DURHAM COUNTY COUNCIL

At a meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held remotely via Microsoft Teams on **Friday 5 February 2021 at 9.30 am**

Present

Councillor J Robinson (Chair)

Members of the Committee
Councillors J Chaplow, 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 and C Wilson

Co-opted Members
G Ciesielska, Mrs R Hassoon and Mr D Logan

Other Members
Councillor L Hovvels

Members and Officers observed one minute silence in memory of the 110,000 people in the United Kingdom who had sadly lost their lives to COVID-19.

1 Apologies

There were no apologies for absence.

2 Substitute Members

There were no substitute Members.

3 Minutes

The minutes of the meeting held on 9 November 2020 were confirmed as a correct record and would be signed by the Chair.

The Principal Overview and Scrutiny Officer advised Members that there had been some recent media announcements around the funding of the Shotley Bridge Community Hospital. Sarah Burns, Head of Integrated Commissioning, County

Durham Integrated Community Care Partnership was in attendance to provide members with an update on the funding.

Sarah Burns advised Members that this had been a long running project that had huge involvement from local members, the community, Clinical Commissioning Group (CCG) and local NHS Provider Trusts. The original proposals around the replacement for Shotley Bridge Hospital were developed in 2016. At that point they had £17.1 million in funding allocated to the project. Since 2016 the work on the hospital and the services that would be based at the hospital had being refreshed due to a period of engagement with the public and local clinicians.

The original model that was developed did not include inpatient beds and the proposals now included 16 inpatient beds which increased the costs of the project. There were a number of services that were planned to be in the facility that included inpatient beds, urgent treatment centre, chemotherapy and medical investigations unit, therapy provision, outpatient services, women and children services and a multi-use space for primary and community care services and hopefully non-medical services for use by people in the community.

Government had confirmed that the Shotley Bridge Hospital was going to be part of the Health Infrastructure Plan Programme (HIP), more information on this could be obtained on the department of health and social care site. Part of this programme there was a requirement for the building to be carbon neutral which increased the costs, it was an upfront investment that would benefit in future years the people that use the services and the provider that worked there in terms of having an energy efficient building.

Since 2016 engineering costs had increased and the cost of land and general inflation had contributed to the increased costs of the project. They were confident that the funding was secured, it was good to be part of the HIP project as they knew that funding was secured for the building and for the project to go ahead. They knew from their engagement work that they had the right services for the community, but this would be tested again at the end of February with a further period of engagement. They did not expect that this project would detract from any of the other services in County Durham, so this investment was not going to take away funding from other NHS services in other parts of the county.

The capital funding for the build was part of a separate allocation for the NHS and their core allocation for the delivery of services remained as it had been and were committed to the delivery of services from other community hospitals sites. They had seen how important these sites had been throughout the COVID outbreak to support continuity of care and significant work had been carried out to improve the services over the number of years and this would continue.

The Chair indicated that he had received representations from members who were not on the committee from the Consett and Shotley Bridge area. There had been

some concern about the future of Chester-Le-Street Community Hospital and other areas and the University Hospital of North Durham for the extra £10 million funding. They were concerned that this was a 50% increase in the funding and how the original costings were so wrong. He then asked why this was not brought to the Scrutiny meeting earlier and why were they not advised of the HIP Programme and this potential issue before it was announced in the media that it was going to cost £30 million and not the original £20 million.

Councillor Temple indicated that he was pleased with what was happening at Shotley Bridge Hospital, he hugely valued the facility in his community but would not want it to detract from any other areas of the county. He thought if they did not have the 16 inpatient beds and a facility that was fit for the 21st century it would have been a huge disappointment. From the point of view of his local community there was unalloyed satisfaction at what they were likely to have now.

The Head of Integrated Commissioning responded that in terms of costs these were their best estimate at the time and a number of things had changed, such as the model and the number of services in the hospital. The infrastructure of the building had changed that came with significant cost, the model had been influenced with engagement with the public and demonstrated that engagement worked. They were unsure if inpatient beds needed to be part of the model but there was a resounding yes from the public and clinicians that this was necessary and had influenced their decisions. They had new engineering requirements, increased land costs, inflation, and the requirements around the energy efficient model, all these things combined lead to the increase in the costs of the programme. She assured the committee that the capital funding stream for this building was completely separate from the NHS allocation to run services and they would not expect this to have any impact on any of the health services across the county.

The Chair commented that the 16 inpatient beds was consistent with other community hospitals and was wonderful that Shotley Bridge Hospital was going to be revitalised.

Gosia Ciesielska asked if they had procedures that would require them to resubmit the budget if was a certain percentage greater than the original budget.

The Head of Integrated Commissioning responded that the capital costs of the initiative were overseen by NHS England Improvement who would look at the project initiation document they had developed and business case for services and they would be assuring that they were in line with what they would expect for a development of this kind. In terms of the services that are delivered locally it was important for this committee to feel fully assured that they had engaged with the public and clinicians and they had fully understood the services that were required for the community in Shotley Bridge. She hoped that the ongoing work that had been done with the committee and the members and officers working group that

they had kept all fully involved and engaged at all points so everybody understood the rationale for the inclusion of services that they were including in the project.

The Principal Overview and Scrutiny Officer assured members that in terms of the latest development with Shotley Bridge Hospital there was further public engagement activity that was due to commence shortly. An item was also scheduled to come to the next meeting on the results and feedback from that engagement activity.

4 Declarations of Interest

There were no declarations of interest.

5 Any Items from Co-opted Members or Interested Parties

Rosemary Hassoon indicated that the patient reference group had been told that there would be no patient reference groups in the future due to staff having to work with frontline staff. The past year public involvement had been greatly reduced from one-month meetings to two months then the last meeting was cancelled. The Mental Health Strategic Partnership Board had not met for 15 months so they were concerned at what was happening now and plans for future public involvement.

Sarah Burns, Head of Integrated Commissioning responded that at this point in time many of the Clinical Commissioning Groups (CCGs) staff had to pause their regular work to enable them to support the vaccination programme and other essential work around COVID. This was not something that they took lightly but had to put their resource in areas of absolute need during an urgent crisis situation. They valued their engagement groups, it was purely a short-term issue of capacity while staff were redeployed and they had to prioritise for COVID response and they would expect those groups to be up and running again in the future and was an unfortunate consequence of the COVID situation.

Rosemary Hassoon responded that they were aware of the demise of the CCGs in April next year and asked what the plans for their future engagement were.

The Head of Integrated Commissioning responded that they were waiting for national guidance around Integrated Cares Systems (ICS) and there was an item on that subject on the agenda today and indicated that the group was extremely valuable to them. Engagement in Durham was never going to change and they would have strong place based working and engagement with patients and the public and stakeholders would always be part of those arrangements but they did now know the form that would take at the moment, it would exist but the how was to be determined.

6 Integrated Care Systems Update

The Committee received a report of the Interim Corporate Director of Resources that provided members with an update in respect of the recently published NHS England and NHS Improvement paper 'Integrating care – Next steps to building strong and effective integrated care systems across England' and associated calls for views on the options contained within the paper (for copy of report, see file of minutes).

The Principal Overview and Scrutiny Officer presented the report that set out the key issues within the consultation report and a response to the report prepared on behalf of the Committee and signed off by the Chair.

Councillor R Bell indicated that he was part of a sub-regional joint scrutiny committee that had been looking at this, but they were not informed about it. He was unhappy with the consultation and had just heard about patient reference groups being suspended due to lack of NHS capacity during the pandemic. However, on the 2 December 2020 in the middle of a pandemic running up to Christmas a five-week consultation was launched that he only found out about after the consultation had closed. He commented that the way this had been done given that they had regional scrutiny meetings going on years with very little progress was appalling and asked that this be conveyed. He was concerned about the abolition of the Clinical Commissioning Groups (CCGs) and what replaced them and how this would affect their relationship that they had built up over the years and were able to work closely together. Abolishing CCGs meant they lost the local focus and engagement and local influence.

The Principal Overview and Scrutiny Officer responded that he concurred with the sentiments expressed by Councillor Bell. In terms of the both regional joint ICS/ICPs there had been a similar response submitted as part of the consultation on behalf of both ICP Joint Overview and Scrutiny Committee that was managed by Gateshead Council and the "Southern STP" Joint OSC that Councillor Robinson chaired. A more generic response reflecting the views across all the participants of that joint overview and scrutiny had also been forwarded as part of the consultation process. The issue was well made around the potential risks to their already established working relationships with CCGs in County Durham and this was reflected in the submitted response. References were made to the fact that previously discussions had occurred around the potential for the two County Durham CCG organisations merging with Tees Valley CCGs. They made representations around the need to ensure that the CCG and commissioning arrangements needed to reflect the footprint of County Durham and the response made a similar plea as far as the future of CCGs were concerned. They referenced that proposals for a single CCG covering the region was a significant departure from the way that the ICS and ICP was being operated and they had long standing relationships with CCGs in other parts of central ICP. There was a history of excellent relationships and collaboration across CCGs and he shared Councillor

Bell's concern that was reflected in the response. The positive relationships were built up and they had a CCG that was commissioning and delivering services in County Durham for County Durham and ensure that this remained in Durham and services were continued to be delivered for the people of County Durham in an area that had historical health deprivation. They did have a commitment for the OCS leads to attend a future meeting to discuss the feedback of the consultation.

The Chair fully agreed with Councillor Bell and the Principal Overview and Scrutiny Officer and indicated that one of the advantages of the lockdown and virtual meetings was that you could record what people were saying and he had assurances that the Durham pound would remain in Durham. He was concerned at the ramifications for County Durham NHS Foundation Trust and the risks that it could be split into two between a North and South ICP.

Joseph Chandy, NHS County Durham CCG responded that he was presenting the item on the Primary Care Strategy which was the outgoing County Durham CCG's way of trying to demonstrate the continued investment that was needed for the Durham patients in primary care and was one of their methods to sustain that funding beyond the current CCG. If he and Dr Stuart O'Neill remained in the structure after the reorganisation they had all practised or practice or professionally work in Durham and had an attachment to Durham and that was partly the motivation they took up these leadership posts in Durham to improve the health and well-being of Durham patients. Assurances from Dr Findley and Dr O'Brien had been given that they would do everything to ensure that they could put into place their ambitions for the Durham residents. Going forward there was going to be a design piece of work and he knew Nicola Bailey was on that task group to look at what would be the new function and the form of the proposed new way of working from an ICS point of view. He envisaged that at the ICP level there would be something like an area team and the ICS footprint was the largest ICS in the country as the distance from local population was too remote to be meaningful. The place based agenda and infrastructure was likely to include Durham, Sunderland and South Tyneside as they did not want to go backwards on the integration work that had been done over the last few years in their respective areas bringing together health and care for the benefit of patients. The delegated authority for money and decisions for patients and residents they would have was yet to be determined.

The Chair indicated that this whole organisation was supposed to bring GPs and Primary Care into making decisions and this had been turned on its side.

The Corporate Director of Adults and Health Services echoed Mr Chandy's comments and as chief officers they were really determined that they wanted to continue with their approach to integration and to get the possible outcomes for local residents. Whilst there was some uncertainty their focus was very much on how they continued to strengthen integration locally.

Resolved: (i) That the contents of the report be noted.

(ii) That the response to the paper submitted on behalf of the committee by the Interim Director of Corporate Resources and Chair of the Adults Wellbeing and Health Overview and Scrutiny Committee be endorsed.

(iii) That a further report on Integrated Care Systems be included as part of the Adults Wellbeing and Health Overview and Scrutiny Committee's 2021/22 work programme.

7 Local Outbreak Management Plan Update

The Committee received a report of the Director of Public Health that provided Members with an update on the COVID-19 response and the updated COVID-19 Local Outbreak Control Plan (for copy of report, see file of minutes).

The Director of Public Health was in attendance to present the report and deliver a presentation that provided members with a summary of County Durham Cases; update on National Lockdown and Tier 4; update of the work of the Health Protection Assurance Board (HPAB) and the COVID-19 Vaccination Programme (for copy of presentation, see file of minutes).

The Director of Public Health explained that three development sessions had been held with elected members to explain the Durham Insight data dashboard for COVID-19 which was on the recommendation of Adults, Wellbeing and Health Overview and Scrutiny Committee that were helpful and had high attendance.

She updated Members on the County Durham 7-day rate that was currently 254.9 per 100,000 which was slightly lower than the England average and a reduction of 40.2 over the last week. There had been a rapid increase in rates up to and just beyond the Christmas period, the 29th and 30th December saw 500 cases per day in County Durham and again on the 4th January. Since then the rates had started to decrease and colleagues in the NHS County Durham Foundation Trust were starting to see the Hospital admissions reduce including intensive care. The rapid increase was also against the backdrop of the new variant stream and based on projections from the health protection team in Public Health England, they thought around 70% of local cases were the new variant strain.

The Director of Public Health reported that out of 27,500 eighty plus year olds across County Durham they had almost 100% uptake of the vaccination. In terms of priority groups, other priority groups including health and social care staff, the hospital hub had vaccinated over 20,000 staff. The vaccination centre was set up very rapidly at County Hall for frontline health and social care workers and had seen around 500 vaccinations per day. The aim was to have the full vaccination of all four of the first priority groups by the 15 February 2021, the limiting factor was

the supply as it was a push model. The mortality would reduce by 99% when all nine groups had been vaccinated.

The Chair on behalf of other members referred to the Minister for vaccinations indicating that the first four priority groups would be completed by next week and the next five by the end of March before they started looking at teachers and police and so on and asked how prepared were Durham to ensure that the remaining five priority groups hit this target. He then asked how Newcastle that had half the population of Durham had four mass vaccination centres and Darlington that had a fifth of the population of Durham had a mass vaccination when County Durham did not have a mass vaccination centre. He then indicated that 80-year olds and 90 years olds in some parts of the county were still waiting to have their vaccination whilst other parts of the County had had their second vaccination. This had raised concerns amongst the population.

The Director of Public Health responded in terms of those priority groups and the role out before the end of March then teachers and fire and that the second phase would consider other groups but was presently based on the clinical need which was predicated on age.

Michael Laing, Director of Integrated Community Services, County Durham Integrated Community Care Partnership responded to the concerns raised about rollout of the vaccination that was partly due to primary cares starting the vaccination at different times. Wave one was asked to mobilize at the end of November 2020 and started the week commencing the 14 December 2020. The second wave started on the 16 December 2020 and the third wave was due to start on the 21 December 2020, but government asked them to push this back until the beginning of January 2021. This resulted in different people getting the vaccine at different time scales. This was linked to GPs ability to have premises where people could socially distance and get staff in place to administer the vaccine and also to store the vaccine at that time in line with clinical guidance. In terms of the mass vaccination centre seven centres had been put forward but the regional organisation have decided that they would have a vaccination centre in Durham and were looking for premises that they could use for a year and the announcement was imminent that would open on the 15 February 2021. The Minister had asked them to start on primary groups five and six which they had expected and would start planning for that and primary care networks were set up to carry out those mass vaccination programmes and if they had a mass vaccination centre this would help. They also had the option of using the facility at County Hall that was mobilised very quickly.

Joseph Chandy, Director of Commissioning Strategy and Delivery indicated that he was leading the general practice delivery of the vaccination campaign and indicated that the sites that got off the ground before Christmas were also administering the second dose of the vaccine within three weeks of the first. It was part way through the programme that the government nationally changed the

guidance and extended to second vaccine to a 12-week gap. This resulted in the programmes that started later were able to quite quickly vaccinate more first dose patients while the original programmes were carrying out their second dose.

Councillor Jopling praised the vaccine rollout and indicated that she had received positive comments from her constituents. She referred to the lateral flow test and the publicity around this and how effective it was and how much they should rely on it and that it was being used quite widely. She asked if they had carried out any work to ascertain if the test was effective.

Councillor R Bell indicated that the rates were falling that was positive and if you looked at the interactive map they were all going in the right direction and the vaccine rollout was going well, he was also pleased to hear the Richardson Hospital was being utilised. His understanding of the lateral flow testing was that the benefit was to detect symptomless positive people. He then referred to the pilot carried out in Liverpool and asked what they had learnt from that pilot. It was not just test and trace as you needed to get people to isolate and that up to 40% of people contacted did not isolate. He asked how effective the mass testing on a lateral flow basis was going to be from the Liverpool experience.

Councillor L Brown wished to praise everyone involved in carrying out the vaccination rollout.

Councillor Reed echoed Councillors Brown and Jopling and wished to praise the NHS. She had been contacted by a number of constituents complimenting the staff at North House surgery in Crook who had indicated that it was very well organised and safety measures were adhered to and praised the staff. Her only negative was people from the Dales were having to travel to Crook for their vaccination and asked why this was the case. She then referred to funding and asked what types of vaccinations were being used and where they were manufactured and the associated costs, including the full cost of the programme.

The Director of Public Health responded in relation to the use of the lateral flow tests and indicated that they were using them as part of the overall programme of work. The test was particularly effective at detecting people who did not have any symptoms when they have a high viral load and was how they were aiming to use the tests locally. The work in the care home setting they were picking up on asymptomatic residents and staff. The targeted community programme that was the learning from Liverpool was a mass testing programme that mobilised test sites across Liverpool and what they found from that programme was that the people who were coming forward were the worried so it did not address inequalities and there was a high percentage of false positives. The local programme that they would be implementing builds on some learning from the university who had been using the lateral flow devices for their students when they returned home before Christmas. They were going to use the lateral flow and ensure they had a programme of tests and not just a one off, at both community sites and front-line

workforces and supporting those to self-isolate. They raised issues nationally when there was no self-isolation payment as they knew people weren't able to self-isolate, so they pushed for the payment. They would ensure in cases where people test positive both cases and contacts had access to information through the community hub. They know that there were some reservations with the lateral flow tests and were part of the overall programme and they would continue to evaluate.

The Director of Integrated Community Services indicated that he would pass on the Committee's comments to North House Surgery who were doing a tremendous job. He then referred to the manufacture of the vaccine and that Pfizer was made in Belgium, Oxford vaccine was initially being made in Germany and the Netherlands but was now manufactured in the UK and the new vaccines that were currently going through registration process the Novavax would be manufactured in Stockton. In terms of cost there was a payment and cost framework for GP practices, the Trust were currently running two hospital hub sites, one in County Hall that had vaccinated about four thousand people but they had not talked about money as the priority was to get people vaccinated and making sure those priority groups were vaccinated by the 15 February 2021 and then move on to groups five and six. A reconciliation of costs would be undertaken and there were funding streams from the government to do that.

Councillor Crathorne wished to echo the comments from her colleagues in the fantastic work the NHS were doing and the volunteers. She then asked about care homes and how fare advanced they were with the vaccination in care homes and were there any current outbreaks of COVID in care homes.

Councillor Henderson referred to a letter he had received from the NHS inviting him to ring 119 to arrange a vaccination. Someone he knew contacted 119 and were offered Morecombe, Leeds, Bradford, and Newcastle and indicated that Morecombe was some distance from Teasdale and current advice was that you should not leave the County and stay at home. He was concerned that these areas were offered and that some people would travel and asked if this could be stopped.

Councillor Savoury commented that she had received nothing but praise from the residents from Weardale who had to travel to Crook for their vaccination and asked why a site had not been set up in Weardale as they had a limited bus service for those who had to travel on the bus.

The Director of Commissioning Strategy and Delivery indicated that NHS England had specifically asked each primary care network area to nominate one site as the Pfizer vaccine which was all they had at that time logistically could not be delivered to every practice. The requirements around mixing and constituting of the vaccine and the 15 minute wait meant that they were unable to administer like a influenza programme as this would make it very challenging for general practice as they were running day to day general practice at the same time. Each primary network was asked to use their local knowledge of residence and travel and capability of

each of the practice sites. Sometimes a practice site was not the right place, and some had chosen community buildings and decided where that main site should be. North House was the chosen site and the Clinical Commissioning Group (CCG) took the decision to see if they could support transport and set aside money as a CCG to support transport and every patient who had been in contact with their GP surgery would have the option from their GP practice to be offered transport through the CCG transport booking service that was set up temporarily for this programme. With the introduction of the Oxford vaccine this gave the opportunity for primary care networks to rethink if they could deliver the vaccine closer to home from individual GP sites, there were still some inflexibilities as unlike the flu vaccination that got delivered to the surgery and put in the fridge, oxford vaccine under the national pharmacy guidance once if left the main vaccination site it had to be in someone's arm within 24 hours and the moving of the vaccination was quite complex so some primary care networks have had the capability of taking the oxford vaccine if they have had a delivery and moving it to local GP surgeries. He would feed back the comments in relation to the119 helpline but they have had patients who had been offered the Nightingale at Sunderland and Bishop Auckland, so he did not know what algorithm they were using.

The Director of Public Health indicated that they were still managing a very small number of outbreaks in care homes. All their existing measures they encouraged and supported within all their settings still needed to be in place until guidance changed.

Sarah Burns, Head of Integrated Commissioning referred to the vaccinations in care homes and indicated that as of Wednesday all care homes had been vaccinated except those that had a current outbreak. They would be making arrangements once the outbreak had passed to go into the care home to vaccinate residents. In terms of staff as at Wednesday they had vaccinated over 4200 care home staff that was just over 71% and there was a push to get the rest vaccinated. They had also provided information sharing sessions for staff if they were concerned about the virus.

The Director of Integrated Community Services gave assurances that housebound patients they were going out to households to vaccinate patients. So far community nursing staff had vaccinated around 2500 housebound patients from a list of 3600 and were working with GP practices so ensure that they did take the vaccine out to patients. They were aiming to have all housebound patients in the County vaccinated by the 15 February 2021, if not before.

Resolved: That the updated COVID-19 Local Outbreak Control Plan be noted.

8 Overview and Scrutiny Review of Suicide Rates and Mental Health and Wellbeing in County Durham - Update report on progress against recommendations

The Committee considered the report of the Director of Public Health that provided Members with an update on the eight recommendations made by the Adults, Wellbeing and Health Overview and Scrutiny Committee and highlighted mental health and wellbeing and suicide prevention activity delivered in County Durham during the COVID-19 response (for copy of report, see file of minutes).

Jane Sunter, Chair of the Suicide Prevention Alliance was in attendance to present the report. She assured members in terms of the eight recommendations that all were integrated into the suicide prevention alliance action plan and had now been completed or developed into further work.

Members were advised that the alliance had continued to meet throughout the pandemic and had a really good attendance and highlighted some of the successes and ongoing work.

Councillor Temple welcomed the report as a member of the scrutiny group that put the report together. He commented that there was a vast amount of work going on and that this was something that they could never take their eye off. He referred to the performance report in relation to localities and members knew what was happening locally and in his area suicide was particularly prevalent. He was worried about COVID and the different behaviours that went on in the community may result in. He commented that it was good to hear of the many varied things that were being done seeking to improve this but this committee would not be able to take its eye off this until R rates were much lower than currently.

Councillor Stephenson referred to a search she had recently being involved in where sadly the person had committed suicide that was tragic. She welcomed the materials in the report about where to sign post people and asked if these could be shared in a format that they could post on social media. The Principal Overview and Scrutiny Officer indicated that he would arrange for Members to receive a jpeg copy of the Mental Health and Emotional Support leaflet.

Gosia Ciesielska referred to prevention that was the key moving forward and people in her area before COVID were waiting three to six months to access mental health therapies. She asked if there was any data on the average wait time for these therapies and how they could approach better access to these services.

Councillor Jopling was pleased with all the work that was being undertaken and they were stepping up a lot to try and capture the people that were suffering from mental illness. She was worried about front line staff who were running on adrenaline and was concerned that when they started to slow down what

processes were in place when they realised what had happened to them and what they had seen would really affect them.

Councillor Crathorne indicated that in her area they had a local charity conference partnership who dealt with a lot of people with mental illness and asked if they fed into small charities to see how many people they were actually dealing with. A number of people go to their first local point which was often in their local village and if you fed into these charities then you would get a more local depth of what was happening in areas.

The Chair of the Suicide Prevention Alliance responded that there was a perception that there was a waiting list for mental health therapies, she did not have the data on how long the waiting lists were but this was being considered under the mental health community framework that was reviewing mental health services that were based within local communities. That framework also had money attached to it and was currently led by TEWV NHS Foundation Trust under a partnership arrangement to look at how they could better integrate more mental health services within local communities so that people were not having to wait. In terms of voluntary sectors, they did provide support and were networked as part of the mental health provider forum. The work of the County Durham Community Hub was also significant and a piece of work had been carried out where they used the HUB to respond to people phoning in who were distressed and COVID had accelerated a lot of this process and would be something that they would build on. Looking at the numbers and the deaths that occurred they take their data from the coroner and supported the family and the community. If they felt that they had trend, then they would reach out to the community to engage with them to provide wider support.

Michael Laing, Director of Integrated Community Services, County Durham Integrated Community Care Partnership reassured Councillor Jopling that from the Acute Trust point of view and community services staff they were aware of the emotional intensity as well as the physical effort that staff have put in on the wards and in community settings and had increased the psychological support available.

Sarah Burns, Head of Integrated Commissioning indicated that they had also worked with TEWV NHS Foundation Trust to develop a psychological support service for social care providers. In the event that there was an outbreak in a care home then the team would go in and support either at an individual or group level. In terms of connection with the voluntary sector the mental health disability partnership had invested in some roles to connect mental health services, NHS mental services with the voluntary sector working in mental health.

Resolved: That the contents of the report be noted.

9 NHS County Durham Clinical Commissioning Group - Development of a Primary Care Strategy for County Durham

The committee considered the report of the Director of Commissioning Strategy and Deliver – Primary Care, NHS County Durham Clinical Commissioning Group that presented the Draft County Durham Primary Care Commissioning and Investment Strategy 2020-22 before ratification was sought by the County Durham CCG Governing Body on 16 March 2021 (for copy of report, see file of minutes).

Joseph Chandy, Director of Commissioning Strategy and Delivery was attendance to present the report and deliver a presentation that set out their Vision; Key Achievements from the last Primary Care Strategy; Strategic Themes; Priorities; How they intended to deliver their priorities; Local Incentive Scheme; Investment; Measuring Success and Engagement Timeline (for copy of presentation, see file of minutes).

The Chair asked the Officer what the Committee could do to protect the Durham Pound. He also had a question from a Member who asked what the process was for patients who could not get a face-to-face appointment with their GP, was there any escalation processes in place.

Councillor R Bell thanked the Officer for the report and the reason why he was very defensive of the Clinical Commissioning Groups (CCGs) and the excellent work that they had done particularly in primary care that had been outlined in the presentation. He asked what the committee could do to ensure that the legacy bodies that closely resemble the CCGs and all the plans that they had for investment and protection of services going forward.

Councillor Crathorne agreed with Councillor R Bell and they should look at ways where they could move forward to try and protect what was currently in County Durham. She indicated with COVID doctors were under great pressures and patients could not access them as easily and asked if enough had been done to utilise pharmacies as an alternative to GPs to take the pressure off doctors.

The Director of Commissioning Strategy and Delivery responded with regard to face-to-face appointments and indicated that every practice in County Durham had moved to total triage where every patient request for a consultation was triaged. This was usually a one step process where the doctor or nurse practitioner triaged the patients need and treats at the same time. This wasn’t done in the past commonly but had proved from a clinical evidence point of view as effective as a face-to-face appointment. Clinically there were times where a GP needed to see the patient and was the clinical judgement of the clinician who was triaging to decide if they needed to be seen face-to-face. COVID screening was important but they did not want patients coming out of their home unnecessarily, the clinicians overriding factor was the need to see the patient on a face-to-face basis that overrides the COVID imperative so there should be no barriers. There were

demands placed by the COVID vaccination programme and a number of staff from GP practices were manning that vaccination programme that was putting pressure on GP practices but this should not be a determining factor for determining whether a face-to-face appointment was required over and above the first telephone triage appointment. If a patient found that they did require a face-to-face appointment and they did not agree with the clinical decision to be treated remotely they should take this up with the practice manager in the first instance.

In terms of what the Committee could do to support the Durham Pound lobbying through the transition process. There were a number of officers attending today who would join him and had an input into shaping the arrangements that were going to come forward. A lot of the decision making would be done nationally or at ICS level but these plans would be brought forward and shared with the committee on how they believed place based arrangements should work for patients including financial and decision making and budget setting. He would ask the committee to look through those plans and give it the appropriate scrutiny and stand by them in fighting for what they believe was best for patients.

With regard to pharmacies, pre COVID they were working hand in hand with pharmacies promoting patients receiving care from pharmacies and all pharmacies with exception developed consulting rooms and that may have been pushed back due to COVID as the footfall into pharmacies had reduced. In addition, if GPs felt under pressure there were a number of staff attached to a collective of GP practices called the primary care network that they did not have before.

Councillor Crathorne referred to the private consultation rooms in pharmacies and the wait was deterring people, so could an appointment system be introduced that could be advertised through the NHS.

Councillor Huntington referred to bringing all the health services into the local communities and she remembered going around factories organising basic health checks and these people had not sought help before and it was wonderful to see how far the health service had come on. She shared some of the concerns that had been expressed and would hate to think they had lost all the work that they had achieved.

Michael Laing, Director of Integrated Community Services, responded that there were three things that the committee could do to support the officers to protect health funding and decision making. The first was to give advice on integrating more closely health and social care in the county. They were part way down the journey and there was still much more to do that included acute services that were currently delivered in the hospital that could be delivered closer to home in the community. The second was to exercise scrutiny on any changes to local partnership arrangements that they would bring forward and would strengthen those partnership arrangements so that it inspired confidence in the regional bodies to delegate finance and decision making to them. The third was have a

consistent message to the region and to the NHS nationally so that there was a consistent message coming out from this committee, Health and Wellbeing Board, Trust Executive Board and the CCG that had a tremendous track record in County Durham with integrated working that needed to be preserved and built on and not dispensed with and that they were more than capable of manging their own affairs and making decisions and spending money together and had done for the past five years. If this message was consistently given this would be a tremendous advantage in making sure this committee got what it thinks was right for the people of the county. He advised that he would take up Councillor Crathorne's point in relation to pharmacies with Joseph Chandy outside of the meeting.

The Principal Overview and Scrutiny Officer indicated that it was important that the committee's views were fed back to the primary care commissioning committee when they meet to formally agree the strategy. On behalf of the committee if members were agreeable he would formally respond to the strategy and send a letter on behalf of the committee into that primary care commissioning committee expressing the views of the committee and the support for the excellent integrated work being achieved in County Durham in partnership with the CCG with providers with the County Council and the community and voluntary sector.

Resolved: (i) That the report be noted.

(ii) That a formal response be sent to the Primary Care Commissioning Committee expressing the views of the Committee.

10 Quarter 2 2020/21 Performance Management Report

The committee considered a report of the Interim Corporate Director of Resources presented by Angela Harrington, Strategy Team Leader, which detailed progress towards achieving the key outcomes of the council's corporate performance framework (for copy see file of minutes).

The performance report was structured around the three externally focused results-based ambitions of the County Durham Vision 2035 alongside a fourth 'excellent council' theme contained within the Council Plan. It also included an overview of the impact of COVID-19 on council services, staff, and residents.

Resolved: That the report be noted.

11 Adult and Health Services - Quarter Two Forecast of Revenue and Capital Outturn 2020/21

The Committee considered a report and presentation of the Corporate Director of Resources, presented by Andrew Gilmore, Finance Manager for Adult and Health Services, which provided details of the quarter two forecast outturn budget position for the Adult and Health Service grouping, highlighting major variances in

comparison with the budget for the year, based on the position to the end of September 2020 (for copy of report and presentation, see file of minutes).

The Finance Manager explained that Durham County Council had received a headline grant of over £40 million in respect of COVID-19 cost pressures. There were also various other recovery related funding streams made available to the council. Approximately £22 million of the headline grant had been allocated to support pressures withing the NHS budget. Overall expenditure was significantly higher than the original budget, however, the overall position was a cash limit underbudget of over £3 million after utilising the additional government funding.

Within the £22 million of COVID related cost pressures £19 million was to provide support to adult social care providers. Other corporate pressures included £2 million for PPE and some additional staffing and double running costs. The position also included over £5 million under budget directly attributed to the pandemic for things such as £400,000 in respect of reduced transport cost, reduction of over £4 million relating to activity in care homes and a contribution from County Durham CCG towards adult social care provider support.

The Finance Manager also provided details of the AHS Revenue Budget that had a projected under budget of £3.198 million. He also provided details of the five main areas of financial support provided to adult social care providers. Members were advised that there were no specific AHS capital programmes at present.

Councillor R Bell referred to the 10% additional uplift fee related to the occupancy levels of care homes and asked for data on what the occupancy levels of care homes and if there were any issues on the viability of care homes going forward.

The Finance Manager responded that they were seeing less than usual activity in care homes. In terms of the sustainability payments due to reduced occupancy, they were continuing for a number of homes. There was an additional uplift that was linked to 10% of fees which stopped on the 31 October 2020, but they were considering additional support in the short-term.

Resolved: That the report be noted.

12 Any Other Business

The Chair on behalf of all County Councillors passed on his most sincere thanks to all the NHS staff, they appreciated all the work they were doing and were behind them with any support needed.