Adults, Wellbeing and Health Overview and Scrutiny Committee

Date **Thursday 5 March 2020**
Time **9.30 am**
Venue **Committee Room 2, County Hall, Durham**

Business

Part A

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

1. Apologies
2. Substitute Members
3. Minutes of the meeting held on 17 January 2020 (Pages 3 - 16)
4. Declarations of Interest, if any
5. Any Items from Co-opted Members or Interested Parties
6. Media Issues
7. Health Protection Assurance Report 2018/19: (Pages 17 - 38)

   Report of the Director of Public Health County Durham.
8. North East Ambulance Service - Post Implementation Audit of National Ambulance Response Standards: (Pages 39 - 60)

   Presentation by Paul Liversidge, Deputy Director of North East Ambulance Service and Mark Cotton, Assistant Director Communications and Marketing, North East Ambulance Service.
9. Review of Stroke Rehabilitation Services and Inpatient Rehabilitation Services (Ward 6 Bishop Auckland Hospital) Update: (Pages 61 - 74)

   Presentation by representatives of North Durham and Durham Dales, Easington and Sedgefield Clinical Commissioning Groups.

10. Future of Services currently provided at Shotley Bridge Community Hospital Update: (Pages 75 - 82)

    Presentation by representatives of North Durham Clinical Commissioning Group.

11. 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
26 February 2020

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, T Henderson, E Huntington, P Jopling, C Kay, K Liddell, S Quinn, A Reed, A Savory, M Simmons, H Smith, J Stephenson, O Temple, T Tucker and C Wilson

Co-opted Members: Mrs R Hassoon and Mr C Cunnington Shore

Contact: Jackie Graham Tel: 03000 269704

DURHAM COUNTY COUNCIL

At a meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in Committee Room 2, County Hall, Durham on **Friday 17 January 2020 at 9.30 am**

Present

Councillor J Robinson (Chair)

Members of the Committee
Councillors A Batey, R Bell, L Brown, P Crathorne, R Crute, T Henderson, P Jopling, K Liddell, S Quinn, A Reed, A Savory, M Simmons, H Smith, J Stephenson and O Temple

Co-opted Members
Mrs R Hassoon and Mr C Cunnington Shore

Also Present
Councillor L Hovvels

1 Apologies

Apologies for absence were received from Councillors J Chaplow, E Huntington and C Wilson.

2 Substitute Members

There were no substitute members.

3 Minutes of the meeting

The minutes of the meeting held on 9 December 2019 were agreed as a correct record and signed by the Chair.

4 Declarations of Interest, if any

There were no declarations of interest.

5 Any Items from Co-opted Members or Interested Parties

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

6 Media Issues

The Principal Overview and Scrutiny Officer referred members to the recent prominent articles and news stories relating to the remit of the Adults, Wellbeing and Health Overview and Scrutiny Committee.

'CQC rate Darlington Memorial and Durham Hospitals as good' (Northern Echo - 3 December 2019) related to County Durham and Darlington NHS Foundation Trust receiving a 'Good' rating from the Care Quality Commission following its latest inspection. The article was related to item 11 on the Committee's agenda and would be presented by the Chief Executive, County Durham and Darlington NHS Foundation Trust.

'Stroke reforms warning for Bishop Auckland Hospital' (Northern Echo - 7 January 2020) related to NHS bosses announcing plans to move stroke rehab services from Bishop Auckland Hospital to Durham City. A Joint Health Scrutiny Committee for County Durham and Darlington had been set up to look at the potential impact of the proposed changes to stroke services. The first meeting of the joint committee was held on 6 January 2020.

'Why 2020 will be a crucial year for the NHS' (BBC website - 19 December 2019) related to the Queens speech referring to the new Government prioritising the NHS. Ministers would need to meet the challenges faced by the health service as both A&E and routine operations were at their worst levels and waiting times had deteriorated since targets were introduced making 2020 a crucial year for it. The Principal Overview and Scrutiny Officer confirmed that these issues featured in the Committee's Work Programme.

'Strengthening services at County Durham Community Hospital' (DCC Press Release - 7 January 2020) related to the decision by County Durham and Darlington NHS Foundation Trust, the Council, and NHS commissioners to relocate District Nurses and Social Workers to the Richardson Community Hospital in Barnard Castle. This was implemented to allow them to liaise with ward staff to ensure quicker and safer discharges to enhance the services available at the NHS facility. The article was related to item 7 on the Committee's agenda and would be jointly presented by the Director of Integrated Community Services and the Head of Integrated Strategic Commissioning.

Councillor Savory was disappointed that there had been no public consultation events for the Stroke Rehabilitation service or Ward 6 reviews scheduled to be held in Weardale. She had now arranged for an event to be held at a Parish Council meeting in February.

Councillor Quinn had also arranged a meeting in Shildon.

Resolved
That the verbal presentation be noted.

The Chair with the consent of the committee changed the order of business for the agenda. The item on the Care Quality Commission Inspection Report would be considered as the last item on the agenda.

7 Health and Social Care Integration

The Committee considered a joint report of the Corporate Director Adult and Health Services, Durham County Council and the Director of Integration, Durham County Council/North Durham and DDES CCG that updated members on progress to date in relation to integration of health and social care across County Durham (for copy see file of Minutes).

The Director of Integrated Community Services gave an overview of the continued work on Health and Social Care Integration through County Durham's established tradition of strong partnership working. She demonstrated examples of successful integrated working between Tees, Esk and Wear Valleys NHS Trust and Durham County Council through the development of Intermediate Care Plus, 0-19 Pathway and Mental Health and Learning disability services.

The Director of Integrated Community Services explained that there were further opportunities for integration that focused on primary care through community service models, wrapped around services and integrated commissioning functions. She added that the concept of integration was featured heavily in the programme nationally for the next five years for intermediate services.

The Director of Integrated Community Services further explained that the Teams Around the Patient (TAP) model had been introduced with 13 teams working across the County. The TAP worked with frail and older people with long term illnesses to enable them to remain living independently in the community. The TAP had received positive outcomes since October 2018 in reducing the length of stay in hospitals for older people and the number of elderly people having to be placed in care homes. She added that there had been encouraging feedback from staff, GPs and service users and carers for the TAP.

The Director of Integrated Community Services informed the committee that in 2019 saw the emergence of Primary Care Networks (PCN) to build upon primary and co-ordinated care that covered areas that were consistent with the already established TAP's. A Clinical Director for each PCN helped influence the area in which they worked as a set of principles were established that were to be adhered to in order to deliver services within the community seamlessly.

The PCN covered 100% of the population of Durham and were already an advanced organisation as a partnership between General Practice, Community Providers, Mental Health Providers, Social Care, the Voluntary Sector and other primary care providers such as pharmacists, dentists and opticians and would drive up the quality of care for their population supported by the CCG.

The Director of Integrated Community Services highlighted that the Health and Wellbeing Board had a statutory duty to promote integration. She added that Durham, Sunderland and South Tyneside were working more closely as part of the central integrated care partnership (ICP).

The Integrated Management Board formed part of the governance structure. In addition, Commissioning functions had been integrated between Durham County Council and Durham Clinical Commissioning Groups which had been agreed by both Cabinet and the CCG and would be implemented from April 2020.

Referring to the recent new Government and changes to the Cabinet, Councillor Robinson asked what the future held for the integration of health and social care services.

The Chief Clinical Officer responded that integration of services would remain for the foreseeable future as the way forward, however he could not comment on how the new Government or Cabinet would influence the integration.

Councillor Robinson wanted to know if assurances would remain that the Durham Pound would be safe or if it would be required to fund developments at St James Cook hospital.

The Chief Clinical Officer gave Tees Esk and Wear Valleys NHS Trust as an example of how it had been done as a separate statutory body. Budgets would be looked after by CCG's unless different governance arrangements were made.

Councillor Bell congratulated the Head of Integrated Strategic Commissioning on her new role. Following a report to full council to create the post he wanted to know if the post was funded by the County Council, the NHS or whether it was a hybrid of both.

The Head of Integrated Strategic Commissioning confirmed that the post was a joint appointment funded by both the Local Authority and the NHS.

Councillor Bell asked if the Teams around the Patient (TAP) were evenly distributed throughout the County.

The Head of Integrated Strategic Commissioning explained that each TAP had their own budget that was based on the population of the area and weighted towards areas of deprivation distributing them evening across the County.

These budgets historically were administered through the local authority but were now being used and invested differently and were influenced by the needs of the community. She added that the budgets were monitored and every contract would be reviewed to see what was being offered but it would be a long process.

Councillor Bell requested that a further report be submitted to Committee to show how things were progressing with the TAP's.

Councillor Jopling notified the Committee that the "Durham Pound" was difficult to monitor as the bigger the Clinical Commissioning Group became, the harder it would be to observe.

Councillor Henderson was pleased that the District Nurses and Social Workers were now based at Richardson Community Hospital in Barnard Castle but was disappointed that this issue had been raised at a subgroup five years previously with no action taken.

Mrs Hassoon informed the committee that she had attended a meeting on the national reduction of bed days programme and wanted to know if this would affect the proposals for integrating services.

The Director of Integrated Community Services notified the committee that if a hospital bed was in the best interests of the patient then they would have it. It was felt that it was easier to rehabilitate a patient in their own home if they didn't require acute care resulting in moves to reduce the number of patients in hospital beds.

The Head of Integrated Strategic Commissioning reiterated that the reduction in patients in hospital beds would offset costs across systems.

Councillor Crute in relation to costs requested to know how spends would be monitored and what Government systems were in place within the PCN and CCG structures to direct performance indicator figures.

The Director of Integrated Community Services stated that at present each statutory body was responsible for monitoring their own budgets and performance indicators. She noted that this created duplication. She added that to move forward professionally the Integrated Care Board (ICB) would be looked at sitting below the Health and Wellbeing board to act as the main point of contact, being responsible for both the budget and performance indicators. She added that the ICB did receive performance indicators and did oversee the broad budget but that there was a difference in overseeing and taking responsibility for them. She explained that Authority for this had not been dissolved to the ICB as yet.

Councillor Crute was concerned that if this was not carried out correctly then how would issues be highlighted or show if the process was working right.

The Chief Clinical Officer highlighted that this was an opportunity to do things right.

Councillor Robinson thought that this Committee should be overseeing the process and used to scrutinise the process to ensure it was done properly.

Councillor Temple commended the work relating to the reduction in delays at getting patients back into the community. He was surprised in the breakdown in the PCN numbers for his area. He wanted to know why Derwentside's population was summarised for each PCN.

The Chief Clinical Officer informed the committee that the Primary Care Network came together under the General Practices to work out skills. There were larger networks across the County than Derwentside which worked well but individuals had responsibility for smaller areas.

The Director of Integrated Community Services stated that in appendix four of the report that showed the summary of delayed transfers of care there was an error with the figure. She noted that it should read that "Between April – October 2019 County Durham, compared to all single tier and county councils was ranked 6 out of 151, on the overall rate of delayed days per 100,000 adults population across England" instead of 6 out of 15.

Councillor Quinn was concerned that the integration of systems was talked about 20 years ago and wanted to know if this was ever going to happen.

The Chief Clinical Officer agreed that integration had been implemented 20 years ago with GP services losing District Nurses and Health Visitors. He noted that integration was the way forward with professionals providing positive feedback with services coming together once more.

The Director of Integrated Community Services informed the committee that the integration of the Mental Health and Learning Disability services in 1998 had been successful and still remained in place to date. She thought there were no reasons why this could not be done again with primary care services.

The Chief Clinical Officer commented that Tees Esk and Wear Valleys NHS Trust had focussed on integration wrapping Mental Health services around Primary Care services. He added that it was proposed to extend this integrated model to North Durham to include Mental Health Services, and dentists along with voluntary services.

Councillor Robinson agreed that it worked successfully in the 1980's with nurses being based in Community centres with doctors referring patients to them.

Resolved
(i) That the report and the progress made to date in respect of integrated working in County Durham be noted.

(ii) That an update report be received in May 2020

8 Draft Joint Health and Wellbeing Strategy 2020-2025

The Committee received a joint report from the Corporate Director Adult and Health Services and the Director of Public Health that presented the draft Joint Health and Wellbeing Strategy (JHWS) 2020-2025 (for copy see file of Minutes).

The Strategic Manager confirmed that the draft Joint Health and Wellbeing Strategy (JHWS) 2020-2025 was a legal requirement under the Health and Social Care Act 2012 that was to be delivered by the Health and Wellbeing Board. She noted that the previous strategy ran until the end of 2019 and the vision 2035 for the next 15 years 'County Durham is a healthy place, where people live well for longer' had been signed off in September 2019 by the Cabinet. She added that the vision had three strategic ambitions and would be reviewed after a year to ensure that nothing had fallen through the gaps:

- More and better jobs
- People live long and independent lives
- Connected communities

To help enable the delivery of the vision the Strategic Manager noted that the Health and Wellbeing Board had three strategic priorities that set out areas to be focused on:

- Starting well – that looked at care provided before, during and after pregnancy ensuring children had the right start in life
- Living well – that looked at the provision of mental health and wellbeing care
- Ageing well – that looked at the quality of end of life care

Additionally, across the three strategic priorities were six objectives chosen that impacted on people's health and showed where the service wanted to be in 2025.

- Improve healthy life expectancy and reduce the gap within count Durham and between county Durham and England
- We will have a smoke free environment with over 95% of our residents not smoking and an ambition that no child will be born to a mother who smokes
- Close the gap in the employment rate between those living with a long-term health condition, learning disability in contact with secondary mental health services and the overall employment rate
- Over 90% of our children aged 4-5 years and 79% of children aged 10-11 years are of a health weight

- Improved self-reported wellbeing
- Increase the number of organisation's involved in better health at work award

The Strategic Manager notified the Committee that the strategy was out for consultation until 14 February 2020.

Councillor Jopling queried if the Area Action Partnerships had been involved in the consultation process.

The Strategic Manager reinforced that work was ongoing with both the Area Action Partnerships and Durham Community Action Group to promote the strategy.

In response to Councillor Batey's question the Strategic Manager responded that the consultation was online and a hyperlink that had been sent to Members in December 2019 would be recirculated.

Councillor Bell was concerned that figures in the report for the life expectancy and healthy life expectancy was lower for County Durham than in England resulting in 22 years of poor health in the later stages of life. He wanted to know what action was being taken within the strategy objectives to change people's behaviour to lead healthier lifestyles.

The Strategic Manager confirmed that changing people's behaviour towards a healthier lifestyle was a key area of work for the Public Health Team who promoted walking routes, cycling and other activities across partnerships and individuals, however it was the responsibility of the individual to want to change.

The Chief Clinical Officer stated that people were living longer but there was an increase in mental health illnesses. He noted that prosperity with the provision of better jobs and housing was the key to change as mental health illnesses were linked to poverty and deprivation within the population.

He acknowledged that deprived areas and affluent areas were different that linked into the plan with more integration with Health, Mental Health and the Acute Trust so that all plans were aligned across the board. The Chief Clinical Officer informed the committee that some changes had taken place that had made a difference with mortality rates reducing in County Durham to the rest of England.

Councillor Smith was concerned that funding for Public Health could be affected with the new Government and that they should be lobbied to prevent the loss of funding from happening.

Both the Strategic Manager and Councillor Hovvels confirmed that letters had and would continue to be sent to the Secretary of State for Health and Social Care objecting to any reductions in funding for Public Health.

The Strategic Manager acknowledged Councillor Crute's comment that in the report with regards to public transport it should state that people should actively travel via sustainable transport to factor in the implications on emissions and climate change.

Councillor Temple commended the work to reduce smoking in pregnant women but he wanted to know if there was a difference between the harms of smoking and vaping on the embryo.

Councillor Temple was also concerned with the figures in the report relating to a child's development and how the numbers reduced from 2 ½ years old to the end of reception class. He wanted to know if this tied into poverty and if the strategy addressed the issue. He was disturbed that obesity in young children increased as they got older.

Councillor Hovvels stated that figures in the report relating to a child's development tied in with two-year-old funding for nursery places. There was a difference across County Durham as some children would qualify and others would not. She added that those attending nurseries would develop further than those who did not.

The Strategic Manager agreed to investigate and circulate her findings. The Partnerships Team Manager informed the committee that this work linked in with the Children and Young People Strategy.

The Chief Clinical Officer notified the committee that all children started off the same but it was the environment around them that created changes.

Councillor Jopling agreed that it was a shame that learning was lost when children went to school. She felt that pre-school learning in nurseries was important.

Councillor Quinn informed the group that there may be a gap in a child's development when children started school because parents were reluctant to send their children to school.

Councillor Smith was surprised that children's developments had decreased by the time they went into reception class. She felt that as Chair this would be a topic that should be included in the work programme for the Children and Young Peoples Overview and Scrutiny Committee and that this would be followed up after the elections in 2021.

Councillor Reed explained that the decline in children's development may also be contributed to children living in care. Family break downs and trauma in a young child's life would affect their focus on education.

Councillor Batey stated that there may be a correlation between children and young people home schooled and children with special educational needs and disabilities (SEND) that may have caused the decline in children's development stages.

The Strategic Manager agreed to take all comments back to the service area.

Councillor Bell noted that there would be financial benefits to schools who had SEND children on their registers. He agreed that this should be included in the agenda for the Children and Young People's Overview and Scrutiny Committee.

Referring to the report Councillor Quinn informed the committee that loneliness could account for the high figures in elderly people falling and seeking medical help. She added loneliness was dangerous and falls may not always be accidental. She thought the figures may increase further round Christmas and holiday times.

Councillor Stephenson reiterated the comment made by Councillor Quinn around loneliness as the Local Government Association had illustrated loneliness as a major issue that needed to be addressed as it impacted on mental and physical health statistics.

Councillor Robinson commended all the hard work in preparing the report and the Committee endorsed the plan. He added that it should remain in the work programme for the future to track progress made.

Resolved
That the report and presentation be noted and the Committee's comments be submitted as a formal response to the Draft Health and Wellbeing strategy consultation.

9 Quarter 2 2019/20 Performance Management report

The Committee considered a report from the Corporate Director of Resources which presented progress towards achieving key outcomes of the Council's corporate performance framework aligned to the Adults, Wellbeing and Health Overview and Scrutiny Committee (for copy see file of Minutes).

The Strategy Team Leader informed the committee that following consultation a shared vision for the County had been developed that was structured around three externally focused ambitions which were:

- More and better jobs
- Long and independent lives
- Connected communities

She noted that work progressed around the ambitions with the stop smoking service that had awarded a contract for commissioning to ABC Health from 1 April 2020 that would run for three years.

A focus group had been established within Public Health to work with pregnant women who smoked or had previously smoked to see what prevented them from giving up. She added that this would give an insight into the journey of pregnant women who smoked. She announced that Durham and Darlington NHS had its smoke free status from 1 October 2019 to develop free tobacco dependency at the hospital.

Further work continued with AAP funding given to the Fit for Farming project to increase engagement within the farming community in partnership with public health and Upper Teesdale agricultural support services. Additionally, the Join the Dots initiative ran by Macmillan had engaged with several cancer patients and the family and carers to provide varying levels of support.

Resolved
That the report and overall position and direction of travel in relation to quarter two performance and the actions taken to address areas of underperformance be noted.

10 Budget Revenue and Capital Forecast Q2 2019/20

The Committee received a report from the Corporate Director of Resources that provided details of the forecast outturn budget positions for the Adult and Health Services (AHS) service grouping. A presentation was given by the Principal Accountant, Adults and Health (for copy of reports and slides, see file of Minutes).

The Principal Accountant referred members to the tables within the report regarding the forecast outturn by expenditure type that showed that there had been a £2.4 million underspend on a £116 million budget with a 2.1% variance. The tables showed the budget broken down by service area including the public health budgeted expenditure that had been requested by Members. The Principal Accountant added that savings had been made through careful management, control of vacancies and an early achievement of MTFP savings across the service that showed it to be a well-managed budget.

Councillor Robinson was concerned that the budget for Public Health should not be reduced, as it needed to be increased.

Councillor Temple thanked the Officer as the table showed the budget broken down by service area.

In response to Councillor Bell's question on what happened to the underspend within the budget the Principal Accountant responded that the money would be added to the reserves which at present was £10 million.

Councillor Hovvels replied to Mrs Hassoon's comment that the community had a right to a good public health by declaring that the Secretary of State for Health and Social Care had stated that there was a statutory responsibility for Local Authorities to provide a public health service and that there was no choice on what was delivered and what the budget was spent on.

Resolved
That the information in the report be noted.

11 Care Quality Commission Inspection Report

The Committee were given a presentation by the Chief Executive, County Durham and Darlington NHS Foundation Trust (CDDFT) relating to the Care Quality Commission Inspection Report that had taken place on the County Durham and Darlington NHS Foundation Trust (for copy see file of Minutes).

The Chief Executive (CDDFT) explained that the inspection had been based on the core services for the County Durham and Darlington NHS Foundation Trust based on Acute and Community services against 5 domains:

- Safe
- Effective
- Caring
- Responsive
- Well Led

The Chief Executive (CDDFT) informed the committee that the algorithms that were used by the CQC were complicated and only services available on the day of the inspection could be looked at. Previous inspections had been carried out in 2015 and 2017 but services such as the end of life care were not chosen until the inspection in 2019 where it received outstanding. The Surgical Service rated best both regionally and nationally.

She felt it was a shame that inspections were so strict as it was thought the paediatrician unit would have inspected well but unfortunately it was not fully operational on the day of the inspection.
Additionally, the A&E area that was undersized would have also rated well but Inspectors were not allowed to foresee the potential of a future service only those that were operational at the time of the inspection.

The Chief Executive (CDDFT) explained that the inspection had highlighted a few minor things that required action. An action plan had been drawn up to address the issues but the service already had a must do action list in place. She added that they were not obliged to have both.

Councillor Bell congratulated the service on a great achievement and wanted to know where quality of treatment sat.

The Chief Executive (CDDFT) informed the committee that quality was looked at through two lenses – one through the clinical outcome and the patients experience of the service and secondly through the Care Quality Commission (CQC) that categorised services into boxes. The two approaches were very different and did not use the same approach. She added that the approach taken by the CQC was not practical when measuring quality on a day to day basis. She noted that information from the CQC was available on their website that showed how they quantified services.

Councillor Bell was concerned that the categories used were not useful to the man on the street using the service and was not easily translated.

The Chief Executive (CDDFT) stated that as a regulator there was no control over how the CQC measured services. She added that information was displayed in entrances to hospitals but dates of when inspections took place could not be included so patients were unaware of when inspections took place.

Councillor Robinson wanted to know if the collapse of Carillion and the Government's decision to intervene with funding would affect funds being released for the improvements that had been proposed at the A&E at University Hospital North Durham.

The Chief Executive (CDDFT) could not speculate either way but there would be Capital funding across the NHS for infrastructure. As a region the priority for capital funding would include the A&E provision at University Hospital North Durham. She added that capital funding should be forthcoming but if not then the organisation would need to look for other ways to source finance for any developments.

In response to Councillor Robinson's offer of support to her by the committee the Chief Executive (CDDFT) replied that she had felt she had received a lot of support from the committee which she greatly appreciated.

The Committee agreed to Councillor Robinson's request to write out to the End of Life Care Team on behalf of the Committee to commend them on their achievement.

Resolved
That the presentation be noted.

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Adults, Wellbeing and Health Overview and Scrutiny Committee

5 March 2020

Health Protection Assurance Annual Report 2018-19

Report of Amanda Healy, Director of Public Health

Purpose of the Report

1 This report provides an update to the Adults Wellbeing and Health Overview and Scrutiny Committee on health protection assurance arrangements in County Durham.

2 Updates come from the implementation of the health protection action plan, which is overseen by the Health Protection Assurance and Development Group (HPADG).

Executive summary

3 In County Durham, new health protection assurance arrangements were established in August 2018 following a cross-organisational event focusing on this topic.

4 The HPADG was subsequently convened and oversees the implementation of a local health protection action plan.

5 HPADG meets quarterly and seeks assurance on five main strands of health protection activity, in addition to data and communications which are threaded throughout:

- Screening programmes
- Immunisation programmes
- Outbreaks and communicable diseases
- Strategic regulation interventions
- Preparedness and response to incidents and emergencies

6 Key achievements overseen by HPADG to date include:

- Sustained local coverage of national cancer screening programmes above the national and regional averages
- Sustained local uptake of national childhood vaccinations above the national and regional averages (see **Appendix 2**)

- Working group established to raise awareness and increase uptake of vaccinations at Aycliffe Secure Centre, including promoting vaccination uptake amongst staff members
- Establishing a County Durham and Darlington Flu Prevention Board to improve uptake, particularly amongst priority groups
- Development of a local operating protocol to ensure a rapid response to non-routine outbreaks of infectious diseases – the first of its kind in the North East, and
- Changes to licensing policy include encouragement of licensees to raise alcohol health awareness, make the offer of free tap water visible, and support local efforts to take action on obesity
- Review of Scientific & Technical Advice Cell (STAC) arrangements to increase robustness of cover arrangements.

7 Areas for future development include

- Improving uptake of certain vaccinations including shingles and pneumococcal
- Ensuring equitable coverage and uptake of screening and immunisations programmes
- Taking account of a national review of adult screening programmes, and a forthcoming national immunisations strategy
- Development of a sexual health strategy for County Durham
- Ensuring health protection and public health related emergency preparedness is assured during organisational change.

Recommendation(s)

8 AWH OSC is requested to:

(a) note the content of the report;
(b) note that local performance continues to be higher than England and regional averages and above target for most screening and immunisation programmes;
(c) note that the report provides broad assurance that effective processes are in place for each of the key strands of health protection activity;
(d) note that the DPH is seeking further assurance in relation to flu immunisation and the outcome of a national review of screening, and;
(e) support further identification and response to emerging health protection priorities.

Background

9 The protection of the health of the population is one of the five mandated responsibilities given to local authorities as part of the Health and Social Care Act 2012. The Director of Public Health (DPH) for County Durham is responsible under legislation for the discharge of the local authority's public health functions.

10 The health protection element of these statutory responsibilities and the mandatory responsibilities of the DPH are as outlined below:

(a) The Secretary of State's public health protection functions.
(b) Exercising the local authority's functions in planning for, and responding to, emergencies that present a risk to public health.
(c) Such other public health functions as the Secretary of State specifies in regulations.
(d) Responsibility for the local authority's public health response as a responsible authority under the Licensing Act 2003, such as making representations about licensing applications.
(e) A duty to ensure plans are in place to protect their population including through screening and immunisation.

11 Within Durham County Council, the remit for health protection is delivered by Public Health in conjunction with the Community Protection Service (CPS) and the Civil Contingencies Unit (CCU). The local Clinical Commissioning Group employs an Infection Prevention and Control Team (IPCT) through an agreement with Public Health.

12 Public Health England (PHE)'s core functions include protecting the public from infectious diseases, chemicals, radiation and environmental hazards and supporting emergency preparedness, resilience and response. Teams responsible for delivering these functions in the North East sit within the PHE Centre based in Newcastle upon Tyne.

13 NHS England (NHSE), working jointly with PHE, is responsible for commissioning and quality assuring population screening and immunisation programmes. This includes a team covering the Cumbria and the North East, also based in Newcastle.

14 Regular liaison between Directors of Public Health (DsPH), the Centre Director of PHE in the North East, and the Head of Public Health for NHSE in Cumbria and the North East occurs via monthly North East DsPH meeting and monthly telephone catch ups as well as via the Public Health Oversight Group.

Health protection assurance arrangements in County Durham

15 The HPADG, chaired by the DPH, was established in 2018, and aims to enable the Director of Public Health to fulfil the statutory role in assuring the Council and Health and Wellbeing Board that satisfactory arrangements are in place to protect the health of the local population.

16 The HPADG has developed a detailed action plan built on five pillars of health protection, in addition to data and communications which are threaded throughout:

- Screening programmes
- Immunisation programmes
- Outbreaks and communicable diseases
- Strategic regulation interventions
- Preparedness and response to incidents and emergencies

17 The action plan is supported by a scorecard that includes a range of appropriate health protection indicators and outcomes (see **Appendix 2**).

18 The Health, Safety and Wellbeing Safety Strategic Group (HSWSG) is in place in DCC to ensure that suitable priority is given to the management of Health, Safety and Wellbeing across the Council. This includes representation from Public Health.

19 NHSE established a County Durham & Darlington Screening and Immunisations Oversight Group which provides assurance to the DPH in relation to screening and immunisation programmes. In addition, the management of incidents and the quality assurance for screening programmes are reported separately to the DPH. Programme boards have been established for each of the screening and immunisation programmes.

20 PHE established the County Durham and Darlington Area Health Protection Group and this brings together organisations involved in protecting the health of the population. The group meets quarterly and is attended by a Consultant in Public Health. The purpose of the group is to provide a forum to discuss strategic and operational health protection issues; review outbreaks and incidents (local, regional and national) and learn from lessons identified; provide a forum where cross-boundary and cross-organisational issues can be discussed and solutions identified; identify local priorities alongside implementing national policy and guidance, and identify any joint training and development needs. The group does not have a formal accountability or governance structure.

21 PHE NE has a bespoke surveillance system in place for communicable diseases with daily and weekly alerts for exceedances and identification of linked cases. The DPH is informed of outbreaks, incidents and exceedances via email alerts. The DPH is represented at all local outbreak control meetings and outbreak reports are also shared.

22 The DsPH for County Durham and Darlington established the County Durham and Darlington Healthcare Acquired Infections (HCAI) Assurance Group in 2004. This group is chaired by a DPH and has wide membership from all provider organisations, enabling the DsPH to have a clear line of sight to all providers in County Durham and Darlington. HCAI information is also reported directly to CCGs where action plans are put in place to address identified issues. These are reported to the CCGs' Governing Bodies as part of the regular quality reports.

23 County Durham has retained an in-house team of community IPCT nurses who can support the care homes, GP surgeries with infection control issues (especially reducing rates of reportable infections such as C difficile, MRSA and E.coli bacteraemia).The team also complete yearly environmental audits to ensure care homes and GP practices are compliant with current legislation. As a result of joint working with colleagues in Adult and Health Services, DCC training sessions have been provided for domiciliary care trainers.

24 The IPCT deal with alert organisms on a daily basis and offer advice and support to care homes, staff and patients on HCAI. Progress against national targets are fed back to the DPH on a monthly basis.

25 NHS England established the County Durham and Darlington and Tees Local Health Resilience Partnership (LHRP) in 2013. This has now merged with the LHRP in the north of the patch to form a North East group. One of the responsibilities of the LHRP is to provide the DPH with assurance that the health sector has well tested plans to respond to major incidents that contribute to multi-agency emergency planning. The LHRP is co-chaired by NHSE and a DPH and attended by a County Durham Consultant in Public Health.

26 NHSE and CCGs have a duty to cooperate with local authorities on health and well-being under the NHS Act 2006. This includes cooperating on health protection, including the sharing of plans. The 2012 Health and Social Care Act makes clear that both NHE England and the CCGs are under a duty to obtain appropriate advice in the protection of the public health. CCGs are also Category 2 responders under the Act giving them a duty to provide information and cooperate with civil contingency planning as needed.

27 The Civil Contingencies Unit (CCU) is essentially the local authority's point of contact for business continuity and emergency planning both internally and externally in response to incidents and emergencies. The CCU are also a conduit for information for multiple agencies through the LRF and have a duty officer on call at all times.

28 CCU holds a community risk register which provides assurance to the DPH about key risks to the community including: pandemic influenza; flooding; adverse weather; emerging infectious disease; fuel shortage; widespread long duration electricity network failure; animal disease and building collapse.

29 The CCU produce extensive emergency preparedness plans on 'Resilience Direct' and work with the LRF to co-ordinate the training exercise calendar. This also includes running exercises for the local university.

30 All internal plans are reviewed on a regular basis. The DPH is involved in the initial development of relevant plans and is sent updates once plans are reviewed. Access to LRF plans is through 'Resilience Direct' from the LRF or the CCU. The DPH is a member of the LRF.

31 Durham County Council leads the recovery co-ordination group, responsible for community engagement and recovery assurance in the event of an incident (for example an extensive fire that may have led to land contamination).

32 PHE's Health Protection, NHSE's Screening and Immunisation and the local IPCT produce annual reports.

33 PHE's annual report covers the NE geography and includes details of the prevention and surveillance of communicable diseases, their response to communicable disease outbreaks and incidents; emergency preparedness, resilience and response, environmental issues and quality and health inequality issues in health protection. The annual report is supplemented by quarterly reports to the DPH that detail outbreaks and issues in County Durham.

34 NHSE's annual flu programme report describes uptake amongst eligible groups and highlights areas for improvement. This is preceded by a local evaluation of the flu programme delivered locally.

35 The IPCT annual report details the range of support and interventions initiated to reduce HCAI and reports in year activity details. This report also includes the work plan for the IPCT for the upcoming year.

36 The DCC Community Protection Service (CPS) provides assurance to national regulators including Department for Environment, Food & Rural

Affairs (DEFRA), Food Standards Agency (FSA) and Health & Safety Executive (HSE) through the implementation and regular reporting on their air quality strategy; contaminated land strategy; food safety plan; food hygiene plan; annual enforcement programme; various licensing and enforcement polices and disease contingency plans. Services provided by CPS are regulated nationally by the FSA, HSE and DEFRA to provide further assurance on the quality of service provision.

37 A Local Air Quality Management Area currently exists within Durham City. Action and implementation plans are in place to reduce Nitrogen Dioxide emissions and improve air quality standards within that area.

Updates on key areas

38 Data provided below are collated from numerous sources and compiled in the scorecard attached at **Appendix 2.**

Screening and immunisations

Screening

39 Breast screening coverage rates in County Durham are consistently above the 70% minimum standard.

40 Coverage rates for cervical screening are higher than the England average, but fail to meet the 80% standard. Rates are showing a slight decline in recent years.

41 A Cervical Cancer Task and Finish Group has been set up by a Public Health Advanced Practitioner to increase and reduce inequalities in uptake. Actions to be taken forward by the Group include improving communications and community engagement and exploring incentives to service users and providers.

42 County Durham has the second highest coverage for bowel screening in Cumbria and the NE (above 60%) and is performing above the England and regional average.

43 Where data is available for the seven antenatal and new-born screening programmes, performance for the County Durham population is good. Some data is missing from CDDFT due to problems with their IT systems, which is currently being addressed although this remains a concern.

44 The diabetic retinopathy screening programme covering County Durham and Darlington consistently exceeds the national quality standard attendance rate of 80%.

45 The Abdominal aortic aneurysm screening programme covers the North East and North Cumbria. By the end of March 2018, 100% of eligible individuals were offered AAA screening. Testing rates also reached the acceptable standard (77.2%).

46 A report on the independent review of adult screening programmes led by Professor Sir Mike Richards was published in October 2019. This stated that the national decline in bowel, breast and cervical cancer screening 'must be reversed' and made several recommendations to reform the current system. These include the creation of single a) advisory and b) commissioning/ quality assurance functions.

Immunisations

47 Overall, the universal childhood immunisation programmes demonstrate high uptake rates across County Durham, with rates generally above national targets and averages (see **Appendix 2)**. This includes the following coverage:

- 97.3% of the combined diphtheria, tetanus, whooping cough, polio and Haemophilus influenzae type b (Dtap / IPV / Hib) vaccine at 1 year
- 97.4% of pneumococcal vaccine (PCV) at 1 year
- 98.8% of the Dtap / IPV / Hib vaccine at 2 years
- 97.5% of the PCV booster at 2 years
- 97.14% for one dose of Measles, Mumps and Rubella at 2 years
- 98.1% for one dose of MMR at 5 years
- 96.4% for two doses of MMR at 5 years

48 The World Health Organisation withdrew measles elimination status from the UK in 2018 (after granting it in 2017) as the percentage of children receiving a 2nd dose of MMR at 5 years old fell to 87.8% nationally.

49 The evaluation of the 2018/19 seasonal flu vaccination programme led to the establishment of a County Durham and Darlington Flu Prevention Board in July 2019. Separate papers are available on the flu programme evaluation and the development of the Board. Highlights from the work overseen by the Board are given in the following paragraphs.

50 The DCC staff vaccination programme, which is targeted at staff who provide up close and personal care, has been extended to include a parallel scheme covering around 300 staff working in integrated teams with the NHS.

51 Preliminary results of the internal campaign indicate that:

- Of the five staff teams that received a voucher only offer, 51% of identified eligible staff intended to receive a vaccination through the voucher scheme (or are eligible through the NHS). This compares with a 25% uptake of the voucher offer within the four staff teams last year.
- 55% of identified eligible staff intended to receive a vaccination at on on-site clinic (or are eligible through the NHS). This compares with a 18% uptake through on-site clinics in the previous year.

52 The Board has a coordinated action and communications plan that complements the plans of member organisations.

53 Members of the Health and Wellbeing Board were challenged to champion flu vaccination within their organisations and have fed this work back to the Board.

54 An evaluation of the 2019/20 campaign will be produced by the Board in Spring 2020. This will inform the flu programme for 2020/21.

55 Uptake of Shingles vaccine remains stubbornly low. Discussions have been held with NHSE on ways to improve uptake locally.

56 There is a national shortage of pneumococcal vaccine covering 23 strains of the bacteria that may be impacting on uptake.

57 There have been challenges in the delivery of the flu programme in 2019/20 relating to the complexity of commissioning arrangements and interdependencies within the vaccine supply chain. These issues have led to the DsPH in the region and the local Flu Prevention Board writing to NHSE to raise their concerns.

58 The recent Government Green Paper on prevention proposed a vaccine strategy in addition to the implementation of the existing Measles and Rubella Elimination Strategy. It was expected that the Department of Health and Social Care, working with PHE and NHS England, would deliver this comprehensive strategy this Autumn.

Communicable disease control and outbreaks

59 IPCT support a network of infection control champions provided by the care homes, who have the potential to attend regular study days depending on resources. This was particularly valuable in 2018/19 as, due to a reduction in capacity within the IPCT, care homes undertook self-audits of infection control practices. Targeted homes were visited and re-audited against their returns. IPCT expect to be back at full capacity in Winter 2019.

60 In hours, information about infection exceedances and outbreaks is easily communicated between organisations. There are also good working arrangements between the health protection team and Environmental Health officers in hours.

61 The CCU provides a conduit for dissemination of information across the local authority both inside and outside of normal working hours. However, dissemination of information across and within CCGs, NHSE, local authorities, PHE and provider organisations can be challenging in the event of an outbreak when out of hours.

62 There is no formal environmental health officer rota out of hours, which can lead to delays in gathering the requisite information for risk assessments to be accurately undertaken in the event of an outbreak of infectious disease. Whilst the CCU cannot elicit information required for outbreak risk assessments, they are the best route for PHE to make contact with an EHO out of hours. A proposal relating to out of hours cover is currently being considered in DCC.

63 It can be challenging to mobilise NHS resources to respond to cases or outbreaks of infection such as influenza, pneumococcal outbreaks, meningococcal infection, hepatitis A in care homes or schools that require swab testing, or provision of antivirals, vaccination or antibiotics. Much of what happens currently works informally on the basis of longstanding relationships. There is no formal commissioning of services to meet these requirements besides the contract with Harrogate and District Foundation Trust, which provides vaccination services children. Work is well underway to develop a protocol to describe how the system will respond to these incidents.

64 The presence of several prison establishments in Durham presents challenges in the management of infectious diseases, particularly blood borne viruses and TB. Changes in IT systems expected in 2020 are expected to improve communications between primary care and prisons.

65 The Public Health in Prisons North East meetings have been held since June 2017. These are chaired by one of the Consultants in Health Protection. The meetings allow for the dissemination and discussion of key material and learning relating to health protection and infection control; opportunities for individual prisons to share learning and good practice in relation to public health; and CPD for prison staff and commissioners in relation to public health.

66 A working group has been established in relation to health protection at Aycliffe Secure Centre. Public Health (PH), Occupational Health (OH), and Adult Social Care attended an initial meeting.

67 Public health and colleagues from PHE developed a briefing programme around Blood Borne Virus, MMR and Flu. The briefing raised awareness and the implications of any illness and the importance of being vaccinated to protect against common and rarer viruses. Efforts are underway to improve vaccination rates through a combination of onsite delivery or signposting into primary care.

68 The Sexual and Reproductive Health Activity Dataset (SRHAD) together with Genito-urinary Medicine Clinic Activity Dataset (GUMCADv2), form the basis for the sexual health dataset collected from sexual health clinic settings. The integrated sexual health service (ISHS) is requested to provide data analysis relating to GUM attendances, activity and sexually transmitted infection (STI) trends on a quarterly basis.

69 PHE Sexual and Reproductive Health profiles continue to show County Durham as having a lower than average diagnosis rate for STI's.

70 Antimicrobial resistance (AMR) remains a growing threat to public health. At the time of writing, NHS Durham Dales, Easington And Sedgefield (DDES) ranked 10th highest amongst 191 CCGs in the number of prescribed antibiotic items per 1000 resident individuals. North Durham ranked 38th highest. The CCGs employ a Medicines Optimisations Team who take the lead on appropriate prescribing practices. PHE are leading campaign work on this and more in depth action is anticipated locally in 2020.

71 In September 2019, PHE published an Infectious Diseases Strategy 2020-2025. This is organised around six core functions: Prevent & protect; Detect & control; Prepare & respond; Build & apply; Advise & collaborate; Generate & share. Implications for practice will be considered at the next meeting of the HPADG in December 2019.

Strategic regulation intervention

72 The Community Protection Service (CPS) delivers key frontline services which are mainly regulatory in nature and encompass environmental health, trading standards and licensing functions. The service is adopting a more strategic and risk-based approach to regulation and works closely with a range of key partners to achieve better regulatory outcomes which protect and promote the health and wellbeing of local communities. The Service is now responsible for community safety, including Anti-Social behaviour and the Vulnerability Interventions Pathway Team who signpost into a variety of support services including addictions, mental health, alcohol and drug misuse and crisis services.

73 CPS' food safety team are integral to the management of cases and outbreaks of food-borne infection. The incidence of some

gastrointestinal (GI) infections is similar higher in Durham compared to the England average. However, the latest annual data date back to 2017.

74 Despite team capacity issues and a constant uncertainty around workload (due to the nature of the work), the team work to deliver proactive projects alongside their statutory duties (including business and housing inspections, air water and land quality improvement work) and reactive work (including infectious disease outbreaks and accidents in the workplace etc.) These projects include a 'community action team', and the 'better business for all' initiative.

75 The team are also capitalising on their access to businesses and people in the community to deliver health improvement initiatives alongside their statutory duties. Examples of this include alcohol harm reduction linked to licensing applications, smoking cessation linked to illicit control work, and gas safety inspections linked to food hygiene inspections. Future opportunities include work on falls, and fuel poverty linked to housing inspections, including a recent empty property protocol to reduce the risk of arson and antisocial behaviour as well as improving the health of the wider community.

76 There may be challenges around succession planning, as 38% of staff are over 50.

77 In October 2019 DCC published a revised Licensing Act 2003 Statement of Licensing Policy for 2019 to 2024. Changes to licensing policy include the encouragement of licensees to raise alcohol health awareness, make the offer of free tap water visible, and support local efforts to take action on obesity.

Preparedness and response to incidents and emergencies

78 The LHRP has played a key role in coordinating communications between Government and health organisations across the North East region in planning and preparing for EU Exit. Representation from the Public Health team has ensured there is a clear line of communication into the local Brexit group.

79 There are now 2 Control of Major Accident Hazards (COMAH) sites in Durham.

80 The Cabinet Office has extended the period for the National Capabilities Survey (NCS) to 3 years. County Durham is due next in or around May 2020.

81 An Excess Death Framework has been written by the excess deaths task and finish group, co-chaired by Durham and Darlington DPHs. The

next stage for the framework is for it to undergo an exercise. This will be in the form of a table top exercise, Exercise Coil, which will be held at in February 2020. Planning for the exercise is currently ongoing. The exercise will be focusing on excess deaths caused by a series of heatwaves.

82 The Director of Public Health, along with other DsPH across the North East are part of a Scientific & Technical Advice Cell rota in a major incident when a STAC is called by the Strategic Co-ordinating Group the DPH will chair the STAC. The DPH has undergone Major Incident Gold Command Training this year. This is to ensure the DPH can operate at SCG level and understands the working arrangements of STAC and the SCG.

83 Following a major incident on Teesside were a STAC was called changes have been made to the arrangements. These include a review of contractual arrangements with PHE and additional CPH training to ensure cover arrangements locally and across the North East.

Main implications

84 It is critical that the DPH receives assurance in relation to the health protection functions of: screening; Immunisation; outbreaks and communicable disease management; strategic regulation interventions and; preparedness and response to incidents and emergencies.

85 Following engagement with representatives from Public Health England, NHS England, DDES CCG and DCC Civil Contingencies Unit, Department for Environment, Health and Consumer Protection and community infection control assurance mechanisms are now in place through the formulation of a health protection action plan. This action plan has identified priority areas for action, achievement of which will be monitored through the HPADG and health protection scorecard. The HPADG group meets quarterly and reports to the HWB.

Conclusion

86 The health protection functions delivered by a range of organisations in County Durham continue to demonstrate good overall performance.

87 On the whole, good communication exists between the commissioners of the various programmes and the DPH and remedial and corrective interventions are instigated when necessary. Escalation procedures are in place in the event the DPH needs to raise concerns. There have been some challenges this year in relation to the seasonal flu vaccination programme. Furthermore, the reporting of antenatal and newborn screening needs to be resolved.

88 There remain areas for potential improvement across screening and immunisation services, Communicable disease control and outbreaks, Strategic regulation intervention, and Preparedness and response to incidents and emergencies. This includes understanding and addressing variation in access to services by sociodemographic characteristics. Monitoring towards achievement of the identified actions will be undertaken by the HPADG and using the health protection scorecard. The HPADG meets quarterly and reports to the HWB.

Background papers

- None

Other useful documents

- None

Contact: Amanda Healy, Director of Public Health

Tel: 03000 264323

Appendix 1: Implications

Legal Implications
Section 2B NHS Act 2006 places a duty on each local authority to take such steps as it considers appropriate for improving the health of the people in its area.
The steps that may be taken include:
providing information and advice; providing services or facilities designed to promote healthy living; providing services or facilities for the prevention, diagnosis or treatment of illness; providing financial incentives to encourage individuals to adopt healthier lifestyles; providing assistance (including financial assistance) to help individuals to minimise any risks to health arising from their accommodation or environment; providing or participating in the provision of training for persons working or seeking to work in the field of health improvement; making available the services of any person or any facilities; providing grants or loans (on such terms as the local authority considers appropriate).

Finance
Funding for the staff flu vaccination programme comes from the Public Health (health protection) budget.

Consultation
There is no requirement for consultation in relation to this report.

Equality and Diversity / Public Sector Equality Duty
There are no implications in relation to the Public Sector Equality Duty in relation to this report.

Climate Change
Exposure to potential harms arising from the effects of climate change would fall within the umbrella of health protection, for example severe weather patterns.

Human Rights
This report has no implications for human rights.

Crime and Disorder
This report has no implications for crime and disorder.

Staffing
This report has no implications for staffing.

Accommodation
Not applicable.

Risk
No risks are identified for the Council.

Procurement
Not applicable.

Appendix 2: Health protection scorecard

See attached.

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Health Protection scorecard - November 2019

	Significantly worse than England
	Not significantly different to England
	Significantly better than England
	Significance not tested
-	No sub-regional data available
	Above national goal
	Close to national goal
	Below national goal

	Data updated since previous scorecard?	Indicator	Measure	Period	County Durham		North East	England	Recent trend
					No.	Measure			
Screening	N	2.19 - Cancer diagnosed at early stage (experimental statistics)	%	2017	1,171	49.3%	52.4%	52.2%	
	N	C24a - Cancer screening coverage - breast cancer	%	2018	49,295	**77.8%**	77.0%	74.9%	
	Y	C24b - Cancer screening coverage - cervical cancer (25 - 49 years)	%	2019	62,576	**76.7%**	74.2%	69.8%	
	Y	C24c - Cancer screening coverage - cervical cancer (50 - 64 years)	%	2019	38,824	**77.3%**	76.3%	76.2%	
	N	C24d - Cancer screening coverage - bowel cancer	%	2018	53,245	**61.1%**	60.4%	59.0%	
	N	C25a - Abdominal Aortic Aneurysm Screening - Coverage	%	2017/18	2,616	**83.2%**	82.3%	80.8%	
	N	C25b – Diabetic eye screening - uptake (%)	%	2017/18	-	-	84.1%	82.7%	
	N	C25d - Infectious Diseases in Pregnancy Screening – HIV Coverage (%)	%	2017/18	-	-	99.5%	99.6%	
	Y	C25e - Infectious Diseases in Pregnancy Screening – Syphillis Coverage (%)	%	2017/18	-	-	99.5%	99.5%	
	Y	C25f - Infectious Diseases in Pregnancy Screening – Hepatitis B Coverage (%)	%	2017/18	-	-	99.6%	99.5%	
	N	C25g - Sickle Cell and Thalassaemia Screening – Coverage (%)	%	2017/18	-	-	99.5%	99.6%	
	N	C25h - Newborn Blood Spot Screening – Coverage (%)	%	2017/18	-	-	98.6%	96.7%	
	N	C25i - Newborn Hearing Screening – Coverage (%)	%	2017/18	4,912	**99.5%**	99.0%	98.9%	
	N	C25j - Newborn and Infant Physical Examination Screening – Coverage (%)	%	2017/18	-	-	94.5%	95.4%	

	Data updated since previous scorecard?	Indicator	Measure	Period	County Durham		North East	England	Recent trend
					No.	Measure			
Imms and Vaccs		**12 months**							
	Y	D03b - Population vaccination coverage - Hepatitis B (1 year old)	%	2018/19	-	100%	-	-	
	Y	D03c - Population vaccination coverage - Dtap / IPV / Hib (1 year old) **<90% 90% to 95% ≥95%**	%	2018/19	4,958	**97.3%**	95.4%	92.1%	
	N	3.03iv - Population vaccination coverage - MenC ***From 1st July 2016 the dose of MenC offered at 3 months is to be discontinued and so the 1 year evaluation 3.03iv indicator will become obsolete within the next two years (data for 2016/17 will be the last collection)*** **<90% 90% to 95% ≥95%**	%	2015/16	5,399	**98.7%**	97.8%	*	
	Y	D03f - Population vaccination coverage - PCV (1 year old) **<90% 90% to 95% ≥95%**	%	2018/19	4,964	**97.4%**	95.7%	92.8%	
		24 months							
	Y	D03g - Population vaccination coverage - Hepatitis B (2 years old)	%	2018/19	-	100%	-	-	
	Y	D03h - Population vaccination coverage - Dtap / IPV / Hib (2 years old) **<90% 90% to 95% ≥95%**	%	2018/19	5,386	**98.8%**	96.7%	94.2%	
	Y	D03m - Population vaccination coverage - Hib / MenC booster (2 years old) **<90% 90% to 95% ≥95%**	%	2018/19	5,315	**97.5%**	94.7%	90.4%	
	Y	D03k - Population vaccination coverage - PCV booster (2 years old) **<90% 90% to 95% ≥95%**	%	2018/19	5,318	**97.5%**	94.7%	90.2%	
	Y	D03j - Population vaccination coverage - MMR for one dose (2 years old) **<90% 90% to 95% ≥95%**	%	2018/19	5,298	**97.1%**	94.5%	90.3%	
		2-3 years							
	Y	D03l - Population vaccination coverage - Flu (2-3 years old) **<40% 40% to 65% >65%**	%	2018/19	4,874	**44.0%**	44.4	44.9%	
		5 years							
	Y	D04b - Population vaccination coverage - MMR for one dose (5 years old) **<90% 90% to 95% ≥95%**	%	2018/19	5,164	**98.1%**	96.6%	94.5%	
	N	3.03vi - Population vaccination coverage - Hib / Men C booster (5 years old) **<90% 90% to 95% ≥95%**	%	2017/18	5,768	**97.2%**	95.1%	92.4%	
	Y	D04c - Population vaccination coverage - MMR for two doses (5 years old) **<90% 90% to 95% ≥95%**	%	2018/19	5,077	**96.4%**	91.4%	86.4%	
		Other Children and young people							
	N	D04e - Population vaccination coverage - HPV vaccination coverage for one dose (females 12-13 years old) **<80% 80% to 90% ≥90%**	%	2017/18	2,487	**89.7%**	85.5%	86.9%	
	N	D04f - Population vaccination coverage - HPV vaccination coverage for two doses (females 13-14 years old) **<80% 80% to 90% >90%**	%	2017/18	2,325	**87.9%**	85.5%	83.8%	
		Other							
	N	Persons entering substance misuse treatment - Percentage of eligible persons completing a course of hepatitis B vacc		2016/17	32	3.6%	6.0%	8.1%	
	Y	D05 - Population vaccination coverage - Flu (at risk individuals) **<55% ≥55%**	%	2018/19	33,857	**49.0%**	49.2%	48.0%	
	Y	D06a - Population vaccination coverage - Flu (aged 65+) **<75% %≥75%**	%	2018/19	78,105	**71.4%**	73.1%	72.0%	
	N	D06b - Population vaccination coverage - PPV (aged 65+) **<65% 65% to 75% ≥75%**	%	2017/18	37,998	**70.2%**	71.0%	69.5%	
	N	D06c - Population vaccination coverage - Shingles vaccination coverage (70 years old) **<50% 50% to 60% ≥60%**	%	2017/18	3,513	**47.6%**	45.0%	44.4%	No trend

	Data updated since previous scorecard?	Indicator	Measure	Period	County Durham		North East	England	Recent trend
					No.	Measure			
Sexual health	N	D02a - Chlamydia detection rate / 100,000 aged 15-24 <1,900 1,900 to 2,300 ≥2,300	R/100,000	2018	980	1504	1815	1975	
	N	D02b - All new STI diagnoses (exc Chlamydia aged <25) / 100,000	R/100,000	2018	1944	586	640	851	
	N	Gonorrhoea diagnosis rate per 100,000 population	R/100,000	2018	288	55	66.5	98.5	
	N	Syphilis diagnoses rate per 100,000 population	R/100,000	2018	32	6.1	9.3	13.1	
	Y	D07 - HIV late diagnosis (%) ≥50% 25% to 50% <25%	R/100,000	2016-18	20	33.3%	42.9	42.5	
Infectious diseases	N	Legionnaire's disease confirmed incidence rate / 100,000	R/100,000	2016	3	0.57	0.53	0.61	
	Y	Typhoid and paratyphoid confirmed incidence rate / 100,000	R/100,000	2018	2	38.0%	0.15	0.61	
	N	D08b - TB incidence (three year average)	R/100,000	2016-18	31	2	4.4	9.2	
	N	3.05i - Treatment completion for TB (%)*	%	2017	4	50	74.7	84.7	
	N	Measles (reported cases confirmed, Year to date)	R/100,000	Q2 2018	0	0	0.15	-	
	N	Measles new diagnosis rate	R/100,000	2018	1	0.2	0.5	1.7	
	N	*Mumps (confirmed cases,quarterly number and annualised rates)*	R/100,000	Q2 2019	14	10.4	1.3	-	
	N	*Whooping cough (confirmed cases,quarterly number and annualised rates)*	R/100,000	Q2 2019	6	4.55	3.31	-	
	N	*Rubella (confirmed cases, year to date)*	R/100,000	Q2 2019	0	0	0	-	No trend
	N	*Meningococcal Infection (confirmed cases,quarterly number and annualised rates)*	R/100,000	Q2 2019	1	0.76	1.2	-	
	N	*Scarlet Fever (all notifications)*	R/100,000	Q2 2019	20	15.2	27.2	-	
	N	*Haemophilus Influenzae Type B (HiB)*	R/100,000	Q2 2019	0	0	0	-	
	N	Non-typhoidal Salmonella (incidence)	R/100,000	2017	92	17.6	16.6	15.7	
	N	*Quarterly Salmonella Enteritidis (incidence)*	R/100,000	Q2 2019	5	3.8	3.2	-	
	N	*Quarlerly Salmonella Typhimurium (incidence)*	R/100,000	Q2 2019	5	3.8	1.8	-	
	N	*Quarterly Salmonella other (incidence)*	R/100,000	Q2 2019	9	6.8	5.7	-	
	N	Campylobacter (incidence)	R/100,000	2017	689	132	123	97	
	N	*Quarterly Campylobacter (incidence)*	R/100,000	Q2 2019	168	127.5	126.7	-	
	N	Cryptosporidium (incidence)	R/100,000	2017	75	14.4	10.4	7.3	
	N	*Quarterly Cryptosporidium (incidence)*	R/100,000	Q2 2019	11	8.3	4.7	-	
	N	Giardia (incidence)	R/100,000	2017	35	6.7	11.9	8.5	
	N	*Quartlerly Giardia (incidence)*	R/100,000	Q2 2019	10	7.6	8.6	-	
	N	STEC serogroup O157 (incidence)	R/100,000	2017	10	1.9	1	1	

	Data updated since previous scorecard?	Indicator	Measure	Period	North Durham CCG		North Durham recent trend	Durham Dales, Easington And Sedgefield CCG		STP	England	DDES recent trend
					Count	Value		Count	Value	Value	Value	
Health Care Acquired Infection	Y	All C. difficile rates by CCG and financial year	R/100,000	2018/19	48	19.3		60	21.9	28.8	22	
	Y	All MRSA bacteraemia rates by CCG and financial year	R/100,000	2018/19	3	1.2		2	0.7	1	1.4	
	N	CCG-assigned MRSA rates by CCG and financial year	R/100,000	2016/17	1	0.4		3	1.1	0.57	0.4	
	Y	All MSSA bacteraemia rates by CCG and financial year	R/100,000	2018/19	50	20.1		59	21.5	27.7	21.8	
	N	Trust-assigned MRSA counts by CCG and financial year	R/100,000	2016/17	3	3		4	4	-	315	
	N	Third party-assigned MRSA counts by CCG and financial year	R/100,000	2016/17	0	0		0	0	-	276	
	Y	All E. coli bacteraemia rates by CCG and financial year	R/100,000	2018/19	180	72.3		301	109.6	104.7	77.7	
	N	Counts and 12-month rolling rates of C. difficile infection, by CCG and month	R/100,000	Sep-18	8	20.2		8	22.2	28.7	23.8	
	N	Counts and 12-month rolling rates of all MRSA bacteraemia cases, by CCG and month	R/100,000	Sep-18	0	2		0	0.7	1.2	1.5	
	N	Counts and 12-month rolling rates of MSSA bacteraemia cases, by CCG and month	R/100,000	Sep-18	4	17.4		6	20.4	27.9	21.7	
	N	Counts and 12-month rolling rates of E. coli bacteraemia by CCG and month	R/100,000	Sep-18	17	71.1		22	91	101	76.2	
	N	Counts and 12-month rolling rates of hospital-onset E. coli bacteraemia, by CCG and month	R/100,000	Sep-18	8	17.1		3	10.1	20.1	13.8	
	N	Counts and 12-month rolling rates of community-onset E. coli bacteraemia, by CCG and month	R/100,000	Sep-18	14	61		17	73.9	81	62.4	

North East Ambulance Service NHS
NHS Foundation Trust

For Life

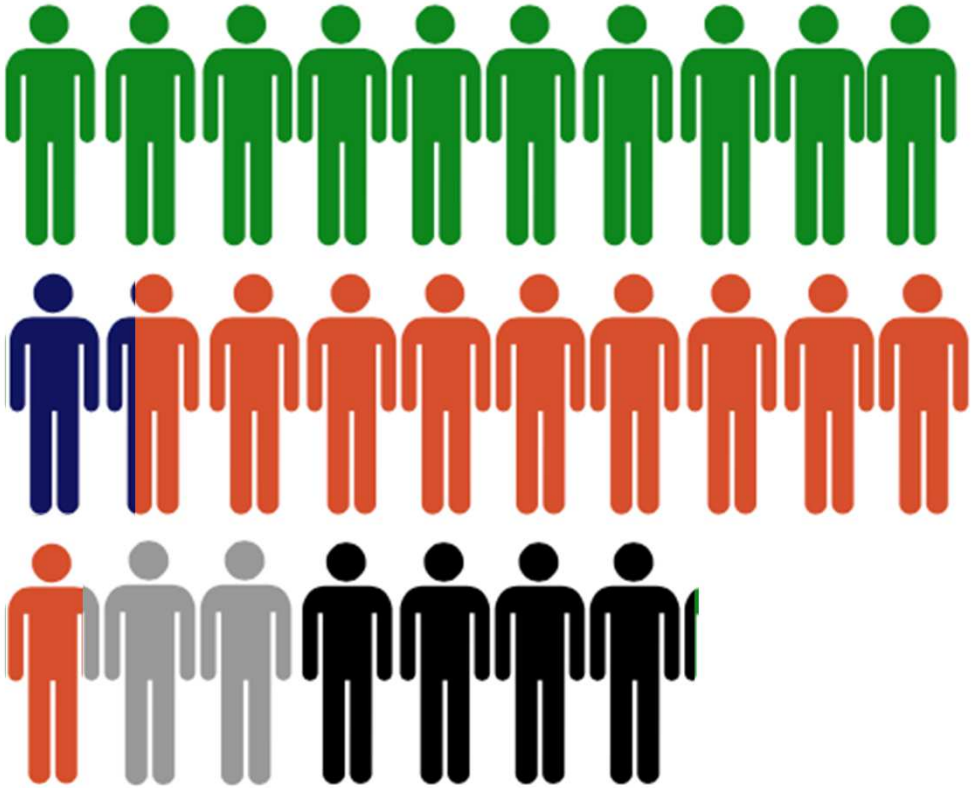
Health Overview & Scrutiny

Ambulance performance update

Paul Liversidge, Deputy Chief Executive

Mark Cotton, Assistant Director of Communications

Bridging the Gap



NEAS contribution through efficiencies will save almost £9.4 million:

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

Commissioners' contribution through additional resources will fund NEAS by a further £10.4 million over five years.

Ambulance resourcing

	Previous VEHICLES			FUTURE VEHICLES			CHANGE IN VEHICLE NUMBERS		
	Rapid Response	Two-crew vehicles	Inter tier	Rapid Response	Two-crew vehicles	Inter tier	Rapid Response	Two-crew vehicles	Inter tier
VEHICLE TOTALS	38	74	27	18	112	18	-20	+36	-9
OVERALL STAFFING	PARA 540	CCA 450	ECT 70	PARA 641	CCA 540	ECT 47	PARA +100	CCA +90	ECT -23

Ambulance resources across North of Tyne

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

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

Ambulance resources across South of Tyne

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

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

Ambulance resources across Tees Valley

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

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

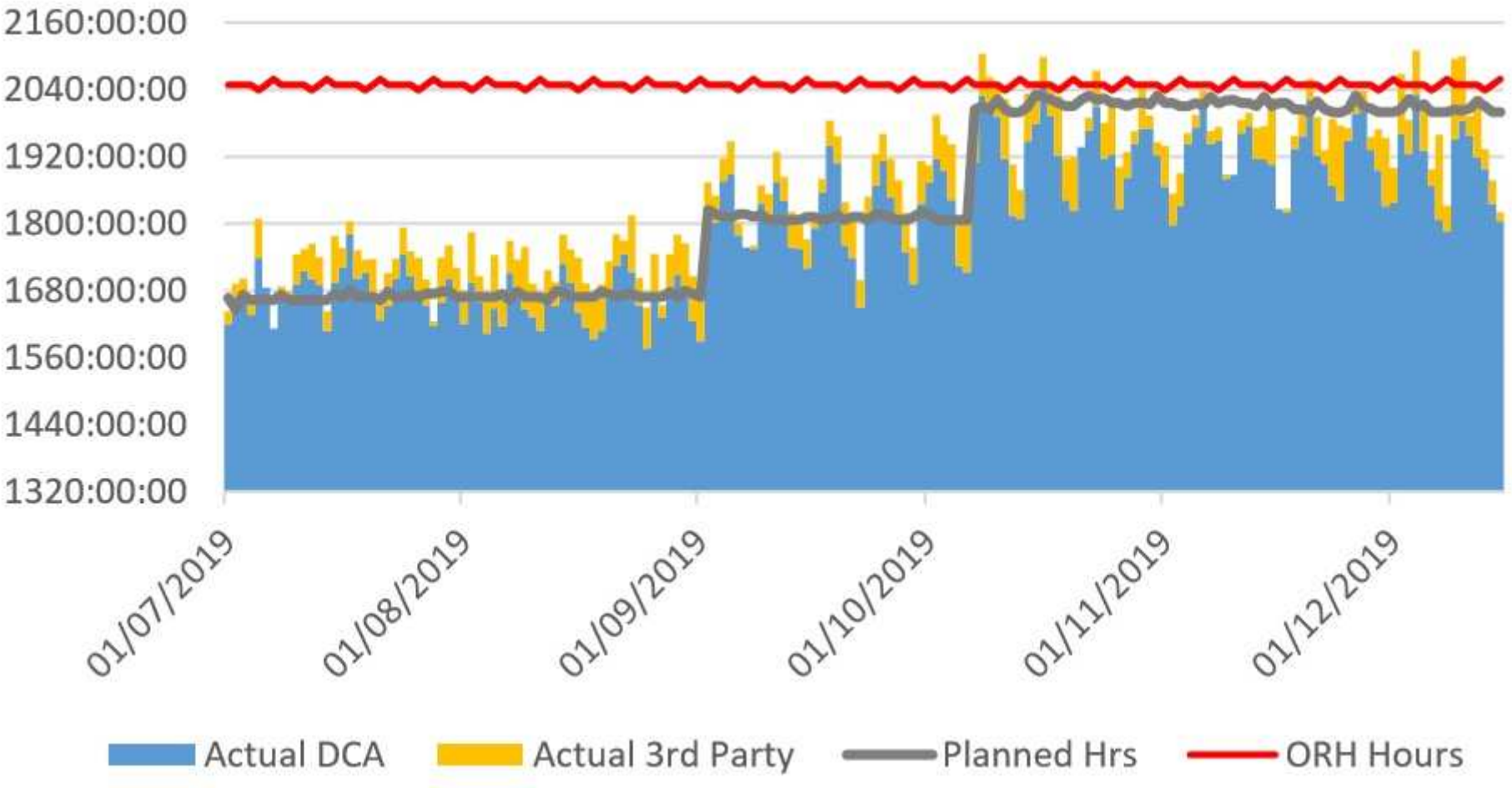
How are we performing?

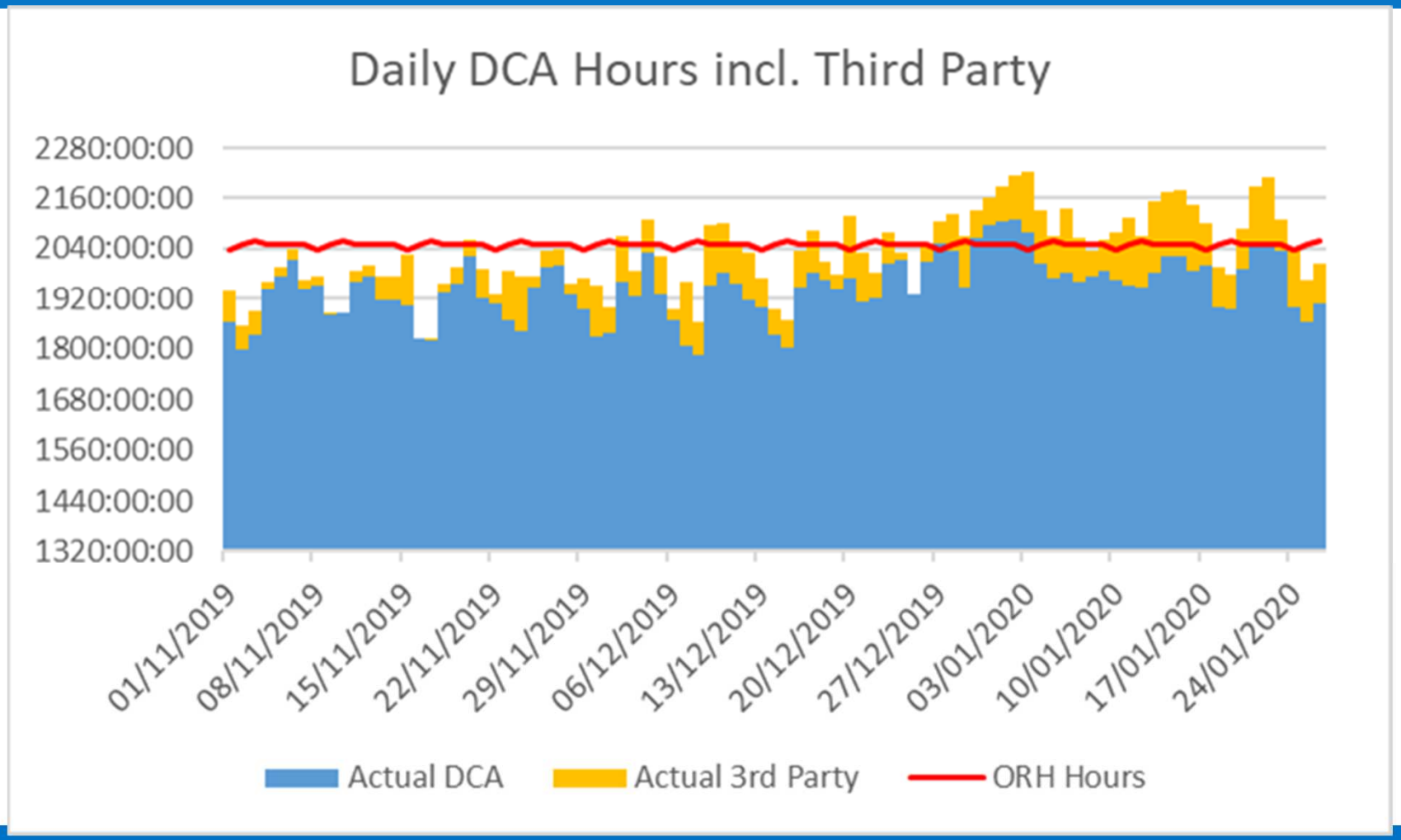
Summary position

	Year 2 Target	Improvement to date
Recruitment	Recruitment on trajectory	605.19 paramedics in post YTD an increase of 78.59wte
Rotas and Abstractions	Re-rostering Overall abstraction rate reduced to 30%	Rosters live 28.4% YTD reduced from 36% March 2018
Handover to Clear	17 minute average handover to clear achieved	00:18:06 YTD reduced from 00:24:20 April 2018
Conveyance Rate	Conveyance rate reduced to 64.8% for Q4	66% Nov MTD reduced from 69.6% 2018/19
Activation Time	Average C1 activation time reduced to 80 seconds	00:01:13 reduced from 00:01:35 2018/19
Response Times	Achieve C1 and C4, Improve C2 and C3	C1 achieved, C2 and C3 worsening, all categories are deteriorating

How are we performing?

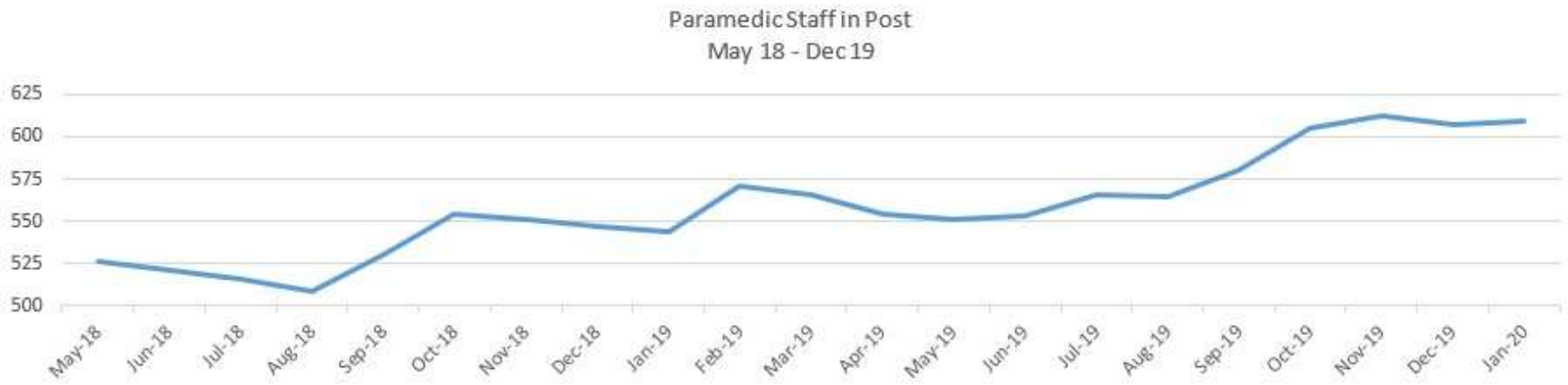
Daily DCA vehicle hours (incl. third party resources)




Daily DCA Hours incl. Third Party
2280:00:00
2160:00:00
2040:00:00
1920:00:00
1800:00:00
1680:00:00
1560:00:00
1440:00:00
1320:00:00
01/11/2019
08/11/2019
15/11/2019
22/11/2019
29/11/2019
06/12/2019
13/12/2019
20/12/2019
27/12/2019
03/01/2020
10/01/2020
17/01/2020
24/01/2020
Actual DCA
Actual 3rd Party
ORH Hours

How are we performing?

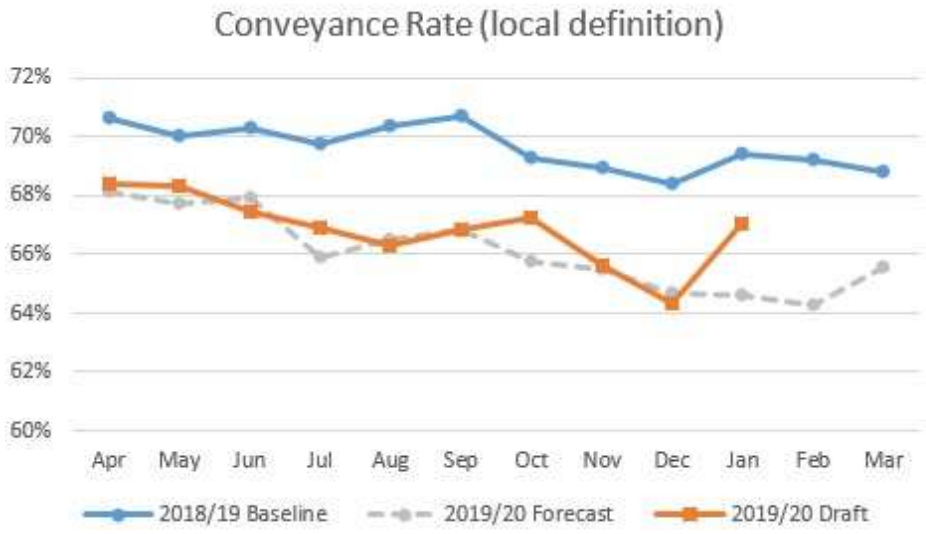
Recruitment – investing in front line delivery

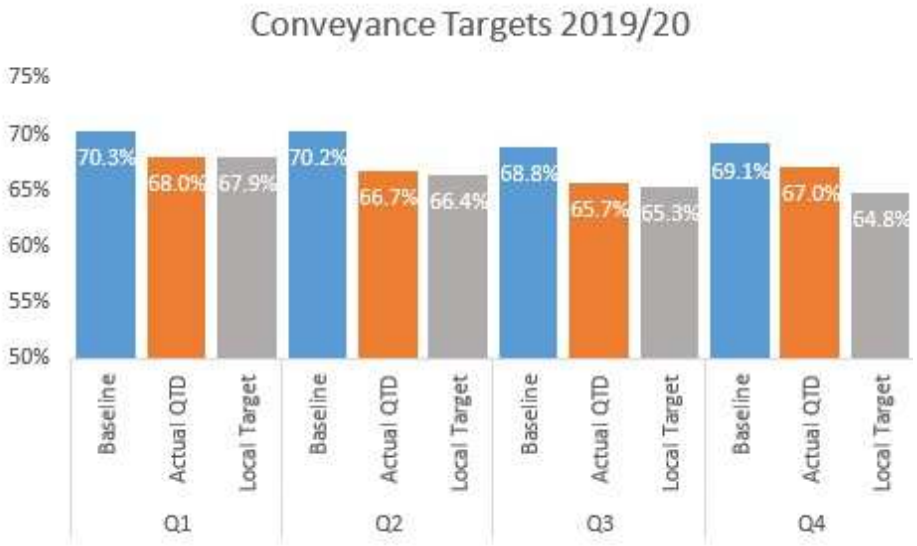


- Increased paramedic establishment for 2019/20 set at 613 wte
- Paramedic recruitment includes:
  - External qualified paramedics
  - External Teesside University graduates
  - Internal Sunderland University graduates
- Paramedic recruitment remains on track, with establishment figures forecast to be achieved by year end.

How are we performing?

Reducing conveyance – improving system efficiency

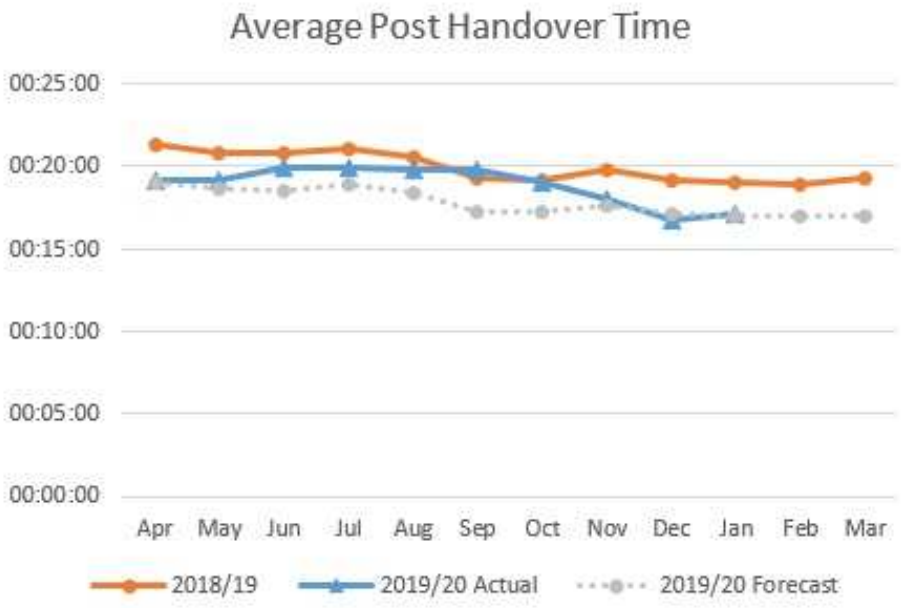


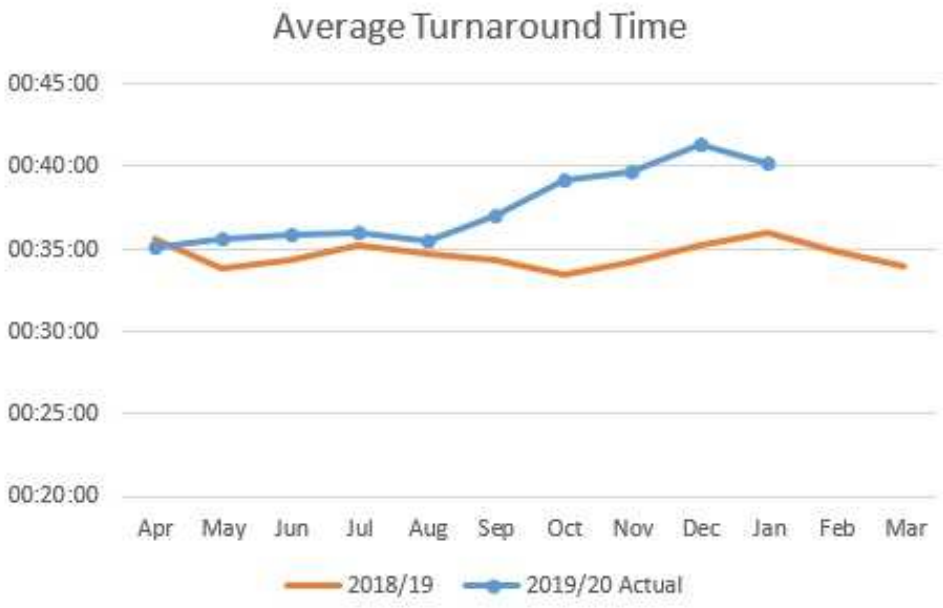


- Improved upon 18/19 – see and treat and hear and treat both improving
- Improving trajectory – generally on track – Q3 and Q4 always looked challenging – risk to delivery here
- **Reducing pressure on EDs – improving system efficiency**

How are we performing?

Improving turnaround – getting resources back on the road

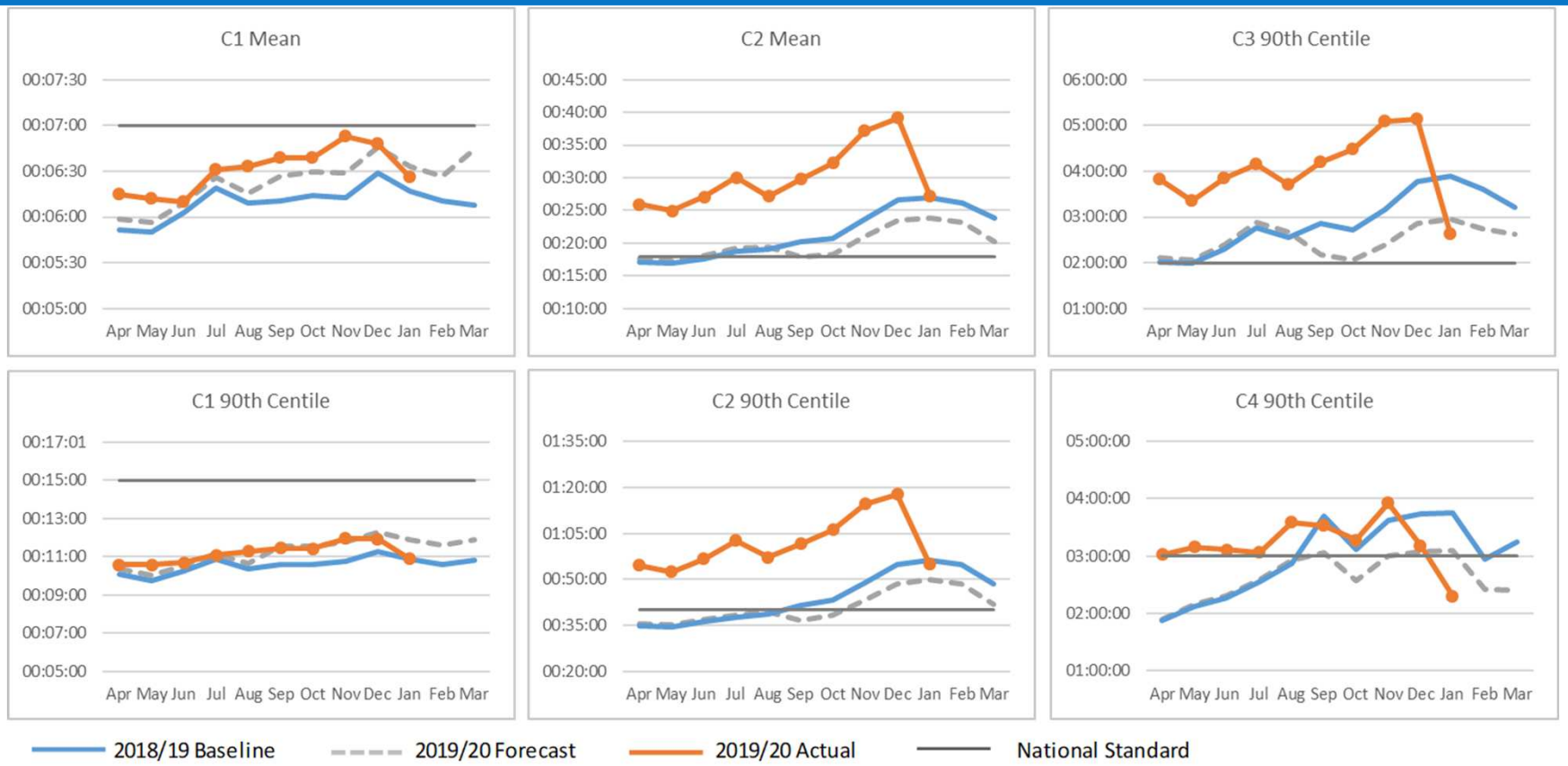




- Post handover time has improved from 18/19
- Turnaround time is deteriorating though – EDs need support and focus to improve throughput
- **We want to own the solution jointly and are improving, but pressured EDs are impacting ambulance availability overall**

How are we performing?

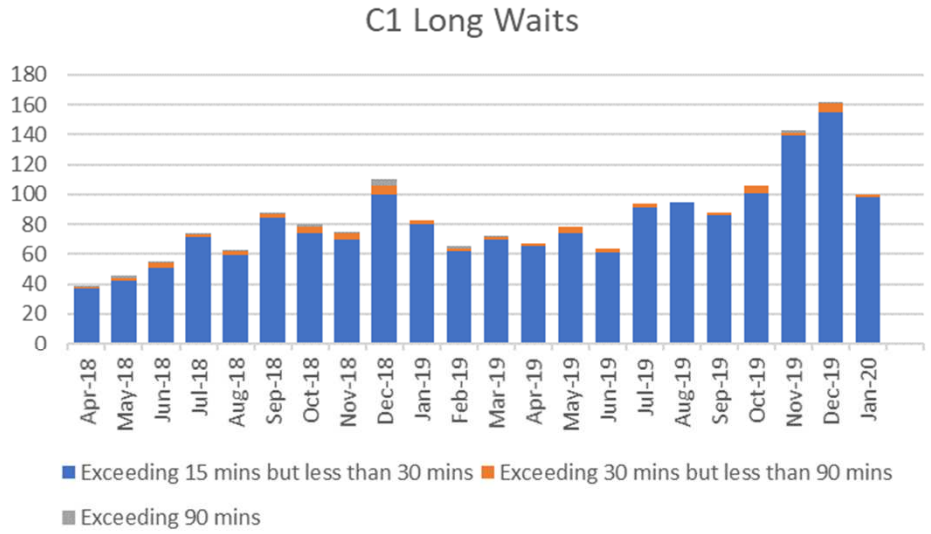
Improving overall response

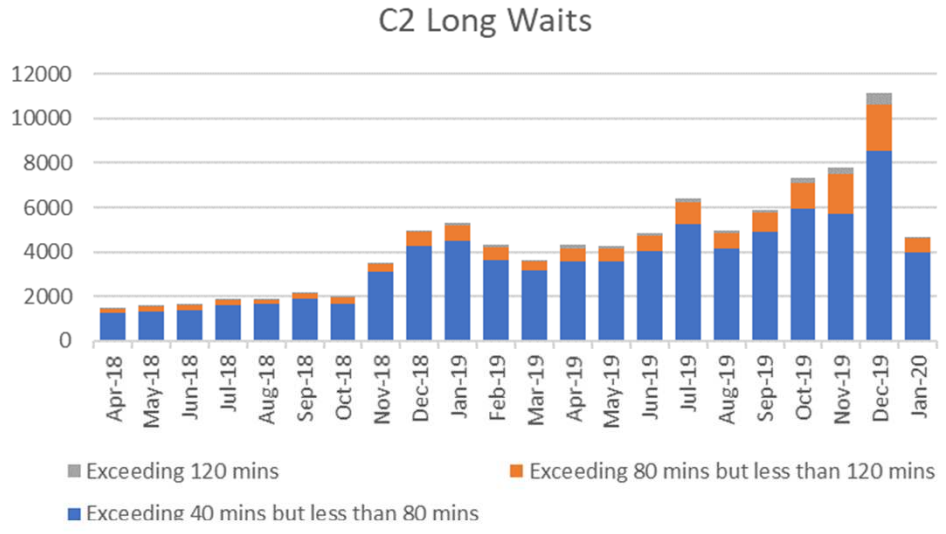


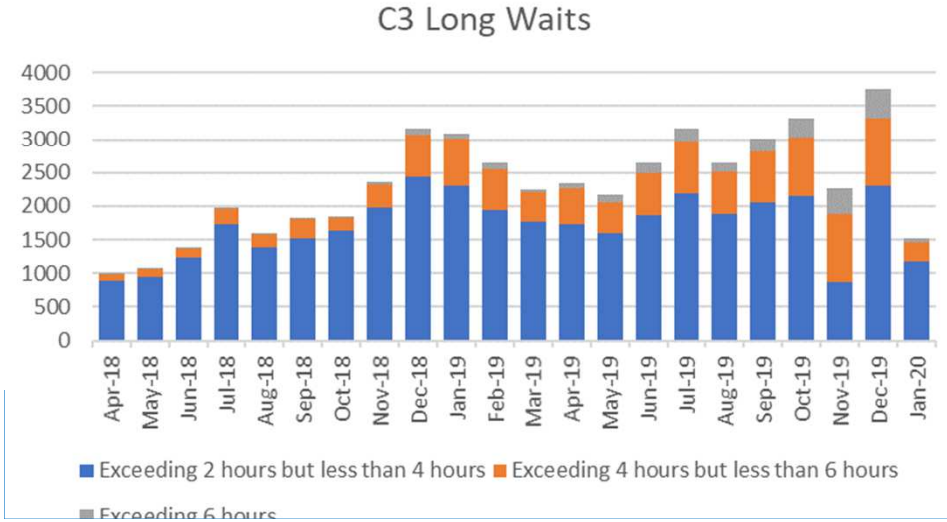
Increased staffing and reduced demand has delivered a significant improvement in response times for January across all categories.

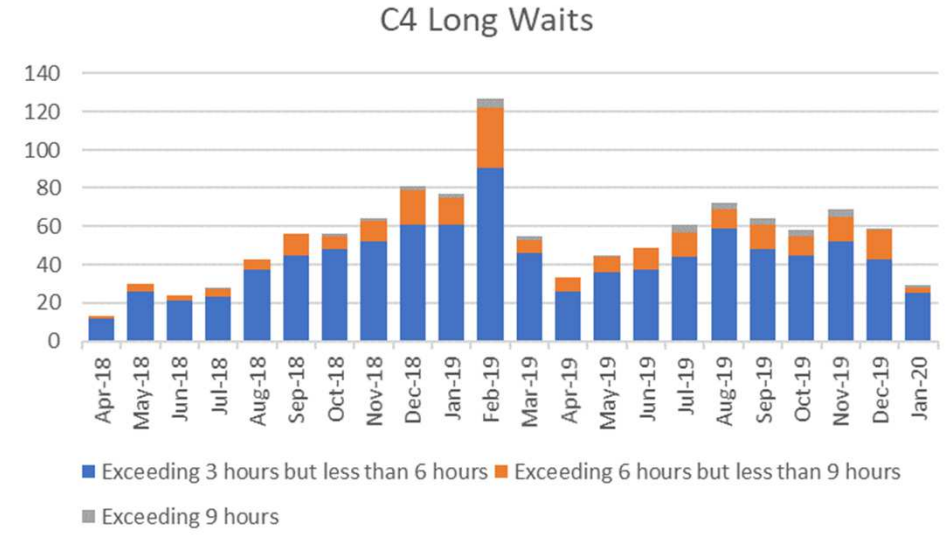
How are we performing?

Long waits are getting worse…



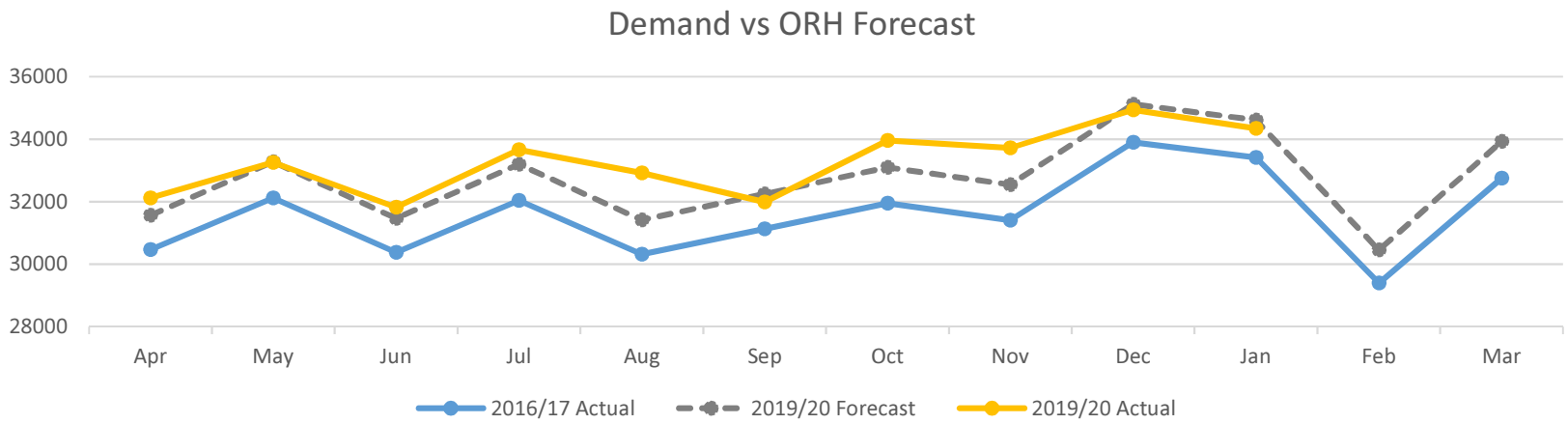






What are the key drivers?

Incident demand – higher than anticipated

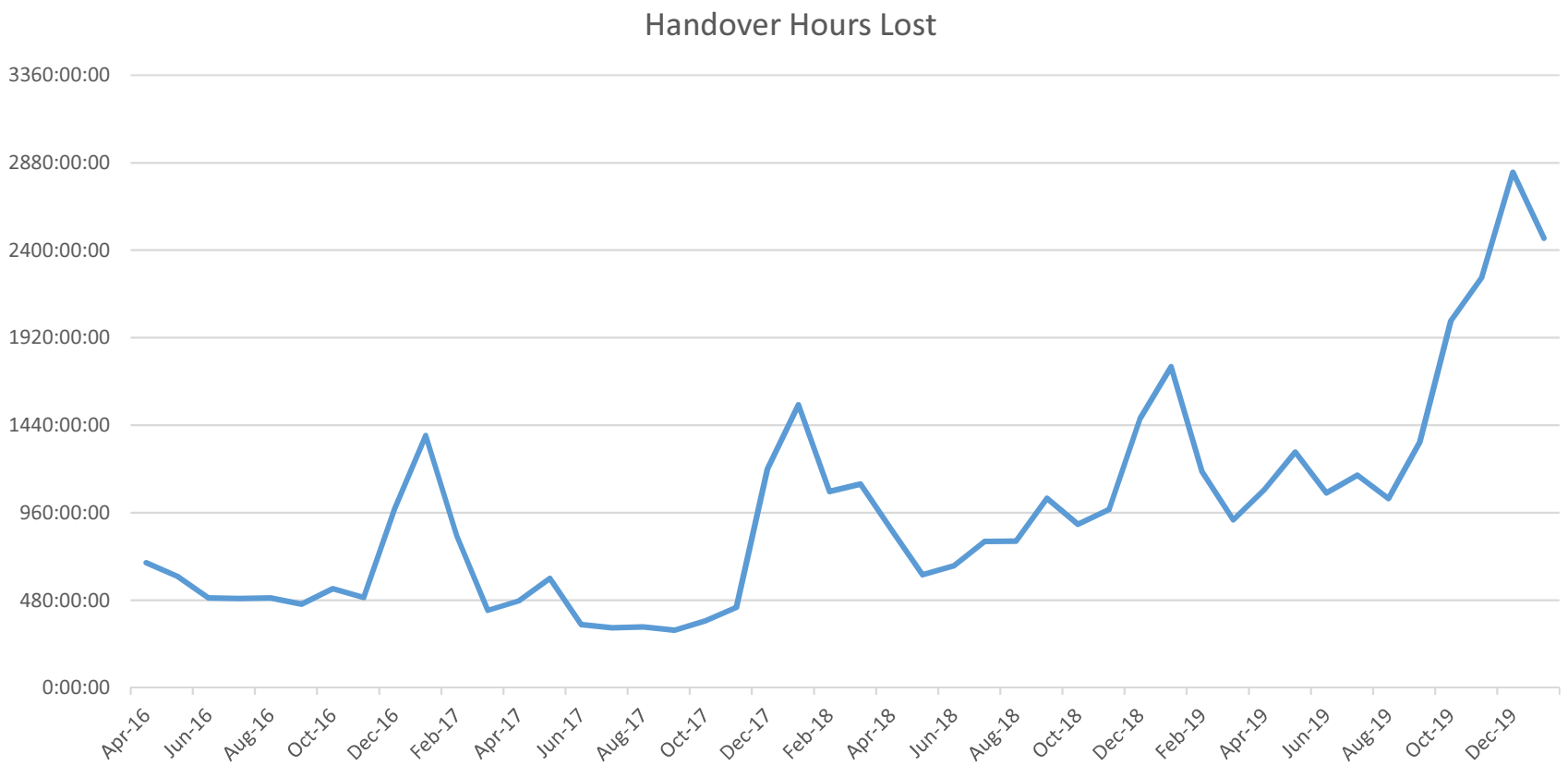


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17 Actual	30470	32122	30377	32040	30321	31126	31951	31411	33901	33411	29396	32755
2019/20 Forecast	31567	33278	31471	33193	31413	32247	33101	32542	35121	34614	30454	33934
2019/20 Actual	32115	33258	31821	33662	32917	31988	33958	33718	34940	34349		

- ORH forecast an increase in incident volume of 6% between 2016/17 and 2021/22, 1.2% per year
- Demand has so far increased by 4.9% Jan 2020 YTD, 1.3% above forecast (expected 3.6%)
- 2 years into the contract, experienced more than 3 years of estimated growth

What are the key drivers?

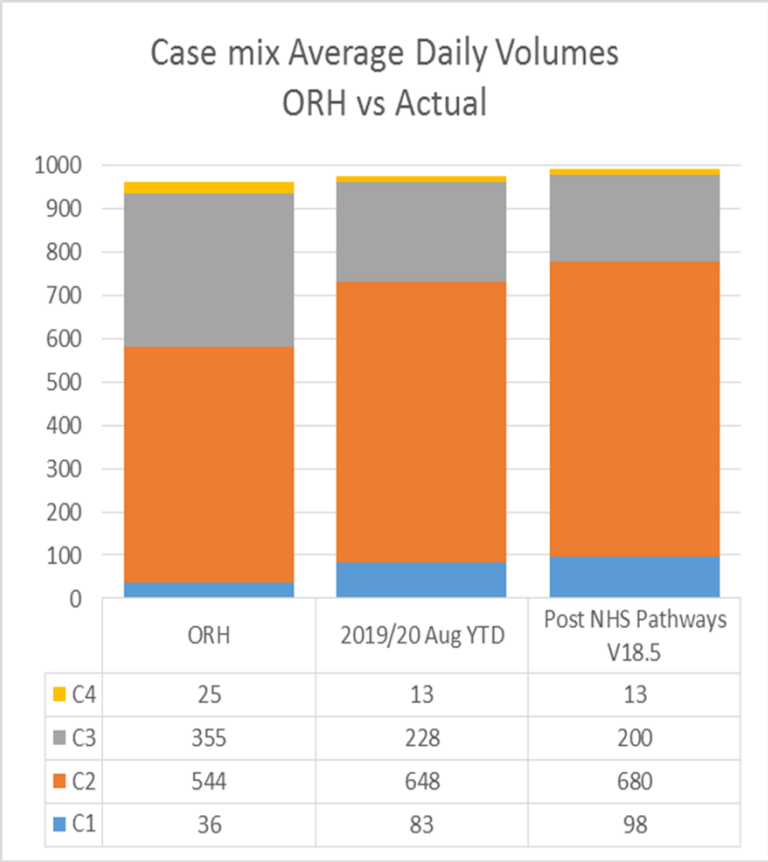
The impact of handover delays is severe



- 5.5 double crewed ambulances lost each day (c4.6% of fleet)

What are the key drivers?

Increasing acuity – contracting assumptions are wrong

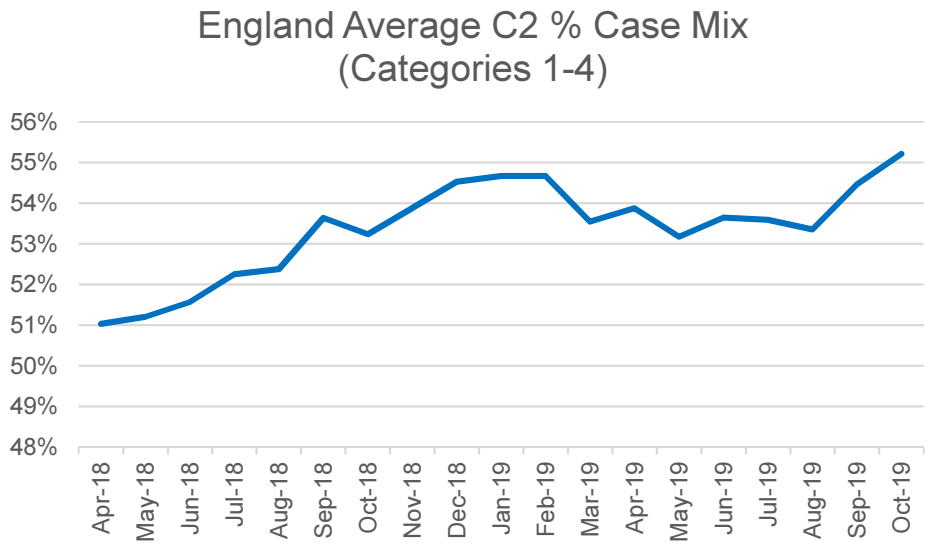


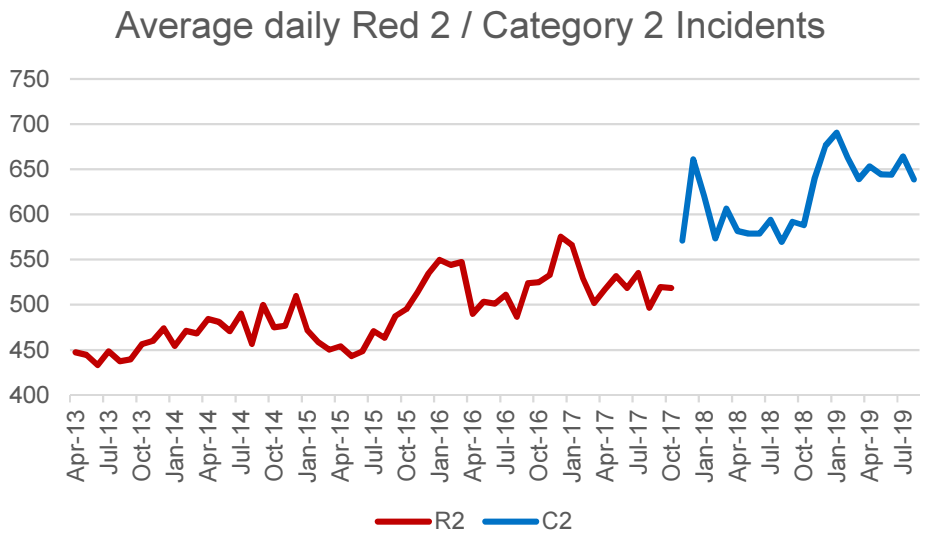
	ORH	2019/20 Aug YTD	Post NHS Pathways V18.5
C4	25	13	13
C3	355	228	200
C2	544	648	680
C1	36	83	98

- Handover is playing a part, but acuity increases track against long term performance issues
- Acuity is significantly higher than originally forecast and assumed within the contract
  - Cat 1 c4% assumed, 9% observed
  - Cat 2 c57% assumed, c70% observed (pre winter)
- Initial forecast based on ARP pilots in West Mids, Yorks and South West
- Acuity is also increasing –increase in anaphylaxis and aortic dissection classification – before and after shown opposite
- 'Coding' not the key driver here
- ***Contract assumptions need revisiting – ORH forecasts***

The national picture

Increasing acuity – we're not alone…

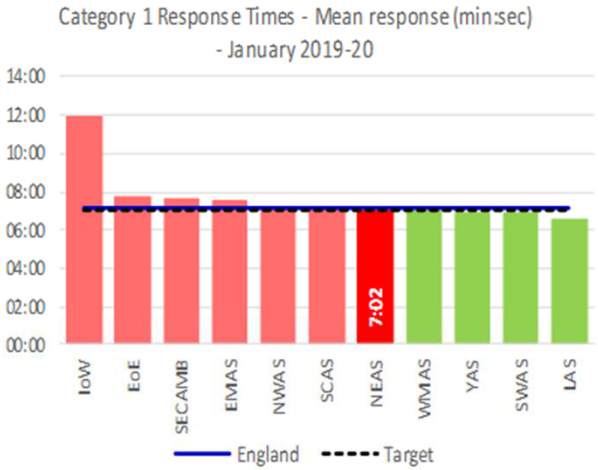


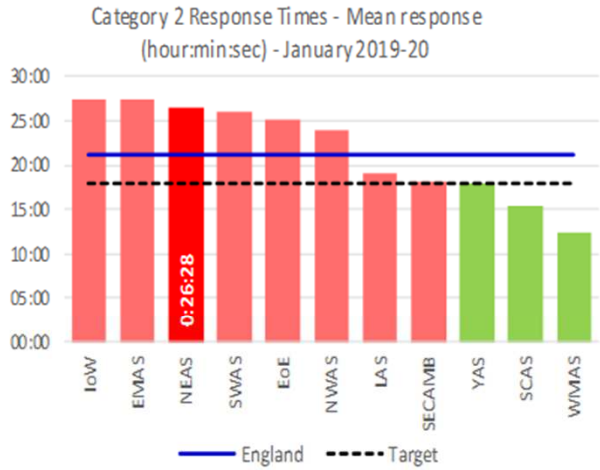


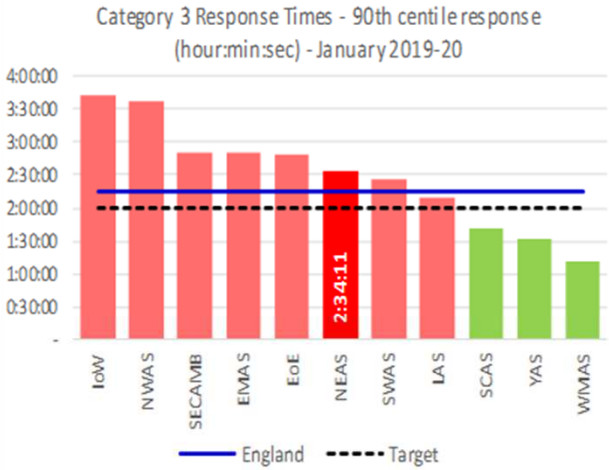
- Nationally C2 case mix has continued to increase
- Increasing acuity is a long standing trend

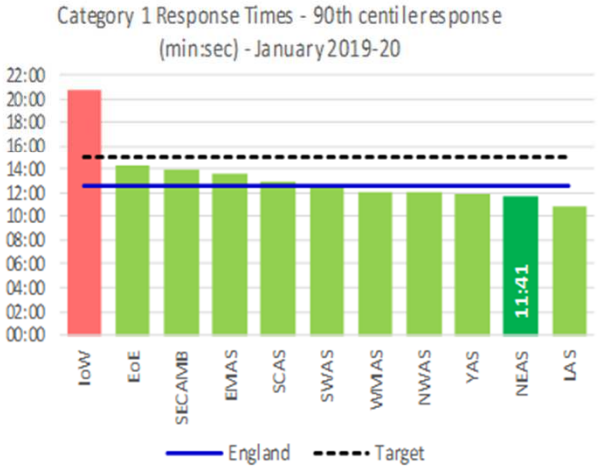
The national picture

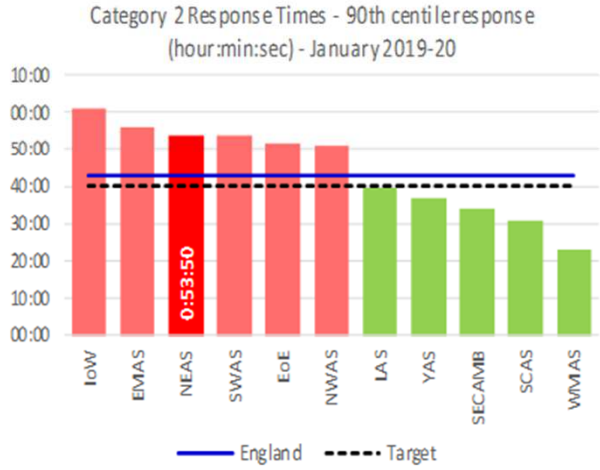
…but we are falling behind

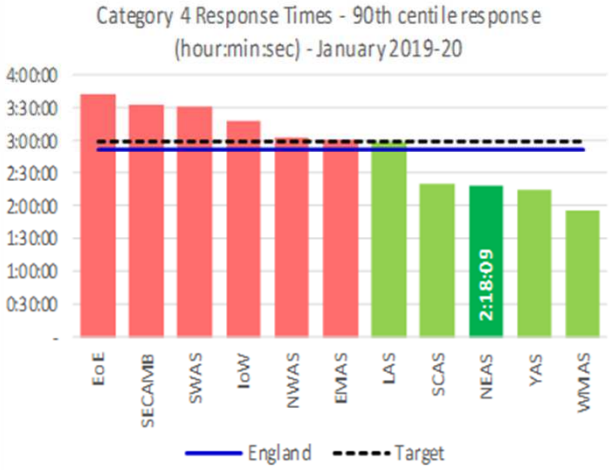






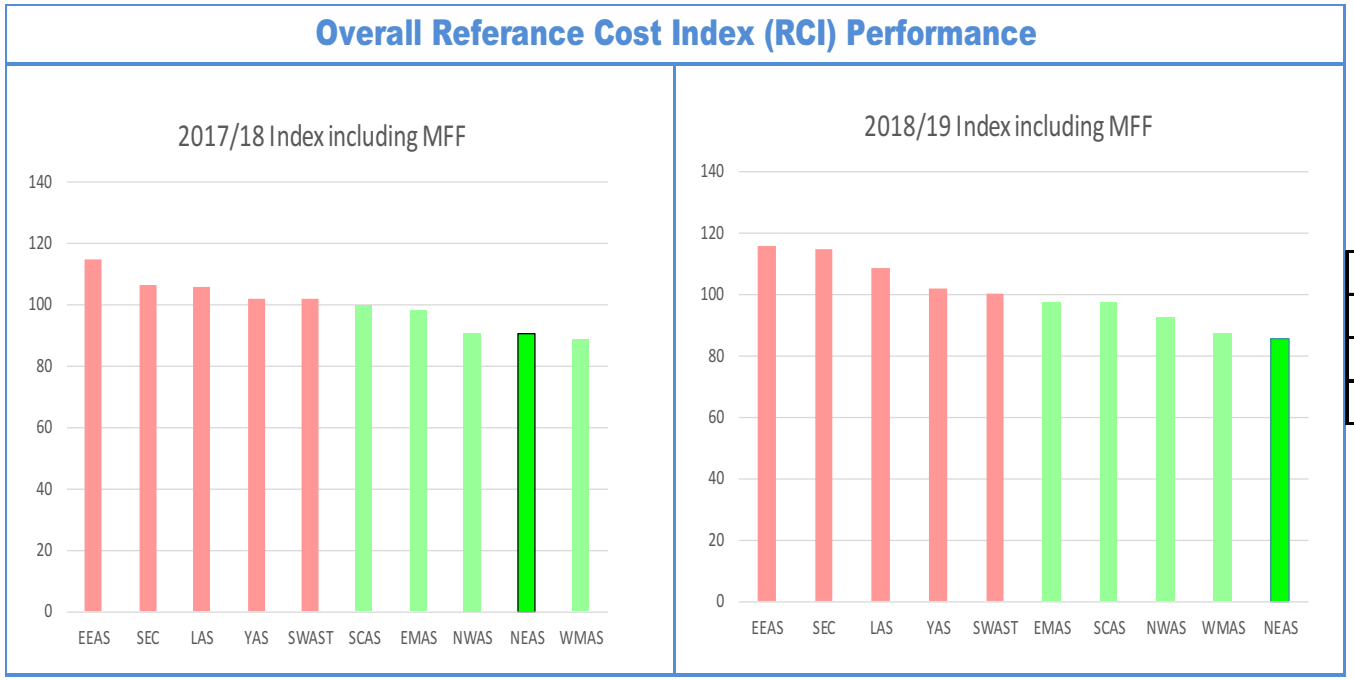






The national picture

Are we investing too slowly?



	Rank (10 is cheapest)
Calls	8
Hear and Treat	4
See and Treat	8
See and Convey	10

- Despite additional investment, NEAS's reference cost index shows we are becoming cheaper relative to the average (18/19 - RCI = 91, 19/20 – 86 (draft))
- NEAS has become the cheapest ambulance service in the country again
- **Pace of investment is not keeping up with rest of the sector - 'lower and slower'?**

Additional innovations

What are we doing

- Operational changes;
  - Performance Task and Finish - #1 priority
  - Specialist paramedic urgent care resources – reducing conveyance
  - Increased dispatch resource
  - Clinicians triaging outside of NHS Pathways – reducing conveyance
  - Emergency Care Intensive Support Team (ECIST)
  - Managing police ambulance requests
  - Community paramedics
  - Falls teams
- System leadership – managing diverts

Adults Wellbeing and Health Overview and Scrutiny Committee

5 March 2020

Stroke Rehabilitation services in County Durham and Inpatient Rehabilitation services at Bishop Auckland Hospital (Ward 6)

Report of Corporate Management Team

John Hewitt, Corporate Director of Resources

Electoral division(s) affected:

Countywide

Purpose of the Report

1 To provide members of the Adults Wellbeing and Health Overview and Scrutiny Committee with information in respect of the future of Stroke Rehabilitation services in County Durham and Inpatient Rehabilitation services at Bishop Auckland Hospital (Ward 6) following cessation of the statutory consultations for both reviews.

Executive summary

2 The Adults Wellbeing and Health Overview and Scrutiny Committee has previously met on a number of occasions to consider proposals by North Durham CCG and Durham Dales, Easington and Sedgefield CCG in respect of the review of Stroke Rehabilitation services in County Durham and Darlington and the Review of Inpatient Rehabilitation services at Bishop Auckland Hospital (Ward 6).

3 At the Committee's meeting held on 6 September 2019, details of the future service models being consulted upon in respect of Stroke Rehabilitation services in County Durham and Darlington and the Review of Inpatient Rehabilitation services at Bishop Auckland Hospital (Ward 6) were considered alongside the consultation and communications plans for both reviews.

4 Notification was received from North Durham CCG, Durham Dales Easington and Sedgefield CCG and Darlington CCG on 31 January 2020 that " Due to unprecedented demand on inpatient hospital beds and taking into consideration patient, carer and stakeholder feedback

the NHS Clinical Commissioning Groups (CCGs) in County Durham and Darlington have decided to stop the consultations on stroke rehabilitation and ward 6 at Bishop Auckland Hospital (BAH) with immediate effect. NHS Durham Dales, Easington and Sedgefield CCG, NHS Darlington CCG and NHS North Durham CCG believe that the clinical proposals presented for both ward 6 and stroke rehabilitation are valid, however the current level of demand for inpatient beds has far exceeded expectations and this needs to be taken into account."

5 In view of the previous rationale for the proposed reviews, namely the below target performance against SSNAP Indicators for Stroke Patient services and also the inequity of community-based stroke rehabilitation services across County Durham, representatives of the CCGs have been invited to attend the Committee to explain how these issues will be addressed given the cessation of the previous reviews.

Recommendations

6 Members of the Adults Wellbeing and Health Overview and Scrutiny Committee are requested to receive this report and comment on the presentation by CCG representatives.

Background

Stroke Rehabilitation Services in County Durham and Darlington

7 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).

8 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%.

9 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.

10 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.

11 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.

12 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.

13 It was anticipated at the time that this work would be completed within 12 weeks and a report brought back to the Committee.

14 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.

15 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.

16 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.

17 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.

18 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.

19 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.

20 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.

21 A report and presentation considered at the Committee's meeting held on 6 September 2019 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.

Inpatient Rehabilitation services at Bishop Auckland Hospital (Ward 6)

22 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.

23 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 post discharge support.

24 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.

25 The RPIWs and staff consultation identified several 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

26 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.

27 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 attended the Committee's meeting on 6 September 2019 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.

Latest Position

28 The consultations in respect of both reviews commenced on Monday 7 October 2019.

29 In view of the relative impacts upon Durham and Darlington and their respective local authority sizes a joint OSC comprising 25 members (21 from Durham and 4 from Darlington) politically balanced at individual local authority level was established to oversee the consultations.

30 Notification was received from North Durham CCG, Durham Dales Easington and Sedgefield CCG and Darlington CCG on 31 January 2020 that " Due to unprecedented demand on inpatient hospital beds and taking into consideration patient, carer and stakeholder feedback the NHS Clinical Commissioning Groups (CCGs) in County Durham and Darlington have decided to stop the consultations on stroke rehabilitation and ward 6 at Bishop Auckland Hospital (BAH) with immediate effect. NHS Durham Dales, Easington and Sedgefield CCG, NHS Darlington CCG and NHS North Durham CCG believe that the clinical proposals presented for both ward 6 and stroke rehabilitation are valid, however the current level of demand for inpatient beds has far exceeded expectations and this needs to be taken into account." A copy of the stakeholder briefing published by the CCGs is attached to this report. (Appendix 2)

31 In view of the previous rationale for the proposed reviews, namely the below target performance against SSNAP Indicators for Stroke Patient services and also the inequity of community-based stroke rehabilitation services across County Durham, representatives of the CCGs have been invited to attend the Committee to explain how these issues will be addressed given the cessation of the previous reviews.

32 A copy of the presentation slides is attached to this report. (Appendix 3)

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, 18 January 2019 and 6 September 2019.

- Agenda minutes and reports of the County Durham and Darlington Joint Overview and Scrutiny Committee – 6 January 2020

Contact: Stephen Gwillym 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

Not applicable.

Equality and Diversity / Public Sector Equality Duty

Not applicable.

Human Rights

Not applicable

Climate Change

Not applicable

Crime and Disorder

Not applicable

Staffing

Not applicable

Accommodation

Not applicable

Risk

Not applicable

Procurement

Not applicable

STAKEHOLDER BRIEFING

Consultations stopped due to unprecedented demand on hospital services

Due to unprecedented demand on inpatient hospital beds and taking into consideration patient, carer and stakeholder feedback the NHS Clinical Commissioning Groups (CCGs) in County Durham and Darlington have decided to stop the consultations on stroke rehabilitation and ward 6 at Bishop Auckland Hospital (BAH) with immediate effect.

NHS Durham Dales, Easington and Sedgefield CCG, NHS Darlington CCG and NHS North Durham CCG believe that the clinical proposals presented for both ward 6 and stroke rehabilitation are valid, however the current level of demand for inpatient beds has far exceeded expectations and this needs to be taken into account.

As local leaders responsible for planning and buying healthcare for the local population, the CCGs have taken a number of different factors into consideration when reaching the decision to stop the consultations.

They, along with County Durham and Darlington NHS Foundation Trust remain committed to the long term future of Bishop Auckland Hospital.

The CCGs have also carried out further analysis of the complexity of patients' health conditions and given the unprecedented pressure faced across the health system during the winter have concluded that the proposed model of care is not deliverable at the moment.

Significant improvements are being made to the community element of the stroke pathway and there is an acknowledgement that additional therapy support is also required for hospital based stroke rehabilitation and ward 6.

This means that there will be dedicated therapy provision made for stroke services on both Bishop Auckland Hospital and University Hospital of North Durham (UHND) sites and additional resources will be made available on ward 6 to enhance the level of therapy for patients.

The consultations recently resumed following a pause just before Christmas due to the General Election.

The local NHS will continue to review services across County Durham and Darlington to ensure high quality services are available to all, whilst ensuring where possible care is delivered close to home.

The CCGs would like to thank everyone that has contributed to the public consultation to date and apologise for any inconvenience caused.

Background information about the consultations is available on the CCG websites:
www.durhamdaleseasingtonsedgefieldccg.nhs.uk
www.darlingtonccg.nhs.uk
www.northdurhamccg.nhs.uk

ENDS

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

Ward 6 and Stroke Rehabilitation Update

Adults Wellbeing and Health Overview and Scrutiny Committee

March 2020

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

Future provision – stroke

- Safe high quality services
- Home first philosophy – care closer to home
- Inpatient specialist stroke rehab to be delivered at BAH and UHND
- Improved therapy services – investment in acute and community
- Work to develop more seamless transitions
- Continue to review usage of the system

Future provision – ward 6

- 24 nurse-led beds
- Location to remain as is
- Improved therapy provision – additional investment
- Continue to ensure where possible people are cared for closer to home
- Continue to ensure appropriate use of inpatient resource
- Continue to do discharge planning - to start at the beginning of the patients inpatient pathway
- Health and social care will continue to work in an integrated way to avoid delayed discharges

NHS
North Durham
Clinical Commissioning Group

Shotley Bridge Community Hospital Services

Adults Wellbeing and Health Overview and Scrutiny Committee March 2020

Better health for the people of North Durham

Vision

- To develop a fit for purpose Integrated Care Centre
- Integrating across all health (PC, community, acute) social care, mental health and voluntary sectors
- Maintaining people's independence and preventing admission into hospital/supporting timely discharge
- Need clinical input into developing model

Principles

- Clinically led
- Ongoing patient and public engagement
- Reference group – local councillors and MPs
- Working across the County Durham system
- Future proofing model of care and estate solutions

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Model of Care

- Work ongoing to review current activity and predicted future demand
- New GP clinical lead facilitating series of clinical discussions across Primary, community and acute care as well as mental health services
- Key discussions include community inpatient bed models, urgent care, outpatient clinics, community based services

NHS
North Durham
Clinical Commissioning Group

Estates Update

- Estate infrastructure old and deteriorating
- Requires significant investment just to stand still
- Not suitable for modern healthcare delivery
- Almost three times too large for our current requirements

NHS
North Durham
Clinical Commissioning Group

Estates Update

- Full appraisal now being undertaken on a number of sites (including existing) using
  - Non Financial criteria (inc Speed of Delivery/ patient accessibility /functionality / flexibility)
  - Financial Assessment (in terms of affordability to local health economy and best value for NHS)
- Options currently under consideration
    - Upgrade existing estate
    - Genesis Site (speculative planning application granted)
    - Site off A692 (English Martyrs School)
    - Former Blackfyne School site
  - Discussions ongoing with Council and Developer to determine conditions and costs
-

Engagement and Consultation

NHS
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- Period of engagement took place 27 March - 22 May 2019

- Ongoing work with dedicated patient reference group and CCG groups and AAP

- Consultation due to start Sept 2020

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Key Milestones

- Outline Business case completed end of June 2020
- Internal approval – July and August 2020
- NHSE Assurance (service change process) ongoing
- Full business case completed Autumn 2021
- Construction to start early 2022
- Build completion 2023