
- Ensure an integrated approach to rehabilitation

Community rehabilitation is a key element of stroke rehabilitation and is defined within National Strategy/NICE guidance with 2 key elements – Early Supported Discharge and on-going stroke specific community rehabilitation. Section 8.3 shows current best practice compared to our current service offer and highlights any gaps in provision against recognised clinical standards.

4.0 Local Context

There are three CCGs leading this review of stroke services across County Durham and Darlington, they are North Durham, Durham Dales, Easington and Sedgefield (DDES) and Darlington. The main provider of services for both acute and community is County Durham and Darlington NHS Foundation Trust (CDDFT) who are key partners/experts supporting the review of stroke rehabilitation services. They operate out of three main acute sites with a range of community hospitals and services delivered in local settings.

	Acute Sites	Community Hospitals
County Durham and Darlington NHS Foundation Trust	University Hospital of North Durham	Chester-le-Street Hospital
	Bishop Auckland Hospital	Shotley Bridge Hospital
	Darlington Memorial Hospital	Sedgefield Hospital
		Weardale Hospital
		Richardson Hospital

Figure 7

The overall population of County Durham and Darlington is just less than 650,000.

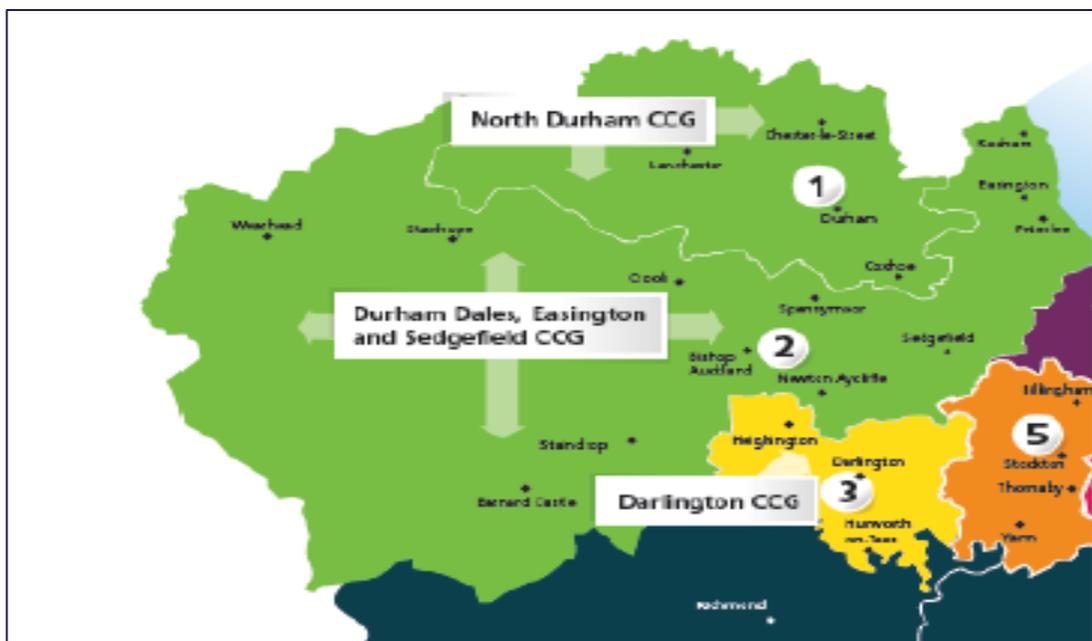


Figure 8

A public consultation took place during 2011 to consolidate hyper acute stroke care to one site based at University Hospital North Durham (UHND) and rehabilitation care at Bishop Auckland Hospital (BAH) for those patients requiring further inpatient therapy support.

The Department of Health's National Stroke Strategy for England (2007) identified care in a stroke unit as the single biggest factor to improve outcomes after stroke. Direct admission to a dedicated stroke unit remains the most important intervention we have for acute stroke. A major review, 'Organised inpatient (stroke unit) care for stroke', found that stroke patients who receive organised inpatient care in a stroke unit are more likely to be alive, independent, and living at home one year after the stroke. In addition to the access required to a specialist unit at the time of an emergency, it is also highlighted that robust discharge processes are needed to ensure people leave in a timely way with the support of an integrated team.

County Durham and Darlington CCGs have made a commitment to review the rehabilitation elements of local pathways any improvements made during the hyperacute stage are sustained throughout the patient’s journey to recovery.

There is an opportunity to improve both the quality and efficiency of the care we commission and provide. If we are to have a safe, sustainable stroke services that are set up to facilitate greater advances in care and outcomes we need to address three key factors:

- Changing patterns of need;
- Improving clinical standards of care;
- Making the best use of an expert workforce;

A change to the model of delivery for stroke rehabilitation care is a key initiative for County Durham and Darlington CCGs and County Durham and Darlington Foundation Trust (CDDFT) and supports recommended guidance and the #Next Step Home agenda. In line with CCG strategic aims and priorities the proposed service will:

- Secure the right services in the right place - the service will ensure patients are treated in the right place, at the right time, by the right clinician.
- Manage resources effectively - through reducing lengthy stays in secondary care providing a cost saving.
- Deliver a standard, equitable and appropriate stroke rehabilitation pathway.
- Make services more accessible and responsive to the needs of our communities

Organisation (provider)	Number of provider spells	Number of bed days	Average length of stay (LOS)
SOUTH TYNESIDE NHS FOUNDATION TRUST	37	199	5.38
CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST	658	11745	17.85
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	849	8396	9.89
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	946	14016	14.82
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	659	10789	16.37
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	567	6278	11.07
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	852	11612	13.63

Figure 9 – 2018/19

Figure 9 shows the average length of stay for inpatient stroke services at CDDFT across UHND and BAH. The data suggests that there is scope to reduce length of stay particularly in light of the focused transformation on community based services and the overall aim of delivering care closer to home.

CDDFT has been involved with a series of hospital-based improvement programmes including SAFER and PJ Paralysis. Both of these transformation programmes focus on the time spent during an acute episode ensures the benefits of hospital based care are maximised and that patients have a focus of recovery.

SAFER is a tool used to aid patient flow – that is the transition of care within a system, from the time a patient enters the hospital to the point at which they are discharged. The toolkit is designed to reduce unwarranted variation and to ensure care is delivered in a seamless way. The key elements of SAFER include

- Patients receiving a senior review before midday to ensure robust decision making and action
- All patients will have an expected discharge date at the earliest point in their care episode
- Early (supported) discharge will be delivered
- Where patients are in hospital longer than 7 days, a multi-disciplinary team will review patients with a clear 'home first' mindset

PJ Paralysis is an initiative aimed at getting patients out of bed and into a chair with their own clothes on wherever possible. This is proven to aid recovery, reduce length of stay, promote wellbeing and enable people to feel dignified. Staff on all wards throughout CDDFT were engaged in this work to ensure patients have the opportunity to gain the best possible outcomes from their care in hospital and to be discharged home at the earliest point.

We are supporting...

#EndPJparalysis

NHS
County Durham
and Darlington
NHS Foundation Trust

Help us, to help you.

Evidence shows that patients who get dressed during the day; recover quicker and feel better.

What can you do: If you are a patient or a loved one visiting a patient you can help by making sure there is a change of clothes available as well as a pair of sensible shoes rather than slippers.

Aiming for 1 million patient days dressed in own clothes & moving in 70 days. Let's help our patients get home back to loved ones

If you had 1000 days left, how many would you want to spend in Hospital? That's why EVERY DAY matters

PJ paralysis...

FACT: Reduces mobility
FACT: Loss in strength
FACT: Loss of independence
FACT: Longer stay in Hospital

with you all the way

www.cdft.nhs.net

Figure 10

Stroke is a national priority and the lack of standardised rehabilitation services within our CCG areas does not serve the rehabilitation needs of patients who have had a stroke.

During 2018/19 County Durham and Darlington CCGs conducted a whole scale review of community services which resulted in a procurement exercise in order to bring about positive change. Throughout this period multiple providers have been replaced with one major provider, who also delivers acute care in the locality. The advantage of having one provider across acute and community affords the local health system the opportunity to deliver transformational change in partnership with local clinicians and patients in a seamless way. As part of the mobilization of this new contract, work to prioritise service developments was undertaken and as a result stroke was identified as an area which needed some focused service development.

4.1 Quality and Performance

Organising stroke care effectively across a whole network is one of the main priorities for the NHS as outlined in the NHS LTP. This may mean that patients need to travel further to access the specialist care that they need but there is little point being admitted to a hospital that cannot provide the necessary treatments.

This work to consolidate specialist stroke units was done in County Durham and Darlington in 2011. The outcome of this work was the implementation of a single specialist stroke unit at University Hospital of North Durham (UHND) with hospital based rehabilitation being delivered out of Bishop Auckland Hospital and variability in terms of the community offer.

The **Sentinel Stroke National Audit Programme (SSNAP)** is a major national healthcare quality improvement programme, measuring the quality and organisation of stroke care in the England, Wales and Northern Ireland. This audit tool is completed by all organisations within the NHS providing stroke care and is based on nationally recognised clinical standards. NHS Trusts record data which is analysed and reported on by the national team so that clinicians, commissioners and members of the public can identify how well local services are performing. We have used this information (shown in figure 11) to identify areas for improvement as part of the review.

The **Getting It Right First Time (GIRFT)** programme is designed to reduce variation in care pathways, share best practice and use information to ask questions about the quality and efficiency of care being delivered. GIRFT looks at many different care pathways including surgery, cancer care and in this instance stroke care. The ambition of the programme is to identify examples of innovative, high quality and efficient service delivery. The national GIRFT team visited the North East on the 15th March 2019. Some of the information and discussion below includes the data shared with the team and outlines their recommendations as a result. The GIRFT team's recommendations focus on the work outlined within this business case. These recommendations will also be used to help shape a set of national guidelines which will be published by GIRFT in the next 12 months.

SSNAP Scoring Summary:		Team	University Hospital of North Durham
		Time period	Jan-Mar 2019
		SSNAP level	B
Patient-centred Domain levels:		1) Scanning	A
		2) Stroke unit	B
		3) Thrombolysis	B
		4) Specialist Assessments	B
		5) Occupational therapy	C
		6) Physiotherapy	A
		7) Speech and Language therapy	C
		8) MDT working	C
		9) Standards by discharge	A
		10) Discharge processes	C

Figure 11

Hyperacute phase

Since its implementation the quality of care and performance of the hyperacute service has significantly improved.

- ✓ For example UHND administers blood clot busting drugs (thrombolysis) within an average of 30 minutes, well below the national average of 50 minutes. In the last quarter the unit had the best performing clock stop to thrombolysis time in the country at 26 minutes.
- ✓ The Getting it Right First Time (GIRFT) team commended CDDFT for the process they have in place and for the performance of direct access 24/7 into a hyper acute unit and as a result the excellent door to needle times being achieved.
- ✓ The stroke unit at UHND were able to, on average, have a first consultant review within 7 hours, with the England national average at over 9 hours.

Therapy provision

- ✗ Due to the service currently operating across two sites it is a significant challenge to meet the standards associations with therapy due to a limited workforce.
- ✗ Therapists are unable to follow best practice currently in terms of following the patient from acute ad into a community setting
- ✗ The national target around swallow screening, which is meant to happen within four hours of admission, and being able to deliver a swallow assessment within 72 hours is not performing as well as it could.
- ✗ According to SSNAP data and following the recent GIRFT review there is a potential improvement to be made in terms of the percentage of people who are

identified as having an Occupational Therapy (OT) requirement. In addition, of those people identified as having a need for OT, the ability to deliver the average of 40 minutes per day is not achieved (currently 32 minutes).

- ✘ University Hospital of North Durham are currently assessing fewer than 65% of patients deemed applicable for physiotherapy, compared to the national average of 87%. The number of minutes of physiotherapy received per day by patients was also lower than the national average of 35 minutes per day.
- ✘ Those assessed as being suitable to receive Speech and Language Therapy (SALT) is lower than average at just 25% compared to 50% nationally. However the minutes of SALT per day is higher than the national rate of 32 minutes per day and is in fact performing at 36 minutes per day.
- ✓ Performance regarding nutrition screen, and patients being seen by a dietician before discharge, was achieved by CDDFT.

Rehabilitation and long term care

- ✘ The latest regional GIRFT report showed that combined nursing therapy and rehabilitation goals, were achieved at a rate of above the national average of 65%, in all units apart from University Hospital of North Durham, and Cumberland Infirmary, where this was achieved in 46% and 47% respectively.
- ✘ There are very few CDDFT patients who are classed as being discharged into an Early Supported Discharge (ESD) Team and these are only within the Easington locality.
- ✘ Also currently although patients are being seen by the Stroke Association for their six month review, this information is not being recorded against the standard (please see section 7.5 for actions taken to remedy this).

Bed occupancy

	2017/18	2018/19
Ward 2 (UNHD) and ward 4 (BAH)	92.11%	91.66%
Ward 2 (UHND)	86.06%	86.52%
Ward 4 (BAH)	97.98%	96.95%

Figure 12

Figure 12 outlines the bed occupancy for ward two at UHND and ward four at BAH. Bed occupancy has remained fairly static across the two years across both sites.

Length of stay

Ward	2017/18				2018/19			
	DDES	Dton	Durham	Other	DDES	Dton	Durham	Other
Ward 4 (BAH)	25.6	27.1	28.6	18.3	23.1	19.0	20.4	16.1
Ward 2 (UHND)	3.9	4.3	3.8	4.7	4.3	4.2	4.8	4.7

Figure 13

Figure 13 outlines length of stay (LoS) for both stroke wards for DDES, Darlington and North Durham. LoS is longer on ward 4 at BAH for all CCG localities than at ward 2 at UHND, the overall aim of the health system is to reduce LoS by delivering more care in the community. Families of those who stay on ward 4 at BAH for this length of time and who don't live close by may find it a challenge to access the hospital to visit. Although it is anticipated that the current LoS at UHND will increase due to the proposed change, the overall length of time required for inpatient based rehabilitation should reduce due to;

- the improved supported discharge process
- the enhanced levels of community based care

Stroke admissions by postcode

Postcode	Postcode area	2017/18	2018/19
DH1	Durham	51	56
DH2	Chester Le Street	37	42
DH3	Chester Le Street	27	35
DH6	Durham	65	47
DH7	Durham	56	63
DH8	Consett	55	63
DH9	Stanley	56	48
DL1	Darlington	66	70
DL12	Barnard Castle	24	26
DL13	Bishop Auckland	24	27
DL14	Bishop Auckland	56	80
DL15	Crook	38	45
DL16	Spennymoor	27	39
DL17	Ferryhill	53	32
DL2	Darlington	17	12
DL3	Darlington	56	65
DL4	Sildon	17	19
DL5	Newton Aycliffe	50	49
TS28	Wingate	1	2
TS29	Trimdon Station	1	0

Figure 14

Figure 14 shows stroke admissions by postcode area. There are a proportion of these admissions from ward 2 at UHND who are then transferred to ward 4 at BAH. The table has had the limited number of out of area admissions removed, so the data reflects admissions per postcode within the three CCG areas. As is evident there are admissions from across County Durham and Darlington who may require ongoing inpatient rehabilitation following their stay at UHND. Currently patients would be transferred to ward 4 at BAH which provides care closer to home for those in the Bishop Auckland area however not for those elsewhere in the county.

The GIRFT review process recognized the variability in community based rehabilitation and recommended a need to review in line with national policy and standards.

Further Recommendations from GIRFT Team

Therapy

- Increase therapy staffing on Acute stroke unit and provision for Early Supported Discharge (ESD) to facilitate discharge and reduce Length of Stay (LoS)
- **Consider ring fenced stroke therapy or Combined Stroke unit (acute and rehab) at single site**

Consultant Cover

- **Review of split site working to improve efficiency of medical workforce cover.**

6 month reviews

- To ensure data is captured on the SSNAP system

5.0 Patient Experience and feedback

CCGs and provider organisations have a duty to engage and consult on any potential major service change as described within the NHS Act 2006.¹

It was really important for the CCGs to understand people's experiences of stroke rehabilitation across County Durham and Darlington. The CCGs wanted to understand what currently works well and what could be improved, especially with regards to rehabilitation from a patient and carer perspective.

At this stage of the review the engagement needed to focus on people's experiences of services at UHND and BAH (if applicable) and within the community. This Pre-consultation Business Case (PCBC) outlines the preferred option in which to consult on. During this time there will be an outline of the current service and the proposal for future stroke rehabilitation services to seek views on.

The information below provides an overview of the different phases of engagement and a summary of some of the key themes which emerged as a result. The full communications and engagement report is available in appendix one.

¹ NHS Act 2006
www.legislation.gov.uk

Phase One

During November and December 2018, across County Durham and Darlington, a period of eight weeks engagement was undertaken by North Durham CCG and Durham Dales, Easington & Sedgefield CCG with past and current service users and local stakeholders to gather views about the rehabilitation services.

A range of engagement activities were carried out which included an online survey, local focus groups, service user engagement meetings and targeted engagement with groups with protected characteristics.

- There were over 160 responses to the engagement exercise
- Survey developed – used online and as a print out
- Spoke with existing community groups
- Patient survey carried out on the wards at BAH and UHND
- Social media used to publicise

Key Themes from Phase One

- Positive experiences of hospital care
- Limited dedicated community based stroke provision
- “Too many people involved in my care”
- People would value care closer to home
- People value peer support

What does good look like...patient engagement feedback

- Being cared for by one team during your hospital stay and into your home
- Providing information once, to a multi-disciplinary team
- Care is joined up and coordinated as part of a plan
- Known relationships with patient and family
- Improved patient experience and health outcomes

Phase Two

It has been recognised that further work was required to ensure that all views were captured from people who had recent experience of stroke services. The feedback that was received in phase one was comprehensive and to enhance this with more feedback from people who had had a stroke within the last year to gain further understanding.

As part of the review a patient engagement exercise took place with patients that have recently suffered a stroke. The engagement was carried out by the Stroke Association. The Stroke Association carry out holistic reviews of patients six months after they have had a stroke. This review provides the opportunity to assess whether a patient's needs have been met, to have their progress reviewed and future goals set and if further support is needed. This service is commissioned locally and both County Durham and Darlington patients were included in the dataset. Letters were sent to individuals with an accompanying survey and pre-paid return envelope. During this engagement phase there were 79 responses across County Durham and Darlington.

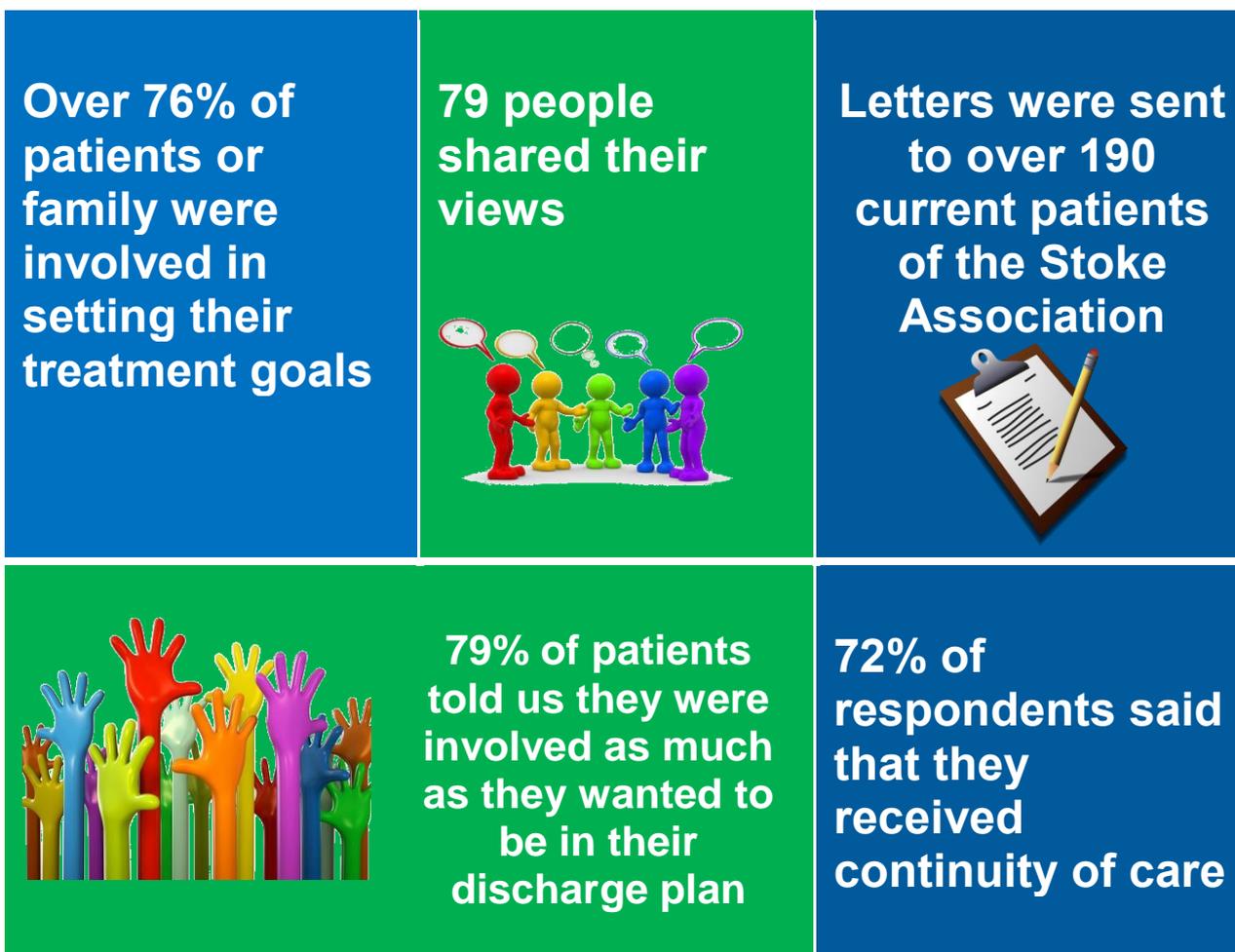


Figure 15

Key Themes from Phase Two

- On discharge from UHND the majority of patients 75% (45) patients went home, 22% (13) went to Bishop Auckland Hospital and 3% (2) went to intermediate care eg: a community hospital / residential home or another service.
- Many people felt they would have benefited from more therapy input both in a hospital and community setting
- Out of 59 respondents to the question, over 42% (25) said that they were contacted by a member of the Community Stroke Rehabilitation team within 24 hours of their discharge from hospital. Over 25% (16) said they were not and 30% (18) said they can't remember.

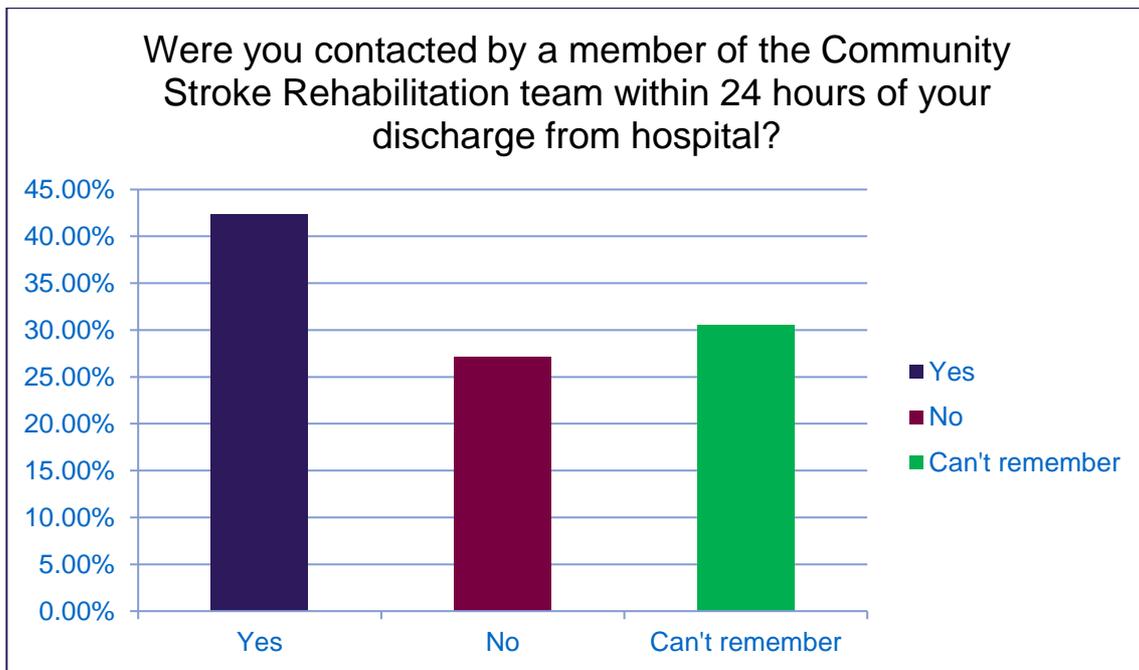


Figure 16

Some Comments

- “I was well looked after in both Durham and Bishop Auckland on both occasions and the help has helped me to remain positive”.
- “I received a lot more (therapy) at Bishop Auckland than at UHND”.
- “It was about four months before I received help from a very good speech therapist after returning home from Bishop Auckland Hospital”.

The information collected during phase one and two will be used to inform the overall decision making process regarding future provision for stroke rehabilitation across County Durham and Darlington. Appendix two contains the plan for consultation.

6.0 Staff Engagement

Throughout the review of the stroke pathway, the CCGs have been working with staff across hospital and community based settings. We have had ongoing dialogue with the teams to understand the challenges faced and working with them to understand how stroke services could be maximised and improved for patients and their families.

The highly skilled staff within this area have been using their knowledge and expertise to outline where within the current service there maybe some gaps in terms of achieving the very best possible clinical outcomes. We have listened and involved them throughout this process (see options appraisal process section nine) and will continue to communicate and engage as we continue with this project.

7.0 Current State

This section outlines the current pathway for stroke services within County Durham and Darlington. The information below outlines the end to end pathway from prevention through to long term care, however the focus of this service review is on acute and community based rehabilitation (see section 2.1).

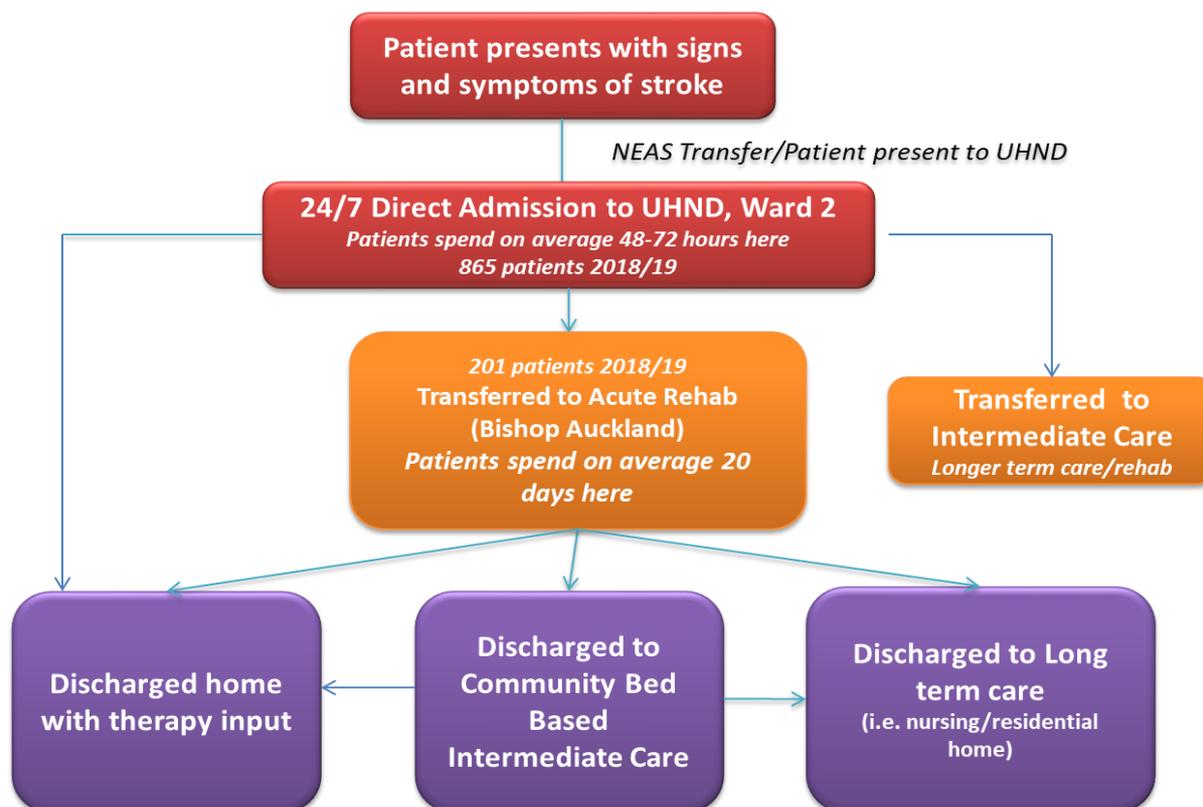


Figure 17

7.1 Stroke prevention

Atrial Fibrillation (AF) significantly increases the risk of someone suffering a stroke if left untreated. A programme of work is underway across local CCGs to improve the detection rates and treatment of AF. A programme of work has been rolled out within primary care to:

- Implement a local clinical pathway to reduce variation, improve clinical outcomes and reduce strokes
- Improve clinical confidence and knowledge across primary care networks
- To ensure medicines are optimised to treat and control patients diagnosed with Atrial Fibrillation and reduce the risk and incidence of AF related stroke

This work is being rolled out and evaluated in partnership with the Academic Health Science Network (AHSN).

7.2 Hyperacute Model of Care

People who are suspected as having had a stroke are taken as an emergency, usually via an ambulance directly to ward 2 which is a specialist hyperacute stroke unit at UHND. This unit has 24 beds currently. This service was implemented in 2011 and as the performance information (section 4.1) suggests the hyperacute elements are delivering high quality and high impact services.

It is expected that patients receive fast access to a specialist assessment from a senior clinician; they receive required diagnostics and are treated appropriately in a timely manner. Rehabilitation starts at the earliest opportunity and the ethos of recovery very much part of the culture. Discharge planning starts at an early stage with dialogue between clinicians, the patient and their family/carers.

The majority of patients (76%) are then discharged into the community for ongoing rehabilitation. Some are discharged for ongoing hospital based specialist rehabilitation on ward 4 at Bishop Auckland Hospital (24%).

7.3 Stroke Rehabilitation

There are currently 26 beds at BAH which are dedicated to inpatient based stroke rehabilitation, as detailed around 24% of patients currently use this facility from across County Durham and Darlington. There is however also an opportunity for other community hospitals to be utilised for rehabilitation. The current usage of these wards is shown in figure 18. This table identifies the number of admissions compared to the patient's location (broken down by locality).

Admitting Hospital	2018/19					
	Easington	Durham Dales	Sedgefield	Dton	Durham	Other
Weardale	2	209	26	20	87	2
Sedgefield	61	57	233	104	87	15
Richardson	1	291	58	216	8	32
Shotley Bridge	15	67	9	5	2294	81
Chester le Street	2	2	3		36	4
B16	2	20	21	9	19	3

Figure 18

Following the patient's hyperacute episode the majority of patients (76%) will be transferred home/residential care for ongoing community based specialist rehabilitation. For these patients there is variability in the level of care available depending on whereabouts in County Durham and Darlington the patient lives. Currently there is no transition between acute and community based services. At present the only stroke specific community service provided is within the Easington Locality.

There are also specialist neurological rehabilitation teams within North Durham. In the Darlington locality there is a Responsive Integrated Assessment Care Team (RIACT) in place to manage people in the community. There is generic therapy input as part of the community service throughout County Durham and Darlington, however currently the specialist stroke element is sporadic.

Currently some patients (24%) are transferred from the hyperacute ward at UHND to BAH (ward 4) for ongoing specialist rehabilitation. There are currently 26 beds on this ward. For these patients they are transferred by ambulance when they are clinically safe to do so and handed over to another team for the next phase of their care. Currently people stay on this ward on average for 20 days before then being discharged into the community.

7.4 Psychological Support

Currently there is no dedicated clinical psychological support available for people who have suffered a stroke; however patients have access to the Improving Access to Psychological Therapies (IAPT) service. Psychology will be reviewed at a later stage in this programme of work and links have already been made between the Stroke Consultants and local Psychologists to scope potential future provision.

7.5 Stroke Six Month Review

Currently within County Durham the Stroke Association delivers a six month review service (service pathway shown in figure 20). National guidelines outline the importance of a longer term review exercise for those people who have had a stroke to ensure individuals get the support they need. The Stroke Association carries out a review with the patient and (in some cases) the carer/family to understand physical, emotional and any other practical needs.

The 6 month review service allows a person with stroke to be reviewed by a trained professional to understand how they are recovering, whether they need to make changes to lifestyle or whether further therapy is needed. An assessment at six months also allows patient outcome data to be reported on which demonstrates the impact that treatment has had on patients. Measuring patient outcomes over time is an important tool for improving stroke services.

Six month reviews will be offered to 100% of adults resident in County Durham or who are registered with a GP in county Durham excluding Easington locality as a service already exists (provided by CDDFT), who have been diagnosed as having had a stroke by a secondary care physician.

The service has been in place since June 2018 and the number of reviews offered, completed and declines during 2018/19 can be seen below.

Reviews	1	2	3	4	Total
Offered	23	63	70	69	225
Completed	18	52	49	32	151
Declined	5	11	21	33	70
GP informed within 10 days	18	52	49	32	151

Figure 19 – number of reviews offered, completed and declined during 2018/19

Some of the key outcomes during this time include;

- *Better understanding of stroke and risk - All service users are educated about the effects of a stroke and stroke prevention.*
- *Feeling Reassured - All service users given reassurance about their ongoing needs.*
- *Reduced anxiety and stress – Stroke recovery coordinators have been able to calm service fears and anxieties.*

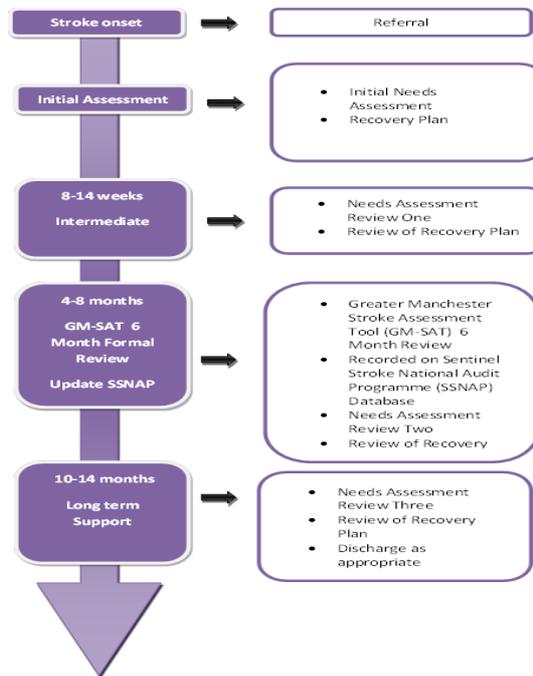


Figure 20 – SA 6 month review pathway

Currently this information is not captured as part of the SSNAP data collection; however work is underway to understand how this can be remedied. This will be resolved in the very near future to ensure that regardless of the provider, such information can be recorded and fed into the overall position for stroke services in County Durham. Both the County Durham CCGs and CDDFT value the service currently being delivered by the Stroke Association and the local health system see the value of this continuing.

8.0 Case for change – Stroke Rehabilitation

The current model of stroke rehabilitation care is inequitable across the county and not compliant with national evidence and best practice.

As you will see from figure 17 the majority of people are discharged from UHND into a community setting and receive varying levels of therapy input. There is also a proportion that requires longer acute specialist rehabilitation that are currently transferred to BAH ward 4.

8.1 Acute based rehabilitation

The resource for acute based stroke services is currently stretched across two sites – this includes consultant, nursing and therapy based provision. Acute based rehabilitation is delivered from both UHND and BAH sites currently. The current LoS on ward 4 at BAH is 20 days and national best practice suggests this should be no longer than 7 days. It is recognised however that one of the major causes of this prolonged LoS is that currently clinicians do not feel confident in the level of provision being offered in the community. Clinicians feel that they “hold onto” people for longer in a hospital setting whereas if there was a robust and consistent community based rehabilitation service in place they would discharge people at an earlier opportunity.

8.2 Community based rehabilitation

During 2018/19 a total of 865 patients suffering a stroke were admitted to UHND, a significant proportion of which would require some level of stroke rehabilitation in the community each year.

National research suggests 41% of stroke patients would benefit from community stroke rehabilitation, a total of approximately 354 of the 865 patients would be requiring community rehabilitation in our area recognising that the physical and mental capacity to participate in rehabilitation varies widely from person to person.

Within the North Durham, Durham, Dales Easington and Sedgfield and Darlington CCG areas there are differences in the community therapy rehabilitation provision for patients who have sustained a stroke and who require rehabilitation following their in-patient stay.

Historically community stroke services have been formed in an unstructured way in an attempt to cope with demand but with limited funding opportunities. To reduce the impact of this postcode lottery in terms of provision, and for the benefit of the patient population group we serve, there is a need to provide a standardised community rehabilitation pathway for patients who have suffered a stroke to follow.

Additionally the current geographical inconsistencies in provision cause difficulties in managing expectations and the opportunity to optimize rehabilitation potential.

There is currently a designated stroke community service operating within Easington locality, however in the other Localities there is a variable levels of community stroke rehabilitation delivered as part of a wider therapy service provision. Those gaps / limitation of community rehabilitation provision contribute to increased length of stay in hospital, especially in the DDES locality (with the exception of Easington).

There is therefore a need to level up services across the County for OT, Physio and rehab assistants as well as ensuring the provision of SALT and Dietetic clinicians to ensure standardisation of service delivery.

8.3 Gaps within current state vs. best practice

Policy Context	Key Theme	Gap in Current Provision
Stroke Strategy 2007	Hand offs of care	The current pathway promotes multiple transfers of care
NHS England's Quick Guide: Discharge to Assess and benefits for older, vulnerable people.	Discharge to assess	Therapy assessment takes place within a hospital setting rather than in the person's home setting

Policy Context	Key Theme	Gap in Current Provision
Stroke Guidelines 2016	Equity of access to comprehensive specialist community rehabilitation	Current community based rehab services are inequitable across County Durham
SSNAP Audit 2016	Levels of recommended therapy input	Rehabilitation within the community doesn't provide the intensity required as detailed in national guidance
SSNAP Audit 2016	Levels of recommended therapy input	Patient based outcomes could be improved upon e.g. time for therapy based interventions
Stroke Specific Education Framework	Efficient use of clinical staff	Currently staff have to cover two sites, for example medical rotas for consultants are difficult to manage and sustain with limited workforce
NICE guidelines - continuity of care and relationships in adult NHS services	Continuity of care	Currently many patients are handed off to another team so patients don't have the familiarity of staff
Stroke Specific Education Framework	Effective recruitment and retention of staff	The expertise is diluted currently across two sites and staffing levels are limited – lack of contingency
Stroke Guidelines 2016	Early supported discharge	Currently not in place

8.4 Workforce challenges

As described the current service model for acute stroke rehabilitation is spread across two sites – UHND and BAH. This means that staffing is stretched across different locations and there is an inability to operate as “one team”. In terms of medical staffing, there is a requirement to have consultant leadership in place across both sites. Due to the limited medical workforce this creates a further difficulty in relation to planning rotas and the sustainability of this longer term. As discussed in a recent GIRFT visit it was highlighted that although CDDFT were managing to ensure clinical standards were upheld they did share their concern regarding the ability to maintain medical cover on multiple sites in the longer term. Staff time isn't used as efficiently as it could be due to travel time required between sites.

Within the current model there is a reduction in the levels of contingency in place across all staffing groups. The sense of “team” is somewhat lost, particularly in relation to training and team working. Ideally all staff groups would benefit from caring for people throughout their acute episode, learning from each other and creating development opportunities for

staff. The service feels that the current model potentially inhibits their ability to effectively recruit and retain staff, particularly in relation to the therapies workforce.

They will also lead to an exacerbation of the workforce challenges we are already facing. Staff frustration at being unable to provide the care to the standard they know is needed can lead to lower morale, recruitment and retention problems, leading ultimately to reduced staff productivity, and reliance on high-cost bank and agency staff.

County Durham and Darlington stroke services want to promote their model of care to demonstrate that it is a great place to work; to retain and attract the very best in terms of highly skilled and competent staff.

8.5 Financial challenges

- Inefficient care models are driving up costs. Insufficient focus on prevention and treating people in the wrong care setting both push up the cost of care. This is most obvious in the occupation of acute beds by patients who could have been better treated in community settings, discharged sooner, or whose admission could have been avoided in the first place.
- The current service model means that there are two sets of running costs dual to the dual site model.
- The cost of bank and agency staff has an impact on all services. Any initiative implemented to improve the recruitment and retention of staff, means that limited resources can be used to provide high quality direct patient care.
- Unwarranted variation in clinical practice is increasing the cost of care, increasing opportunity cost through increased claims on clinical time, or both.

9.0 Options Criteria & Process

A clinically led group was set up to develop options for the future model for acute stroke rehabilitation across County Durham and Darlington. Representation on the group included specialist stroke consultants, matron, ward sister, therapy leads, operational managers and commissioners. Alongside this the group had access throughout to the feedback received from the engagement work which was done with patients and their families who have recently had experience of local stroke services.

The criteria, which was used to measure options against, was the same used during the exercise completed in 2011 for the reconfiguration of hyperacute stroke services (see section 4). The criteria used (table below) were chosen to help ensure a high quality, long term acute stroke rehabilitation service for County Durham and Darlington.

Clinical quality	Maintains or improves clinical outcomes; timely and appropriate services; minimises clinical risk	Patient, Public and carer Engagement – Experience and Feedback
Sustainability/flexibility	Ability to meet current and future demands in activity; ability to respond to local/regional/national service changes	
Equity of access	Reasonable access for urban and rural populations	
Efficiency	Delivers patient pathways that are evidence based; supports the delivery though access to resources	
Workforce	Provides environments which support the recruitment/retention of staff; supports clinical staffing arrangements	
Functional suitability	Provides environments suitable for delivery of care; clinical adjacencies with other relevant services/dependencies e.g. imaging	
Acceptability	Acceptable to service users, carers, relatives, other significant partners	
Cost effectiveness	Provides value for money	

Each option was assessed against the range of criteria identified by the multi-disciplinary group with supporting information used from the patient engagement exercise carried out.

9.1 Options Appraisal

The table below outlines the options that were assessed. There were further scenarios which were explored but they were discounted on the grounds of being unable to meet core clinical safety standards at an early stage. This included the inability to house both hyperacute and acute rehabilitation at BAH. The main reason for this being disregarded as an option is the fact that there are no critical care facilities available at this site. Without critical care the unit would be unable to accept people at the point of emergency i.e. immediately following a stroke.

On this basis there are essentially two options to consider, one of which includes continuing to deliver the current model of service.

Option	Description
1	Do nothing
2	Co-locate in-patient rehabilitation care within hyperacute facility (UHND) and develop an effective and seamless community rehabilitation service.

The options appraisal process was undertaken and each option was assessed against the criteria and given a score out of 10 for each component. The table below summarises some of the key points raised and outlines the scores for each element.

Option one – do nothing

Criteria	Score (out of 10)	Narrative
Clinical quality	5	<ul style="list-style-type: none"> Majority of SSNAP indicators met Issues in relation to therapy quality indicators unable to be met Unnecessary hand-offs between teams on each site
Sustainability/flexibility	4	<ul style="list-style-type: none"> As medical advances continue, length of stay reduces and there is an emphasis on care closer to home i.e. in the community Operating two sites is not sustainable in terms of workforce Loss of clinical time available due to travel
Equity of access	8	<ul style="list-style-type: none"> BAH is closer for acute rehab for those who live in the South of County Durham and Darlington Currently those in the North are travelling to BAH All patients have access to same level of inpatient care

Criteria	Score (out of 10)	Narrative
Efficiency	6	<ul style="list-style-type: none"> Increased length of stay, which could be improved by more effective discharge processes and community provision Transport required to transfer patients between sites
Workforce	6	<ul style="list-style-type: none"> Staff are diluted across two sites Limited consultant workforce required to cover multiple rotas Learning and development opportunities reduced Workforce complement doesn't provide medical cover 24/7 at BAH
Functional suitability	6	<ul style="list-style-type: none"> Facilities at BAH suitable for rehab Where a patient becomes medically compromised there may be a need to transfer back to UHND
Acceptability	6	<ul style="list-style-type: none"> The level of care experienced by patients and their families at both sites is good overall People in the south of the county and in Darlington benefit from the location
Cost effectiveness	5	<ul style="list-style-type: none"> Operating two stroke acute sites is not cost effective The money could be better used to firm up staffing to enable contingency The cost of transport in relation to transfers across sites needs to be taken into account
Total	46	

Option two – Co-locate in-patient rehabilitation care within hyperacute facility (UHND) and develop an effective and seamless community rehabilitation service.

Criteria	Score (out of 10)	Narrative
Clinical quality	9	<ul style="list-style-type: none"> • Consolidation of staff would provide a more concentrated resource to deliver against quality standards • Clinical continuity would be realized • Creates an ethos of recovery as patients see others being rehabilitated in the same environment
Sustainability/flexibility	7	<ul style="list-style-type: none"> • The majority of models both regionally and nationally house hyperacute and acute rehab on the same site • There is the ability to use community based hospitals for generic rehab if required – closer to patients home • It is more sustainable for the workforce to manage a one site model • There is some degree of limitations in terms of physical space however it is anticipated that LoS will be reduced.
Equity of access	8	<ul style="list-style-type: none"> • Patients are already on the ward at UHND • LoS will be reduced therefore ensuring a bed is available for those who need it • Those in the BA area will still be able to access BAH if required for generic rehab needs
Efficiency	8	<ul style="list-style-type: none"> • The provider organisation will realise efficiencies in estate/equipment and staffing which can be re-purposed to ensure more robust model of care at one site • The system will benefit from potentially less transport requirements
Workforce	9	<ul style="list-style-type: none"> • Staffing – particularly medical and therapy will be strengthened. Currently issues with staffing rotas and re: recruitment and retention • A more senior workforce available 24/7 to manage patients more effectively and safely.

Criteria	Score (out of 10)	Narrative
Functional suitability	8	<ul style="list-style-type: none"> • Adaptations would be made at UHND to accommodate rehabilitation requirements • Patients wouldn't need to travel back and forth between sites • Limitations on space but this is outweighed by clinical benefits
Acceptability	6	<ul style="list-style-type: none"> • The level of care experienced by patients and their families at UHND is good overall • The ability to use BAH as a community hospital facility is still available where appropriate • Other community hospitals across the geography will be used as necessary
Cost effectiveness	9	<ul style="list-style-type: none"> • Resources will be re-purposed to ensure a more sustainable model is in place • Running one site is more cost effective and funding released could be used for more direct patient care
Total	64	

9.2 Preferred Option

Following consideration of the necessary risks and challenges for each option, option two is the preferred model for future service delivery.

The preferred model will be assessed using NHS England's four key tests in relation to major service change which is fundamental to any proposed transformation.²

1. Strong public and patient engagement
2. Consistency with current prospective need for patient choice
3. Clear clinical evidence base
4. Support for proposals from clinical commissioners

The preferred model will need to provide assurance against the fifth test affecting bed reconfiguration:

² Planning, assuring and delivering service change for patients
NHS England
www.england.nhs.uk

- 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 new workforce will be there to deliver it.
- Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions.
- Where a hospital has been using beds less efficiently than the national average, it has a credible plan to improve performance without affecting patient care for example Getting it Right First Time Programme (GIRFT)

The preferred option following the appraisal for a new model for specialist stroke rehabilitation services is to consolidate services at UHND. This recommendation follows a process of evaluation on a range of options based on the information available at that time. The service will deliver better care, value and quality for our local population and wider neighbouring geographical areas.

The proposal moves inpatient stroke rehabilitation from ward 4 at BAH and re-provides the service at UHND as a specialist stroke unit with supported discharge. Retaining ward 2 at UHND is important to the stroke pathway as it is on the ground floor of the building with quick access to radiology for urgent CT scanning, has access to a gymnasium on the unit and close access to other rehabilitation facilities within the OT and physio department. By combining the two units and applying the better value efficiencies of 20%, there will be an average length of stay reduction to 9.09% days.

The better values for stroke applied are based on:

- One site provision with combined therapy resource gives immediate benefit of a consistent parent team and reduces handovers and waste.
- Eradicates the need to transfer patients between sites.
- Earlier therapy intervention will improve the frequency of ward based treatment which will enable reduced length of stay.
- A clinician will follow the patient home for up to two visits to support discharge.

The net reduction in stroke is eight beds as compared to the current model. However there has been a review of current bed utilisation across all CDDFT estate to ensure that all acute and community bed provision is optimised and care is delivered closer to home wherever possible. The Trust have given assurance that they could house the additional beds if BAH stroke rehabilitation unit was to move to UHND due to their clinical effectiveness and efficiency programmes and bed reconfiguration measures.

The better value calculation (of 20%) is based on innovation and improvements to productivity, of which the Trust is currently implementing several initiatives for example SAFER (explained in section four); which has been rolled out across stroke, care of the elderly and medical wards.

CDDFT has increased the trusted assessor resource to facilitate “Discharge to Assess”, and “Assess to Admit”, along with recent improvements to internal discharge facilities to allow an increase in the daily usage of discharge lounges.

The investment in community services has also been taken into account. By developing the specialist community stroke rehabilitation provision acute clinicians will feel confident in discharging patients in a timely manner, which will ultimately reduce length of stay.

CDDFT are currently reviewing the levels and location of all of their beds across County Durham and Darlington to ensure that they best meet the needs of the local population.

The realignment of beds would mean that there are a higher proportion of people who require inpatient rehabilitation who would be treated within a community hospital closer to home.

9.2.1 Community Specialist Stroke Rehabilitation

The ward based stroke therapists will provide two home based therapy interventions in the first two weeks post discharge. This will ensure a more streamlined and coordinated hand-over to a stroke specific community pathway (provided by designated community staff) delivering ongoing community based care.

To optimise patient's recovery post stroke, the new community pathway will provide active rehabilitation for up to 6 months post stroke and ongoing reviews 6 monthly as clinically indicated and in partnership with the Stroke Association.

This community pathway will ensure that where practical and clinically appropriate, stroke patients can leave hospital to access rehabilitation services in the community at an earlier point in their current care pathway.

The principles for service delivery will include;

- Patients are followed up within 48 hours post discharge by physio and/or OT and an ongoing rehab. plan agreed
- Patients will have access to services over 7 days a week across all Localities
- Patients will have access to dietetic and SALT input according to clinical need in the community and telephone consultant advice if required
- Patients will have their rehab. delivered in their own home/setting or in a local clinical based facility

DDES and ND CCGS are committed to increasing funding for community services, particularly for front line staffing.

Profession:	Role:
Occupational Therapy	To optimise patients' committed participation to regular daily activities such as dressing, washing or meal preparation
Physiotherapy	To address stroke patients' recovery of sensory motor functions and mobility, and assist in the treatment of musculoskeletal problems or complications
Speech and Language Therapy	To work with patients who have difficulty with communication, cognition and swallowing disorders
Dietician	To support patients who, as a direct result of stroke, require

	modified diets, nutritional support, cardiovascular dietetic input or alternative feeding
Therapy Assistants	To facilitate practice under the guidance of qualified therapists, and to teach patients, families and carers how to maintain optimum health
Administration support	Are to provide clerical and organisational support to the service to include data input.

North Durham and DDES CCGs are investing over £800k into dedicated community based stroke rehabilitation. The funding will be used directly for patient care and will fund additional workforce to provide equity of access for all stroke patients across County Durham. Figure 21 outlines the staffing levels to be increased as a result of this investment. The specialist teams will be equitable and enable them to take a handover from the acute team and continue ongoing specialist stroke rehabilitation.

DDES		North Durham	
OT - B6	2.0 wte	OT - B5	1.0 wte
Physio – B6	2.0 wte	Physio – B5	1.0 wte
Dietician - B7	0.5wte	Dietician - B7	0.5 wte
Dietician - B6	0.25 wte	Dietician - B6	0.55 wte
SLT - B6	0.8 wte	SLT - B6	0.8 wte
SLT - B3	0.5 wte	SLT – B3	0.55 wte
OT/PT assistant - B4	2 wte	OT/PT assistant - B4	1.0 wte
Dietetic assistant - B3	0.5 wte	Dietetic assistant - B3	0.5 wte
Admin Post - B2	0.4 wte	Admin Post - B2	0.5 wte

Figure 21 – additional staffing

10.0 Benefits Realisation

What are the benefits to patients of consolidating specialist inpatient rehabilitation onto the hyperacute site with a transition model into the community?

The main aim of the proposal is to deliver best practice and service provision which includes rehabilitation for stroke sufferers on one site and allows care to be delivered in the home rather than at hospital at the earliest opportunity.

Delivery of patient care on two sites is no longer fit for purpose and this is reflected in the deterioration in SSNAP data for therapies. The two site model does not facilitate delivery of the seven day service for all patients. Stroke patients will benefit hugely having care centered in one place as they will be admitted directly to UHND, receive acute care and move toward rehabilitation on the same site. This will eliminate the need to transfer patients to BAH for rehabilitation. Transfer does cause a delay and confusion for many patients, as a further assessment of their condition takes place and a new team is allocated to manage their care.

The benefits of a Combined Stroke Unit will include:

- Patients not being transferred around the system
- Medics would see patients across the whole pathway
- Redirection of resources in therapy staff
- Patients would see other patients recover helping to promote a positive mindset
- Reducing stress on patients having to move across sites
- Sometimes patients are unable to do swallow assessment with x-ray before discharge to BAH, the patient then has to return to have assessment at UHND. This causes stress to the patient and family and additional nurse time is required (for a minimum of 2 hours per patient) and the requirement of an ambulance
- Patients who deteriorate overnight are currently assessed by an Advanced Nurse Practitioner (ANP) at BAH. At UHND this is a consultant who can provide a more skilled assessment and urgent treatment if required.
- Ongoing consistent access to specialist stroke consultants, including out of hours assessment by specialist stroke consultants and the necessary multi-disciplinary team
- This model would enable joint acute and rehabilitation patient goals
- There would be a single joint care plan from the outset improving the clinical outcomes which would enhance patients' recovery following stroke
- The model would support an earlier discharge from hospital
- The model would provide continuity of care from hospital to home
- The ability to provide a more equitable service for all patients

Workforce

- Team training, team building and so greater understanding of roles that will aid a patients care pathway.
- Easier to plan medical rotas and more efficient use of staff
- Consolidating therapy staff onto one site means that posts are easier to recruit to – there is a better skill mix, support and feeling of team, contingencies in place and concentration of expertise, creating a learning and development culture.
- The preferred model could improve the reputation nationally and regionally for the stroke service
- Improved relationship with community team and social care with only one discharging site, ensuring the patient remains at the centre of the pathway
- Improved recruitment and retention of all staff
- Six month review service – currently the Stroke Association (SA) have to visit two sites, (3 times per week at UHND and once per week at BAH) a single site would allow further support/developments with SA and improve MDT working.

Better use of resources

- It would enable capacity to deliver reduced length of stay from supported discharge
- Enable compliance with national best practice on ALoS for stroke rehabilitation
- It would be a more cost effective service for the whole system
- Clinicians feel it would help to improve SSNAP compliance
- Increase in therapy complement due to better use of resources

Quality and performance

- Greater ability to sustain hyper acute performance
- The model would help to improve SSNAP rehabilitation data
- Preventing admissions to hospital (for acute rehab) where appropriate.
- Facilitating and supporting discharge from hospital in a timely manner

Further details of benefits realisation for therapy support are highlighted below:

- Consolidating the whole Stroke MDT will allow more efficient proactive scheduling of all therapy provision giving patients an individualised patient focussed rehabilitation plan as well as allowing better cover for unplanned staffing absence.

Speech and Language Therapy (SALT)

- The Speech and Language Therapy workforce fully support this stroke service transformation. Centralising Stroke services on one site will have a number of patient experience/patient outcome benefits for communication and swallowing impaired patients. Communicating basic every day needs and consenting for treatments for this patient group can be a daily struggle where a patient has suffered both comprehension and verbal communication disabilities (dysphasia, dyspraxia, dysarthria, and dysphagia) in addition to other new disabilities.
- Transitioning to another hospital part way through the stroke pathway is less than ideal for this vulnerable population as both nursing and AHP staff will have built-up rapport with the patient and their families/ carers and begun to use effective communication strategies in the hyper-acute phase. If the patient is then transferred this all needs to be re-established with a new MDT team on a different site which can be very frustrating for a patient with word-finding difficulties.
- Consolidating existing SALT staffing from both sites will help to increase the amount of available SALT provision to the combined unit, improving SNAPP scores from a consistent poor grade E mark so that those patients who require 5 x 45 minutes will receive a higher intensity of Speech Therapy which complies with National RCP Guidelines. This will improve patient outcomes in both communication and swallowing function, reducing the risk of social isolation, depression, long-term tube-feeding costs as well as reducing the burden on the overall healthcare economy and social care costs.

Occupational Therapy (OT)

- With the preferred model there would be less duplication on handover, a greater level of consistency in therapy staff involved with each patient and their families (i.e. key therapist).
- Less distress associated with the physical transfer between hospital sites.
- Less risk of belongings becoming lost in transit.
- Pooling of staff resource on one site will aid 'spreading cover' during annual leave, staff absence due to sickness/ training/and when staff are off the ward on community visits it is easier to manage and plan.

- Co-location of a larger staff group lends itself to improved colleague support/communication.

Dietetics

- The preferred model would enable dedicated nutritional intervention and care planning for stroke patients; it is known malnutrition is the biological substrate for frailty.
- Pre stroke a patient may not be malnourished, if not appropriately assessed and treated nutritionally with individualised care plans the stroke patient may be unable to maximise their rehabilitation potential.
- With the aim of optimisation of recovery from stroke, the dietetic role will be to support patients home when their nutritional status is still uncertain, correct dietary intake may not yet be clear to the patient and their carers and the nutritional supplement choice may require change.
- Appropriate advice on alerted consistency diets will aid quality of life for this patient group and this will be facilitated by dedicated dietetic time within the stroke team.
- Full assessment and follow up care planning will enable improved rehabilitation with physiotherapy and occupational therapy to be optimised as the patient will have an optimised nutritional status.

Physiotherapy

- The preferred model enables the ability for the same staff to be involved for the patient's whole pathway.
- Improved familiarity with staff as rehabilitation progresses aiding acceptance of change due to condition and preparing for discharge home.
- Improved relationships for families with medical team as no change between sites.
- Team training can occur, team building and so greater understanding of roles that will aid a patients care pathway.
- Improved relationship between community team and social care ensuring the patient remains at the centre of the pathway from one discharging site.

Estates benefits

- CDDFT value BAH site, which is a pivotal resource in delivering patient care particularly for the frail and elderly population.
- We do not anticipate depleting this hospital resource but allocating wards to stroke rehabilitation on a separate site to acute stroke care impedes the delivery of best practice for patients who have suffered a stroke.
- The preferred single site option increases capacity at BAH to deliver excellent patient care relating to other services, particularly the growing frail elderly population.

11.0 Risks

The associated risks with the preferred option have been reviewed and mitigations would be actioned if it was agreed to commission the proposed model of care. The table below details these risks and accompanying mitigations.

Risks Associated with Preferred Model	
1	Risk – Demand on beds outstrips capacity
	Mitigation – The clinical team have used best practice guidance which confirms that LoS is reduced where teams are consolidated and robust community services are in place. The service will be intensely monitored if the new model is rolled out.
2	Risk – Patient flow is compromised due to site pressures
	Mitigation – Modelling work has been undertaken to ensure the optimum level of beds is achieved. Service implementation will be carefully monitored to ensure that any delays in the system are addressed at the earliest opportunity.
3	Risk – The proposed model doesn't achieve its ambition in terms of improving recruitment and retention levels
	Mitigation – CDDFT will work with the service to explore ways of promoting the new model of care and set out a clear OD plan for delivery

12.0 Testing out the Preferred Option

In addition, the PCBC seeks to demonstrate compliance with the NHS England four tests of service reconfiguration:

- strong public and patient engagement;
- appropriate availability of choice;
- clear, clinical evidence based; and
- clinical support.

What this means for patients

Overall 26% of all stroke cases from UHND currently transfer to BAH, 217 patients who currently transfer to BAH are:

- 38% are from North Durham locality,
- 36% are from DDES locality,
- 21% from Darlington locality
- 4% from out of area.

The removal of the transfer to another site reduces the amount of time patients need to be in hospital.

It is important to note that at present all stroke patients are admitted to UHND for acute stroke assessment and treatment. With this proposal, all patients requiring stroke rehabilitation will remain on the same ward in the CSU rather than transferring to another site. Continuing on the pathway in UHND will ensure that patients receive specialist dedicated stroke rehabilitation from one single MDT. If on-going stroke rehabilitation is needed, the primary aim is to discharge the patient home with outreach from Stroke ward therapy staff.

The single site model negates the need for transfer to BAH where multiple handoffs don't add value to patient care. With this proposal we can assure patients of best practice stroke care for optimising their recovery however, 'Patient Choice' can be incorporated into the proposal.

Patients will be presented with the evidence that a single, combined pathway is the option with the best outcomes for patients who have suffered a stroke and will be encouraged to follow the pathway which will enable those best outcomes to be achieved. This is based on intensive, daily rehabilitation therapy post stroke 7 days per week.

The patients who are cared for on the CSU will demonstrate a shorter LoS than now with earlier discharge facilitated by offering stroke rehabilitation at home from the therapy staff based on the combined stroke unit. These staff will offer up to 2-3 home visits to enable stroke rehabilitation at home and, if deemed necessary, transfer on-going follow-up to the community TAPs staff.

There may be some patients who are too vulnerable to be discharged home for stroke rehabilitation and, whilst this is anticipated to be the vast minority, those patients must be offered an alternative. There may also be a small number of patients who do-not wish to go home for stroke rehabilitation, for whatever reason, and these patients must also be offered an alternative demonstrating our commitment to patient choice.

That alternative is a choice of community hospitals, wherever possible, for their rehabilitation care but it must be noted that this does not comply with best evidence (reference). BAH is one of the hospitals that will be offered as a possible place for rehabilitation as described.

This model will continue to fit with the plans for developing specialist frail elderly pathways of care as the beds freed up by combining stroke rehabilitation from BAH and ward 2 at UHND, will be utilised for direct admission from the community TAPS, to facilitate more appropriate care for this growing number of frail patients within County Durham and Darlington. It is anticipated that the beds at community hospitals, including BAH, will be fully utilised from this pathway development but every effort will be made to accommodate those patients who express a preference for rehabilitation following a stroke outside their place of residence.

Such follow on care for those people who have suffered a stroke will take place on wards 6 or 16 at BAH, Francizca Willer Ward at Sedgefield, Starling ward at Richardson or Weardale Community Hospital; it must be noted that these facilities offer only general rehabilitation and not dedicated stroke rehabilitation. The staff from ward 2 (CSU) at UHND will offer the first 2 or 3 stroke rehabilitation visits as they would for those patients going home but then instead of handing rehabilitation care to the TAPs staff, should it still be required, will hand over continuing care to the general rehabilitation staff.

At this point it is not possible to calculate how many people will choose to follow this pathway for stroke rehabilitation but current under-utilisation of some community beds will enable those people who choose a community hospital for their rehabilitation to be accommodated. However, this model does not follow documented best practice and this will be discussed with patients at the time on an individual basis.

13.0 Proposed Future State

The CCGs and CDDFT are proposing to co-locate stroke rehabilitation in-patient provision to the one site at UHND. This service delivery change will bring CDDFT in line with the approach of other Trusts delivering stroke services with acute stroke assessment and rehabilitation on one site (avoiding disruption to patient flow and supporting continuity of treatment).

Patients will be discharged home with care and support from the stroke community rehabilitation team. For the small proportion of patient that require in-patient provision for a longer period of time, will be transferred to the Community Hospitals across the County close to their home, for example Weardale, Richardson and Sedgfield Community Hospitals.

Patients' value therapy and the effect it can have on their recovery. There is strong evidence to show that skilled therapy provided at the right intensity can greatly improve outcomes. Some patients, especially soon after stroke, are not well enough for therapy, or get very tired, and cannot tolerate much. Many patients, though, feel they do not get enough therapy on the stroke unit that is productive, especially at the weekend. It is recognised by the NHS that stroke patients need to be offered greater intensity of rehabilitation after their stroke both in hospital and when their care is transferred to home.

The proposed model contributes towards the CCG's priorities to provide high quality care closer to home.

13.1 Service Model

Patients will be discharged home with care and support for a period of time by the acute therapy teams before being transferred to the community stroke rehabilitation team. The proposed service model (figure 22) outlines the need to shift the emphasis of stroke rehabilitation care from an inpatient setting into the community – delivering care closer to home.

For the small proportion of patients that require in-patient provision for a longer period of time, they will be transferred to the Community Hospitals across the County close to their home, for example Weardale, Richardson and Sedgfield Community Hospitals.

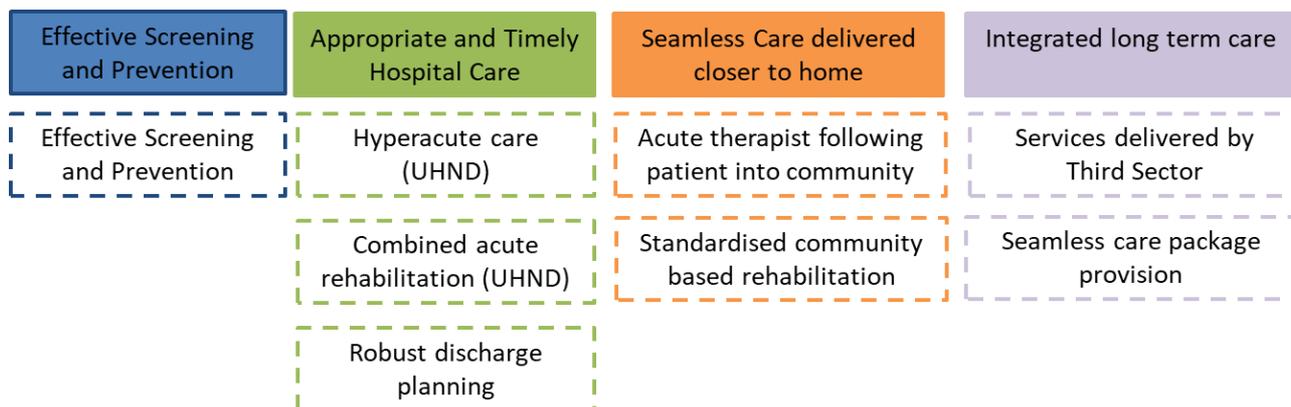


Figure 22 - Stroke Proposed Model of Care

13.2 Referral and Access

Patients registered with a member GP practice of Hambleton, Richmond and Whitby CCG may also have their rehabilitation care transferred to BAGH following in-patient stroke care at James Cook University Hospital (JCUH). Discussions have taken place with the CCG regarding the proposal to co-locate rehabilitation care to the UHND site therefore provision for this population will be considered as part of the consultation process.

13.3 Specific Measurable Outcomes

Focusing on outcomes is one way of enabling the transformational change required in the healthcare system. Outcomes need to be meaningful to people who use rehabilitation services and enable them to maximise their potential, manage their healthcare themselves and promote independence. **The Government's Mandate to NHS England for 2016-17³** has an expectation that improvements will be demonstrated against the **NHS Outcomes Framework⁴** so as to provide evidence of progress and enable comparison of services locally.

Consideration will be given to the level of outcome data to collect which demonstrates a patient centred approach and impact upon their individual rehabilitation goals.

Outcome measurement tools need to be appropriate for the client group, health condition and method of service delivery.

Data collection should allow for benchmarking against other services and show how existing inequalities have been reduced in terms of access to services, experiences of services and if outcomes have been achieved.

Nationally, two large groups of rehabilitation teams, the UK Rehabilitation Outcomes Collaborative (UKROC)⁵ and Sentinel Stroke National Audit Programme (SSNAP)⁶, have already established systems to record service level, patient dependency level and

³ The Government's Mandate to NHS England for 2016-17

www.gov.uk/government/publications/nhs-mandate-2016-to-2017

⁴ NHS Outcomes Framework

Department of Health (2014) The NHS outcomes framework 2015/16

www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015

⁵ UK Rehabilitation Outcomes Collaborative

www.ukroc.org/NCASR/

⁶ Sentinel Stroke National Audit Programme

www.strokeaudit.org

individual patient function and ability. This now allows national benchmarking and comparisons of both care and rehabilitation pathways.

The following key areas will be covered:

- Key performance indicators
- Monitoring of service and patient outcomes (quarterly meetings and evaluation metrics)
- Patient waiting times (assessment and treatment)
- Patient satisfaction
- Clinical governance

Continuous improvement of the service and impact upon the length of stay and will be reviewed through existing governance arrangements and mechanisms

Where are we now? (BASELINE)	Where do we want to be? (OBJECTIVE)	How will we know if we have got there? (MEASURES)
Admissions to Ward 2 / Transfers to BAH Ward 4	Reduce patient transfers / handoffs to improve patient care.	Admission data - Weekly
Average LoS for rehabilitation is 23.2 days	Reduce average LOS to 9.09 days	LoS data - Weekly
Two site MDT approach to assessment and management for all patients with stroke.	Develop a single MDT approach to assessment and management for all patients to the stroke unit	Admission data Occupancy figures Single site model implemented SSNAP data
Multiple pathways based upon 2 site approach and services available at the site specific.	Review and revise the Streamlined patient pathway to deliver improved outcomes and equitable service for all patients	SSNAP data
No alternative to in-patient rehabilitation.	Implement supported discharge and community based care	SSNAP data
Need to ensure any change to model doesn't have a negative impact on quality of care	Readmission rates reduced	Trust data
Limited therapy input throughout pathway	45 minutes of stroke rehabilitation therapy for a minimum of 5 days a week	SSNAP data

13.4 Performance Management

Focusing on outcomes is one way of enabling the transformational change required in the healthcare system. Outcomes need to be meaningful to people who use rehabilitation services and enable them to maximise their potential, manage their healthcare themselves and promote independence. The Government's Mandate to NHS England for 2016-17 has an expectation that improvements will be demonstrated against the NHS Outcomes Framework so as to provide evidence of progress and enable comparison of services locally.

Consideration will be given to the level of outcome data to collect which demonstrates a patient centred approach and impact upon their individual rehabilitation goals. Outcome measurement tools need to be appropriate for the client group, health condition and method of service delivery.

Data collection should allow for benchmarking against other services and show how existing inequalities have been reduced in terms of access to services, experiences of services and if outcomes have been achieved.

Nationally, two large groups of rehabilitation teams, the UK Rehabilitation Outcomes Collaborative (UKROC) and Sentinel Stroke National Audit Programme (SSNAP), have already established systems to record service level, patient dependency level and individual patient function and ability. This now allows national benchmarking and comparisons of both care and rehabilitation pathways.

The performance management framework for this service will be implemented through contract management arrangements.

The following key areas will be covered:

- Key performance indicators
- Monitoring of service and patient outcomes (quarterly meetings and evaluation metrics)
- Patient waiting times (assessment and treatment)
- Patient satisfaction
- Clinical governance

Continuous improvement of the service and impact upon the length of stay and will be reviewed through existing governance arrangements and mechanisms.

14.0 Project Plan

The Director of Commissioning Strategy and Delivery for Durham Dales, Easington and Sedgfield and North Durham CCGs will sponsor this project with the support of colleagues from CDDFT, Local Authorities and Commissioning and Delivery Team to implement the preferred model.

A consultation plan accompanies this business case (see appendix 2). It is proposed to consult between the 7th October – 12th December 2019.

The governance arrangements in place to deliver this project are below (figure 23). The Systems Assurance Group meets on a regular basis with senior teams from both CCGs and CDDFT on the membership.

A transformation Steering Group has been set up to oversee three major transformations – one of which is the acute stroke rehabilitation project. This Group has representation from CDDFT, CCGs and Local Authorities at director level. The group is designed to oversee progress and identify and manage any risks to successful project implementation.

A dedicated project team is in place to manage the project. The project team is multi-disciplinary with strong clinical leadership. Its role is to ensure due process is carried out to ensure successful completion of the stroke project and to provide assurance to the Transformation Steering Group.

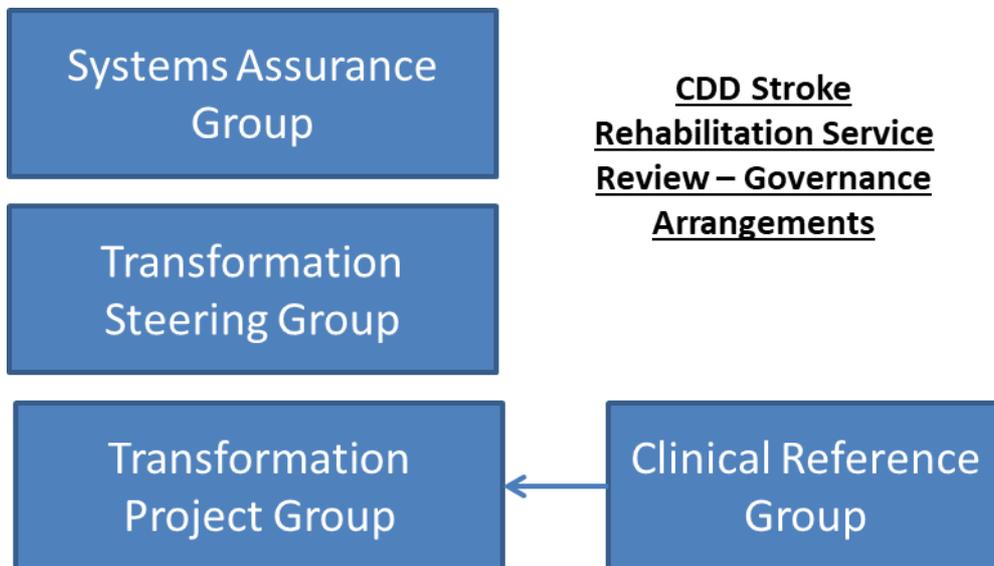


Figure 23



North Durham Clinical Commissioning Group
Durham Dales, Easington and Sedgefield Clinical Commissioning Group
Darlington Clinical Commissioning Group

STROKE Consultation and Communications Plan

Tina Balbach, Engagement Lead, County Durham CCGs

Rachel Rooney, Commissioning Manager, County Durham CCGs

Project Title:	Stroke Rehabilitation Services - consultation
Authors:	Tina Balbach – Engagement Lead
Owner:	Rachel Rooney
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4				
5				
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7				

Contents

Contents.....	3
Introduction and background.....	4
Background.....	4
Policy and legislation	5
Aims and objectives	7
Generic CCG Communications and engagement objectives	7
Stroke Communications and Engagement Objectives	7
Scope of the consultation	8
Pre-engagement	8
Stakeholders and mapping.....	10
Stakeholder Mapping	11
.....	Error! Bookmark not defined.
What we already have in place	13
Methodology	13
Consultation Communications and Engagement Action Plan	15
Pre-engagement activity	15
Consultation activity	18
Post consultation activity.....	19
Standard formats of information	20
Key messages for consultation	21
Questions for consultation.....	21
Timeline.....	23
Reporting and feedback	24
Equality Impact Assessment	25

Introduction

County Durham and Darlington Clinical Commissioning Groups (CCGs) and County Durham and Darlington Foundation Trust (CDDFT) have made a commitment to review stroke rehabilitation services.

Following a period of engagement the CCGs were able to understand what works well and what could be improved, especially with regards to rehabilitation from a patient and carer perspective. Also by engaging with those who have used services, the CCGs have been able to understand how the decisions they make have an impact on those using the services.

The aim of this consultation and communication plan is to ensure that complex messages are easy for the local people of County Durham and Darlington to understand. This will be reinforced by good communications and engagement processes.

The aim is to ensure that the consultation is accessible to all so an informed decision can be made. This will also mean the decision makers and commissioners can understand public feedback in a systematic way, which can be fed into the decision making process.

Background

Back in 2011 a public consultation took place during to consolidate hyper acute stroke care to one site based at University Hospital North Durham (UHND) and rehabilitation care at Bishop Auckland Hospital (BAH) for those patients requiring further inpatient rehabilitation.

Following the public consultation, County Durham and Darlington Primary Care Trust (PCT) and CDDFT agreed to review stroke rehabilitation services. The CCGs and CDDFT recognise that although significant improvements have been made in the hyperacute stage (the short term care provided at the pit someone has a stroke) there is a need to ensure that high quality patient experience and outcomes are continued into the rehabilitation phase.

Longer term rehabilitation is a key area for improvement in the NHS long term plan. It is recognised that currently patients are unable to access sufficient therapy to maximise recovery and it is particularly difficult to obtain vocational rehabilitation to help people get back to work. Stroke is a national priority and the lack of standardised inpatient and community rehabilitation services within our CCG areas does not currently optimise the potential to meet rehabilitation goals.

Policy and legislation

In the development of this consultation and communications plan, the CCGs in County Durham and Darlington have referenced national guidance setting out their legal duty to involve patients and the public in the planning of service provision. Included below is a summary of the various legislation, guidance and principles relevant to this consultation, such as, the requirements set out in the Health Act 2006 as amended to Health and Social Care Act 2012:

- Section 242, of the Health Act 2006
 - *Places a duty on the NHS to make arrangements to involve patients and the public in planning services, developing and considering proposals for changes in the way services are provided and decisions to be made that affect how those services operate.*
- Section 244, of the Health Act 2006
 - *Requires NHS bodies to consult relevant OSCs on any proposals for substantial variations or substantial developments of health services. This duty is additional to the duty of involvement under section 242 (which applies to patients and the public rather than to OSCs).*
- Section 14Z2 of The Health and Social Care Act 2012,
Places a duty on CCGs to make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways):
 - *in the planning of the commissioning arrangements by the group,*
 - *in the development and consideration or proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them,*
 - *in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.*

Other specific considerations have related to:

The ‘four tests’:

The 2014/15 mandate from the Government to NHS England outlines that proposed service changes should be able to demonstrate evidence to meet four tests:

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

NHS England introduced a new test applicable from 1 April 2017. This requires that in any proposal including plans to significantly reduce hospital bed numbers NHS England will expect commissioners to be able to evidence that they can meet one of the following three conditions:

- I. 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
- II. Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
- III. 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).

The Gunning Principles

- I. Consultation must take place when the proposal is still at a formative stage
- II. Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response
- III. Adequate time must be given for consideration and response and
- IV. The feedback from consultation must be conscientiously taken into account

The Equality Act 2010

The Equality Act 2010 unifies and extends previous equality legislation. Nine characteristics are protected by the Act, age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

The NHS Constitution

The NHS Constitution came into force in January 2010 following the Health Act 2009. The constitution places a statutory duty on NHS bodies in England and explains a number of patient rights which are a legal entitlement protected by law. One of these rights is the right to be involved directly or through representatives:

- In the planning of healthcare services
- The development and consideration of proposals for changes in the way those services are provided, and
- In the decisions to be made affecting the operation of those services.

Aims and objectives

Generic CCG Consultation and Communication 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.

- To communicate the recommended service model for each CCG area 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
- 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.
- To ensure that all key stakeholders are aware of the consultation, surveys and events and have the opportunity to get involved should they wish to do so.

Stroke Consultation and Communication Objectives

For this stroke rehabilitation services consultation, the objectives are as follows;

- To consult with patients and carers/families who have used stroke services to gain an understanding of their experiences and their views on a different approach to their care
- To outline a range of options for the provision of stroke rehabilitation within a hospital setting as well as the community
- To outline a preferred option for a new model of care which assesses impact on the system and individual patient care
- Communicate 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, especially those seldom heard and from protected characteristic groups, in order to ensure that local people are given the opportunity to consider and comment on the options for the proposals around a new model of stroke rehabilitation in County Durham and Darlington areas;
- Using the comments and feedback from the local communities to inform consideration by the CCG as to how it should provide the Stroke Rehabilitation Services to best meet the needs of the local population
- Ensuring that the CCG is complying with all its legal obligations in relation to public consultations and engagement
- Arrange our meetings so they cover the local geographical areas

- Arrange meetings in accessible venues and offer interpreters, translators and hearing loops if required
- Inform partners of our consultation activity and share plans

Scope of the Consultation

The purpose of this plan is to describe our process for formal consultation and how we will reach stakeholders including patients, their carers, families and members of the public across County Durham and Darlington. This process will ensure that our methods and approaches are inclusive and tailored to the people we want to reach so that they can have their say. These include:

- Public, patients, carers and their representatives
- Key stakeholders including partner organisations
- Voluntary and community sector organisations
- Staff of affected partner organisations
- Local Councillors and MPs
- County Durham Health Overview and Scrutiny Committee
- Darlington Health Overview and Scrutiny Committee
- Healthwatch County Durham and Healthwatch Darlington
- Particular interest groups, including seldom heard groups

The plan sets out the activity which will take place and the timelines involved, including the resources required to deliver the plan. The intention of the plan is to help people understand what to expect from the formal consultation, how they can be involved and how long the process will take.

The purpose of the consultation, communications and engagement activity is to:

- Raise awareness of and provide information on the changes being proposed
- Involve stakeholders in discussions about the proposed changes and closures and to draw out any issues and concerns
- Work with stakeholders to consider potential solutions to any issues raised
- Gather feedback which will inform the decision about the future model of this service
- Ensure we meet our statutory duties as set out later in this document.

Pre-engagement

As part of the review a patient engagement exercise took place with patients that have recently had a stroke.

A period of engagement was carried out in autumn 2018 and then again in May, June and July 2019.

An extensive period of pre-engagement was carried out with patient, carer and public engagement to help the CCGs to understand the experience of people using Stroke Rehabilitation Services.

Views and feedback were gathered via an online and paper survey and also from focus groups where people, who have suffered a stroke, were invited to attend to tell us about their care.

This engagement gave us rich feedback around what patients thought of their stay in hospital and the treatment they received, the discharge process, rehabilitation and on-going care.

More recently we have worked with the Stroke Association who supported the CCGs with engagement. The Stroke Association carries out a six month review with patients, and assesses their progress six months after their stroke.

The CCGs engagement team wrote a survey and covering letter in conjunction with the Stroke Association. The Stroke Association then sent a letter and accompanying survey to patients who had signed up to a six month review and live in County Durham and Darlington. The feedback received gave a clear view from patients/carers and family of their recent experiences.

A copy of the full report can be found on the CCGs websites.

Stakeholder Mapping

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.

The key stakeholders that need to be considered by this process include:

Patients and the public	Healthcare professionals / providers	Partner organisations and Voluntary and Community Groups	Political / Governance
Patients who access these services	CDDFT staff teams at Bishop Auckland Hospital	Local Authority directors of Social Care / Adults services	Local MPs
Family members and carers	CDDFT staff teams at other hospital sites	County Durham Healthwatch, Darlington Healthwatch	Health Overview and Scrutiny Committees
Patient Reference Groups (PRGs)	Community staff and teams	Voluntary and Community sector providers	Local Councillors and elected members
MY NHS members with an interest in stroke	Physiotherapists / Orthopaedic staff	Area Action Partnerships	Health and well-being boards
People who have responded or taken part in stroke rehabilitation engagement	Ambulance Service / Patient Transport	Durham County Carers Support	CCG Governing Body
	GPs and Primary Care	Housing organisations	NHS England
	Primary Care Networks	Health networks	
	CCG Staff	Neighbouring CCGs	
	NHS Improvement		
	Staff Unions		
	Local Medical Committee		

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 include 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 County Durham and Darlington areas 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) will be key partners in supporting 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.

Stakeholder Mapping

This map shows the levels of interest of identified stakeholders have alongside the scope to influence as part of this process.



What we already have in place

The CCG already engages and communicates extensively with a range of key stakeholders and regularly through Patient Reference Groups (PRGs), Health Networks, Area Action Partnerships (AAPs), community council and various community groups.

The Health and Wellbeing Boards and Adults Overview and Scrutiny Committees are also regularly kept up to date. This is important as it engages on its commissioning priorities and the CCGs strong beliefs and commitment to put local communities at the heart of everything they do.

There are dedicated pages on the CCGs websites which contain a range of information including evidence of pre-engagement. Social media will continue to be a pro-active communications tool to promote the consultation but more traditional methods will also be utilised

More detailed information and the findings of the engagement carried out around Stroke Rehabilitation can be found in on the DDES, North Durham and Darlington CCG websites.

The engagement activities helped to inform the development Stroke Rehabilitation '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, an on-going dialogue was maintained with the local health Overview and Scrutiny Committees (OSC) for both County Durham and Darlington.

In particular, the rationale for the proposed changes to Stroke Rehabilitation Services were presented at a meeting in November 2018.

Methodology

These intended methodologies will be used to enable the CCGs to deliver effective and meaningful consultation with the identified stakeholders. This will be a working document and may alter slightly depending on feedback and suggestions.

A consultation document will be written which will be available for people to access online and as a paper version. This will give people full information and inform them to able them to complete a survey which will be available on line and as a paper version.

We will hold a small number of public events to give the public the opportunity to hear from staff at the CCGs and CDDFT about the proposals and the background information. This will also be an opportunity for attendees to share their experiences and thoughts to help to inform their own decisions.

The CCG Engagement Teams will attend already established meetings with local groups and community organisations with the intention of speaking to as many people as possible to gather views from patients themselves and families / carers.

Consultation Communications and Engagement Action Plan

Pre-engagement activity

Activity	Detail	Additional information
Pre-engagement	<p>Stage 1 pre-engagement activity 2018</p> <p>Stage 2 pre-engagement activity 2019</p>	
Stakeholder Mapping	<p>Develop stakeholder spreadsheet - contacts</p> <p>Establish existing stakeholder mapping from pre-engagement</p> <p>Conduct additional stakeholder mapping to ensure complete stakeholder list for consultation</p> <p>Review and update stakeholder list throughout consultation</p>	
Communications Key Messages	<p>Development of key messages, FAQs</p>	
Developing and supporting dialogue – programme of events and activities	<p>Identify suitable, accessible venues for public events. Four formal public events across North Durham, Durham Dales, Easington and Sedgefield and Darlington</p> <p>Visit venues to check suitability (disability access, parking, bus route, acoustics, large numbers)</p> <p>Promote events</p> <p>Send invites to all stakeholders, including those who took part in the pre-engagement</p> <p>Develop facilitator packs for facilitators at events</p>	

	<p>Develop agendas and evaluation sheets for events</p> <p>Identify and confirm facilitators and scribes for events</p>	
<p>Consultation briefing document</p>	<p>Develop Communication and consultation document</p> <p>Consider different languages and formats that may be required, including large print, braille, audio, easy/read etc. Work with expert partners to ensure documents meet best practices requirements and communication needs</p> <p>Determine number of each type of document</p> <p><i>Have documents produced by agreed supplier within agreed timescales</i></p>	
<p>Stakeholder briefings</p>	<p>Briefing prepared stakeholders about the consultation and what we want to do, the events and any other information</p>	<p>NECS comms to support</p>
<p>Consultation Dialogue</p>	<p>Plan content and format of required communications and engagement activity</p> <p>Develop, make arrangements for and publicise consultation activity, including:</p> <p>Press / media</p> <p>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</p> <p>Additional meetings - People's Parliament/ Investing in Children/Gypsy Roma</p>	

	<p>Travellers Practitioners Forum/LGBT group/Macmillan</p> <p>Information stall and presence at local public events</p> <p>Online and hardcopy consultation document and survey</p> <p>Information and surveys in public places</p>	
Development of survey questions	Confirmation of the agreed questions and key feedback that is required	
Development of animation / video for consultation messages	<p>Summary of key information and issues to help inform people with feedback.</p> <p>Work with PRG / Healthwatch members to help review content and language to ensure that key messages and issues being proposed are clear and in plain English</p>	
Online	<p>Design dedicated section on CCG website</p> <p>Ask for partners and stakeholders to place on their websites and to cascade via their social media channels</p> <p>Develop content and schedule for social media</p>	
Confirm freepost address responses and identified information collection points	Work with partners to help ensure a variety of methods and locations are available for stakeholders to share feedback	
Public Relations and Advertising	Press release prepared for circulation at launch of consultation	
Distribution of Consultation Materials	Develop distribution plan for flyers and posters to public places	

Recording	Develop and maintain consultation action log	
Analysis and Reporting	Ensure independent supplier identified and procured in good time to conduct analysis and reporting when the consultation closes	
Quality and risk assurance	Provide quality and risk assurance of the engagement process	

Consultation activity

Activity	Detail	Additional information
Public events	<p>Deliver the public events, likely to include presentation to set out scenario and proposals, table discussions for participants to share comments and gather group feedback.</p> <p>Open opportunities for questions</p>	
Presentations	Attend AAPs, Parish councils or other local groups requesting presentations on issues and consultation options	
Targetted outreach sessions	<p>Meetings with specific and identified audiences from stakeholder list</p> <p>Visit open public events and space; farmers markets, community evets etc.</p>	

PR Activity	<p>Updates on events and activities on the websites and social media.</p> <p>Continued promotions of ways to respond and contribute.</p>	
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Post consultation activity

Activity	Detail	Additional information
Data input and collection	Ensure all feedback from surveys and events is gathered and appropriately compiled and recorded for analysis	
Analysis of feedback for key themes and preferred options	Key themes and preferred options identified.	
Consultation summary briefing	In conjunction with the NECS Communications Team and provide to stakeholders	
Update website pages	Ensuring information is continuously updated and reflects what is happening at that current time and to mark that the consultation is closed	
Draft full consultation report	Written in conjunction with Communications Department	
Consultation report published	Document shared with all stakeholders including OSC, Governing Body and ensure the document is available through CCG websites	

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 County Durham and Darlington populations. 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.

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
- Surveys – online and paper
- Flyers
- Leaflets (including leaflet drop)
- Stand-up banners
- Venues for public events

Key messages for consultation

Key messages to be used:

- There is an opportunity to improve both the quality and efficiency of the care we commission and provide for stroke rehabilitation in County Durham and Darlington. If we are to have safe, sustainable stroke services that are set up to facilitate greater advances in care and outcomes we need to address three key factors:
 - Changing patterns of need;
 - Improving clinical standards of care;
 - Making the best use of an expert workforce;
- Currently stroke rehabilitation care is not compliant with the national model which recommends inpatient rehabilitation should provide a multi-disciplinary approach to care with dedicated and adequate therapy input with supported discharge into the community.
- People should be further assessed in their home through early supported discharge with as few handoffs of care as possible
- The transition between inpatient and community care should be seamless
- Community based services should provide the right level of therapy input to improve individual patient outcomes.
- Evidence to show that people especially older and frailer people benefit from timely discharge from hospital – to promote independence and the right environment for effective rehabilitation
- We want to secure the right services in the right place at the right time and delivered by a skilled, multi-disciplinary workforce
- We want to manage resources effectively - through reducing lengthy stays in secondary care providing a more efficient use of resources and promoting care closer to home where possible
- Deliver a standard, equitable and appropriate stroke rehabilitation pathway.
- Make services more accessible and responsive to the needs of our communities

Questions for consultation

As a structure for the engagement that will take place, the following questions will be included as part of all of the conversations undertaken during the consultation process. To enable appropriate analysis of the feedback from the information

provided, these are a mixture of closed and open-ended questions. This format enables analysis to include direct measurement of responses as well as more qualitative feedback.

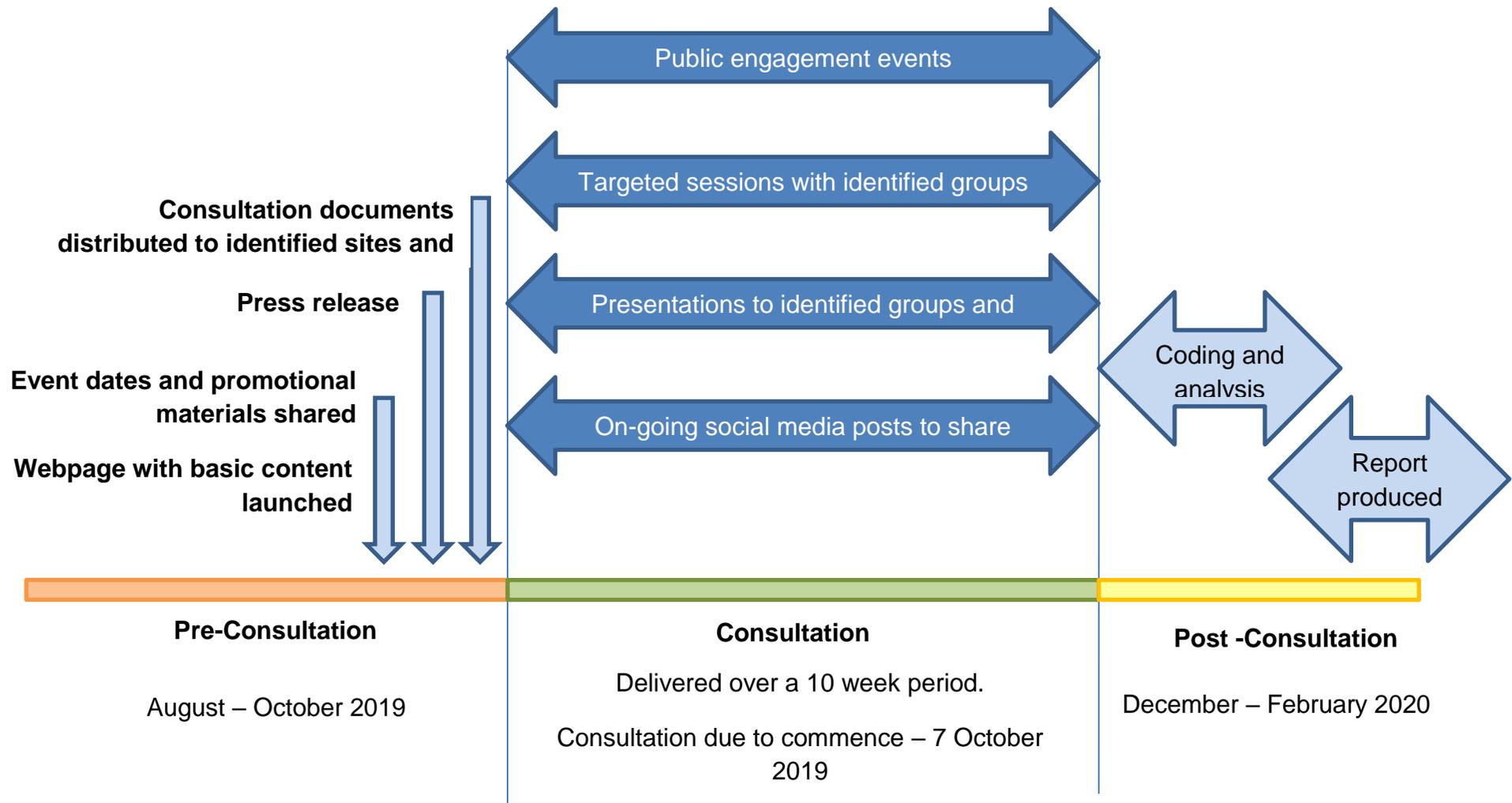
The proposed questions are as follows:

1. Have you been a stroke patient within County Durham and Darlington?
2. Have you had a family member utilising stroke services within County Durham and Darlington?
3. Do you understand the proposals outlined?
4. Based on the information available what is your preferred option?
5. What do you think are the benefits of the preferred option?
6. Are there any barriers associated with the preferred option?
7. Is there anything that we haven't considered?
8. First four digits from postcode

There will also be further equal opportunity questions to help us understand more about the range of people who have been able to respond.

Timeline

Included below is an overview of some of the key activities and at what points in the process these will be completed. The timing of the consultation will be dependent on receiving assurance from NHS England and NHS Improvement.



Reporting and Feedback

The consultation feedback will be received and reviewed by the CCGs 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 stroke rehabilitation 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.

Equality Impact Assessment

<u>STEP 3 - FULL EQUALITY IMPACT ASSESSMENT</u>	
<p>The Equality Act 2010 covers nine 'protected characteristics' on the grounds upon which discrimination and barriers to access is unlawful. Outline what impact (or potential impact) the project/service review outcomes will have on the following protected groups:</p>	
<p>Age A person belonging to a particular age</p>	<p>The service benefits the local population of County Durham and Darlington CCGs. There are no foreseen negative consequences for people accessing the services due to age. All attendances may include particular protected groups but these would be reviewed in line with the CCGs Equality and Diversity Strategy.</p>
<p>Disability A person who has a physical or mental impairment, which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities</p>	<p>The service benefits the local population of County Durham and Darlington CCGs. There are no foreseen negative consequences for people accessing the services due to age. All attendances may include particular protected groups but these would be reviewed in line with the CCGs Equality and Diversity Strategy.</p>
<p>Gender reassignment (including transgender) Medical term for what transgender people often call gender-confirmation surgery; surgery to bring the primary and secondary sex characteristics of a transgender person's body into alignment with his or her internal self perception.</p>	<p>The service benefits the local population of County Durham and Darlington CCGs. There are no foreseen negative consequences for people accessing the services due to gender reassignment. All attendances may include particular protected groups but these would be reviewed in line with the CCGs Equality and Diversity Strategy.</p>
<p>Marriage and civil partnership Marriage is defined as a union of a man and a woman (or, in some jurisdictions, two people of the same sex) as partners in a relationship. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must be treated the same as married couples on a wide range of legal matters</p>	<p>The service benefits the local population of County Durham and Darlington CCGs. There are no foreseen negative consequences for people accessing the services due to marriage or civil partnership. All attendances may include particular protected groups but these would be reviewed in line with the CCGs Equality and Diversity Strategy.</p>
<p>Pregnancy and maternity Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context.</p>	<p>The service benefits the local population of County Durham and Darlington CCGs. There are no foreseen negative consequences for people accessing the services due to pregnancy or maternity. All attendances may include particular protected groups but these would be reviewed in line with the CCGs Equality and Diversity Strategy.</p>

Race It refers to a group of people defined by their race, colour, and nationality, ethnic or national origins, including travelling communities.
The service benefits the local population of County Durham and Darlington CCGs. There are no foreseen negative consequences for people accessing the services due to race. All attendances may include particular protected groups but these would be reviewed in line with the CCGs Equality and Diversity Strategy.
Religion or belief Religion is defined as a particular system of faith and worship but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.
The service benefits the local population of County Durham and Darlington CCGs. There are no foreseen negative consequences for people accessing the services due to religion or belief. All attendances may include particular protected groups but these would be reviewed in line with the CCGs Equality and Diversity Strategy.
Sex/Gender A man or a woman.
The service benefits the local population of County Durham and Darlington CCGs. There are no foreseen negative consequences for people accessing the services due to sex/gender. All attendances may include particular protected groups but these would be reviewed in line with the CCGs Equality and Diversity Strategy.
Sexual orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes
The service benefits the local population of County Durham and Darlington CCGs. There are no foreseen negative consequences for people accessing the services due to sexual orientation. All attendances may include particular protected groups but these would be reviewed in line with the CCGs Equality and Diversity Strategy.
Carers A family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person
The service benefits the local population of County Durham and Darlington CCGs. There are no foreseen negative consequences for people accessing the services who are carers. All attendances may include particular protected groups but these would be reviewed in line with the CCGs Equality and Diversity Strategy.
Other identified groups relating to Health Inequalities such as deprived socio-economic groups, substance/alcohol abuse and sex workers
The service benefits the local population of County Durham and Darlington CCGs. There are no foreseen negative consequences for this group of people accessing the service. All attendances may include particular protected groups but these would be reviewed in line with the CCGs Equality and Diversity Strategy.



North Durham Clinical Commissioning Group
Durham Dales, Easington and Sedgefield Clinical Commissioning Group
Darlington Clinical Commissioning Group

PHASE 2

Acute and Community Stroke Rehabilitation Service Review – Patient and Carer Engagement

May and June 2019

Tina Balbach, Engagement Lead

Contents

Introduction	3
Executive summary	4
Phase one	4
Phase two	5
Purpose of engagement (phase 2)	8
Engagement methodology (phase 2)	8
Phase 2 engagement findings – May / June 2019	9
University Hospital of North Durham experience	9
Bishop Auckland experience	10
Community Stroke Rehabilitation Team	11
Care planning	13
Demographics	15
Thank you	18

Introduction

Any successful service change benefits from a period of sustained engagement with members of the public, patients, carers and stakeholders. Indeed one of the four key tests of any proposed service change is to ensure robust patient and public engagement has taken place.

It is really important for the CCGs to understand people's experiences of stroke rehabilitation across County Durham and Darlington. The CCGs want to understand what currently works well and what could be improved, especially with regards to rehabilitation from a patient and carer perspective.

It is extremely valuable to receive views on what is important to the local population, as the CCGs can use this information alongside clinical opinion to determine how future service provision may be commissioned. By engaging with those who have used services, the CCGs can begin to understand how the decisions they make have an impact on those using the services.

At this stage of the review the engagement needs to focus on people's experiences of services at the University Hospital of North Durham (UHND) Bishop Auckland Hospital (BAH) (if applicable) and within the community. Once we understand any future options for the service model we will undertake a consultation exercise which will be open to members of the public. During this time we will outline the current service and the proposal for future stroke rehabilitation services and seek their views on this.

The following report details the feedback received within phase one (as an executive summary) and phase two of the engagement process; highlighting key themes. This information will be used to inform the overall decision making process regarding future provision for stroke rehabilitation across County Durham and Darlington.

Executive summary

The information below is a summary of phase one and phase two of engagement.

Phase one

During November and December 2018, across County Durham and Darlington, a period of eight weeks of engagement was undertaken by North Durham (ND), Durham Dales, Easington & Sedgefield (DDES) and Darlington Clinical Commissioning groups (CCGs) with past and current service users, families and local stakeholders to gather views about stroke rehabilitation services.

A range of engagement activities were carried out which included an online survey, local focus groups, service user engagement meetings and targeted engagement with groups with protected characteristics.

Key points emerging from the online survey are;

- Over 67% (n53) of people who responded to the survey were patients, 25% were a family member/carer and 8% were 'other', which incorporated a partner, nurse and a stroke survivor
- Most respondents (20%, n16) were at University Hospital of North Durham for one to two days
- Nearly 58% (n46) of patients felt that they were discharged from University Hospital of North Durham at the right time
- Over 41% (n32) of patients felt they or their carer / family member were involved as much as they wanted to be in their discharge, whereas the same amount (41%) felt they were not involved as much as they wanted to be
- The majority of patients (55%, n43) felt they did not receive enough information in relation to the Community Stroke Rehabilitation Service before they were discharged from University Hospital of North Durham
- Three quarters of patients (77%, n60) were transferred to Bishop Auckland Hospital following their stay at University Hospital of North Durham.

The more negative comments included:

- being on their own after discharge
- the lack of information given
- didn't receive any community service once left Bishop, you are on your own
- When asked about what could be improved, respondents said:
 - counselling should be offered at the end of the treatment,
 - more blocks of speech and language therapy are needed
 - giving out consistent information
 - More information in general around coping after stroke

- When asked about if they had any further comments on their experience of the service, respondents said:
 - “Amazing, if I didn't have this service I wouldn't be where I am”
 - “Excellent. I didn't need therapy as I had a small TIA which didn't affect my speech, movements or cognitive functions”
 - “In the hospital I was left to my own devices, as it was only a mini stroke, they didn't seem to bothered, stroke team contact was weeks and weeks apart with regards to visits to the house or a phone call every three weeks”
 - “The therapies team are amazing and fantastic. I wish there was a service - something to go to after the therapy has finished”

- The majority of patients (73.96%) said that they received continuity of care – seem mostly but the same team of therapists

Key points emerging from the qualitative feedback are in relation to;

- Communication challenges
- Emotional wellbeing and support
- Inconsistency of community rehabilitation provision
- People would appreciate a longer period of therapy once discharged from a hospital setting

Phase two

During May, June and July 2019, across County Durham and Darlington, a period of seven weeks of engagement was undertaken by CCGs with current service users, carers and families to gather views about their experiences and stroke rehabilitation services. This was done to further enhance the information already collected and to ensure that we targeted particularly those who had recently suffered a stroke to understand their experiences.

On behalf of the CCGs, the Stroke Association sent a letter with an accompanying survey to over 150 individuals within County Durham and 45 in Darlington who had been offered a six month review. The survey was also available online through a SurveyMonkey link. The letter also detailed contact details for patients / carers who needed support with completing the survey.

A summary of the key points emerging from the online survey are;

Over 76% of patients or family were involved in setting their treatment goals

79 people shared their views



Letters were sent to over 190 current patients of the Stoke Association



79% of patients told us they were involved as much as they wanted to be in their discharge plan

72% of respondents said that they received continuity of care

- Nearly eighty (79) people completed the survey with the majority 94% (73) being patients and 6% (5) being a family member or carer
- When asked if they had any other comments on their experience of the service at UHND over 37 patients / carers responded:

Positive

- “They were very caring and friendly”
- “I was treated with gentle care and respect even when I fell behind the toilet door. The understanding even extended over the nights.”
- “I received the best of care by courteous professional staff, I can’t commend them highly enough”
- I have nothing but praise for ward 2 stroke ward”
- “Exceptionally well cared for”.
- I hope the stroke unit continues to be at UHND as it is easily accessed by public transport to all the outlying areas which makes visiting and follow up appointments much easier if only one bus is required”.

Negative

- “Rushed to move on”
- “lacked any rehab, next steps were not discussed”
- “No therapy, sat for 2 hours waiting to go home because a nurse on duty didn’t give me the paperwork”

- “I am still waiting for the therapy, both speech and physical it would be better if someone gave you a clue on what to do on the physical instead of leaving you to wait”
- “
- “I saw a physiotherapist once whilst I was in hospital. No speech therapy or explanation or other support groups”.

Key points emerging from the qualitative feedback are in relation to;

- Good care and compassion of staff
- Communication challenges
- Information
- Inconsistency of community rehabilitation provision
- Timespan of therapy
- Emotional wellbeing and support

Purpose of engagement (phase two)

Phase two of the engagement took place between May and June 2019. This engagement was in addition to the 2018 work carried out to hear views from patients/carers and families around their experience following a stroke. The 2019 engagement focused more on those patients who had experienced a stroke more recently i.e. in the past year.

Engagement methodology (phase two)

The engagement work was carried out in conjunction with the Stroke Association who were instrumental in pulling together patient details.

CCGs commission the Stroke Association to deliver six month reviews to patients who have suffered a stroke. As a result they have a wealth of information regarding patients who have recently had experience of stroke services in County Durham. They also deliver the stroke recovery service in Darlington which again gives them the advantage of having access to a rich source of data.

The Stroke Association sent out a letter and questionnaire with an offer of support for people for people who needed it to complete the questionnaire.

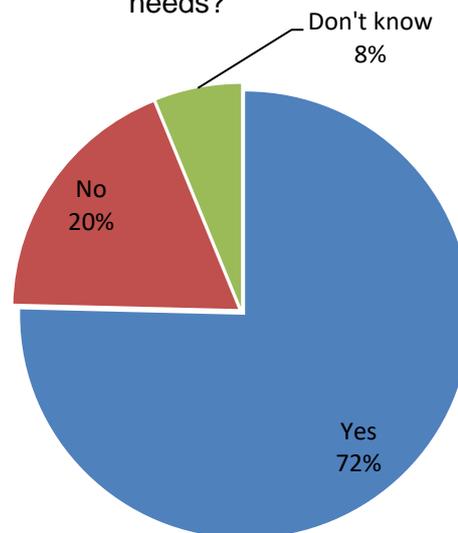
The questionnaire focused on their experience during the hospital stay in the acute ward at UHND it also focused on peoples discharge in terms of the destination and their level of care following their inpatient stay. This included those people who were cared for at Bishop Auckland Hospital as part of their pathway as well as those who went straight home from UHND. There was a specific focus on the level of therapy input as well as being involved in care planning and self-care to manage their condition. The engagement exercise also offered the opportunity for people to outline any other feedback as part of their experience.

Phase 2 engagement findings – May / June 2019

University Hospital of North Durham experience

- **Discharge planning** - over 79% (62) of patients/family member/carer were involved as much as they wanted in planning their discharge from the University Hospital of North Durham (UHND). Whereas 15% (12) said they were not as involved as they wanted to be and 5% (4) saying they didn't know.
- **Discharge destination** - On discharge from UHND the majority of patients 64% (49) patients went home, 33% (25) went to Bishop Auckland Hospital and 3% (2) went to intermediate care eg: a community hospital / residential home or another service.
- **Therapy input** - when asked if they received enough therapy to meet their needs at UHND, 72% (54) said yes they had, 20% (15) said no they hadn't and 8% (6) said they didn't know.

Do you feel you received enough therapy in UHND to meet your needs?



- **Other comments re: UHND** - When asked if they had any other comments on their experience of the service at UHND over forty (41) patients / carers responded:

Positive

- "They were very caring and friendly"
- "I was treated with gentle care and respect even when I fell behind the toilet door. The understanding even extended over the nights."
- "I received the best of care by courteous professional staff, I can't commend them highly enough"
- I have nothing but praise for ward 2 stroke ward"
- "Exceptionally well cared for".

- I hope the stroke unit continues to be ay UHND as it is easily accessed by public transport to all the outlying areas which makes visiting and follow up appointments much easier if only one bus is required”.

Negative

- “Rushed to move on”
- “lacked any rehab, next steps were not discussed”
- “No therapy, sat for 2 hours waiting to go home because a nurse on duty didn’t give me the paperwork”
- “I am still waiting for the therapy, both speech and physical it would be better if someone gave you a clue on what to do on the physical instead of leaving you to wait”
- “I saw a physiotherapist once whilst I was in hospital. No speech therapy or explanation or other support groups”.

Bishop Auckland experience

For those people who were discharged to Bishop Auckland Hospital, we asked they received enough therapy to meet their needs, 35 people responded and the majority, 21 people said yes. Others gave their views detailed below:

Other comments re: Bishop Auckland Hospital (BAH) - When asked if they had any other comments on their experience of the service at BAH people commented:

“I was well looked after in both Durham and Bishop Auckland on both occasions and the help has helped me to remain positive”.

“I received a lot more (therapy) at Bishop Auckland than at UHND”.

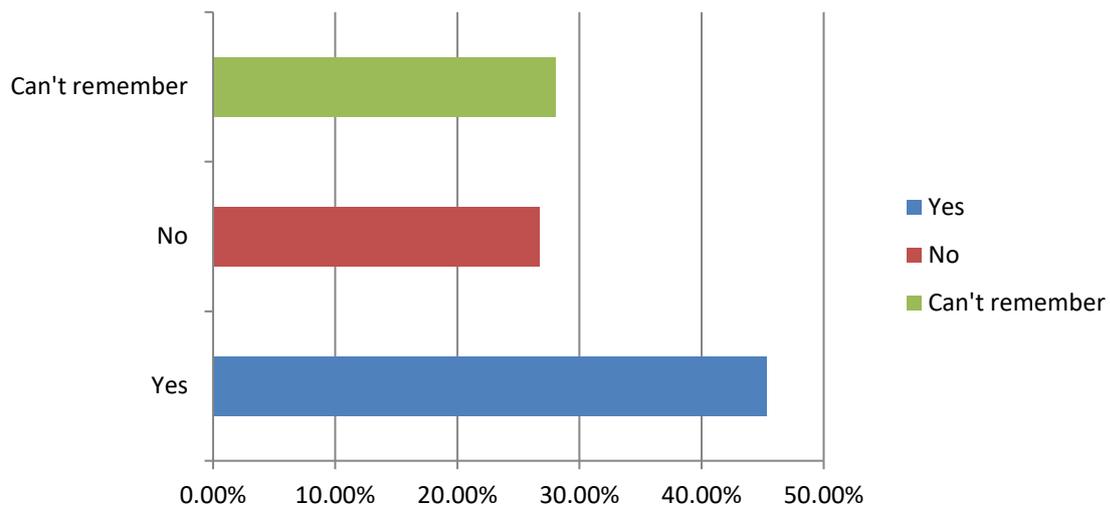
“I was able and encouraged in use of equipment (parallel bars, stairs and traffic crossing)”.

“Excellent therapy at Bishop Auckland”.

Community Stroke Rehabilitation Team

- Out of the 75 respondents, over 45% (34) said that they were contacted by a member of the Community Stroke Rehabilitation team within 24 hours of their discharge from hospital. Whereas 27% (20) said they were not and 28% (21) said they couldn't remember.

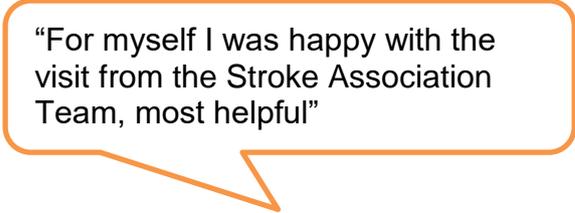
Were you contacted by a member of the Community Stroke Rehabilitation team within 24 hours of your discharge from hospital?



- When asked if members of the Community Stroke Team arrived as planned for visits over 83% (60) respondents stated always, 7% (5) saying usually or rarely and 10% (7) don't know or other.
- Out of the 69 respondents, almost three quarters of patients / carers / family 72% (50) said that they received continuity of care eg: seen mostly by the same team of therapists. 13% (9) said no they hadn't and 14% (9) said they didn't know.

Comments received included:

Positive



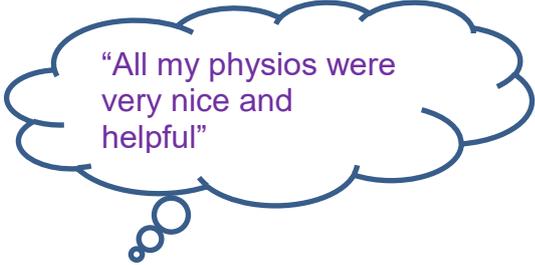
"For myself I was happy with the visit from the Stroke Association Team, most helpful"



I currently go to Chester le Street Hospital and feel I am improving with their help".



"A big thank you to all involved in my treatment in hospital and the community rehab team for all the work they did with me once home"



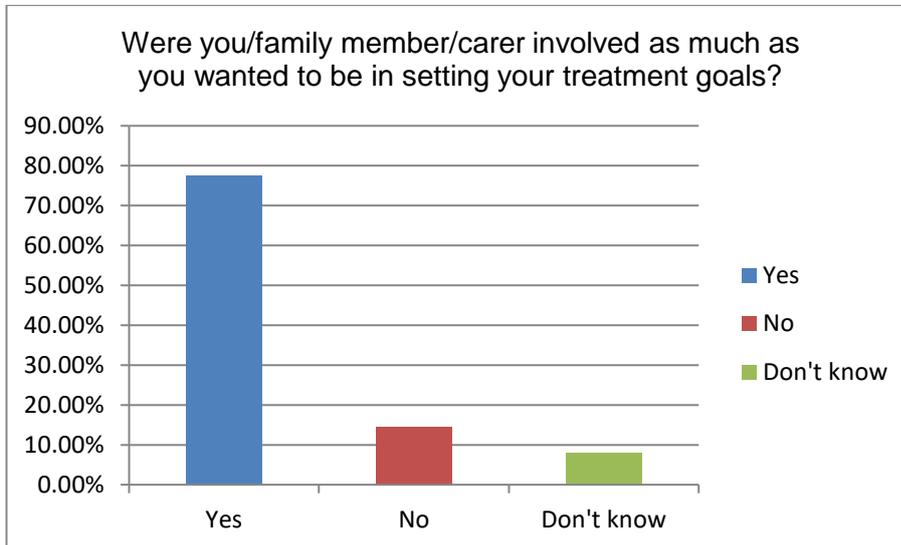
"All my physios were very nice and helpful"

Areas of improvement:

- "It was about four months before I received help from a very good speech therapist after returning home from Bishop Auckland Hospital".
- "I think I should have been referred to physio. I did a self-referral"
- "Only had one visit"
- "Need more rehab"
- "The quickness of therapy (still waiting)"
- "general attitude of some nurses would be a great help"
- "A better understanding after discharge of what the rehab programme is and the goals that are trying to be achieved within a certain timeframe".

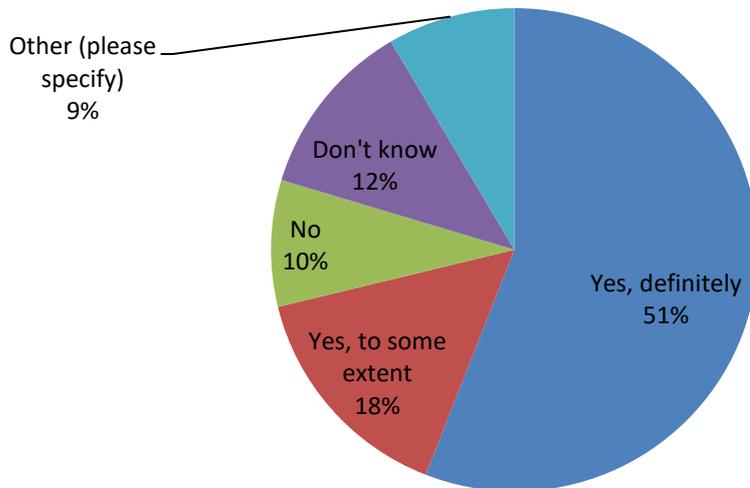
Care planning

- Nearly 77% (52) of respondents said that they felt involved as much as they wanted to be in setting their treatment goals. Fourteen per cent (10) said no and 9% (6) said they didn't know.



- When asked about whether respondents felt that they received enough therapy/rehabilitation to meet their needs over 67% (47) said yes they had, 20% (14) said no they hadn't and 13% (9) said they didn't know.
- Almost half of respondents 46% (32) said that they felt supported in managing their condition, 41% (28) said that they did to some extent and 7% (5) said no and 6% (4) said they didn't know.
- Out of 68 responses, over half of respondents 51% (35) said that they found it beneficial to receive their therapy at home and 18% (12) said yes to some extent. Over 10% (7) said no, they did not and 12% (8) said they didn't know and of the 9% (6) who stated other gave reasons such as did not need therapy at home and having therapy at a centre.

Did you find it beneficial to receive your therapy at home?



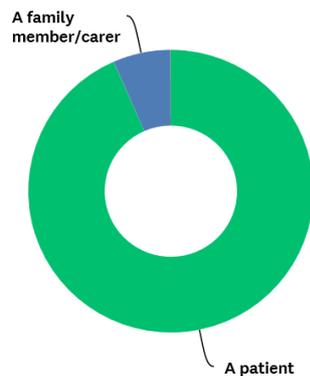
When asked if there was anything we could improve on, 41 people responded with a range of suggestions such as:

- Improved communication with patient and family members especially if there are other health conditions
- Training and supervision of staff
- Patients felt they were well looked after
- Getting more rehabilitation
- Quicker therapy
- More information required from staff

Demographics

Detailed below are the demographics of the 71 people who completed the survey.

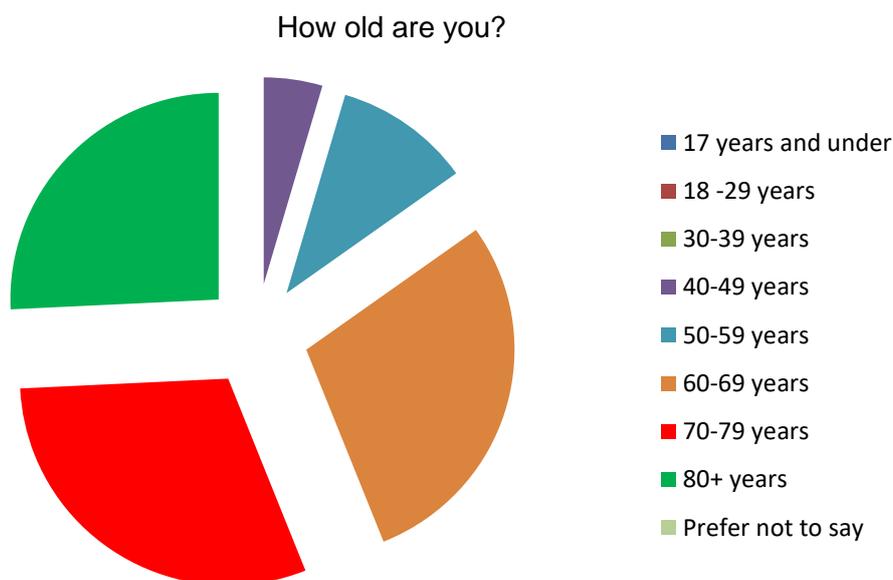
- Most people who completed the survey were the patient 94% (73) and 6% (5) were a family member/carer (Q1).



- Out of the 71 who responded to the question about their gender, over half (56%) of respondents were males with (44%) being female.

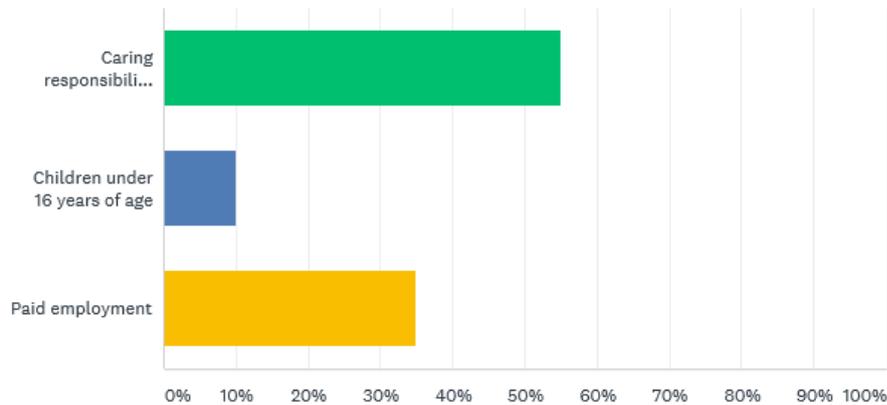
Age range of patients

- The majority of respondents, 30% (21) were between 70-79 years of age, closely followed by 28% (20) who were between 60-69 years of age. Just over 27% (19) were 80-89 years of age, with 15% (11) being between 40 – 59 years of age



Caring responsibilities

Twenty people responded to the question about caring responsibilities. Over 50% (55) said they had caring responsibilities for a family member, friend or neighbour, 10% said they had children under 16 years of age and 35% had paid employment.



Disability, long term illness or health condition

Over sixty five people (67) answered the question around whether they had a physical or mental impairment, which has lasted or will last at least 12 months and affects your ability to carry out normal day-to-day activities. Over fifty (57%) said that they did whereas over 43% said that they did not.

The people who said they did have a disability, long term illness or health condition told us that they had problems with their memory, eye sight, Chronic, Obstructive, Pulmonary Disorder (COPD), problems with their mobility, back problems, unsteadiness, shaking and loss of confidence, mental health problems, suffered a stroke and arthritis.

Most respondents, 89%, said they were White British, 94% said they were heterosexual and 86% said they were Christian and 9% said they had no religion.

Postcodes

The table below highlights, by postcode, where the 60 respondents who answered this question live.

CCG	Postcodes	Count	Percentage %
North Durham CCG	DH1, DH1 5, DH2, DH3, DH7 9, DH7 6, DH7 7, DH7 8, DH8 6, DH8 7, DH9 7	23	38%
DDES CCG	SR8, TS21, DH6, DL12, DL12, DL13, DL14, DL15, DL16, DL17, DL4 2, DL5 7	25	42%
Darlington CCG	DL1 4, DL2 1, DL3 6, DL3 8, DL3 9, DL11	12	20%

Thank you

On behalf of Durham Dales, Easington and Sedgefield and North Durham and Darlington Clinical Commissioning Groups, we would like to thank all of those who have contributed to this engagement including:

- The stroke patients, their families and carers who took the time to share their experiences with us or completed the survey
- The Stroke Association

Improving Stroke Rehabilitation For the People of County Durham and Darlington

Adults, Wellbeing and Health Scrutiny Committee
6 September 2019



Background

- In 2011 the local system moved to a single site model for hyperacute stroke
- Since this time there has been an improvement in outcomes for patients at the point of emergency
- It was recognised that a review of stroke rehabilitation was required as patient outcomes were not being fully realised

Vision

To develop a person-centred model of care that delivers care closer to home

To minimise variation and maximise the health outcomes of our local population

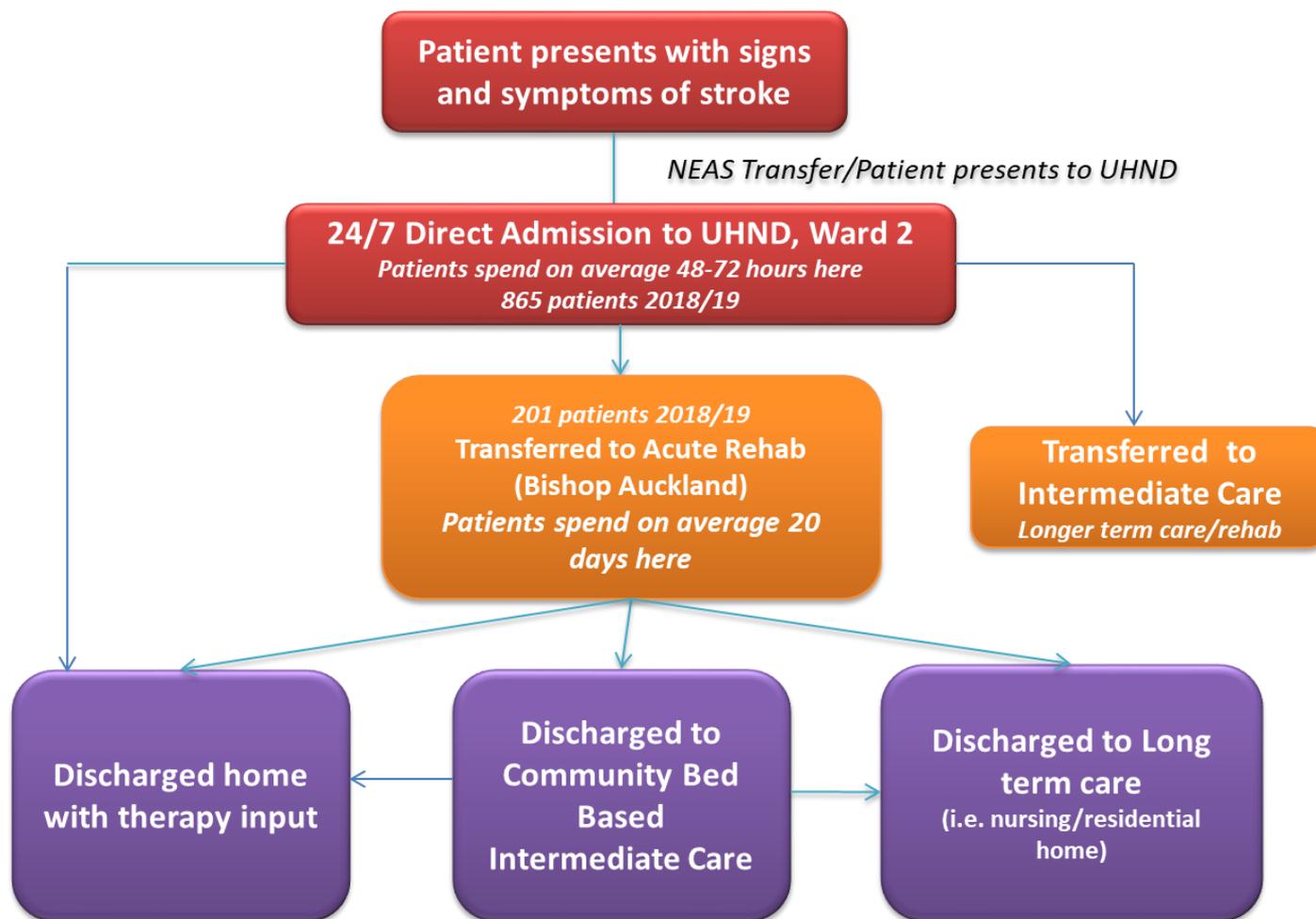
To ensure care is accessible and responsive to people's needs

To develop a service which retains and attracts an excellent workforce

Scope of Review

- The scope of this service review relates to the rehabilitation elements of the pathway following an acute episode due to stroke
- This includes:
 - Community based rehabilitation
 - Hospital based rehabilitation
- CCGs and CDDFT have a major emphasis on community services focussing on
 - Prevention and maintaining independence
 - Supporting patients with long term conditions
 - Managing crisis and supporting a return to independence

Current Pathway



Quality and Performance



SSNAP Scoring Summary:		Team	University Hospital of North Durham
		Time period	Jan-Mar 2019
		SSNAP level	B
Patient-centred levels:	Domain	1) Scanning	A
		2) Stroke unit	B
		3) Thrombolysis	B
		4) Specialist Assessments	B
		5) Occupational therapy	C
		6) Physiotherapy	A
		7) Speech and Language therapy	C
		8) MDT working	C
		9) Standards by discharge	A
		10) Discharge processes	C

**Emergency Care
Improvement Programme**

Safer, faster, better care for patients



Improvement

County Durham and the Tees Valley
Clinical Commissioning Groups



Patient and Carer Feedback

Phase one

There were over 160 responses to the engagement exercise
Survey developed – used online and as a print out
Spoke with existing community groups
Patient survey carried out on the wards at BAH and UHND
Social media used to publicise

Phase two

<p>Over 76% of patients or family were involved in setting their treatment goals</p>	<p>79 people shared their views</p> 	<p>Letters were sent to over 190 current patients of the Stoke Association</p> 
	<p>79% of patients told us they were involved as much as they wanted to be in their discharge plan</p>	<p>72% of respondents said that they received continuity of care</p>

Key Themes

- Positive experiences of hospital care
- People would value care closer to home
- Many people felt they would have benefited from more therapy input both in a hospital and community setting
- Many people felt a lack of support during discharge
- People didn't want to have to repeat 'their story' multiple times

Clinical Case for Change

Policy Context	Key Theme	Gap in Current Provision
Stroke Strategy 2007	Hand offs of care	The current pathway promotes multiple transfers of care
NHS England's Quick Guide: Discharge to Assess and benefits for older, vulnerable people.	Discharge to assess	Therapy assessment takes place within a hospital setting rather than in the person's home setting
Stroke Guidelines 2016	Equity of access to comprehensive specialist community rehabilitation	Current community based rehab services are inequitable across County Durham
SSNAP Audit 2016	Levels of recommended therapy input	Rehabilitation within the community doesn't provide the intensity required as detailed in national guidance
SSNAP Audit 2016	Levels of recommended therapy input	Patient based outcomes could be improved upon e.g. time for therapy based interventions
Stroke Specific Education Framework	Efficient use of clinical staff	Currently staff have to cover two sites, for example medical rotas for consultants are difficult to manage and sustain with limited workforce
NICE guidelines - continuity of care and relationships in adult NHS services	Continuity of care	Currently many patients are handed off to another team so patients don't have the familiarity of staff
Stroke Specific Education Framework	Effective recruitment and retention of staff	The expertise is diluted currently across two sites and staffing levels are limited – lack of contingency
Stroke Guidelines 2016	Early supported discharge	Currently not in place



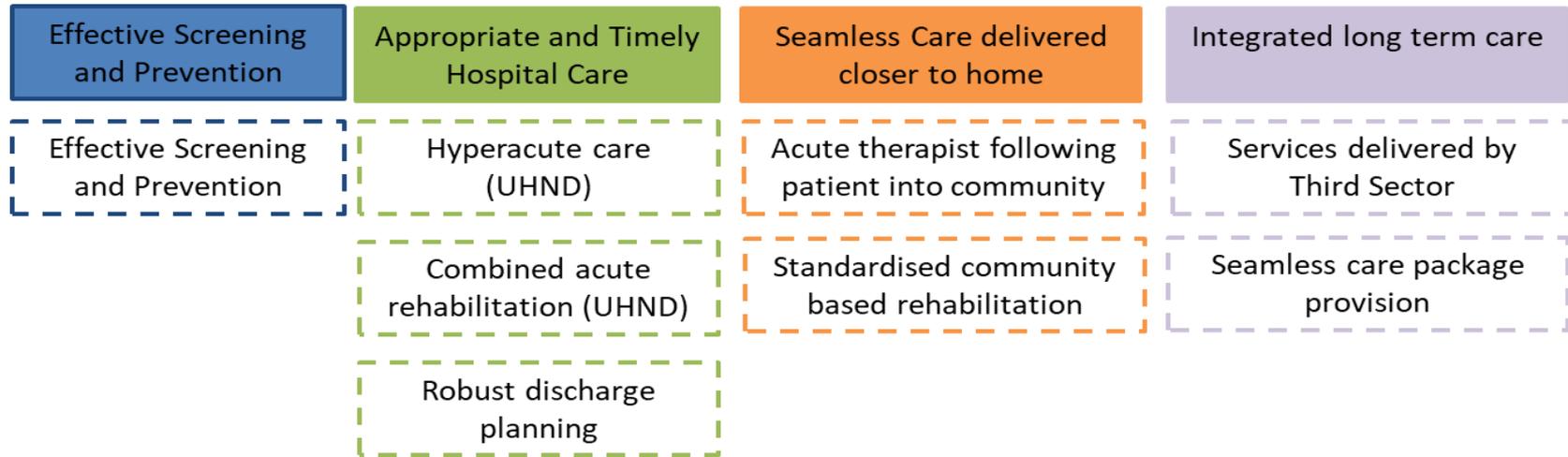
GETTING IT RIGHT FIRST TIME

- **Therapy** - Increase therapy staffing on stroke unit and provision for Early Supported Discharge (ESD) to facilitate discharge and reduce Length of Stay (LoS)
- **Consider ring fenced stroke therapy or Combined Stroke unit (acute and rehab) at single site**
- **Consultant Cover** - Review of split site working to improve efficiency of medical workforce cover.
- **6 month reviews** - To ensure data is captured on the SSNAP system

Options Appraisal

Clinical quality	Maintains or improves clinical outcomes; timely and appropriate services; minimises clinical risk	Patient, Public and carer Engagement – Experience and Feedback
Sustainability/flexibility	Ability to meet current and future demands in activity; ability to respond to local/regional/national service changes	
Equity of access	Reasonable access for urban and rural populations	
Efficiency	Delivers patient pathways that are evidence based; supports the delivery though access to resources	
Workforce	Provides environments which support the recruitment/retention of staff; supports clinical staffing arrangements	
Functional suitability	Provides environments suitable for delivery of care; clinical adjacencies with other relevant services/dependencies e.g. imaging	
Acceptability	Acceptable to service users, carers, relatives, other significant partners	
Cost effectiveness	Provides value for money	

Proposed Future Model



- To consolidate acute rehabilitation onto the Specialist Stroke Unit at UHND
- To provide robust discharge planning and implementation with seamless transition into the community
- Enhanced specialist stroke community rehabilitation

Page 230

Proposed Pathway

Patient presents with signs and symptoms of stroke

NEAS Transfer/Patient present to UHND

24/7 Direct Admission to UHND, Ward 2

Early Supported Discharge
Therapist follows patient into community for up to two visits within two week period

Discharged home with therapy input

Discharged to Community Bed Based Intermediate Care
(Greater utilisation of this)

Discharged to Long term care
(i.e. nursing/residential home)

Discharged to Inpatient rehab bed

What this would mean for patients in County Durham

- Equity of specialist inpatient stroke rehabilitation
- High quality and sustainable workforce available to deliver care in the most appropriate setting
- A seamless transition into the community supported by Early Supported Discharge
- Enhanced specialist community stroke rehabilitation
- Services delivered within the context of the integrated model of care with LA, primary and community care
- Working in partnership with the Stroke Association to ensure robust longer term care

Next Steps

- The proposals have been ratified by executive and governing body committees in CCGs and Trust
- Public document on proposals to be developed
- Public consultation planned – 7 October 2019 for 10 weeks
- NHSE assurance process to be followed
- Outcome of consultation to be considered by CCGs and Trust in the new year
- Ongoing communication with OSCs on progress

TITLE:	Crisis service improvements; integration of the North Durham and South Durham & Darlington Crisis Teams into one service across the Durham & Darlington locality and proposal to close the Crisis and Recovery House
REPORT OF:	Levi Buckley, Director of Operations
REPORT FOR:	Consideration and Decision

Executive Summary:

The purpose of this paper is to outline the next stage of crisis service improvement plans, specifically to describe the integration of crisis services across County Durham and Darlington to improve patient experience and allow more efficient and effective use of resources. Currently there are two separate teams (North Durham and South Durham and Darlington) and there is variance across staffing and ways of working. The paper also outlines the stakeholder engagement undertaken to review the useage and function of the crisis and recovery house in Shildon and recommends that it is closed permanently with resource released to increase capacity to deliver home based treatment.

A three-day Improvement Event was held in September 2018. Attendees were asked to consider the following topics: access to the crisis service; location of bases and how this will work; how the teams should look; assessment and intensive home treatment; key skills of the team and team members; attitudes, culture and values; co-production with service users, carers and families. This paper summarises the outputs from this event and consequent detailed proposals that have been developed to support our transformation of crisis services. These proposals have been supported by TEWV Executive Management Team and the Tees, Durham and Darlington MH & LD Partnership.

At the same time TEWV with commissioners has reviewed the usage and function of the Crisis and Recovery House in Shildon and completed an engagement exercise with stakeholders across County Durham and Darlington in June/July 2018. This identified that a bed based service was not a high priority and attendees identified a 'safe space' particulary out of hours as well as more flexible and increased home based treatment as things which would help them if/when the experience a mental health crisis. Further workshops have taken place to develop further the function of a safe space/haven and Commissioners have secured funding via the NHS 10 year Long Term Plan to develop this further. The paper outlines the engagement event process and feedback, reviews the use and effectiveness of the crisis house and recommends that it is closed permanently with resource used to increase capacity to deliver home based treatment.

Savings made from the closure of the Crisis & Recovery House will be re-invested into the Crisis Service to enhance the offer of Intensive Home Treatment (IHT) that the team is currently able to provide. The clinical leadership structure of the team has also been reviewed. There will be 1.0 WTE consultant and 0.8 WTE senior psychologist post for the new Crisis Service, working across the locality. This is in addition to the current clinical leadership provided primarily by advanced practitioners. IHT will be undertaken by both qualified clinicians and support workers.

The model for the new crisis service is a 'hub and spoke' model with a hub based centrally within the locality and two spokes in the North and South of the locality. Crisis clinicians will be responsible for managing calls directed to them by triage workers for clinical decisions and/or further advice. A crisis clinician will act in a Duty Supervisor/Shift Coordinator capacity. There will be a single contact number that will enable all calls to reach the central hub, with a queue system in place for times of peak demand. Standard work will be in place to support Triage workers to manage incoming calls safely and efficiently. Triage workers will have

constant access to a comprehensive and up-to-date Directory of Services so that callers can be accurately signposted.

The single crisis service was implemented in Quarter 1 2019/20 and although currently the teams are still separate there is increasingly more generic support across the 2 areas including input from Advanced Practitioners and Team Managers who now work into both teams. The hub will be established at Auckland Park Hospital from October 2019.

The 3-day improvement event was attended by stakeholders, service users and carer representatives to ensure that the action plan was truly co-produced and all recommendations are in line with the Commissioner led crisis review and discussion at the Crisis Concordat.

Recommendations:

The Overview and Scrutiny Committee is asked to note the outcome of the work undertaken so far and the integration of crisis services across Durham and Darlington

The Overview and Scrutiny Committee is asked to support the single service approach and the implementation of the revised model in Quarter 1 2019/2020 and establishment of a hub at Auckland Park Hospital in October 2019.

The Overview and Scrutiny Committee is asked to note the work to date to engage with stakeholders to consider the function and use of the crisis house and is asked to consider if any further consultation is required prior to seeking support to permanently close the Crisis and Recovery House.

MEETING OF:	County Durham Overview and Scrutiny Committee
DATE:	
TITLE:	Crisis service improvements; integration of the North Durham and South Durham & Darlington Crisis Teams into one service across the Durham & Darlington locality and proposal to close the Crisis and Recovery House

1. INTRODUCTION & PURPOSE:

- 1.1. The purpose of this paper is to inform the Overview and Scrutiny Committee of the improvements across crisis services and describes the integration of crisis services across County Durham and Darlington. Bringing the two crisis teams together and having one standard way of working; patients across the locality receiving a consistent approach and service irrespective of where in the locality they live. The changes will also support effective and efficient use of resource and increase resilience and flexibility of service provision. The paper also seeks support for the permanent closure of the crisis and recovery house in Shildon which will allow increased capacity to deliver home based treatment. Investment to develop safe haven(s) has been secured via the NHS Long term plan to progress this element of provision.
- 1.2. A three-day Improvement Event was held in September 2018 and was attended by a range of clinical and corporate staff, and involved service user and governor representation. The Trust-wide Urgent Care Pathways Lead also attended the event and is supportive of the proposals and how it links with the trust-wide models work on crisis. This paper summarises the output, further work and considerations that came out of this event.
- 1.3. Following support by TEWV EMT and Commissioners (via the Tees, Durham and Darlington MH & LD Partnership), the single service was implemented in Q1 2019 with a hub to be established at Auckland Park Hospital (APH) in October 2019.

2. BACKGROUND INFORMATION AND CONTEXT:

- 2.1. There are currently two separate crisis teams covering the North Durham and South Durham and Darlington areas. However, there are significant variances across the teams in terms of staffing levels and ways of working.
- 2.2. The Adult Crisis Service works on a 24/7 basis to undertake comprehensive triage assessment of individuals who are currently experiencing a mental health crisis, with the aim of preventing their admission to hospital. Where the individual is admitted to inpatient services, the crisis team works with them to support leave and recovery-based discharge, and enable productive bed flow. The crisis service is also responsible for providing intensive home treatment and facilitating S136 assessments outside of street triage working hours.

The Street Triage Team (STT) works in partnership with Durham Constabulary to provide mental health advice and guidance to assist the Police in joint decision making process around managing risk. The team provides support around mental health legislation as well as offering telephone triage and face-to-face triages to those who come into contact with Police where there is concern for their mental health. Core working hours for STT are between 14.00 and 00.00 hours, 7 days a week.

- 2.3 The North Durham team is based at Lanchester Road Hospital, Durham and the South Durham and Darlington team is based at West Park Hospital, Darlington. Each team currently comprises a Team Manager, Advanced Practitioner, crisis clinicians and support workers with variance in terms of substantive medical input and admin support between teams..
- 2.4 There have, however, continued to be significant differences identified in the functioning of the two teams and their ways of working, including the criteria used to refer the patient into inpatient services.
- 2.5 Staff, patients and stakeholders, through the workshop in September, have therefore proposed that the current crisis service be integrated to form one team and to provide a more standardised approach. This approach has been supported by members of the local Crisis Concordat.
- 2.6 This work is intrinsically linked to discussions about the future of the Crisis & Recovery House in Shildon. The crisis and recovery house in Shildon is a nine bed roomed house, registered with the CQC to provide social care. Feedback from people who have spent time in the crisis house is very positive. However, the service is only being used by a very small number of people. In 2017 there were only 88 admissions to the crisis house (with an average length of stay of 11 days) and, on average, less than half the beds were being used at any one time. During the same period over 1300 people received intensive home based treatment in their own home (over 7700 visits).

In 2018 there were 28 admissions to the house - with 1412 people receiving intensive home based treatment (over 7098 visits). The table below details the occupancy by Durham residents.

Month	% Occupancy (all admissions)	% bed days used by Durham residents
January - June 2018	0%	0
July 2018	6.45%	61% (11 bed days)
August 2018	43.01%	72% (86 bed days)
September 2018	36.67%	68% (67 bed days)
October 2018	14.7%	83% (34 bed days)
November 2018	14.4%	44% (17 bed days)
December 2018	1.79%	100% (5 bed days)

On average, a bed in the crisis and recovery house costs the Trust £478 per day to run. In comparison, it costs us on average £380 per day for an inpatient bed in one of our assessment treatment wards and £324 for one of the beds in our rehabilitation units

- 2.7 There are a number of factors which explain why we have seen a reduction in the use of the crisis house. The way we provide mental health services is changing and there is a greater range of support available for people when they are experiencing a crisis such as:
- a liaison service (working closely with colleagues in Darlington Memorial Hospital and University Hospital of North Durham to support people with mental health problems). This service is available 24 hours a day, seven days a week
 - a street triage service - the team provide support for people with mental ill health who come into contact with the police

We know that people get better more quickly if they have increased support at home. We also know that the length of time people need to spend in hospital can be reduced if we offer intensive home treatment in their own home

3. KEY ISSUES:

3.1 New Service Model

The model for the new crisis service is a 'hub and spoke' model with a hub based at APH.) and two spokes in the North and South of the locality (Lanchester Road Hospital and West Park Hospital).

3.2 Staffing of the Hub

Triage workers in the Hub will be predominantly support worker/health care assistants who are appropriately trained to safely provide initial support to individuals presenting in crisis. There will be three triage workers working 8am-8pm and two working 8pm-8am, 7 days a week which is the same level of resource as currently available in the Recovery House. From 9am-5pm the Hub will also be staffed by administration staff and one administration apprentice.

Admin staff will provide support and assistance to triage workers and will also undertake additional activities such as producing discharge letters, liaising with GPs etc. It has also been suggested that admin staff are able to directly book assessment/triage appointments into the crisis team diaries. The administration team will have a joint central email account.

There will be at least two crisis clinicians based at the hub for the whole day time shift and at least one crisis clinician based there at night. These staff will be responsible for supervising and supporting the triage workers and triaging calls directed to them by triage workers for clinical decisions and/or further advice. The crisis clinician will act in a Duty Supervisor/Shift Coordinator capacity.

3.3 Calls to the Hub – Access to the Crisis Service

There will be a single contact number for D&D crisis services that will enable all calls to reach this central hub. Particularly for times of peak demand, there will be a queue system employed on all calls which would let the caller know their position in the queue of calls to give them some idea of how long they will be waiting before their call is answered. While they are waiting, callers will hear a recorded message providing advice and guidance e.g. Samaritans telephone number, advice to call care coordinator if known to services and their call is during office hours, etc.

There will be no answerphone option available on this phone line as there have previously been. Serious Incidents identified after delays in crisis teams responding to patient's answerphone messages. This would ensure that patients always receive a timely response from the service, as current feedback indicates that they can sometimes be difficult to get in touch with. The proposal is that there will be increased staffing resources in the hub, especially to manage times of known peak demand, across the 24 hour period to respond in a more timely basis and with less interruption.

Standard work will be in place to ensure consistency.

Based on evidence from the commissioner crisis review, it is very likely that a percentage of callers coming through to the hub will require signposting to other, more appropriate services outside of the crisis teams, i.e. across the wider crisis pathway; for example, third sector providers, wellbeing services, social welfare provision e.g. housing services/resources, financial advice, employment advice, local food bank/fuel services as well as signposting to other local resources such as Aspire, Waddington Street, St. Margaret's, ARCH Recovery College, etc. To support this, work is ongoing through the crisis concordat to develop a centralised directory of services for the crisis pathway as a whole that can be used to support all agencies and ensure individuals access the right care for their needs.

3.4 Leadership Team

The team will be led by a Service Manager who will be responsible for the locality Crisis Team and the Street Triage Service, ensuring close alignment between the two elements of specialist crisis support. There will be 2 Team Managers and 2 Advanced Practitioners working with the Service Manager. With additional leadership capacity, the intention is that the Team Managers will be able to deliver direct clinical work for 20% of their role. Resource has been identified to implement 2 Peer Workers within the team.

3.5 Assessment and Intensive Home Treatment Teams

Savings made from the closure of the Crisis & Recovery House would be re-invested into the Crisis Service to enhance the offer of Intensive Home Treatment that the team is currently able to provide. Specifically the level of support worker resource would be increased to the level in the crisis and recovery house (three workers 12 hours per day 7 days per week and two workers 12 hours per night 7 nights per week). There would be 1.0 WTE consultant post for locality. The service would also have input from a 0.8 WTE psychologist. The provision of dedicated psychology input will mean the IHT service meets the requirements of RCP, and would also provide enhanced capacity for specialist supervision within the team. Intensive home treatment would be undertaken by both qualified clinicians and support workers.

3.6 Culture, attitudes and values and the integration of the two Teams

It is important that the two teams work together to build trust in each other. During the event, the teams highlighted the need for transparency and for open and honest conversations at all times. Staff also acknowledged that they need to be willing to change, and agreed to voice any concerns that they have. Work continues to be undertaken on the attitudes and cultures within the teams to improve the image of the service and the way that it is perceived currently by service users, carers and families, as well as to improve interagency working.

3.7 Co-Production

The 3-day workshop was attended by service users and carer representatives to ensure that the action plan was truly co-produced. The Trust ladder of engagement was used and it is felt that this piece of work has achieved the 'Involve' level (People have an active role in influencing options and outcome but the final decision remains within the organisation), with some elements of the 'Collaborate' level (People working together with clear roles and responsibilities and direct involvement in decision making and action).

Suggestions and plans for future involvement to ensure that the model continues to involve people with lived experience through mobilisation, implementation and monitoring/evaluation include:

- Undertake periodic phone consultation exercise with ten recent users of each Crisis team to gain insights into perceptions of the team
- Establish Focus Groups of Service Users to gain better perspective of how the teams can work together to ensure their service users, their carers and families are getting what they want out of their experiences with the service.
- Establish a Service User/Carer Group that can be consulted regularly, including Recovery Experts.
- Undertake further work to look at how Peer Support/Peer Workers (including potentially paid Peer Support) can be best utilised by the service, in line with the Trust-wide Recovery approach and to ensure maximum benefit for service users and carers.
- Involve and integrate service users/experts by experience into the co-delivery of training to the new team

3.8 Crisis House Engagement

As part of the review of the crisis and recovery house an engagement exercise was undertaken during May and June 2018. This included 5 engagement events; 1 in Darlington and 4 in County Durham, along with a dedicated session with the crisis house staff. A briefing detailing the engagement events was sent to stakeholders which included all service user groups, the voluntary sector, local authorities (including overview and scrutiny committees), MPs, all TEWV members and governors. Commissioners were requested to share the briefing with their engagement leads to ensure it was sent to established forums across the locality. The events were promoted widely via TEWV core brief, e-bulletin, TEWV website and using social media. (Briefing attached in Appendix 1). The Darlington event was part of a wider locality engagement to share information and good practice across a range of partners.

The format of the engagement events followed a ‘world café’ style to encourage group discussion with options for attendees to make individual comments privately to staff or via the TEWV email address. A short presentation was also given providing information on the crisis house provision, usage, cost and feedback from patients and regulators. Stakeholders were asked their views on the following 4 questions:

Intensive home treatment

1. What support would you find helpful when experiencing a crisis? (and what isn't helpful?)
2. Where should this support be provided (e.g. at home, crisis house or somewhere else)?
3. Who are the best people to provide this support?
 - i) What clinical skills should they have?
 - ii) What personal attributes should they have?

The crisis and recovery house (the building)

4. Do you think the current service is the best use of this building and why? Could we make better use of the building and, if so, do you have any suggestions for an alternative use?

There were 32 attendees at the 5 events including TEWV crisis service staff, governors, Darlington LA Adult social care, N Durham CCG, service users, Darlington Health Watch, Durham LA staff, Rethink, Darlington Samaritans and Durham Police. The full list of attendees is attached as appendix 2. Feedback and comments from the engagement events and the dedicated session with the crisis house staff were reviewed by the crisis leadership teams and Commissioner staff from the 3 CCGs.

Using the comments and feedback, the following conclusions and proposals were developed by TEWV and CCG staff:

- **Service model:** a desire was clearly identified for the development of a safe haven / safe space which will be available and out of hours OOH. Whilst the criteria would need careful definition there is a need for this to be centrally based and accessible to all. Feedback during workshop discussions highlighted that the current model is not sufficiently inclusive for all, due to the admission criteria and the necessity for direct management of access via the CRHTs. It may be that this could be developed into something that is peer-led
- **Bed based crisis and recovery house:** this was not identified as a high priority for those attending engagement. However the skills and local knowledge of the staff within the Crisis and Recovery House (such as skilled signposting, engagement skills, empathy) need to be retained within the CRHTs to enable the provision of Intensive Home Treatment (IHT) in a more flexible and responsive way in peoples own homes. Equally, there may be an option for a different bed based model that is peer led.
- **Carers:** the need to develop and provide support to carers was highlighted. Whilst this may not need to be led by TEWV there was a strong view that the needs of the carer are essential to meet when supporting a person in a mental health crisis.
- **Use of current building:** Whilst it is accepted that for those able to access the current service their experience is positive, it was highlighted through the workshops that the provision of IHT should not be reliant on a 'bed base'. Feedback highlighted that the location for the provision of this service did not meet the needs of the majority.

Overall, the findings from the pre engagement exercise suggest we need to consider whether a bed based crisis and recovery house is the most appropriate use of resources to meet patient need.

- 3.9** Work to scope possible Safe Haven Models following commissioner discussions has also commenced and a summary of this work is attached at appendix 3. Alongside this, discussions have been continuing with the Crisis Concordat and Commissioners (linked to the concurrent Commissioner review of the wider Crisis pathway) about wider service developments that need to be taken forward with the wider health economy and community. Investment has been identified as part of bids for NHS Long Term Plan priorities to further develop the safe haven work. And although this is in its early stages the proposals support the principle of a range of availability across the geography of the Locality which addresses the concerns of a single provision of the Crisis and Recovery House across the County Durham and Darlington geography

4. CONCLUSION:

TEWV continues to develop its crisis services to meet the needs of people in County Durham and Darlington, as part of the wider crisis model development which is led by the crisis concordat. The aim is to develop a single crisis team for County Durham and Darlington, offering a standard approach whilst maintaining the flexibility to meet individual needs and changing demand. The hub will be based at Auckland Park Hospital from October 2019.

The feedback from the engagement exercise undertaken in June/July 2018 in relation to the function and use of the crisis and recovery house demonstrated that people who were experiencing a mental health crisis preferred to be supported at home whenever possible.

Staff who previously worked in the crisis house work will continue to provide much needed skills and additional capacity within the crisis team. This will increase the level of intensive support that can be provided to patients. We anticipate being able to support people who would previously have spent time in the crisis and recovery house at home.

Investment has been secured via the NHS Long Term plan to further develop safe haven(s) across County Durham and Darlington with work to commence from October 2019.

5. RECOMMENDATIONS:

The Overview and Scrutiny Committee is asked to note the outcome of the work undertaken so far and the integration of crisis services across Durham and Darlington.

The Overview and Scrutiny Committee is asked to support the single service approach and the implementation of the revised model in Quarter 1 2019/2020 and establishment of a hub at Auckland Park Hospital in October 2019.

The Overview and Scrutiny Committee is asked to note the work to date to engage with stakeholders to consider the function and use of the crisis house and is asked to consider if any further consultation is required prior to seeking support to permanently close the Crisis and Recovery House.

**Levi Buckley, Director of Operations, Durham and Darlington
August 2019**

Appendix 1 – crisis house engagement briefing documents



role and future of
the crisis and recover



Crisis and recovery
house in D&D.pdf

Appendix 2 - crisis house engagement list of attendees



crisis house
engagement Attende

Appendix 3 – safe haven model



Appendix 4 - Safe
Haven Design summa

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May 2018

The role and future of the crisis and recovery house in County Durham and Darlington

Our vision

Our aim is to support service users' recovery by providing fair and inclusive access to treatment and support when individuals are experiencing a mental health crisis.

The crisis and recovery house, Shildon

The nine bedroomed crisis and recovery house is available for men and women living in County Durham and Darlington.

Admissions are planned and the house provides an alternative, safe, supportive environment for *intensive home based treatment* (see description below). The service is for people who are experiencing a period of acute distress and who would benefit from a planned period of time away from home

What is intensive home based treatment?

This treatment, which is agreed with the individual following a crisis assessment, is an alternative to hospital admission.

The treatment is provided in the community by the crisis and intensive home treatment team (usually in the individual's home or, for a small number of people, in the crisis house) and can include talking therapies and medical treatments for a range of mental health difficulties. Visits can be up to twice a day and care is reviewed daily.

Current situation

Feedback from people who have spent time in the crisis house is very positive. However, the service is only being used by a very small number of people.

In 2017 there were only **88 admissions** to the crisis house (with an average length of stay of 11 days) and, on average, **less than half the beds were being used** at any one time.

During the same period over **1300 people** receive intensive home based treatment in their own home (over **7700 visits**).

There have been no admissions to the crisis and recovery house since the end of December 2017 and staff have been working elsewhere within the crisis service, including providing intensive home based treatment. We could, however, reopen the service if we received an appropriate referral.

Why have we seen a reduction in the use of the crisis house?

The way we provide mental health services is changing and

- there is a greater range of support available for people when they are experiencing a crisis such as:
 - a liaison service (working closely with colleagues in Darlington Memorial Hospital and University Hospital of North Durham to support people with mental health problems). This service is available 24 hours a day, seven days a week
 - a street triage service - the team provide support for people with mental ill health who come into contact with the police
- we know that people get better more quickly if they have increased support at home
- we know that the length of time people need to spend in hospital can be reduced if we offer intensive home treatment in their own home

Running the crisis and recovery house

On average, a bed in the crisis and recovery house costs the Trust **£478** per day to run. In comparison, it costs us on average **£380** per day for an inpatient bed in one of our assessment treatment wards and **£324** for one of the beds in our rehabilitation units.

What should we do next?

We need to make sure that we are making the best use of

- the money that is available to us and
- the skills of our staff

to provide the best possible care for the people of County Durham and Darlington.

The crisis and recovery house has been open for approximately four years and we believe it is time to review its role and function.

How can you help?

We would like to hear your views on:

Intensive home treatment

- What support would you find helpful when experiencing a crisis? (and what isn't helpful?)
- Where should this support be provided (eg at home, crisis house or somewhere else)?
- Who are the best people to provide this support?
 - What clinical skills should they have?
 - What personal attributes should they have?

The crisis and recovery house (the building)

- Do you think the current service is the best use of this building and why?
- Could we make better use of the building and, if so, do you have any suggestions for an alternative use?

How to get involved

We are holding a number of workshops:

19 June 2018 : 10am – 12noon

Sedgefield Racecourse, Racecourse Road, Sedgefield TS21 2HW

22 June 2018 : 10am – 12noon

The Four Clocks Centre, 154a Newgate Street, Bishop Auckland, DL14 7EH

25 June 2018 : 10am – 12 noon

The Glebe Centre, Durham Place, Murton, SR7 9BX

27 June 2018 : 1.30pm – 3.30pm

Dolphin Centre, Horsemarket, Darlington, DL15RP

(market place and refreshments available 11.00am – 12.30pm as part of our mental health and learning disabilities information showcase)

28 June 2018 : 10am -12 noon

Durham Indoor Bowling Club, off Ryelands Way, Pity Me, Durham DH1 5GE

It would be helpful if you could let us know if you plan to attend (tewv.enquiries@nhs.net)

You can also send us your views before 30 June 2018:

- tewv.enquiries@nhs.net or
- FREEPOST TEWV

If you would like to speak to someone please call 01325 552019 and someone will get back to you.

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Reviewing the role of the crisis and recovery house in County Durham and Darlington

The nine bedroomed crisis and recovery house in Shildon is available for men and women living in County Durham and Darlington.

Admissions are planned and the house provides an alternative environment for intensive home based treatment.

Intensive home based treatment

- ❖ is an alternative to hospital admission
- ❖ is provided in the community by the crisis and intensive home treatment team (usually in the individual's home or, for a small number of people, in the crisis house) and
- ❖ can include talking therapies and medical treatments for a range of mental health difficulties.

Feedback from people who have spent time in the crisis and recovery house is very positive. However, very few people use the service.

We need to make sure that we make best use of tax payers' money for the benefit of people across County Durham and Darlington.

Come along and have your say at one of our workshops

- ❖ Tuesday 19 June, 10.00am to 12.00noon - Sedgefield Racecourse, Racecourse Road, Stockton-on-Tees, TS21 2HW
- ❖ Friday 22 June, 10.00am to 12noon - Four Clocks Centre, 154a Newgate Street, Bishop Auckland, DL14 7EH
- ❖ Monday 25 June, 10.00am to 12noon - Glebe Centre, Murton, Seaham, SR7 9BX
- ❖ Thursday 28 June, 10.00am to 12noon – Abbey Bowling Centre, off Ryelands Way, Pity Me, Durham, DH1 5GE

Or at our mental health and learning disability information showcase on

- ❖ Wednesday 27 June, 1.30pm to 3.30pm – Dolphin Centre, Horsemarket, Darlington, DL15RP (market place and refreshments available 11.00am – 12.30pm)

It would be helpful if you could let us know if you plan to attend (email tewv.enquiries@nhs.net)

Or you can email us your views to tewv.enquiries@nhs.net

For more information visit our website www.tewv.nhs.uk/getinvolved (public engagement and consultations)

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Crisis House Engagement Attendees

19 June – Sedgefield Racecourse:

22 June – Four Clocks Centre:

Andrea Walsh
Julie Craggs
Gillian Cunningham
Beverly Cairns
Graeme Lee
Julie Williams
Ann Atkins
Clare Hall
Graham Robinson
Sarah Callaghan
Patricia Wilson

25 June – Glebe Centre:

Mac Williams
Sue Challinor
Karen Wilson
Jo Chapman
Simon Robson-Cross

27 July – Dolphin Centre

Audrey Lax	GOLD (Volunteer)
Terry Taylor	GOLD (Volunteer)
J Austin	Healthwatch (j.austin@healthwatchdarlington.co.uk)
P Elliott	Rethink
Jaci Hall	Survivor, Carer, TEWV member (01325 789854)
Keith Mollon	Durham Governor
Gloria Wilson	Director D&D Samaritans
Helen Wandless	D&D Samaritans
Tammy Edwards	Durham Police
Hannah Walden	Student (Learning Disabilities Nurse)
Natalie Robdrup	Student Nurse
Kevin Kelly	Adult Social Care (kevin.kelly@darlington.gov.uk)
Peter Stirling	DBC
Naomi Garbutt	DBC

28 June – Abbey Bowling Centre

Jackie Ball	Manager, Support & Recovery, DCC
Helen Embleton	Urgent Care Pathways Lead, AMH

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Summary of Possible Safe Haven Models for Durham and Darlington

Introduction and Background

An engagement exercise undertaken in June 2018 when local stakeholders were asked about the role and future of the crisis house, and extensive discussions through the Crisis Concordat. The key themes from the engagement exercise, and concurrent Commissioner led review of Crisis Services and the wider crisis pathway, included:

- We need out of hours (out of hospital) support that is centrally based and accessible for all. Although feedback from those who had spent time in the crisis and recovery house was positive, it was agreed that the current model is not sufficiently inclusive. A bed-based service was not identified as a high priority although developing a peer-led model is worth exploring.
- The development of a safe haven / safe space. We have already reviewed how this is provided in other areas of the country such as the crisis care / safe haven in York, the Richmond Fellowship safe haven on the Isle of Wight and the crisis pad in Hull.
- A flexible and responsive crisis resolution and home treatment service is essential if we are to provide people with the support they need to stay at home. Retaining the skills of staff from the crisis and recovery house will be key in developing this service.
- A need to develop and provide support for carers.

Following discussion about this in August 2018, EMT requested that more detailed work and costings of the safe haven model be developed collaboratively with Commissioners and to be presented to the ACP/Partnership board. This paper summarises possible options for a safe haven model in Durham and Darlington as requested by EMT.

Design Event

A design event to work up a more detailed specification for the haven was held on Friday 14 December. Attendees included TEWV staff (including Peer Support and Recovery Expert by Experience Lead, Senior Peer Support Worker), Commissioners (NECS Crisis Concordat lead), MIND and York Haven (to enable us to learn from their models). The design event considered lessons from a range of haven models across the country including Aldershot which is identified as leading practice, York haven which is based on Aldershot model and Leeds peer led model. The purpose of the session was to develop a description/specification of a haven; its functions; the environment; links and partnerships to be connected with; who, how to access it and when; the people who would staff the haven. Attendees were clear that the purpose was to design what might be needed and not to think about which organisation may provide as this was not within our remit.

High level service requirements

As requested by EMT, the service has, with stakeholders including Commissioners, Users and Carers, designed a possible specification for a safe haven model. This is deliberately not organisation specific to enable it to fit with actions identified through the Commissioner Crisis Pathway Review and discussions both internally and at the Crisis Concordat. To assist the crisis concordat and DDTMHLDP (the Partnership) further develop specifications for a safe haven and progress implementation, high level service requirements were developed and are shown below.

Function of the haven: (All essential)

- To provide support for a wide variation of needs:
- Uncomfortable emotions.
- Those who feel unsafe but do not want or require hospital access
- Offer Comfort/listening
- Support individuals to access other services they need (and assertively work with them to achieve this)
- Knowledge of and links with other agencies/Directory of Services
- Should not be seen as a 'health' facility
- Offer trauma informed/recovery focus

Physical environment: (All essential)

- Homely,
- Communal areas as well as bookable 1-1 rooms
- Some ensuite (as bathing often a 'safe space')
- Kitchen and ability to make a drink
- Space to offer groups or for other agencies to come in and provide (or be based in/have access to a facility where groups are already in place)
- Access to respite beds is important. Don't feel beds can't co-exist in haven – but the level of need/support would mean it would not be ideal in a haven environment. Would also have implications for CQC registration and resources.

Access:

- Minimal exclusion criteria:
 - Impact of behaviour on others
 - Legal restrictions
 - Not significant MH or medical needs
- Drop in, not an assessed process
- Available 365 days – desirable. Essential – 3 weekday evenings, weekends – day time opening as well as evening
- Hours of opening will depend on resource, other havens offer evenings until 12pm/2am (may be dependant on venue). Longer weekend opening times. Look at times of high Demand on Crisis Service/Liaison to determine the opening times.
- Central Facility for Darlington - essential
- Different approach for County Durham where one base not as feasible - essential. Hub and spoke: ability to reach out to rural/isolated communities, pop ups. Look at university, care hubs, use of existing community venues

- Examples: Dial house in Leeds: Main road, near shops, is a house on a housing estate rather than city centre. York haven is a central city location
- Transport (budget to be able to offer this to clients) - desirable

People:

- Ability to engage/listen
- Peer led if with appropriate resources, support and structures or to plan to make it peer led within 5 years through an asset development approach:
- Community Support Worker/ Peer support workers.
- Paid peer mentors.
- Volunteers.
- Area Manager oversight.

A range of staffing options (support workers plus management support) have been identified, which can be flexed depending on the required service configuration. For example, the Concordat has considered a range of opportunities from fixed havens to more flexible, “pop up” havens based around specific populations or times of need (eg at the university during exam periods).

Conclusion

There has been a range of work carried out to help us reach the point of design for a ‘haven’ type service which meets the requirements identified by service users and carers who have participated in the engagement process and subsequent service design events. The need for a service which can be responsive to adults in crisis has been consistently identified since the review of the Crisis and Recovery House commenced and via the concurrent Commissioner led review, however it has also consistently been identified that this does not (and possibly should not) need to be provided by TEWV services as there are others better placed to deliver a more flexible and bespoke approach. This is reflected in the actions identified through the Commissioner review and as part of the Crisis Concordat workplan for the coming year.

Recommendations

That the future service model and provision is now passed to the Crisis Concordat to be refined and later considered for implementation through the Partnership.

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Right Care, Right Place Programme (RCRP)

Jo Murray
RCRP Delivery Lead (D&D)

making a

difference

together

Key Drivers for Change



PRIMARY CARE NETWORKS

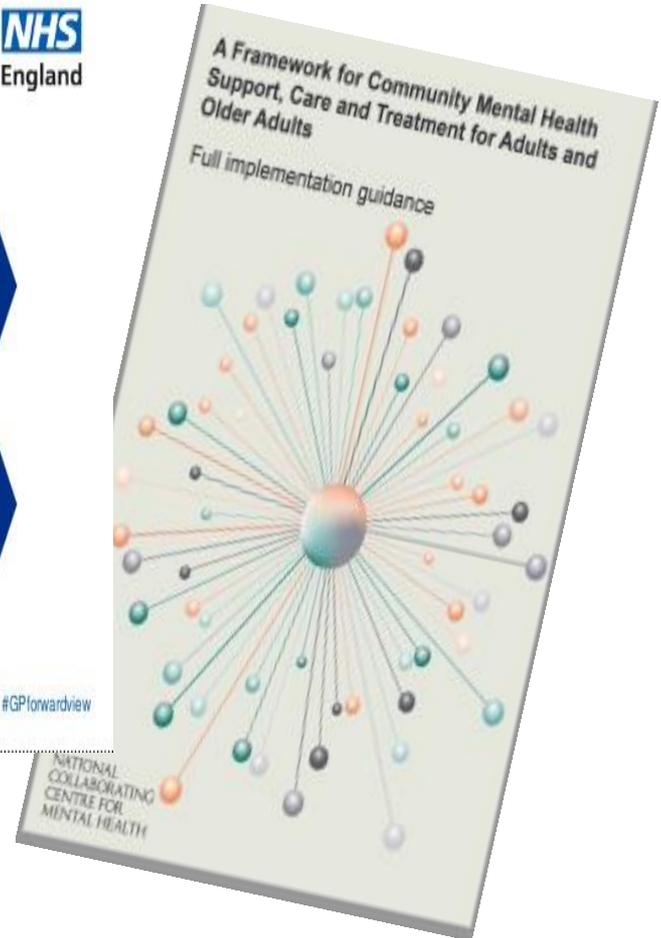
Primary care networks are small enough to give a sense of local ownership, but big enough to have **impact** across a 30-50K population.

They will comprise groupings of 100-150 clinicians and wider staff **sharing a vision** for how to improve the care of their population and will serve as service delivery units and a unifying platform across the country.

www.england.nhs.uk



#GPforwardview



making a

difference

together

Key Drivers for change

“It feels like we are on opposing sides, rather than all working to provide the best patient care we can”
GP

“Better handover to other services so not to feel like a big gap in support and potential to go back down”
Service User

“We have a serious gap in provision for people suffering mental health difficulties who are deemed not “risky” enough for secondary care intervention yet are refused primary care intervention as they are too “risky” or “complex”.
Staff

making a

difference

together

Right Care, Right Place

Page 260

- Improve how the whole system works together for both planned and unplanned care (especially thinking about how services better “wrap around” PCNs)
- Reduce “hand offs” within the Trust and with other providers
- Ensure needs are identified and addressed as early as possible
- Reduce unwarranted variations whilst making sure we provide what local communities need
- Make best use of all resources (money/ staff/ community assets)
- Address physical healthcare needs better and in a more joined up way

making a

difference

together

Next 3-4 months



- Two key, parallel pieces of work for community services over the next 3-4 months:
 - Speak to PCNs and TEWV staff - what would make the biggest difference quickly; where possible test 'prototypes' to assess the impact
 - Plan and deliver wider engagement events to develop a shared (and possibly radical) vision for the future for implementation (within the 'givens' that we have) over the coming 3-4 years

making a

difference

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RCRP Delivery Lead
(Durham and Darlington)

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making a



difference



together

RIGHT CARE, RIGHT PLACE: DURHAM AND DARLINGTON

KEY MESSAGES AUGUST 2019

1. WHAT IS “RIGHT CARE, RIGHT PLACE”?

In response to the NHS Long Term Plan, Five Year Forward View for Mental Health and forthcoming Community Mental Health Framework, the TEWV Trust Board have initiated a new programme of improvement covering community, inpatient and urgent care delivery, needs to be prioritised. This new programme is called “Right Care, Right Place” (RCRP) and it aims to deliver better experience and outcomes for services users, our staff and our partners by focusing on how all of our services, and those of our partners, can work more seamlessly and better together, reflecting staff, users’, carers’ and partners’ feedback. Using a recovery-focused and trauma informed approach, RCRP will work systemically (not just within TEWV) so that we can:

- Improve how the whole system works together for both planned and unplanned care (especially thinking about how services better “wrap around” PCNs)
- Reduce “hand offs” (ie passing people between services) within the Trust and with other providers
- Ensure people’s needs are identified and addressed as early as possible
- Reduce unwarranted variations whilst making sure we provide what local communities need
- Achieve the best use of all resources (money/ staff/ community assets)
- Address physical healthcare needs better and in a more joined up way

The programme will link closely to all other Trust and multi-agency programmes of work to avoid duplication.

2. WHAT IS ALREADY HAPPENING IN DARLINGTON, AND WHAT MIGHT THIS NEW PROGRAMME MEAN LOCALLY?

We do not plan to duplicate existing work and groups. Therefore, the Crisis Concordat will remain the focus for urgent care work, and work to make our use of beds more efficient within TEWV will continue. Development of community services will inevitably be the biggest area for development, in particular to look at how mental health services better “wrap around” PCNs. We will set up a specific project group for Darlington, most likely as a sub group to the New Models of Care work, involving PCNs, third sector, public health, patients, families and other stakeholders to lead this. We have however set up a senior reference group to co-ordinate and oversee the work.

3. THE “GIVENS”

There is a genuine intention to be creative and move away from traditional organisation, commissioning or delivery arrangements where appropriate or where these inadvertently create a barrier to easy access to care. However, there are a range of “givens” that services and partners will need to work within as a framework to support this development. These are currently being finalised but will include national performance measures, CQC and other regulatory requirements etc.

4. ENGAGEMENT AND INVOLVEMENT

We have made a genuine commitment to co-produce our plans with partners, service users, families and staff. Work is developing to make sure we are able to do this properly, balancing rapid testing in some areas of different ways of working with agreeing a shared vision for the future. The Trust’s Expert by Experience Lead has provided advice and guidance re meaningful user involvement. Healthwatch are also engaged to begin to consider how they could help with wider engagement. Priority work for August will be planning the vision development events for October (dates to be confirmed before the end of August), and a Design Events for Darlington is being planned for November to begin to develop implementation plans.

Ideas Generation

A simple “ideas generation” exercise has started across services internally and externally, simply asking people to identify what 2 things (big or small) they think would make the biggest difference to people struggling with their mental health. To date, 180+ ideas have been generated (primarily from PCNs) to date, and there are a number of possible prototypes emerging that services will be encouraged to test through August and September to evaluate the impact.

The NHS MH Implementation Plan has recently been published and outlines plans for a £2.3bn investment nationally in mental health services over the next 5 years. The work commenced to date on the RCRP programme places us in a strong position to take advantage of this by building on the creative and different approaches being developed.

5. WHAT HAS BEEN HAPPENING OVER THE PAST MONTH?

The RCRP programme in Darlington is progressing reasonably well from a system perspective. There has been an increasing level of engagement, including primary care and the voluntary sector, and generally a high level of enthusiasm to take the opportunity we now have to do things differently, building on the good practice already available within the system. In relation to the 3 specific workstreams:

Acute Care – bed action plans are now in place for both adult mental health and older people’s services, although generally, Durham and Darlington locality performs well in this area

Urgent Care - Adult crisis services continue work to move towards a single hub and spoken model. Discussions about RCRP are planned for the next Crisis Concordat meeting. Bids have been submitted in conjunction with the CCGs for additional investment in crisis services. Work is also being considered through the Crisis Concordat to support co-ordination of different strands of work related to high intensity users

Community Services - Much of the work related to RCRP over the past month has related to community services. There has been a significant focus on external engagement and immediate ideas generation to identify potential prototype work. Initial meetings are being held over the summer with the Primary Care Networks, the community and voluntary sector, and other key stakeholders in Darlington (including DBC). Work will include ensuring there are strong links with emerging Social Prescribing Link Worker roles. Discussions have also started more strategically to consider commissioning approaches and resources might be used to best effect to support this programme.

Data packs showing referral trends by directorate, team, PCN and practice have been produced and shared with a small number of people for comment to support further development. It is hoped these may help the system to start to focus questions and explore creative and robust solutions based on a real understanding of specific local issues. For example, if CYP referrals have significantly increased in 1 practice, understanding if this may be linked to new housing or school developments may help focus ideas about possible solutions/work that may be required.

6. NEXT STEPS

We are undertaking two key pieces of work which we will run in parallel over the coming 3-4 months:

1. Through existing forums, speak to PCNs, users/carers/families, stakeholders and TEWV staff to identify what would make the biggest difference quickly, and where possible test these ‘prototypes’ to assess the impact
2. Plan and deliver wider engagement events with service users, families, PCNs, other stakeholders (including voluntary sector) and our staff within TEWV develop a shared (and possibly radical) vision for the future for implementation (within the ‘givens’ that we have) over the coming 3-4 years

This is an exciting but ambitious programme of work and we intend to send updates to all key partners/stakeholders in Darlington services as the work progresses

If you would like to discuss anything in more detail please don't hesitate to contact Jo Murray, Right Care Right Place Delivery Lead (Durham and Darlington), at jo.murray1@nhs.net

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RIGHT CARE, RIGHT PLACE (DURHAM AND DARLINGTON)

Name:

I work/live in (please circle):

Derwentside	Durham	Chester le Street	Darlington
Easington	Sedgefield	Dales	

I am (please circle):

Service User	Carer/Family Member	Primary Care	Local Authority	Voluntary Sector
TEWV staff	Police	CDDFT	Other (please specify)	

What 2 things (big or small) could we do that would make the biggest difference to people who might need help with their mental health?

1.

2.

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What 2 things (big or small) could we do that would make the biggest difference to people who might need help with their mental health?

1.

2.

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Updated Briefing Paper on County Durham Urgent Treatment Centres

Proposed Changes to Overnight Service Delivery at Peterlee Urgent Treatment Centre

Briefing paper for:
DDES and North Durham Joint Executive Committee
DDES and North Durham Governing body
Durham Adults Wellbeing and Health Overview and Scrutiny Committee

Author:
Clair White, Head of Commissioning

Sponsor: Sarah Burns, Director of Commissioning

August 2019

Purpose of Report

1. The purpose of the report is to update the Adults Wellbeing and Health Overview and Scrutiny Committee (the Committee) on the work undertaken at the Committee's request by North Durham and Durham Dales, Easington and Sedgefield Clinical Commissioning Groups (the CCGs) between April 2019 and July 2019.
2. The work between April and July 2019 was requested by the Committee following the presentation of the attached report (see appendix one) to:
 - a) Ensure the CCGs gave the public/patient population the opportunity to voice any concerns and to understand their views.
 - b) Recheck the patient activity data used by managers and clinicians to design the service model.
 - c) Show how NHS111 are directing patients between the hours of 12midnight and 8am and demonstrate there has been no deliberate reduction in activity at Peterlee Urgent Treatment Centre between the hours of 12midnight and 8am as was suggested by the Councillors in addition no increase. The activity at this site **has** always been low overnight which has driven the service redesign.
 - d) Provide the clinical skill mix of the service model.

Additional Work - April to July 2019

Ensure the CCGs gave the public/patient population the opportunity to voice any concerns and to understand their views.

Where we went and what we did

3. The CCGs carried out a four week period of engagement in June 2019. Over the four week period a number of events and venues were targeted to reach the general public.
4. The patient activity data showed that there wasn't any specific age group or group in the community that was using this service more than any other. Therefore the engagement was aimed at a cross section of the local population, with the intention of speaking to as many people as possible to raise awareness of the survey and encourage completion. Through face to face conversations and those who completed the survey, which was offered online and on paper, we gathered rich qualitative data and details of real patient experience.

5. We developed a stakeholder briefing which was emailed to key stakeholders on June 3rd 2019. We wanted to work with local councillors to advise us on where the best places were to visit to meet their constituents. We also wrote and delivered an engagement action plan (below) which detailed where we would visit, who we wanted to speak to and what dates.
6. We also had support from East Durham Trust who kindly distributed the survey to members of their existing groups such as knit and natter groups and coffee mornings to name a few.

Activity	Venue	Date planned	Activity
Targeted engagement	Community Hospital, Peterlee	6 June 19 14 June 19 17 June 19 27 June 19 28 June 19	Discussions with people using Peterlee Urgent Treatment Centre
Face to face engagement	AAP – East Durham	12 June 19	Area Action Partnership
Face to face engagement	Share & Support Health Event, Blackhall Community Centre, Heselden Road Blackhall TS27 4LG	5 June 2019	Community event
Face to face engagement with targeted audiences based on data	East Durham Trust health network meeting	12 June 2019	Discussions with members of the public
PRGs members speaking to patients (face to face)	GP practices in the East Durham area	June 2019	PRG members spoke to patients when they were in the practice
Face to face engagement	Peterlee Town Centre	7 June 19 10 June 19 21 June 19	Discussions with members of the public
Face to face engagement	Dalton Park, Murton	13 June 19 19 June 19	Discussions with members of the public
Face to face engagement	Healthworks, Easington	5 June 19 12 June 19 18 June 19	Discussions with members of the public

Activity	Venue	Date planned	Activity
Meetings with Easington Cllrs	Email sent 07/06/19 with offer to meet	No dates booked	Stakeholder briefing and survey sent
Meetings with Sedgefield Cllrs	Email sent 07/06/19	No dates booked	Stakeholder briefing and survey sent
Letter response to Helen Goodman MP	Correspondence with offer to meet and request for help to engage constituents	Offer to meet not accepted	Helen Goodman MP suggested a full page advert in Teesdale Mercury newspaper as felt everyone in that area reads that paper. Numerous articles have been printed.
Telephone call	Cllr Angela Surtees	29 June 19	Obtain recommendations on where to go to speak to people, how their local meetings are set up and support Cllr Surtees could offer
Face to face meeting	Attended the Thornley Village Centre, High Street, DH6 3EL	25 June 19	Lindsay Fox attended the coffee morning to discuss the proposals and gained views
Face to face meeting	Attending Peterlee parish Council	10 June 19	Clair White attended to discuss proposals and gain views
Face to face engagement	Asda Seaham and Peterlee	June 2019	No response to emails / phone calls

Social Media

- Over the four week period the UTC engagement and the survey were mentioned on twelve Facebook and twelve Twitter posts. The NHS Durham Dales, Easington and Sedgefield CCG Facebook page has 767 followers and Twitter feed has 847 followers.

Findings from the surveys (online and paper)

8. 356 people completed the online survey and we spoke to 76 members of the public face to face, resulting in a total of 432 surveys.
9. The questions we asked were:
 - Have you used the Urgent Treatment Centre at Peterlee?
 - Have you used this service over night (between 12 midnight and 8am)?
 - What was the age range of the patient?
 - Why did you choose to attend overnight? Could this have waited until the morning with the right support?
 - How did you make your appointment?
 - What did you attend the service for?
 - Do you think this condition could have been dealt with at home by a health care professional?
 - If we proposed to carry out these appointments between 12 midnight and 8am at your home instead of an UTC would this be suitable?
 - If we did provide these services via a home visit what would be the most important things for us to consider?
10. Nearly 88% (380) of patients had used the Urgent Treatment Centre (UTC), 12% (52) had not.
11. 50.95% (194) had used the service over night between 12 midnight and 8am. 49.05% (186) had not used the service overnight.
12. The majority of patients 48% (182) who have used the UTC were between 20-65 years of age. 12% (46) of patients were 0-2 years of age, 12% (46) of patients were between 2-5 years of age, 16% (60) were between 6-19 years of age, and 12% (46) were over 65 years of age.

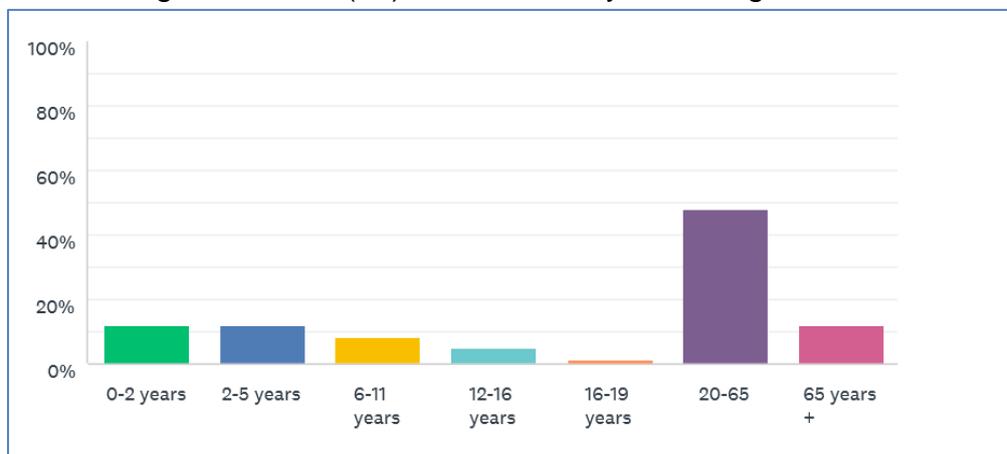


Table 1: age range of respondents

13. On asking people if we did provide these services via a home visit what would be the most important things for us to consider many themes were identified. These themes were:
- The age of the patient
 - Access
 - NHS 111 working correctly
 - Prescribing medicines
 - Capacity
 - People with disabilities such as hearing and sight problems and learning
 - Confidentiality
 - Equipment – will practitioners have the right equipment available
 - Waiting and response times
 - Mental health issues
 - Severity of illness e.g.: heart attack or stroke, would they know what to do?
 - Communication is very important especially via a phone call for reassurance about time it will take and to give advice if it will be a while
 - Proof of identity to those living alone
 - Safety for healthcare professional
 - Expertise of staff
 - To be treated with respect and not as an inconvenience to the health care professional
14. Of the people who went to the UTC, over 56% (213) of patients walked into the UTC without first contacting NHS111, whereas 44% (167) made their appointment through NHS111.
15. Patients attended the UTC for many reasons with the majority 33% (125) being for raised temperature/fever, 12% (46) for urine infections and 24% (92) for other. The other reasons were made up of simple broken bones, wounds/wound infections.

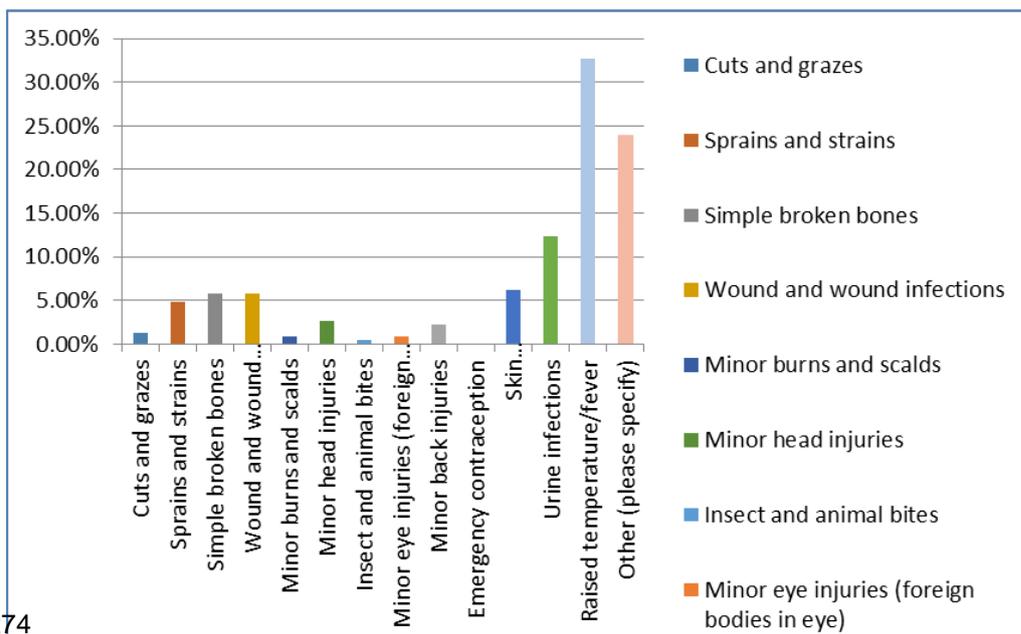


Table 2:
What did you attend the service for?

16. When asked if they think their condition could have been dealt with at home by a health care professional 26% (99) of patients said yes it could whereas 50% (190) said they didn't think it could and 24% (91) said they did not know.
17. 57% (217) of patients said they thought it would be suitable to carry out the UTC appointments out at home between 12 midnight and 8am, 25% (95) said that they thought it would not be suitable and 18% (68) said they did not know.

Qualitative findings

18. We spoke to 76 people face to face over the four week period and 61 of those people had used the Peterlee UTC before. Of the 15 who had never used it 12 of them stated if they were unwell and had to use in the future, they would prefer a home visit. The other three weren't sure and responded as "don't know".
19. Of the 76 people we spoke to, only 15 had used the centre during the period midnight – 8am, 14 of them attending for illness and one for injury who required an x-ray and had to return the next day.
20. On asking how they got to Peterlee UTC and whether it was an appointment booked for them via NHS111 or whether they walked in - 78% of respondents were booked through NHS111 for an illness and 60% of those who walked in were for Minor Injuries.

	Total	Injury	Illness
NHS 111	27	6	21
walked in	35	21	14
not used	14		

21. Over half 65% (40) of respondents felt that their assessments/treatment could have been carried out at home. Of the 35% (21) who felt this couldn't have been dealt with at home, 87% (18) of those assumed the right equipment and treatment wouldn't be available at home.
 - a) As part of the social marketing campaign, which the CCGs will run for 18 months commencing in September 2019, clarification will be given that home visiting is suitable for everything that patients would usually see their GP or attend a primary care service for. The service will have all necessary medication (including emergency and controlled drugs) and equipment required to carry out observations. This includes a nebuliser.

b) As for X-rays, this is not something that could be done in a patient's home. However it is important to highlight that an X-ray service is not available during the 12midnight to 8am time period so even if patients chose to travel to an UTC they could not receive this diagnostic.

22. Out of a total of 76 discussions, 74% (56) of respondents said that they would prefer a home visit during the night, 13% (10) said they would prefer to travel to and be seen in an UTC, with 13% (10) not really having any preference/don't know.

What would you consider to be important if the appointment was carried out at home?	
no comment	23
time to get there/confirm times/response times/make sure definitely come	16
equipment/treatment	6
be good for elderly who live alone	6
X-ray	5
not having to travel when unwell/hurt	5
not having to take kids out/other kids	5
confusing what is open/confident will get seen if go to base	3
if people are fit to drive, they should and free up resource	2
like to know will definitely been seen	1
this is the start of closing it completely	1
needed to hand a sample in	1
will service in this area be thin if mobile and they are further away	1
need to be seen - suspected sepsis	1

Table 3: What would you consider to be important if the appointment was carried out at home?

The reasons why people attended the UTC at Peterlee	
Injury/X-ray	15
Infection/UTI/ear	9
Fall/cut	8
Temp/rash/child	8
Unwell (illness not specified)	7
abdominal pain/condition	4
COPD/Asthma/SOB	4
Headache	2
Slipped disc/bad back	2
dog bite required a tetanus	1
Chest pain	1
? Sepsis	1

Table 4: The reasons why people attended the UTC at Peterlee

(The chest pain patient walked in to the centre and was immediately transferred by NHS funded transport to A&E)

Recheck the patient activity data used by clinicians to design the service model.

- 23. In April 2019 the Committee also asked CCGs to recheck the patient activity data used in the decision making process. Questions were asked over the data in paragraph 28 of the April report which demonstrated that on average 0.6 patients were utilising the service overnight per hour weekdays and 1 patient per hour overnight weekends.
- 24. During June 2019 CDDFT carried out a real time audit of patient activity. The resulting data accurately reflected the data in paragraph 28.
- 25. Throughout June 2019, 171 patients were assessed at Peterlee Urgent Treatment, either face to face or over the telephone.

	00:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00
Walk in	3	4	4	4	1	4	4	8
Booked	11	6	6	3	2	8	13	12
Telephone	18	10	10	8	4	8	7	5
Home	2	2	0	1	2	0	0	1
Total per hour	34	22	20	16	9	20	24	26

- 26. This shows us that approximately 0.8 patients per hour are assessed by a clinician at Peterlee, overnight, in comparison to the approximate one patient per hour in our previous report.
- 27. Removing the telephone contact information, 0.5 patients per hour were physically seen.

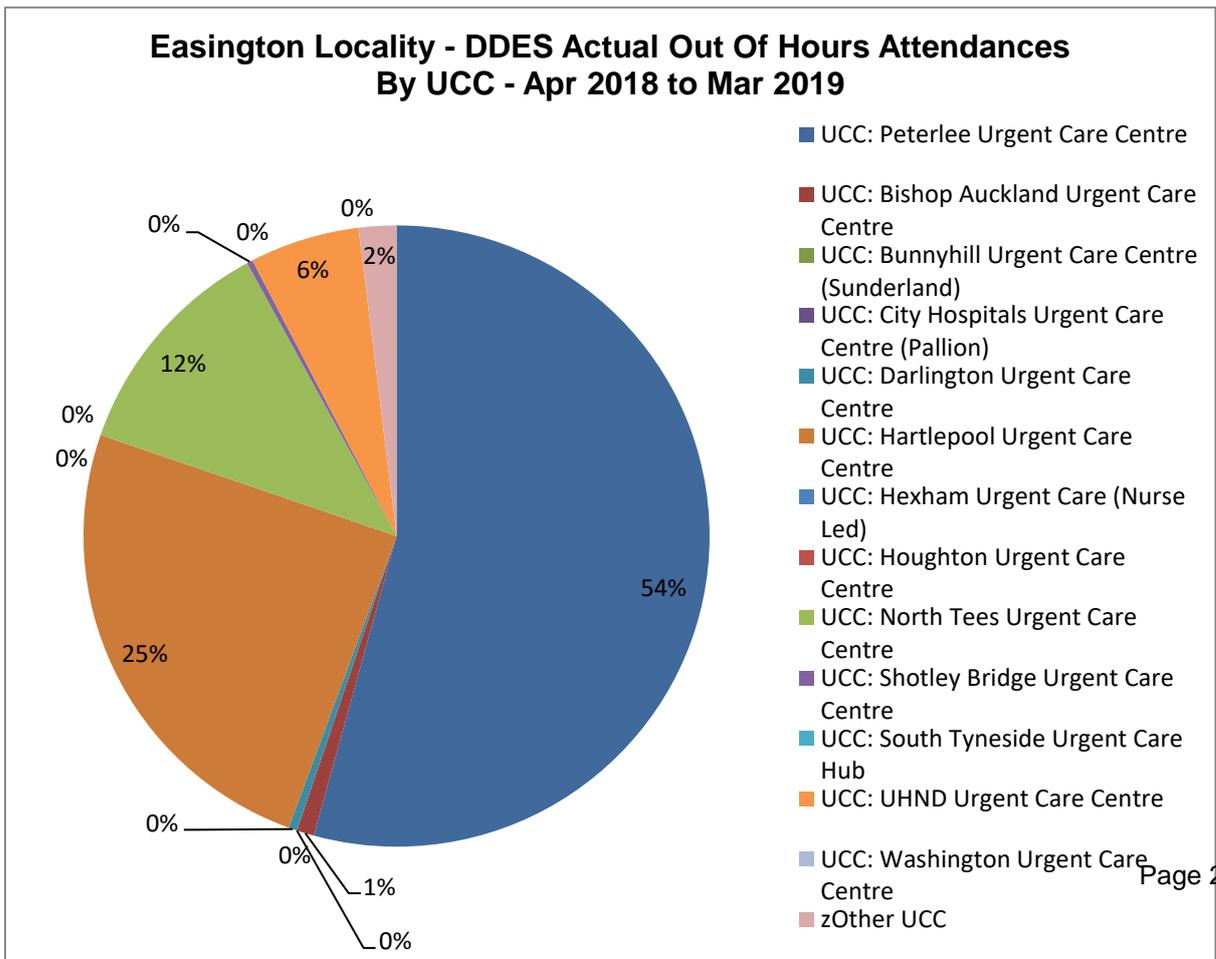
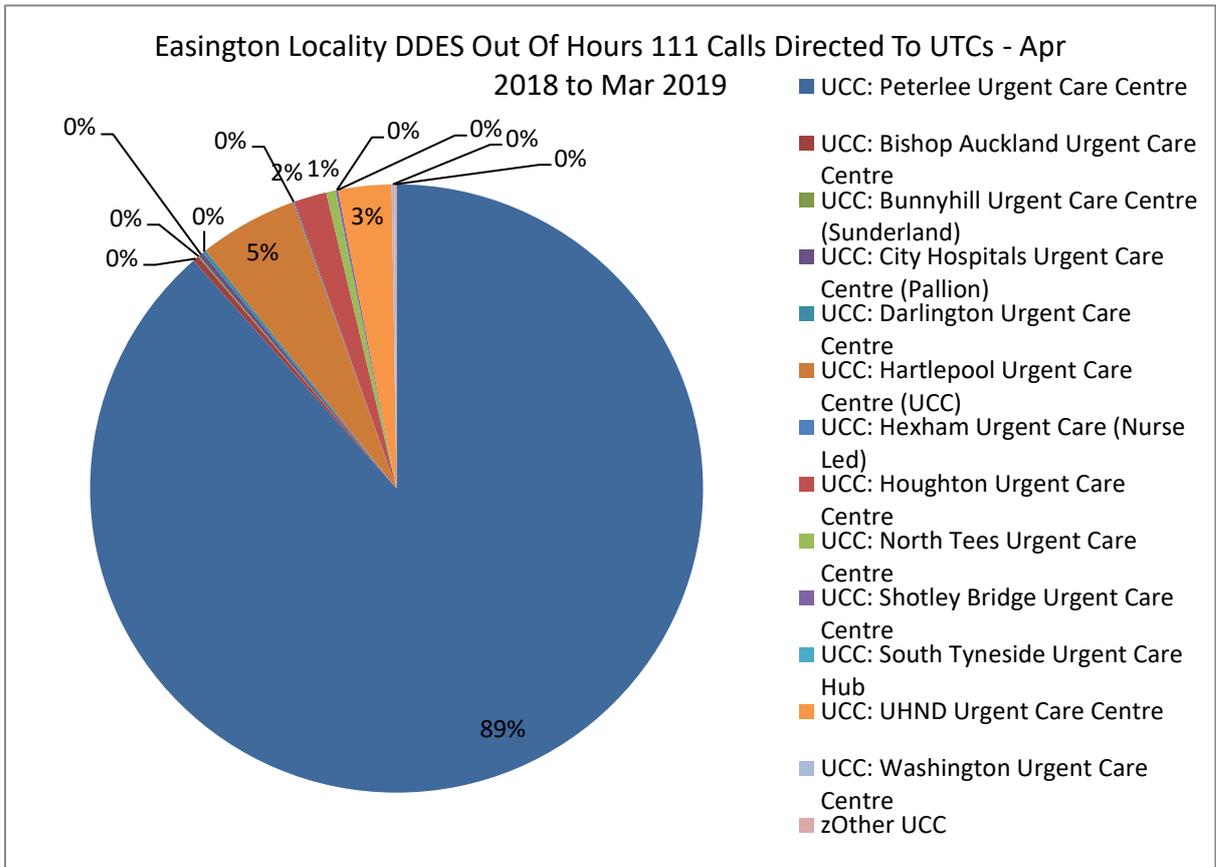
	00:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00
Total	16	12	10	8	5	12	17	21

- 28. The previous report was based on annual data, so we would expect to see a slightly lower figure in June due to it being a summer season.

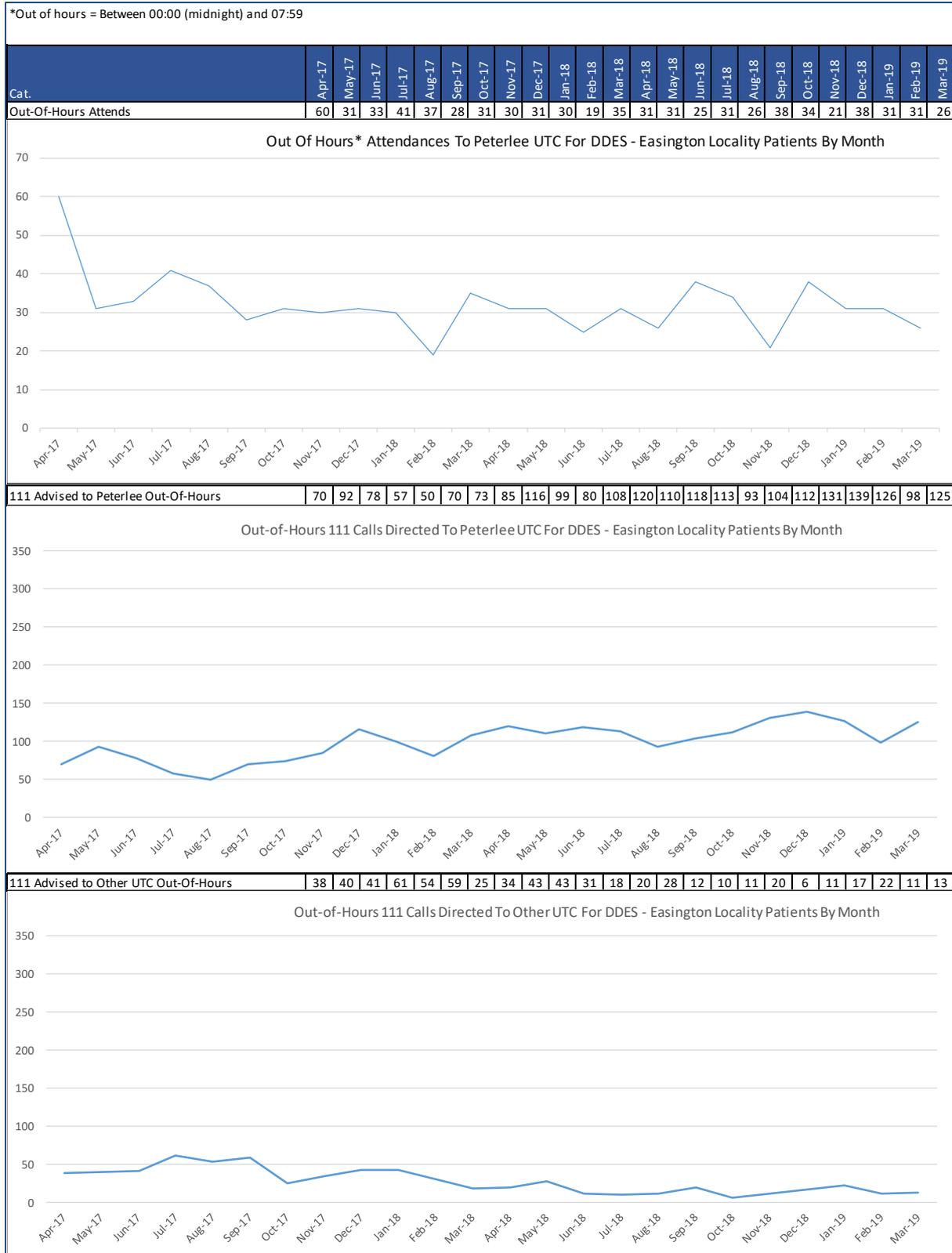
Show how NHS111 are directing patients between the hours of 12midnight and 8am and demonstrate there has been no reduction in activity at Peterlee Urgent Treatment Centre between the hours of 12midnight and 8am as was previously suggested by the Councillors.

29. During our engagement phase concerns were raised around the NHS111 service. Specifically whether NHS111 were booking people into Peterlee Urgent Treatment Centre or redirecting them elsewhere leading us to look further into this. The original proposals were based on activity from 1st April 2017 to 31st March 2018. We obtained NHS111 activity for DDES Easington Locality patients during this period during the hours 12:00am midnight – 8:00am.
30. The report told us that a total 3,852 people telephoned NHS 111 during this period over night with 1,041 of these being directed to Peterlee Urgent Treatment Centre (Please note the total includes all DDES patients, so includes Sedgfield and Durham Dales). *(This is information is based on numbers contacting NHS 111, and not how many of these actually attended).*
31. Of the 2,811 who were redirected elsewhere, only 501 (18%) of these patients lived in the Easington District area. The rest were Sedgfield and Dales meaning on average 1.4 patients per day were advised to attend somewhere other than Peterlee meaning on average one patient per night was directed further than Peterlee.
32. From April 2018 – March 2019 only 11% (181) of 1,570 Easington locality people were advised to attend an alternative UTC.
33. It is important to highlight that NHS111 direct people based on distance to the caller at the time of contact and based on the patient's clinical requirement. Some cases do need to be seen at an alternative UTC co-located with an A&E due to the patient's condition being higher risk.
34. It is also important that the Committee acknowledges that without knowing who these 181 patients are, we are unable to clarify whether this was patient choice, or that they had a clinical need which required they attend an UTC co-located to an A&E due to higher risk.
35. As an example, those patients from the Blackhall area would be likely to 'profile' (come up as an option on the NHS111 system) as Hartlepool over Peterlee.

36. The graphs below demonstrate that the number of patients directed via NHS111 to Peterlee UTC is **higher** than the number of patients choosing to attend.



37. The data below also demonstrates that activity remains static and has not decreased as was suggested in April 2019.



38. The number of Easington locality patients redirected to alternative Urgent Treatment Centres by NHS111, is very low as show above, confirming NHS 111 are utilising Peterlee UTC correctly.

Out of area A&E activity

39. As part of our engagement, the CCGs attended the Local Area Action Partnership meeting where Councillors raised a valid question as to whether patients were choosing to walk into A&E instead of ringing NHS111.
40. Patient data shows that the Easington district population choose to attend either North Tees, Sunderland A&E or UHND. All Emergency Departments (ED) provided the CCGs with information on patients that were treated in A&E but could have been seen in an UTC.
41. The numbers were extremely low. A total of 407 DDES patients who walked into one of these A&E's between 1st April 2017 and 31st March 2018, during the hours of midnight to 8:00am. 118 of these patients lived in the Easington District area. This is an average of 0.32 patients per day from the Easington area, and an average of 1.1 patients per day from the full DDES population.

Attendances by Destination from each TAP

TAP	Attendances by Destination			Total
	Sunderland Royal Hospital	University Hospital Of North Tees	University Hospital Of North Durham	
Dales 1	0	2	38	40
Dales 2	0	5	7	12
Dales 3	1	1	2	4
Durham East	0	1	0	1
Easington 1	0	56	8	64
Easington 2	0	23	25	48
Easington 3	0	3	3	6
Sedgefield 1	0	13	6	19
Sedgefield 2	0	131	82	213
Sedgefield 3	0	0	0	0
Total	1	235	171	407

Provide the clinical skill mix of the service model.

42. The CCG led two improvement events to focus on options around staffing models, opportunities and operating times alongside the project team's work.

43. To gather intelligence from those who know the service best, the group membership included; the staff working within the sites, clinicians - GPs, CCG Urgent Care lead (Dr Jan Panke), CDDFT/CCG managers, CCG business intelligence and data team and CDDFT contract manager. The Urgent Care Lead from NHS England (NHSE) also attended both events in an advisory capacity around the standards and the terminology.
44. Together, some potential staffing options were developed and the group reached an agreement around GP access/leadership, when and where it would be needed but overall agreed GPs do not need to be physically on site in all of the centres except on a Saturday and Sunday 1pm- 10pm. This is due to demand on the services and home visiting; it is also preferable to have a GP on site through the week 8pm – 12pm when the service has the greatest demands.
45. Following this agreement a range of options were developed by the group for consideration. These options have been supported by patient activity data and CDDFT have shared the financial information for all options. The resulting agreement was that the home visiting service will be staffed by two GPs and one Nurse Practitioner. This model, presented in April to the Committee, was, and is still, the preferred model and is clinically supported and endorsed by both CCGs, CDDFT and the County Durham Local A&E Delivery Board.
46. NHSE have given the CCGs assurance that all work to date does support full compliance with UTC standards, also NHSE support the CCGs work around remodelling the service will ensure appropriate staffing at all times across all sites working in an NHS system-wide approach rather than a centre based approach. The model ensures that the system is compliant with the out of hours commissioning standards and is GP led but uses a skill mix of practitioners that is appropriate to actual service demands.
47. The model will utilise the existing GP / practitioner workforce in the out of hours period more effectively. As such CDDFT do not need to recruit to staff the home visiting service.

Social Marketing Campaign

48. The CCGs recognise the need for robust communications to local people so they know what to do when they are unwell. As such we have worked closely with CDDFT and have taken engagement advice from our local councillors and Helen Goodman MP to aid all future work. We have developed a frequently asked questions document which we will add to throughout the process, the current draft can be found as appendix two.

49. Specifically for this work, we will use all of the insight and feedback collected to develop a robust communication strategy and deliver a social marketing campaign to ensure our patient population can make informed choices when accessing healthcare. There will be a focus on:
- Repeating the NHS messages of always “Think GP First” and the importance of contacting NHS111.
 - Ensuring patients know they can’t walk into Peterlee UTC between 12 midnight and 8am.
 - Ensuring patients know that a home visit will offer the same level of diagnosis and treatment as a visit to an UTC between 12 midnight and 8am.
 - If you feel unwell and your GP practice is closed patients must call NHS111 to be signposted to a service appropriate to their clinical need.
50. The Committee is asked to acknowledge that the CCGs have a very limited budget so request the help of the Committee in disseminating information to the local population and for their ideas on how best to communicate with constituents. The CCG will be working very closely with town councillors to disseminate the message and will continue to do so over the coming months.

Summary

- The current delivery model does not make best use of resources (financial or staff skills).
- The CCGs gave the public/patient population the opportunity to voice any concerns and to understand their views during the four week engagement period.
- The CCGs validated the patient activity data used by clinicians to design the service model. County Durham and Darlington NHS Foundation Trust conducted a second audit in June 2019 which evidenced the same, low activity findings and service underutilisation. The original findings were correct.
- The CCGs analysed service data to evidence that NHS111 are directing patients between the hours of 12midnight and 8am appropriately.
- The CCGs analysed service data to evidence that there has been no reduction in activity at Peterlee Urgent Treatment Centre between the hours of 12midnight and 8am as was perceived by the Committee.
- Between the hours of 12midnight and 8am the service will come to the patient (if required) with the provision of a Home Visiting service.
- To note all of the options were considered by the Local A&E Delivery Board (LADB) who were supportive of the preferred option.

- To note the preferred option is fully compliant with the Urgent Treatment Centre (UTC) standards.
- To note that clinical support for the preferred option has been confirmed by Dr Jan Panke CCG clinical lead for Urgent and Emergency Care.
- To note that staff delivering the services have been involved in the development of the alternative delivery model options and the preferred option.
- The key driver for the review is the ongoing issues with staffing in the out of hours period and the low numbers of patients needing a service during the night.
- The specific element that would change under the proposed new model would be between the hours midnight and 8:00 am.
- To note that the new delivery model will be reviewed on an ongoing basis but with particular focus at both three and six months particularly in relation to the staffing model at all sites.
- Acknowledge that a robust communication strategy will be put in place.

Recommendation

The committee is asked to:

- Note the rationale for the proposed changes to service delivery.
- Note the extent of additional work done at the request of the Committee.
- Note that this report is pending CCG governing body approval.
- Consider and comment on the proposal to enable the service changes to move to mobilisation phase.

Appendix One – Report from April OSC



Briefing paper UTC
for OSC v6 FINAL.doc

Frequently Asked Questions

Changes to Overnight Service Delivery at Peterlee Urgent Treatment Centre

Is the centre closing?

No. Peterlee Urgent Treatment Centre will be open 16 hours per day - 8am to midnight. During the hours of midnight to 8am patients will either receive a home visit or NHS funded transport to an Urgent Treatment Centre co-located with an A&E if their need is higher risk (note that as Peterlee is not co-located with an A&E, high risk patients would not have been directed there by NHS111).

Why are you making a change?

The changes are only during the hours of midnight to 8am. The number of patients attending the Peterlee Urgent Treatment Centre site during the night has always been low - an average of 0.6 patients utilising the service per hour during the week and 1 patient per hour at weekends.

The low number of patients coming to the centre has driven the need for County Durham and Darlington NHS Foundation Trust and the County Durham CCGs to redesign the service.

Do I have to call NHS111 to get an appointment at the Urgent Treatment Centre?

No, but the NHS recommends that you do. You might travel all the way to an Urgent Treatment Centre only to find out your condition can't be treated there or there will be a long wait for the next appointment. **Talk before you walk.**



NHS111 can advise you which Urgent Treatment Centre can best meet your healthcare needs, they can book you an appointment to save you from long waits on arrival and in some circumstances, they can even arrange return NHS funded transport.

What type of things do they treat at Urgent Treatment Centres?

Common conditions that can be treated in an Urgent Treatment Centre are:

- Cuts and grazes
- Sprains and strains
- Simple broken bones
- Wound and wound infections
- Minor burns and scalds
- Minor head injuries
- Insect and animal bites
- Minor eye injuries (foreign bodies in eye)
- Minor back injuries
- Emergency contraception
- Skin infections/rashes/allergic reactions
- Urine infections
- Raised temperature/fever

Depending on a patient's symptoms, Urgent Treatment Centres are able to carry out blood tests and x-rays (in hours only) to get a better understanding of what is wrong and, if needed, can prescribe medication and issue prescriptions for some conditions.

What area will the mobile team cover?

The mobile team will operate between **12 midnight and 8am** for Easington Locality patients and any patient that would have been previously directed to the site by NHS111.

What happens if everyone starts calling for the UTC and demand increases?

Even if demand increased, the home visiting model would still be more convenient for most patients along with the option of NHS funded return transport for those patients with a higher risk need needing to travel to a site co-located with an A&E.

Ask yourself, would you rather travel to a site during the night (possibly with your family) or have a clinician come to your home to receive the same treatment?

Will the staff have the right equipment and be appropriately qualified

Yes. The home visiting team is GP led and has a mix of practitioners that is appropriate to patient's health needs.

The home visiting team is fully compliant with the National NHS Urgent Treatment Centre Standards. NHS England fully supports the CCG's and CDDFT's work around remodelling the service as it is an NHS system-wide approach rather than a centre based approach.

The home visiting service will operate between 12 midnight and 8am and they have all of the equipment that practitioners working at Peterlee Urgent Treatment Centre between 12 midnight and 8am would have had.

It's important to note that you could not have had an X-ray between 12 midnight and 8am at Peterlee Urgent Treatment Centre prior to these changes.

How long will I wait for my visit?

Patients with the **most urgent need** will wait around an hour for a home visit. Those with an urgent need will wait up to two hours. Those patients with a less urgent need will wait up to six hours.

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Briefing Paper on County Durham Urgent Treatment Centres
Proposed Changes to Overnight Service Delivery at Peterlee Urgent Treatment Centre

Briefing paper for:
Durham Health Overview and Scrutiny Committee – April 2019

Author: Clair White
Sponsor: Sarah Burns
March 2019

Purpose of Report

1. The purpose of the report is to update the committee on the work undertaken to implement UTCs, advise the committee of the rationale for making changes to the urgent treatment centre bases and staffing model in County Durham and to advise the Committee of the process that was undertaken by North Durham and Durham Dales, Easington and Sedgefield CCGs (the CCGs).

Background and update

2. In July 2017 NHS England published “Urgent Treatment Centres – Principles and Standards” which sets out the 27 standards to be implemented to meet the goals of the Five Year Forward View. A wide variety of Minor Injuries Units, Urgent Care Centres and Walk in Centres currently exist with a confusing variation in opening times, in types of staff present and what diagnostics may be available. These standards will establish as much commonality as possible to reduce the variation in the offer to the public, as well as reducing attendance at and conveyance to A&E.
3. The CCGs have identified implementing these standards as a priority and have been working with CDDFT since January 2018 to implement them. The services have been fully compliant with the Urgent Treatment Centre (UTC) standards since April 2018. The CCG’s approach to service development, in order to meet the key national standards has been endorsed via NHS England and our Local A&E Delivery Board.

What are Urgent Treatment Centres?

4. Urgent Treatment Centres (UTCs) are GP-led, open at least 12 hours a day, every day, offer appointments that can be booked through NHS 111 or through a GP referral, and are equipped to diagnose and deal with many of the most common ailments people attend A&E for.
5. UTCs will also ease the pressure on our hospitals, leaving other parts of the system free to treat the most serious cases. The UTC offer will result in decreased attendance at A&E, or, in co-located services, as well as the opportunity for streaming at the front door. All UTC services will be considered a Type 3 A&E.

Where are our UTCs

- University Hospital of North Durham
- Peterlee Community Hospital
- Bishop Auckland Hospital
- Shotley Bridge Community Hospital

6. These departments within the hospitals are all now named 'Urgent Treatment Centres'.

What conditions do they see?

7. If you have an urgent injury or urgent illness (that has come on suddenly and needs to be seen the same day) that **is not serious, life or limb threatening**, then the nearest Urgent Treatment Centre to you can provide assessment, advice and/or treatment. Common conditions that can be treated in an Urgent Treatment Centre are:
 - Cuts and grazes
 - Sprains and strains
 - Simple broken bones
 - Wound and wound infections
 - Minor burns and scalds
 - Minor head injuries
 - Insect and animal bites
 - Minor eye injuries (foreign bodies in eye)
 - Minor back injuries
 - Emergency contraception
 - Skin infections/rashes/allergic reactions
 - Urine infections
 - Raised temperature/fever
8. Patients can walk into an Urgent Treatment Centre out of hours after 8pm during the week and 24 hours on a weekend at the moment, however it is always recommended to **Talk before you walk** by calling NHS 111. Where appropriate, a clinical advisor will assess a patient's symptoms, decide what medical help is needed and advise patients where to go. Clinical advisors can arrange an appointment at an Urgent Treatment Centre or a home visit that will best meet the patient's needs.
9. Depending on a patient's symptoms, Urgent Treatment Centres are able to carry out blood tests and x-rays to get a better understanding of what is wrong and, if needed, can prescribe medication and issue prescriptions for some conditions.

What do they not see?

10. **Serious, life or limb threatening emergencies**, patients must continue to dial 999 if you need an emergency ambulance. Symptoms of serious illness include:
 - Life threatening choking
 - Chest pain
 - Stroke
 - Blacking out
 - Severe blood loss
 - Severe breathing difficulty
 - Severe injury

- Broken bones (where the bone sticks out or severe deformity)
- Large/deep cuts
- Stab wounds
- Severe burns

GP Out of Hours Services

- The CCGs are required to commission GP services for twenty four hours a day, seven days a week. In 2004 GPs were given the opportunity to opt out of delivering services in the 'out of hours' period. All GPs in County Durham chose to opt out and since this time the service has been commissioned from County Durham and Darlington Foundation Trust.
- The out of hours period runs from 6.30pm in the evening until 8am on weekdays and covers Saturday and Sunday. In DDES as there are extended primary care access hubs, the out of hours service provides access to GP services from 8pm on weekdays.
- The model of delivery at Bishop Auckland and Peterlee UTCs is shown in the table below.

Weekdays

00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
:0	:0	:0	:0	:0	:0	:0	:0	:0	:0	:0	:0	:0	:0	:0	:0	:0	:0	:0	:0	:0	:0	:0	:0
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Treatment of illness									Treatment of minor injuries									Treatment of illness					
GP out of hours services																		GP out of hours services					

Weekends

00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
:0	:0	:0	:0	:0	:0	:0	:0	:0	:0	:0	:0	:0	:0	:0	:0	:0	:0	:0	:0	:0	:0	:0	:0
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Treatment of minor injuries																							
Treatment of illness																							
GP out of hours services																							

How did Changes to Urgent Care Centres in 2017 Affect Provision?

- As of 1st April 2017 DDES CCG no longer commissioned day time urgent care services / walk in Services from Peterlee Community Hospital / Bishop Auckland Community Hospital / Seaham Primary Care Centre and Easington Healthworks following public consultation. Shotley Bridge and UHND services remained unchanged.
- In their place, the CCG commissioned 9 Extended Primary Care Services (EPCA) hubs open until 8pm during the week and 8am – 1pm on a weekend. A consultation has recently been undertaken to help to determine the future model of delivery of these hubs.
- The message that has been promoted and is supported by the national campaigns is simple; ring your GP surgery in normal working day hour

Monday - Friday, 8am - 6pm or NHS 111 outside of those times. They will signpost you to the appropriate service first time.

17. Patients who need to be seen urgently on the same day will be offered an appointment either at their own GP surgery or at one of the EPCA hubs.

Why Have We Considered Changing the Overnight Delivery Model?

18. The driver for this piece of work is the ongoing issues with staffing, service sustainability and demand for services. Providing staffing for the out of hours element of the service has been extremely challenging in recent years. Individual UTC sites historically operated independently. In more recent years there has been more collaboration between the four sites which was driven by staffing difficulties and the need to provide cover across the county.
19. Clinical staff within the UTCs, including practitioners and GPs, have been working collaboratively with the CCG to map future models for all services excluding Darlington UTC which is separately commissioned.
20. It is felt that by working together across the CCGs and CDDFT there is scope to improve the service which addresses the current workforce issues that are resulting in patient diversion to other parts of the U&EC system and will provide a service to patients in a better way.

How was the Alternative Model Developed

21. The CCGs have held improvement events to map out how the local system could meet the standards, without developing a full new service and in addition propose changes to the staffing models in place due to the ongoing issues around GP cover and the low utilisation rates out of hours and low patient demand.
22. The CCG has held/ led two improvement events to focus on options around staffing models, opportunities and operating times alongside the project team's work.
23. To gather intelligence from those who know the service best, the group membership included; the staff working within the sites, clinicians - GPs, CCG Urgent Care lead (Dr Jan Panke), CDDFT/CCG managers, our business intelligence and data team and CDDFT contract manager. The Urgent Care Lead from NHS England also attended both events in an advisory capacity around the standards and the terminology.
24. NHSE have given the CCG assurance that all work to date does support full compliance with UTC standards, also NHSE support the CCGs work around re modelling the service as this will ensure appropriate staffing at all times across all sites working in a more of a systems approach than a centre based approach.

25. Together some potential staffing options were developed and the group reached an agreement around GP access/leadership when and where it would be needed but overall agreed GPs do not need to be physically on site in all of the centres except on a Saturday and Sunday 1pm- 10pm. This is due to demand on the services and home visiting; it is also preferable to have a GP on site through the week 8pm – 12pm when the service has the greatest demands.
26. A range of options were developed by the group for consideration. These options have been supported by patient activity information and CDDFT have shared the financial information for all options. The model presented is the preferred model and is clinically supported and endorsed by both CCGs, CDDFT and County Durham Local A&E Delivery Board.
27. Options were considered on a system model rather than a site/bases model, the system model supports the low demand and provides better value for money and brings services to patients. The recommended model ensures that the system is compliant with the out of hours commissioning standards and is GP led but uses a skill mix of practitioners that is appropriate to actual service demands.

Current Utilisation of Services

28. The following tables show the average activity per evening, one table covers the activity during the week and the second table covers the weekend and bank holidays.

Utilisation rates from midnight – 8.00am Weekdays

Average patients per day	Peterlee	Bishop Auckland	UHND	Shotley Bridge
Home Visiting	0.2	0.6	0.4	0.7
Seen in UTC (inc walk ins)	4.8	10.7	9.9	5.6
Total	5	11.3	10.3	6.3
Walk ins	1.1	2.6	2.2	2.2
Referred via 111	3.9	8.7	8.1	4.1

Utilisation rates from midnight – 8.00am Weekends

Average patients per day	Peterlee	Bishop Auckland	UHND	Shotley Bridge
Home Visiting	0.4	1.3	1.2	0.7
Seen in UTC (inc walk ins)	7.5	15.9	13.2	7.5
Total	7.9	17.2	14.4	8.2
Walk ins	1.7	3.6	2.3	2.5
Referred via 111	6.2	13.6	12.1	5.7

29. From midnight to 8am during the week, an average of 5 patients attend the Peterlee base with 0.2 pts requiring a home visit. This means 0.6 patients utilising the service per hour.
30. From midnight to 8am at weekends and bank holidays an average 8 patients at Peterlee attend the base with 0.4 patients requiring a home visit. This means 1 patient utilising the service per hour. The caveat is that this is based on averages but it illustrates the utilisation of the resources in place.

Changes Proposed

31. Between midnight and 8am a mobile service will be provided which will be centrally managed and used to determine patient need. This will take services to patients in their own home if appropriate or bring patients into the remaining bases via patient transport. (Patients will not be expected to travel out of their area for example from Peterlee to Bishop Auckland, these patients would be seen in their own home).
32. One site will remain open overnight in the DDES area, based at Bishop Auckland. This service will also offer GP advice to patients, support clinically triaging patients based on their conditions, providing services in a different way.
33. It is acknowledged that a GP is not required for every contact with patients and that an alternative staffing model will reflect this. This was identified following an audit of Out of Hours and home visiting activity. Following the audit, clinical triage was implemented for home visits at all sites which enabled CDDFT to identify the appropriate clinician to meet the patient's needs.
34. Remote/mobile service staffing (seeing patients in their own home where required) means that staff can also support the bases where necessary however are not intended to be based at a site and are intended to work the patch remotely.
35. This option was preferred by clinicians as it provides a flexible service that covers the County as a system rather than duplication of geographical hubs during the quietest periods for the service, ensuring better utilisation of practitioner and GP time. These services would be expected to cross cover and work together as one to best meet patient need.
36. Based on the numbers presented the CCG can manage the flow to these services after midnight via NHS111 by offering a home visit or routing patients to alternative services.
37. The Peterlee site would be closed from midnight to 8am seven days per week. This is proposed as the clinical view is staffing sites with a receptionist for example, to simple divert patients is sending the wrong message and would also raise concerns around clinical safety and staff safety.

38. An equality Impact assessment has been undertaken to ensure there are no negative impacts with regard to equality with any necessary mitigating actions being undertaken if required.
39. Changes will be considered in relation to services in the North of the County linked to any engagement or consultation linked to changes at Shotley Bridge Hospital.

Engagement and Communications

40. The CCG recognise the need for robust communications to local people. The CCG will work closely with CDDFT to ensure people are aware before any proposed changes take place.
41. An engagement and comprehensive communications plan will be developed to ensure that patients understand the changes proposed and the rationale for doing so.

Summary

- The key driver for the review is the ongoing issues with staffing in the out of hours period
- The current delivery model does not make best use of resources
- The activity undertaken at the bases which will be closed is low and an alternative service is being put in place where the service comes to the patient if required
- To note that clinical support for the preferred option has been confirmed by Dr Jan Panke CCG clinical lead for Urgent and Emergency Care
- To note that staff delivering the services have been involved in the development of the alternative delivery model
- To note the options that have been considered and that LADB were supportive of this option.
- To note that the new delivery model will be reviewed on an ongoing basis but with particular focus at both three and six months particularly in relation to the staffing model at all sites.
- The specific element that would change under the proposed new model would be between the hours midnight and 8:00 am.
- Consideration would need to be given to changes required in the North of the cut linked to the building re-provision at Shotley Bridge Hospital.
- This option is fully compliant with the Urgent Treatment Centre (UTC) standards.
- Acknowledge that a robust communication strategy will be put in place

Recommendation

The committee is asked to:

- Note the rationale for the proposed changes to service delivery

- Consider and comment on the proposal to carry out engagement and communication to support the changes

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

6 September 2019

**Path to Excellence Phase 2 – Proposed
Joint Health Overview and Scrutiny
Committee**



Report of Corporate Management Team

Lorraine O'Donnell, Director of Transformation and Partnerships

Electoral division(s) affected:

Dawdon, Deneside, Easington, Murton, Seaham, Shotton and South Hetton and Trimdon and Thornley

Purpose of the Report

- 1 To provide members of the Adults Wellbeing and Health Overview and Scrutiny Committee with information in respect of the draft Terms of Reference and Protocol for a Joint Health Overview and Scrutiny Committee to oversee Phase 2 of the Path to Excellence Programme.
- 2 The report also asks members to agree to the appointment of representatives from this Committee to the Joint Health Overview and Scrutiny Committee established as part of consideration of formal consultation on the Path to Excellence Phase 2 proposals.

Executive summary

- 3 The Adults Wellbeing and Health Overview and Scrutiny Committee has previously met on 4 July 2019 to consider plans and proposals by South Tyneside and Sunderland NHS Partnership in respect of pre-engagement regarding options for future service provision in respect of the Phase 2 of the Path to Excellence Programme.
- 4 The Path to Excellence Phase Two focuses on three areas of hospital care. The areas of care are:
 - Acute medicine and emergency care
 - Emergency surgery
 - Planned care including surgery and outpatient care

- 5 The Committee considered proposals for pre-engagement activity to inform formal consultation on the Path to Excellence Phase 2 proposals. Members were advised that this would likely be considered through a Joint Health Overview and Scrutiny Committee involving Sunderland City Council, South Tyneside Borough Council and Durham County Council.
- 6 Correspondence has been received from the Accountable Officers of NHS Durham Dales, Easington and Sedgfield CCG, NHS North Durham CCG, NHS South Tyneside CCG and NHS Sunderland CCG confirming their intention to conduct formally on phase 2 proposals during spring/summer 2020. The CCGs have also requested that scrutiny of these proposals be undertaken by a joint scrutiny panel which includes Durham County Council, South Tyneside MBC and Sunderland City Council. A copy of this letter is attached to this report. (Appendix 2).
- 7 The Committee has also formally requested the appointment of Durham County Council representatives to any such Joint Health Overview and Scrutiny Committee that may be established for this purpose.
- 8 Consideration was given to this request at a meeting of the South Tyneside and Sunderland Joint Health OSC which has overseen phase 1 of the Path to Excellence programme on 29 July 2019 and agreement was given to the appointment of representatives from Durham County Council to the Joint Health Overview and Scrutiny Committee (Phase 2).
- 9 Proposed Terms of Reference and Protocol for a Joint Health Overview and Scrutiny Committee between South Tyneside Borough Council, Sunderland City Council and Durham County Council to oversee Phase 2 of the Path to Excellence Programme are attached to this report. (Appendix 3)

Recommendations

- 10 Members of the Adults Wellbeing and Health Overview and Scrutiny Committee are requested to:-
 - a) Receive this report;
 - b) Consider and comment on the proposed Terms of Reference and Protocol for a Joint Health Overview and Scrutiny Committee between South Tyneside Borough Council, Sunderland City Council and Durham County Council to oversee Phase 2 of the Path to Excellence Programme;

- c) Agree to the appointment of representatives from this Committee to the aforementioned Joint Health Overview and Scrutiny Committee.

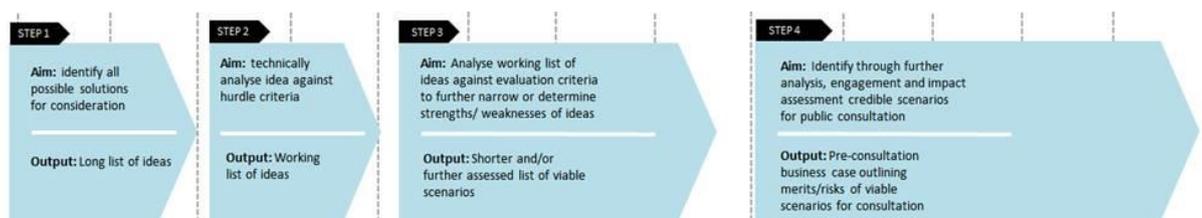
Background

- 11 South Tyneside and Sunderland NHS Partnership launched a public consultation in respect of the Path to Excellence Programme Phase 1 on 5th July 2017 asking for views and ideas on potential options for changes proposed for stroke; maternity (obstetrics); women's healthcare (gynaecology) and children and young people's healthcare (urgent and emergency paediatrics) hospital-based services in South Tyneside and Sunderland.
- 12 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.
- 13 The Consultation referenced a programme of clinical service reviews which commenced in 2016 that involved asking clinical staff in South Tyneside District Hospital and Sunderland Royal Hospital how stroke, maternity, gynaecology and paediatrics services should be delivered. Each clinical team reviewed a number of options against key criteria, which was developed in line with the aims of the Path to Excellence programme and informed by service change best practice and national guidance from NHS England and NHS Improvement.
- 14 Copies of the Path to Excellence Phase 1 public consultation document and the public questionnaire were placed on deposit in the Members Library and representatives of South Tyneside and Sunderland NHS Partnership attended the Committee's meeting held on 6 September 2017 to provide members with information detailing:-
- The rationale for the review of stroke; maternity (obstetrics); women's healthcare (gynaecology) and children and young people's healthcare (urgent and emergency paediatrics) services;
 - The proposed options for future configuration of the services being consulted upon; the number of people from County Durham affected by the proposed changes including admission rates from County Durham for each service;
 - The consultation, 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;

- The decision-making timelines proposed for each service change.
- 15 The consultation process for Phase 1 of the Path to Excellence Programme commenced on 5 July 2017 and ended on 15 October 2017.
 - 16 The Committee agreed a response to the consultation at its meeting held on 2 October 2017.
 - 17 The decision for Phase 1 of the Programme was made in February 2018 by South Tyneside & Sunderland CCGs, however mobilisation of decisions was delayed until the outcome of referral to Secretary of State for Health and Social Care and IPR advice was gained and resolved, and there was also a legal challenge. The challenge was successfully defended by the CCGs in December 2018, meaning that full mobilisation planning could go ahead.
 - 18 The implementation of the agreed proposals for Phase 1 of the Path to Excellence programme is nearing completion and South Tyneside and Sunderland NHS Partnership has undertaken a significant amount of key stakeholder involvement activity in respect of Phase 2 of the Programme.
 - 19 The Path to Excellence Phase Two of the programme focuses on three areas of hospital care. The areas of care are:
 - Acute medicine and emergency care
 - Emergency surgery
 - Planned care including surgery and outpatient care
 - 20 The programme has been engaging with NHS staff, patients with experiences of the services under review, CVS organisations, Health Watch organisations, other key stakeholders on what are the key issues and pressures, and what is important then in delivering or receiving the best care possible.
 - 21 The programme issued its first draft case for change in July 2018 – which can be found on the programme website and link here <https://pathtoexcellence.org.uk/wp-content/uploads/2018/07/NHS-PTE2-CFC-full-document-final.pdf> and this sets out the issues and challenges facing hospital services in Sunderland and South Tyneside along with the key insights gained from staff and patients about what is important to them.
 - 22 Since last summer, further involvement work has taken place, as well as more detailed work by clinical teams in developing a long list of all the

possible solutions that there could be and then applying key hurdle criteria to gain a shorter working list of ideas for wider stakeholder assessment.

- 23 In February 2019, an updated case for change was published building upon the first edition from July 2018, which contained the working list of ideas (as well as the long list of ideas that had been assessed as not viable). Copies of the updated case for change documentation and a summary version were considered at the Committee's meeting held on 4 July 2019.
- 24 The programme is working with the Consultation Institute on a pre-consultation solutions generation process working to Best Practice. This process is set out in the following diagram however it is important to note that the process remains evolutionary and ideas generated at any step of the process will necessitate the re-application of previous steps.



- 25 North Durham and Durham Dales, Easington and Sedgefield CCGs are part of the Path to Excellence programme and currently the programme team is assessing the potential impact on residents of East Durham who use Sunderland Royal as their District General Hospital.
- 26 Representatives of South Tyneside and Sunderland NHS Partnership alongside representatives of North Durham and DDES CCGs attended this Committee on 4 July 2019 to provide members with a presentation setting out the proposed plans for patient and stakeholder pre-engagement together with the options for future service model that are planned to be presented during this pre-engagement activity.
- 27 Members were advised that this pre-engagement activity would inform formal consultation on the Path to Excellence Phase 2 proposals which was likely to be required through a Joint Health Overview and Scrutiny Committee involving Sunderland City Council, South Tyneside Borough Council and Durham County Council.
- 28 The Committee therefore recommended the appointment of representatives from Durham County Council's Adults Wellbeing and Health Overview and Scrutiny Committee to any such Joint Health Overview and Scrutiny Committee that may be established for this purpose.

- 29 Consideration was given to this request at a meeting of the South Tyneside and Sunderland Joint Health OSC which has overseen phase 1 of the Path to Excellence programme on 29 July 2019 and agreement was given to the appointment of representatives from Durham County Council to the Joint Health Overview and Scrutiny Committee (Phase 2).
- 30 Proposed Terms of Reference and Protocol for a Joint Health Overview and Scrutiny Committee between South Tyneside Borough Council, Sunderland City Council and Durham County Council to oversee Phase 2 of the Path to Excellence Programme are attached to this report.(Appendices)

Considerations

- 31 Members are asked to consider and comment on the proposed Terms of Reference and Protocol for a Joint Health Overview and Scrutiny Committee between South Tyneside Borough Council, Sunderland City Council and Durham County Council to oversee Phase 2 of the Path to Excellence Programme attached to this report.
- 32 Members are also asked to consider agreeing to the appointment of representatives from this Committee to the proposed Joint Health Overview and Scrutiny Committee to oversee the Path to Excellence Programme Phase 2 and any associated statutory consultation.

Main implications

Legal

- 33 This report has been produced in accordance with the Local Authority (Public Health, Health and wellbeing boards and Health Scrutiny) Regulations 2013 as they relate to the National Health Service Act 2006 governing the local authority health scrutiny function.

Conclusion

- 34 Implementation of phase 1 of the Path to Excellence programme is nearing completion and the Path to Excellence Programme team has embarked on patient and stakeholder pre-engagement in respect of the Path to Excellence Phase 2 as previously reported to this Committee.
- 35 This report details proposed terms of reference and protocol in respect of a Joint Health Overview and Scrutiny Committee between South Tyneside Borough Council, Sunderland City Council and Durham County Council for the purposes of considering the Path to Excellence Programme Phase 2.

Background papers

- Agenda, Minutes and Reports to the Adults Wellbeing and Health Overview and Scrutiny Committee meetings held on 6 September 2017; 2 October 2017, 19 January 2018 and 4 July 2019.

Contact: Stephen Gwilym

Tel: 03000 268140

Appendix 1: Implications

Legal Implications

This report has been produced in accordance with the Local Authority (Public Health, Health and wellbeing boards and Health Scrutiny) Regulations 2013 as they relate to the National Health Service Act 2006 governing the local authority health scrutiny function.

Finance

Not applicable

Consultation

The report sets out the proposed terms of reference and protocol for a Joint Health Overview and Scrutiny Committee to oversee statutory consultation in respect of the Path to Excellence Phase 2.

Equality and Diversity / Public Sector Equality Duty

Not applicable.

Human Rights

Not applicable

Crime and Disorder

Not applicable

Staffing

Not applicable

Accommodation

Not applicable

Risk

Not applicable

Procurement

Not applicable

Friday 16th August 2019

To:

Terry Collins, chief executive, Durham County Council
Martin Swales, chief executive, South Tyneside Metropolitan Borough Council
Patrick Melia, chief executive, Sunderland City Council

Dear Terry, Martin and Patrick,

Re: Path to Excellence programme - phase two of NHS hospital changes

As you know, our Clinical Commissioning Groups, NHS Durham Dales, Easington and Sedgefield CCG, NHS North Durham CCG, NHS South Tyneside CCG and NHS Sunderland CCG are reviewing the health services provided to our communities through South Tyneside and Sunderland NHS Foundation Trust.

You will be aware that we are currently in a pre-engagement phase of developing proposals for phase two of the programme, and we expect to bring proposals to patients and the public formally during spring/summer 2020 when we will publish a pre-consultation business case.

The Local Authority Regulations 2013 require NHS bodies to notify their local authority partners when they have such proposals under consideration. Currently our planning assumptions are that we expect to make that notification in the early part of 2020.

The services and population affected by these developing proposals covers North and East Durham, South Tyneside and Sunderland, and we would be grateful for your attention in making the appropriate arrangements under section 30 (5) of the regulations for the relevant scrutiny functions to be exercised.

We request that this is undertaken by a joint scrutiny panel to include the three local authorities Durham County Council, South Tyneside Metropolitan Borough Council and Sunderland City Council.

In terms of process, we would be grateful if you would formally acknowledge receipt of this letter.

Members of the Path to Excellence programme team are in touch with democratic services officers from each of your authorities, however, should your own officers wish to discuss these arrangements please do not hesitate to contact a member of the programme team.

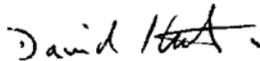
We look forward to working with elected members and scrutiny officers in order to progress future proposals to ensure the best possible health services are available for the communities we collectively serve.

Yours sincerely,



Dr Neil O'Brien

Accountable officer - NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group (CCG) and NHS North Durham CCG



Dr David Hambleton

Accountable officer - NHS South Tyneside CCG



Mr Dave Gallagher

Accountable officer - NHS Sunderland CCG

Copy to: Health Overview and Scrutiny Committee chairs

Cllr Rob Dix, South Tyneside

Cllr John Robinson, Durham

Cllr Doris Macknight, Sunderland

Copy to:

Ken Bremner – chief executive, South Tyneside and Sunderland NHS Foundation Trust

Alison Slater – regional director, NHS England and NHS Improvement

**Protocol for the
Health Scrutiny Joint Committee**

1. This protocol provides a framework under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 for considering and providing a formal consultation response in relation to proposals affecting the population covered by South Tyneside and Sunderland Councils, and part of the population covered by Durham County Council, particularly those considered to be a “significant development or substantial variation” as defined in local protocols, in particular:
 - (a) The Shared Sustainability and Transformation Plan for Northumberland, Tyne & Wear and North Durham and the Local Health and Care Economy Plan for South Tyneside and Sunderland.
 - (b) The service change proposals arising from the Clinical Services Review Programme being undertaken by South Tyneside and Sunderland NHS Partnership. This will include seeking evidence of the economic, social and health impacts of residents in both Boroughs and how any shortfalls in these areas will be mitigated in carrying out service change.
2. The terms of reference of the Health Scrutiny Joint Committee is attached.
3. The Health Scrutiny Joint Committee formed for the purpose of the consultation outlined at paragraph 1 will, following approval of this protocol at its first meeting, circulate copies of the same to:-

Sunderland Council, South Tyneside Council and Durham County Council

(“the constituent authorities”)

South Tyneside CCG

Sunderland CCG

Durham Dales, Easington and Sedgefield CCG

South Tyneside and Sunderland NHS Foundation Trust

County Durham and Darlington NHS Foundation Trust

NHS North of England Commissioning Support

(“the relevant NHS Bodies”)

Health Scrutiny Joint Committee

4. A Health Joint Scrutiny Committee (“the Joint Committee”) comprising representatives of the constituent authorities has been established in accordance with the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 for the purposes of formal consultation by the relevant NHS Bodies in relation to the matters referred to at paragraphs 1(a) of this protocol, and in particular in order to be able to:-
 - i. make comments on the proposals consulted on, to the relevant NHS Bodies under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013; and/or
 - ii. require the relevant NHS Bodies to provide information about the proposals under the Regulations; and/or
 - iii. require an officer of the relevant NHS Bodies to attend before it under the Regulations to answer such questions as appear to it to be necessary for the discharge of its functions in connection with the consultation; and/or
 - iv. make recommendations to the relevant NHS Bodies and expect a response within 28 days.

Membership

5. The Joint Committee will consist of equal representation, with 7 representatives to be appointed from the scrutiny committee of South Tyneside and Sunderland constituent authorities and a further 3 representatives from the Durham constituent authority. A Healthwatch representative for each constituent authority area will be entitled to attend in a non-voting capacity.
6. The term of office for representatives will be for the period from the date of their appointment by their constituent authorities until their relevant authority’s next annual council meeting. If a representative ceases to be a Councillor, or wishes to resign from the Joint Committee, the relevant council shall inform the joint committee secretariat and appoint a replacement representative to serve for the remainder of the original representative’s term of office.
7. To ensure that the operation of the Joint Committee is consistent with the Constitutions of the constituent authorities, those authorities operating a substitution system shall be entitled to nominate substitutes.
8. The Joint Committee may ask individuals to assist it (in a non-voting capacity) and may ask independent professionals to advise it for the purposes of the consultation process.
9. The quorum for meetings of the Joint Committee shall be a minimum of 3 member representatives from each of the South Tyneside and Sunderland constituent authorities and 1 member from the Durham constituent authority.

Chair and Vice-Chair

10. The Chair of the Joint Committee shall rotate each meeting between a named Member representative from South Tyneside Council and Sunderland Council. When

not chairing the meeting this Member representative will assume the position of Vice Chair. The Chair will not have a second or casting vote.

11. If the agreed Chair and Vice-Chair are absent from a meeting, the Joint Committee shall appoint a member to chair that meeting from the representatives present who are members of the same constituent Council as the Chair.

Terms of Reference

12. The Joint Committee will be the formal consultee under the Regulations and the Directions for the purposes of the consultation by the relevant NHS Bodies concerning those matters outlined at paragraphs 1(a) and will have the functions specified at paragraphs 4(a) - (c) inclusively of this protocol. Terms of reference are set out at Appendix 1.

Administration

13. Meetings shall be held at the times, dates and places determined by the Chair in consultation with each of the constituent authorities.
14. Agendas for meetings shall be determined by the secretariat (rotation between South Tyneside Council and Sunderland Council in line with rotation of Chair) in consultation with the Chair.
15. Notice of meetings of the Joint Committee will be sent to each member of the Joint Committee at least 5 clear working days before the date of the meeting and also to the Chair of the constituent authorities' relevant overview and scrutiny committees (for information). Notices of meetings will include the agenda and papers for meetings. Papers "to follow" should be avoided where possible.
16. Minutes of meetings will be supplied to each member of the Joint Committee and to the Chairs of the constituent authorities' relevant overview and scrutiny committees (for information) and shall be confirmed at the next meeting of the Joint Committee.

Final Reports and Consultation Response

17. The Joint Committee is independent of its constituent councils, executives and political groups and this independence should not be compromised by any member, officer or relevant NHS bodies. The Joint Committee will send copies of its final reports and formal consultation responses to the relevant NHS Bodies and the constituent authorities.
18. The primary objectives of the Joint Committee will be to reach consensus and Members will work within the relevant timescales to achieve this. However, where there are any aspects of a consultation on which there is no consensus, the Joint Committee's final report and formal consultation response will include, in full, the views of each of the constituent authorities, with the specific reasons for those views, regarding those areas where there is no consensus, as well as the constituent authorities' views in relation to those matters where there is a consensus.

Principles for joint health scrutiny

19. The constituent authorities and the relevant NHS Bodies will share knowledge, respond to requests for information and carry out their duties in an atmosphere of courtesy and respect in accordance with their codes of conduct.
Disclosable pecuniary interests, and those other interests required to be disclosed under the code of conduct for the constituent authority a Member represents will be declared in all cases in accordance with that code of conduct and the Localism Act 2011.
20. The Joint Committee's procedures will be open and transparent in accordance with the Local Government Act 1972 and the Access to Information Act 1985 and meetings will be held in public. Only information that is expressly defined in regulations to be confidential or exempt from publication will be able to be considered in private. Papers of the Joint Committee may be posted on the websites of the constituent authorities as determined by them.
21. Communication with the media in connection with the Joint Committee's views will be handled in conjunction with each of the constituent local authorities' press officers.

HEALTH SCRUTINY JOINT COMMITTEE

TERMS OF REFERENCE

1. To consider the proposals affecting the population covered by South Tyneside and Sunderland Councils and part of population covered by County Durham Council, including:
 - The Shared Sustainability and Transformation Plan for Northumberland, Tyne & Wear and North Durham and the Local Health and Care Economy Plans for South Tyneside and Sunderland.
 - The service change proposals arising from the Clinical Services Review Programme being undertaken by South Tyneside and Sunderland NHS Partnership. This will include seeking evidence of the economic, social and health impacts of residents in both Boroughs and how any shortfalls in these areas will be mitigated in carrying out service change.
2. The Joint Committee will as part of this process consider the following consultation questions as contained in the public consultation documents,
3. In order to be able to formulate and provide views to the relevant NHS bodies on the matters outlined in paragraphs 1 and 2 above, the Joint Committee may:-
 - a) require the relevant NHS Bodies to provide information about the proposals the subject of the consultation with the constituent local authorities and the Joint Committee. information should be provided within 3 working days of the meeting arranged to consider it; and
 - b) require an officer of the relevant NHS Bodies to attend meetings of the Joint Committee, in order to answer such questions as appear to them to be necessary for the discharge of their functions in connection with the consultation.
4. To formulate a final report and formal consultation response within the consultation and decision making timetable to the relevant NHS Bodies on the matters referred to at paragraphs 1 and 2 above, in accordance with the protocol for the Health Scrutiny Joint Committee and the consultation timetable established by the relevant NHS Bodies.
5. To ensure the formal consultation response of the Joint Committee includes, in full, the views of all of the constituent authorities, with the specific reasons for those views, regarding those areas where there is no consensus, as well as the constituent authorities' views in relation to those matters where there is a consensus.
6. Each constituent Authority will retain their powers of referral to the Secretary of State for Health.

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