Adults, Wellbeing and Health Overview and Scrutiny Committee

Date	**Wednesday 3 July 2013**
Time	**9.30 am**
Venue	**Committee Room 2, County Hall, Durham**

Business

Part A

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

1. Apologies for Absence

2. Substitute Members

3. Minutes of the Meetings held on 28 January and 15 April 2013 (Pages 1 - 14)

4. Minutes, for information, of the Special Joint Meeting of the Safer and Stronger Communities, Adults Wellbeing and Health and Children and Young People's Overview and Scrutiny Committees held on 29 January 2013 (Pages 15 - 20)

5. Declarations of Interest

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

7. NHS England: Durham Darlington and Tees Area Team - Report of Assistant Chief Executive and Presentation by Ben Clark, Assistant Director Clinical Strategy, NHS England - Durham Darlington and Tees Area Team (Pages 21 - 24)

8. Securing Quality in Health Services - Joint Report of Assistant Chief Executive and Rosemary Granger, Project Director, Securing Quality in Health Services, Darlington Clinical Commissioning Group (Pages 25 - 34)

9. Reconfiguration of Emergency Medical and Critical Care Services at North Tees and Hartlepool NHS Foundation Trust - Report of Assistant Chief Executive (Pages 35 - 102)

10. NHS Quality Accounts 2012/13 - Report of Assistant Chief Executive (Pages 103 - 108)

11. Quarter 4 2012/13 Performance Management Report - Report of Assistant Chief Executive, Presented by Peter Appleton, Head of Planning and Service Strategy, Children and Adults Services (Pages 109 - 126)

12. Council Plan 2013/2017 - Refresh of Work Programme for Adults Wellbeing and Health Overview and Scrutiny Committee - Report of Assistant Chief Executive (Pages 127 - 136)

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

Colette Longbottom
Head of Legal and Democratic Services

County Hall
Durham
25 June 2013

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

Councillor R Todd (Chairman)
Councillor J Chaplow (Vice-Chairman)

Councillors J Armstrong, R Bell, A Bonner, P Brookes, J Charlton, P Crathorne, S Forster, O Gunn, D Hall, K Hopper, E Huntington, P Lawton, H Liddle, O Milburn, L Pounder, A Savory, W Stelling, P Stradling and O Temple

Co-opted Members:

Mrs B Carr, Mrs H Gibbon, Mrs R Hassoon and Mrs M Thompson

Contact: Ian Croft **Tel: 03000 269702**

DURHAM COUNTY COUNCIL

ADULTS, WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

At a Meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in Committee Room 2, County Hall, Durham on **Monday 28 January 2013 at 10.00 am**

Present:

Councillor R Todd (Chair)

Members of the Committee:
Councillors J Chaplow, J Armstrong, J Bailey, R Crute, P Gittins, E Huntington, A Savory, P Stradling and O Temple

Co-opted Members:
Mrs B Carr and Mrs M Thompson

Also Present:
Councillors L Hovvels and M Nicholls

Apologies:
Apologies for absence were received from Councillors R Bell, P Brookes, D Burn, T Taylor, A Wright, Mrs H Gibbon and Mrs R Hassoon

Prior to the commencement of the meeting the Chairman welcomed Mandy Thompson as a new co-optee onto the Committee, and welcomed colleagues from both Hartlepool Borough Council and Darlington Borough Councils.

1 Apologies for Absence

Apologies for absence were received from Councillors R Bell, P Brookes, D Burn and T Taylor and Mrs H Gibbon and Mrs R Hassoon.

2 Substitute Members

There were no substitute Members in attendance.

3 Minutes

The Minutes of the meeting held on 26 November 2012 were confirmed as a correct record and signed by the Chairman.

Matters Arising

Quality Legacy Project
The Principal Overview and Scrutiny Officer informed the Committee it was anticipated that the Quality Legacy Project document would be presented to a future meeting of the Committee.

Children's Congenital Heart Services
The Chairman informed the Committee that a Motion which supported the Committee's previous position on this matter had been unanimously endorsed by County Council at its meeting on 5 December 2012.

Momentum Project/North Tees and Hartlepool NHS Foundation Trust Service Developments and Pathway Development
Councillor Crute referred to consultation with the Committee on proposals from North Tees and Hartlepool NHS Foundation Trust mentioned under Minute 5 and asked what consultation/engagement would mean and how far the Committee could influence decisions made by the Trust. The Overview and Scrutiny Manager replied that the Chief Executive of the North Tees and Hartlepool NHS Foundation Trust had attended the last meeting of the Committee to provide members with an update of developments and proposals. This was a long standing agenda item for the Committee to assure Members that there was direct engagement with the Trust and Commissioners. Under the Health and Social Care Act there was a clear role for Scrutiny to respond to any proposals and it was essential that engagement took place with local Members to ensure that the views of local communities were heard.

One Life Hartlepool
Councillor Stradling referred to the One Life Hartlepool survey undertaken 6 August and the information requested at the meeting on 26 November which he had not yet received. The Principal Overview and Scrutiny Officer agreed to follow this up.

4 Declarations of Interest

There were no declarations of interest.

5 Items from Co-opted Members or Interested Parties

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

6 Media Relations

The Principal Overview and Scrutiny Officer showed examples of press articles relation to Adults, Wellbeing and Health which related to:

- A positive assessment by the NHS Commissioning Board for the Durham Dales, Easington and Sedgefield Clinical Commissioning Group.
- Public health concerns in the region.

- A £1.5m Government investment to improve and upgrade maternity units, to be shared by seven hospital trusts in the North.
- The Joint Health and Wellbeing Strategy, which had been approved by Cabinet and was a key document for the work programme of the Committee.
- The first meeting of the North Durham Clinical Commissioning Council of Members.
- Reports of ward closures at the University Hospital of Hartlepool and response from North Tees and Hartlepool NHS Trust. A presentation on Service Transformation was to be considered under agenda Item No 8.

7 Review of Childrens Therapy Services

The Committee considered a report of the Assistant Chief Executive which provided details of proposals by NHS County Durham and Darlington to review Children's Therapy services across County Durham and Darlington (for copy see file of Minutes) and received an update from Mary Bewley and Phil Wray of NHS County Durham and Darlington.

Mary Bewley reminded the Committee that she had reported to its meeting held on 26 November 2012 that a re procurement exercise was being undertaken for speech and language therapy and occupational therapy services to ensure consistency, quality and access was improved. This report outlined the background to the re procurement exercise and provided details of feedback received from service users.

Phil Wray informed the Committee that it was proposed to decommission and re commission the Speech and Language Therapy and Occupational Therapy service providers in line with the findings of the review which had been undertaken.

Councillor Newell, Chair of Darlington Borough Council's Health and partnerships Committee, informed the Committee that concerns had been expressed at service delivery, poor communications and waiting lists, and therefore there was support for the review of the services. Officers at Darlington Borough Council were in support of the proposals arising from the review.

The Chairman informed the Committee that a substantial proportion of key stakeholders, at 91.7%, were also in favour of the proposals.

Resolved:

(i) That the information contained within the report regarding the proposed review of Children's Therapy Services be noted;

(ii) That, in conjunction with Darlington Borough Council's Health and Partnerships Scrutiny Committee, comment be provided to NHS County Durham and Darlington in respect of the proposed review of Children's Therapy Services;

(iii) It be requested that as part of the associated stakeholder engagement process around the service changes, the respective Overview and Scrutiny Committees receive and comment on the proposed service specification documents in respect of the re-commissioning proposals.

8 North Tees and Hartlepool NHS Foundation Trust - Service Transformation

The Committee considered a report of the Assistant Chief Executive and received a presentation from Julie Gillon, Chief Operations Officer/Deputy Chief Executive, North Tees and Hartlepool NHS Foundation Trust, regarding the Trust's service transformation plans (for copy of report and slides see file of Minutes).

The presentation included the following areas of the service transformation plans:

- The key drivers for change
- The strategic aim of the Foundation Trust
- The philosophy and key elements of Momentum
- The transformation of services
- Details of the Primary and Community Planning Project
- An update on the proposed new hospital at Wynyard, including the strategy for the hospital and contextual timescales and progress.
- The Clinical Services Strategy
- Community Renaissance
- The Clinical Case for Change
- The Quality Legacy Document

The Chairman thanked the Chief Operations Officer/Deputy Chief Executive for the presentation and stressed the need for early consultation with the Committee when changes were being considered by the Foundation Trust.

Mr J Chandy, Director of Performance and Information, Durham Dales, Easington and Sedgefield Clinical Commissioning Group stated that the general public in South and East Durham were becoming more aware of NHS changes and stressed the importance of good communication to ensure that key messages were provided around what services were being delivered at the various NHS facilities, particularly Peterlee and Sedgefield Community Hospitals.

Resolved:
That the report and presentation be noted.

9 Tees, Esk and Wear Valley NHS Foundation Trust - Dementia Inpatient Services in Hartlepool

The Committee considered a report of Paul Newton, Director of Operations, Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust which provided details of proposals by the Trust to change the way inpatient services were provided to older people with an organic illness (dementia) (for copy see file of Minutes).

The Chairman and Councillor Crute both referred to the increased travel distance for some service users which would occur as a result of the proposals and asked what support would be provided to these users. The Director of Operations replied that financial assistance would be provided. The impact of the changes would be monitored and a report would be brought back to Committee six months following the introduction of the change.

Resolved:

(i) That the proposed service change be supported

(ii) That, six months after the introduction of the change, the Trust update the Committee on the impact of the change on patients and their carers.

10 Quarter 2 Performance Management Report

The Committee considered a report of the Assistant Chief Executive which presented progress against the council's corporate basket of performance indicators for the Altogether Healthier theme and reported other significant performance issues for the second quarter of 2012/13 (for copy see file of Minutes).

Councillor Temple was pleased to note the improvement in the prevalence of breastfeeding and asked whether any progress had been made regarding funding issues at a breastfeeding café in Derwentside. The Head of Planning and Service Strategy, Children and Adults Services replied that he would provide Councillor Temple with an update on this after the meeting.

Resolved:
That the report be noted.

11 Forecast of Revenue Outturn Quarter 2, 2012/13

The Committee considered a report of the Finance Manager which provided details for the former Adults, Wellbeing and Health service grouping which highlighted material variances between the approved revenue and capital budgets and outturn, based on the position at the end of September 2012 (for copy see file of Minutes).

Resolved:
That the report be noted.

12 NHS Reforms and the Transfer of Public Health functions to Durham County Council

The Committee considered a joint report of the Assistant Chief Executive, Corporate Director of Children and Adults Services and Director of Public Health County Durham which provided an update on recent developments in relation to NHS reforms, including the transfer of public health functions to Durham County Council from NHS County Durham (for copy see file of minutes).

The Chairman informed the Committee that this was one of a series of reports being brought to Committee and that further update reports would be presented to future Committees.

The Principal Overview and Scrutiny Officer informed the Committee that Dr Mike Guy of the Durham, Darlington and Tees Local Area Team (LAT) would be attending the next meeting of the Committee to discuss the development of relationships with the LAT.

Resolved:
That the report be noted and a further report regarding NHS reforms, including public health, be brought to the next meeting of the Committee.

13 Joint Children and Young Peoples' Overview and Scrutiny Committee and Adult Wellbeing and Health Overview and Scrutiny Committee Review

The Overview and Scrutiny Manager provided the Committee with an update of the joint Children and Young People's Overview and Scrutiny Committee and Adults Wellbeing and Health Overview and Scrutiny Committee review of Support for Young People with Mental Health Issues.

The findings of the review would be reported to Cabinet in March, and an executive summary would be circulated to Members in due course.

The Chairman of the meeting was of the opinion that the following item of business was of sufficient urgency to warrant consideration because of the need to keep Members updated on developments regarding GP practices in the Horden area.

14 GP Practices in Horden

The Committee received an update from Joseph Chandy, in his capacity as Practice Manager at The Shinwell Centre, Horden, regarding GP practices in the Horden area.

Mr Chandy informed the Committee that there were currently 3 GP practices in the Horden area, but that discussions which had taken place some three years ago had deemed that the premises of two of these were not fit for purpose. The premises of the third practice were good, but becoming rapidly outdated.

A business case for new premises had been submitted two years ago but was rejected because of financial constraints. The PCT had now approached all three GP practices informing them that it would consider a business case for extending one of the current premises to accommodate all three practices. All three practices would continue to operate independently from within the same building.

Consultation on the proposals had been carried out as follows:

- 8,000 leaflets had been distributed
- Three public consultation events had been held
- With local pharmacies, the Parish Council and the Area Acton Partnership (AAP)

Some concern had been expressed by patients about receiving services from a different site, but generally the feedback on the proposal had been positive. Pharmacies in the

area agreed with the rationale of the proposal and both the Parish Council and AAP were in support of the proposal.

Mr Chamdy informed the Committee that a letter which explained details of the proposal, including the rationale and business case, would be sent to the Local Authority.

Councillor Stradling stressed the need for community consultation and community support when such proposals were made, and asked to be provided with further information regarding the community consultation which had been carried out.

Resolved:
That the update be noted and further updates be brought to future meetings of the Committee.

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DURHAM COUNTY COUNCIL

ADULTS, WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

At a Meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in Committee Room 2, County Hall, Durham on **Monday 15 April 2013 at 10.00 am**

Present:

Councillor R Todd (Chair)

Members of the Committee:
Councillors J Alvery, J Armstrong and O Temple.

Co-opted Members:
B Carr, H Gibbon and R Hassoon

Also Present:
Councillors L Hovvels, B Myers and M Nicholls

The Chairman informed the Committee that the meeting was not quorate and that any item of business which was not for information would be considered at the next meeting.

1 Apologies for Absence

Apologies for absence were received from Councillors R Bell, P Brookes, D Burn, R Crute, A Savory, W Stelling, P Stradling, T Taylor and Mrs M Thompson.

2 Substitute Members

There were no substitute Members in attendance.

3 Minutes

The Chairman informed the Committee that because the meeting was not quorate the Minutes of the meeting held on 28 January 2013 could not be approved and would be brought to the next meeting of the Committee.

Matters Arising

The Principal Overview and Scrutiny Officer provided the Committee with an update on the following items from the last meeting:

- Minute No. 7 – Review of Children's Therapy Services - a joint response from the Committee and Darlington Borough Council's Health and Partnerships Scrutiny Committee had been provided to NHS County Durham and Darlington to confirm support for the re-commissioning of Children's Therapy Services.
- Minute No. 14 – GP Practices in Horden - details of the community consultation which had been carried out regarding the proposed merger of three GP Practices in the Horden area was awaited.

4 Minutes

The Committee noted the Minutes of the Special Joint meeting of the Safer and Stronger Communities, Adults, Wellbeing and Health and Children and Young People's Overview and Scrutiny Committee held on 29 January 2013.

5 Declarations of Interest

There were no declarations of interest submitted.

6 Items from Co-opted Members or Interested Parties

Mrs Hassoon requested an update on the establishment of Healthwatch in County Durham.

Denise Elliott, Strategic Commissioning Manager Lead, Adults, Wellbeing and Health informed the Committee that the contract for Healthwatch in County Durham had been awarded to the Carers Federation with effect from 1 April 2013. The current position regarding Healthwatch County Durham was as follows:

- Healthwatch was meeting with Commissioners on a weekly basis to take forward a work programme
- The majority of staff posts had been filled with the exception of one post which was subject to further discussions with the Carers Federation.
- Adverts would be placed for the posts of Chair and Executive Board Members.
- Discussions were taking place with the Enter and View Committee of LiNK to ensure it was willing to continue in this function. However, national guidance on the role of the Committee was awaited.
- Healthwatch had its own branding and the first Healthwatch newsletter had been produced last Friday.

The Strategic Commissioning Manager Lead informed the Committee that there had been a delay around the remit of Healthwatch regarding the signposting element of the Patient Advice Liaison Service (PALS) and further clarity on this was needed.

Mrs Carr informed the Committee that she had recently attended a conference at Leeds at which concerns had been raised around the social

enterprise aspect of Healthwatch, its sustainability and whether it would need to fundraise.

The Overview and Scrutiny Manager informed the Committee that it had received regular updates on NHS reforms and that a Healthwatch representative would be a member of the Health and Wellbeing Board, with discussions ongoing to ensure a Healthwatch representative would be a Co-optee on this Committee.

7 Annual Report of the Director of Public Health, County Durham and Director of Public Health, Darlington 2012/12

The Committee noted a report of the Director of Public Health County Durham which presented the joint 2011/12 annual report of the Director of Public Health, County Durham and the Director of Public Health, Darlington (for copy see file of Minutes). The Director of Public Health informed the Committee that a full copy of the report was available in the Members Library.

The Director of Public Health County Durham informed the Committee that this would be the final joint report of the Directors of Public Health for County Durham and Darlington as both Council's now had their own Directors.

The report captured progress made since 2006 and identified further work and challenges. It was a statutory requirement to produce the report and a duty to publish the report under the Health and Social Care Act 2012.

The Director of Public Health County Durham highlighted the areas of the report which related specifically to alcohol issues, poor nutrition and poor health, tobacco, levels of obesity and rates of cardio vascular disease and cancer.

The Chairman thanked the Director of Public Health County Durham for her presentation which had highlighted the major health issues which faced County Durham, subject to resources being made available. The issues mentioned in the presentation would feature in the Work Programme of the Committee.

8 NHS Reforms and the Transfer of Public Health Functions to Durham County Council

The Committee noted a joint report of the Assistant Chief Executive, Corporate Director of Children and Adults Services and the Director of Public Health County Durham which provided an update on developments in relation to NHS reforms, including the transfer of public health functions to Durham County Council from NHS County Durham (for copy see file of Minutes).

9 NHS Foundation Trust 2012/13 Quality Accounts

The Committee noted a report of the Assistant Chief Executive (for copy see file of Minutes) which reported the process for the preparation of the 2012/13 Quality Accounts for the following:

- County Durham and Darlington NHS Foundation Trust
- Tees, Esk and Wear Valley NHS Foundation Trust
- North East Ambulance Service NHS Foundation Trust

The Principal Overview and Scrutiny Officer informed the Committee that due to the County Council elections being held on 2 May 2013 and Committee Members not being appointed until the the Annual County Council Meeting on 2 May 2013 comments would be drafted on behalf of the Committee.

The comments, which would include areas of work the Committee had been engaged in, would be developed into formal responses to the Quality Accounts. These comments would be signed off by the Chairman of the Committee, once appointed, and reported retrospectively to the next meeting of the Committee in July 2013.

The Committee commented that, due to the imminent County Council elections, this was a reasonable solution to the Committee commenting on the Quality Accounts.

10 Quarter 3 2012/13 Performance Management Report

The Committee noted a report of the Assitant Chief Executive which presented progress against the Council's corporate basket of performance indicators for the Altogether Healthier theme and reported other significant performance issues for the third quarter of 2012/13 (for copy see file of Minutes).

11 Quarter 3 Revenue and Capital Outturn 2012/13

The Committee noted a report of, and received a presentation from, the Finance Manager, Resources which provided details of the forecast outturn position for the former Adults, Wellbeing and Health service grouping and highlighted material variances between the approved revenue and capital budgets and outturn, based on the position at the end of December 2012 (for copy of report and slides see file of Minutes).

12 Local Authority Health Scrutiny – Proposed Changes to the Council's Constitution

The Committee noted a report of the Assistant Chief Executive which advised Members of changes to the Constitution of the Council relating to local authority health scrutiny which were agreed at the County Council Meeting held on 20 March 2013 (for copy see file of Minutes).

13 Refresh of the Work Programme for the Adults, Wellbeing and Health Overview and Scrutiny Committee

The Committee noted a report of the Assistant Chief Executive which provided Members with information contained within the Council Plan 2013 – 2017 relevant to the work of the Committee which provided the opportunity for Members to refresh the Committee Work Programme to reflect the three objectives and subsequent actions identified within the Council Plan for the Council's 'Altogether Healthier' priority theme (for copy see file on Minutes).

The Principal Overview and Scrutiny Officer informed the Committee that a draft Work Programme would be presented to its meeting in July. Prior to the July meeting, induction sessions would be held for all newly appointed Members to Overview and Scrutiny Committees, and within these sessions Members would be invited to comment on the Work Programmes for all Overview and Scrutiny Committees.

Councillor Armstrong commented that this was a reasonable action for the development of the Work Programme, but added that it was important to ensure there was sufficient capacity within the Scrutiny Team to deliver on any agreed Programme.

The Chairman informed the Committee that this was the last meeting of the Committee before the County Council elections in May 2013 and thanked all Members and Co-optees who had taken part in the Committee for their participation, and Overview and Scrutiny Officers for their support. He also thanked the Overview and Scrutiny Manager, who was due to retire, for his support to, and assistance with, the work of the Committee.

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DURHAM COUNTY COUNCIL

JOINT MEETING OF THE SAFER AND STRONGER COMMUNITIES OVERVIEW AND SCRUTINY COMMITTEES

At a Joint Meeting of **Safer and Stronger Communities Overview and Scrutiny Committees** held in **Council Chamber, County Hall, Durham** on **Tuesday 29 January 2013** at **10.00 am**

Present:

Councillor D Boyes (Chairman)

Members of the Committee:
Councillors M Hodgson, J Armstrong, B Bainbridge, D Bowman, D Brown, J Nicholson, J Turnbull, J Blakey, P Brookes, B Harrison, G Huntington, S Iveson, J Lethbridge, C Potts, R Todd, P Jopling and M Williams

Co-opted Members:
Mr A J Cooke, Ms M English, Mr M Iveson and Mr T Thompson

Also Present:
Councillors P Jopling and M Williams and Ms M Chappell

1 Apologies for Absence

Apologies for absence were received from Councillors B Arthur, R Bell, D Burn, M Campbell, R Crooks, K Holroyd, C Magee, J Maslin, B Myers, A Savory, J Shiell, M Simmons, T Taylor, J Wilkinson, B Wilson and A Wright and Mrs B Carr, Mrs H Gibbon, Mrs R Hassoon, Mr R Patel and Mrs M Thompson.

2 Substitute Members

No notification of Substitute Members had been received.

3 Declarations of Interest

There were no Declarations of Interest.

4 Items from Co-opted Members or Interested Parties

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

5 A Consultation on Delivering the Government's Policies to cut Alcohol Fuelled Crime and Anti-Social Behaviour

The Chair thanked Members of the Adults, Wellbeing and Health, Children and Young People's and Safer and Stronger Communities Overview and Scrutiny Committees for their attendance at this Special Joint Meeting that was to consider the Consultation on Delivering the Government's Policies to cut Alcohol Fuelled Crime and Anti-Social Behaviour (ASB).

The Joint Committee was introduced to the Officers and colleagues from Partner Organisations that would be presenting and facilitating during the meeting:

Feisal Jassat	-	Overview and Scrutiny Manager, Durham County Council (DCC)
Jonathan Slee	-	Overview and Scrutiny Officer, DCC
Owen Cleugh	-	Consumer Protection Manager, DCC
Chief Superintendent Ivan Wood	-	Durham Constabulary
Claire Sullivan	-	Consultant in Public Health, NHS County Durham and Darlington
Colin Shevills	-	Director, Balance
Kirsty Wilkinson	-	Alcohol Harm Reduction Coordinator, DCC
Carol Payne	-	Head of Early Intervention and Partnerships, DCC
Anna Lynch	-	Director of Public Health, NHS County Durham and Darlington

The Director, Balance, Colin Shevills thanked Members for the opportunity to speak and gave a presentation on the National Alcohol Strategy Consultation (for copy see file of minutes).

Councillors noted effect that cheap alcohol made in terms of the impact on the health and economy of County Durham and issues that were driving the problem included not only price, but also availability and marketing by the alcohol industry. Members noted evidence from the World Health Organisation (WHO) as regards Health Services' responses; Community Action; Drink Driving Policies and Countermeasures; Reducing negative consequences; Reducing public health impact of illicit alcohol; and Monitoring and surveillance. The Director, Balance noted that the Government's National Alcohol Strategy Consultation included issues of a Minimum Unit Price (MUP) for alcohol; a ban on multi-buy promotions; Public Health being set as a Licensing Objective; cutting red tape; and reviewing the Code on irresponsible promotions in pubs and clubs.

The Joint Committee learned that the issue of MUP was generally supported by Publicans, with the effect of a 50p MUP being such that a pint of larger or bottle of wine would not see a rise in price, however, a bottle of "own-label" vodka would increase from £8.29 to £13.00 and a 2 litre bottle of cider would increase from £1.85 to £7.50. It was added that other organisations that supported MUP included the British Medical Association (BMA), General Practitioners (GPs), the National Institute for Clinical Excellence (NICE), the Police, the Association of North East Councils (ANEC) - Mayors' and Leaders' Group and the Campaign for Real Ale (CAMRA).
Members noted that 57% of the public in County Durham supported MUP and that the establishment of a MUP in Canada had led to a 20% fall in alcohol related deaths and 9% fall in alcohol related hospital admissions.

Councillors noted that in addition to MUP there were issues of tackling multi-buy promotions and irresponsible promotions that encouraged excessive alcohol consumption

and of inclusion of Public Health as a separate Licensing Objective, not just tied to cumulative impact that could give the opportunity to take the full impact of alcohol related harm into account when making licensing decisions.

The Director, Balance concluded by dispelling the common myths as regards MUP and added that some Government proposals as regards “cutting red tape” in respect of “ancillary sellers”, such as beauty salons or florists, and removing the prohibition on the sale of alcohol at motorway services would only worsen problems associated with the ease of availability of alcohol and was contrary to the powers set out within the Police Reform and Social Responsibility Act 2011.

The Chair thanked the Director, Balance and asked Members for their questions for Officers and colleagues from Partner Organisations.

In response to questions from Councillors J Armstrong, P Brookes and Mr AJ Cooke as regards the issues of parental responsibility, tackling alcohol advertising and the current social norm of excessive alcohol consumption, the Director, Balance noted that the alcohol industry spent around £800 Million on advertising, so the relatively tiny amount that could be spent in highlighting the harm caused by alcohol abuse would only be able to impact positively to a certain extent. The Director, Balance added that there was a role for parents in educating their children, alongside other education in schools, however this was only one part of what needed to be a comprehensive approach to tackling alcohol related harm. Members noted that in respect of changing social norms, there was a role for the alcohol industry themselves in how they promoted alcohol, for example links to sporting events and other activities, inferring that alcohol was a necessary component of these activities and occasions.

The Director of Public Health, Anna Lynch added that parents did have an important role in tackling social norms, however, this was one part of a multi-faceted approach incorporating: education in schools; education in the workplace; including alcohol issues within the “Think Family” approach and through the Safer Durham Partnership (SDP). It was added that a high impact video shown to young people by the Police did have a positive effect, with the powerful footage providing a shock value. The Director of Public Health explained that an important component was to help young people understand that other young people were not all having sex, not all drinking or tacking drugs and that these misconceptions were not a reason to feel pressured into underage or excessive alcohol consumption.

It was explained that there was not one single intervention method and that those that were employed were carried out in partnership; that prevention was preferable; and that treatment would be commissioned by DCC after April 2013. The Director of Public Health noted that it had been shown that legislation as regards the smoking ban had proven effective and campaigning in respect of smoking had been costly, however greatly less than the cost saving made in respect of public health, demonstrating that legislation and public health campaigns can be effective when undertaken nationally.

The Chair noted statistics from the Police that had shown 97% of Officers had noted a risk of assault from those suffering from alcohol intoxication. Chief Superintendent Ivan Wood, Durham Constabulary noted that sadly it was the case that Police Officers did face those kinds of situations and that, while Officers were aware of the issues and how to deal with them, they were slightly desensitised due to the high number of such incidents they are required to deal with.

The Consumer Protection Manager, Owen Cleugh added that DCC was working with Durham Constabulary in tackling underage sales at local premises and that there were several tools currently at the disposal of the Licensing Section in terms of “Cumulative Impact”; Early Morning Restrictions; and Late Night Levies, however in order to be most effective a regional approach was needed. It was added that in order to use the correct tool, there must be a good evidence base and currently evidence was being gathered in conjunction with Durham Constabulary and other partners.

Councillors J Blakey, P Jopling and Mr T Thompson and Ms M Chappell made comments as regards issues of sale of alcohol at petrol stations; government advertising campaigns; the powers available to DCC in tackling irresponsible promotions by those selling alcohol; powers the Police have in arresting those who are intoxicated; and issues of cutting red tape being at odds with measures being put in place to tackle ASB and Health issues caused by excessive alcohol consumption. Councillor J Lethbridge added that there was a need to ensure that legitimate businesses, such as rural public houses, were not negatively affected by any changes and that a balanced approach was taken.

The Director, Balance noted that Balance supported the principle that alcohol should never be cheaper than the cheapest soft drink available and that some of the Government proposals to cut red tape were contrary to other proposals or existing legislation. The Chief Superintendent, Durham Constabulary noted that the Police did arrest people who were drunk and disorderly, and that over weekends around 70% of people arrested would have been drinking alcohol. The Chief Superintendent, Durham Constabulary added that in cases where young people were under-18, their parents would always be contacted. The Director, Balance added that in relation to pubs as community hubs, a survey of over 200 had noted that 80% were in favour of MUP and noted that the biggest impact in tackling alcohol related harm and associated ASB would likely come from any legislation relating to alcohol advertising.

The Chair thanked Members for their comments and the Overview and Scrutiny Manager, Feisal Jassat noted that facilitated groups would discuss specific issues of: MUP and Multi-Buy Promotions; Mandatory Conditions; Cumulative Impact Policy and Health; and Freeing up Responsible Business.

Upon completion of the group discussions, Officers gave feedback on the main points raised, those being: there was support for both a MUP and a ban on multi-buy promotions; support for mandatory conditions for both the on and off-trade; broad agreement for Public Health as a Licensing Objective, with the quality and specificity of the information/evidence being paramount in allowing Members to make reasoned decisions at Committee. In addition, Members did not feel ancillary sellers, and having sellers without an Alcohol Licence, was compatible with Alcohol Strategies attempting to tackle ASB and issues of Public Health.

The Overview and Scrutiny Manager thanked Councillors and noted that the response from Overview and Scrutiny Members would be collated and be one of the responses to Government on this issue, alongside a response from SDP and DCC as a Local Authority. It was added that a draft of the response from Overview and Scrutiny Members would be circulated to those present at the Joint Committee via e-mail to give an opportunity to add any further comments prior to submission to Government. Members noted that there would be responses from other Partners in addition, such as the Police and Crime Commissioner (PCC).

Officers reminded Joint Committee that there would be considerably more responses from the Alcohol Industry as they outnumber Local Authorities and Partners by approximately 43 to 1, therefore each individual response would be welcomed and the Director, Balance noted that Members could contact either himself or the Alcohol Harm Reduction Coordinator as regards adding their support via the Balance website, or submitting individual letters in response to the consultation.

Resolved:

(i) That the information within the report and presentation be noted.

(ii) That a response from Overview and Scrutiny Members to the Government consultation be drafted, based upon the Joint Committee's discussions, and circulated to Members for any final comments as soon as possible.

(iii) That a final response, incorporating any further comments from Members, be submitted to Government prior to their deadline of 6 February 2013.

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Adults Wellbeing and Health Overview and Scrutiny Committee

3 July 2013

NHS England – Durham, Darlington and Tees Area Team

Report of Lorraine O'Donnell, Assistant Chief Executive

Purpose of the Report

1. The purpose of this report is to introduce to members a presentation by Ben Clark, Assistant Director: Clinical Strategy for Durham Darlington and Tees Area Team setting out its role and function as the local area presence for the NHS England (previously known as the NHS Commissioning Board).

Background

2. NHS England is the body nationally accountable for the outcomes achieved by the NHS and which also provides leadership for the new NHS Commissioning system. Established in June 2011, the NHS England has operated in shadow form in October 2011 and became fully operational on 1 April 2013.

3. NHS England is responsible for £80bn budget and will allocate £60bn directly to Clinical Commissioning Groups. It also directly commissions a range of services including primary care and specialised services and has a key role in improving broader public health outcomes.

4. It has now established Area Teams who are the local offices of NHS England. They will have a number of core functions around direct commissioning, the development and assurance of clinical commissioning groups (CCGs), emergency planning, resilience and response, quality and safety, partnerships and service reconfiguration and system oversight.

5. NHS North of England is the regional presence of the NHS England across the north and will provide strategic leadership, including coordination and oversight of Area Teams. It will work with CCGs and partners across the north to ensure we have a strong and innovative commissioning system that improves outcomes for patients.

6. There are 27 Area Teams across England and they will be accountable for the direct commissioning responsibilities for GP services, dental services, pharmacy and certain aspects of optical services, specialised commissioning, offender health commissioning and military health commissioning.

7. Ten Area Teams will lead on specialised commissioning across England with Cumbria, Northumberland, Tyne and Wear (CNTW) undertaking this on behalf of Durham, Darlington and Tees.

8. The Durham, Darlington and Tees Area Team will undertake primary care and offender health commissioning on behalf of CNTW. Military health is being led by the in North Yorkshire and Humber Area Team.

Durham, Darlington and Tees LAT

9. Dr Mike Guy, has been appointed medical director for Durham, Darlington and Tees Area Team and has been invited to attend today's Adults Wellbeing and Health Overview and Scrutiny Committee to present members with information around the role and function of the Area Team.

10. This will be an important opportunity for the Committee to develop its relationship with the Area Team and share expectations on the contribution that it can make to support the improvement of health, reduction in health inequalities and the improvement in healthcare experiences for the people of County Durham. This will build on the previous recommendations agreed by the Committee regarding the development of closer working relationships between the Adults Wellbeing and Health Overview and Scrutiny Committee and NHS Partner organisations as well as recently agreed changes to the Constitution of the Council in respect of Health Scrutiny.

Recommendation

11. Members are asked to note the information contained within this report and the presentation provided by the Area Team and agree to further periodic updates on the work of Durham, Darlington and Tees Area Team.

Background Papers – None

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

Appendix 1: Implications

Finance - None

Staffing - None

Risk - None

Equality and Diversity / Public Sector Equality Duty – None

Accommodation - None

Crime and Disorder – None

Human Rights – None

Consultation – None.

Procurement - None

Disability Issues – None

Legal Implications – The engagement of local authorities within proposals for NHS service transformation is a requirement of the Health and Social Care Act 2012.

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Adults Wellbeing and Health Overview and Scrutiny Committee

3 July 2013

Securing Quality in Health Services

Report of Lorraine O'Donnell, Assistant Chief Executive

Purpose of the Report

1. The purpose of this report is to update members of the progress of the Securing Quality in Health Services project (formerly the Acute Quality Legacy Services project).

Background

2. At the Adults Wellbeing and Health Overview and Scrutiny Committee held on 1 October 2012, a detailed report and presentation was given by Rosemary Granger, Project Director in respect of County Durham and Tees Valley Acute services' Quality Legacy project.

3. At that meeting, members were advised that the objective of the Quality Legacy Project was to reach consensus on the quality standards in acute services it was wanted to achieve, using levels of national best practice. The Project would identify opportunities for meeting these standards and assess the financial environment and workforce constraints in which such improvements may take place. The Project would support and enhance the commissioning of acute hospital services as Primary Care Trusts transferred their commissioning responsibilities to Clinical Commissioning Groups (CCG's) over the next year

4. It was previously reported that the outcome of the Acute Services Quality Legacy Project will be a synthesised set of analysis and clinical recommendations, supported by wider workforce and economic modelling that will help inform CCGs as they develop their commissioning plans and contracting intentions for the 2013/14 financial year and onwards. This will help ensure that the focus on sustainable, high-quality care remains the key driver for all organisations commissioning or providing secondary care for the patients of County Durham, Darlington and Tees as the next phase of NHS reform begins. The report will also describe the next steps and the process for taking forward the recommendations.

5. The Adults Wellbeing and Health Overview and Scrutiny Committee as part of its agreed work programme have asked that the Quality Legacy Project report and recommendations be presented to the Committee.

Current Position

6. Following the transition from the Primary Care Trusts to Clincial Commissioning Groups, the project has been renamed 'Securing Quality in Health Services' (SeQIHS).

7. A report on this issue has also been considered by the Durham Health and Wellbeing Board and is attached to this report. (Appendix 2)

8 Rosemary Granger, Project Director, will be in attendance to provide an update to members which will highlight the main findings and recommendations of the project.

Recommendations

9. Members are asked to note the information contained within the report and agree to receive further update reports on the project as part of the Committee's work programme.

Background Papers – None

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

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Appendix 1: Implications

Finance - None

Staffing - None

Risk - None

Equality and Diversity / Public Sector Equality Duty – None

Accommodation - None

Crime and Disorder – None

Human Rights – None

Consultation – None.

Procurement - None

Disability Issues – None

Legal Implications – None

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Health and Wellbeing Board

21st June 2013

Securing Quality In Health Services

Report of Rosemary Granger, Project Director

Purpose of Report

1. The purpose of this report is to update the County Durham Health and Wellbeing Board on the Acute Services Quality Legacy Project. (ASQL)

Background

2. In September 2012, County Durham Shadow Health and Wellbeing Board received a report and presentation on the Acute Services Quality Legacy Project. The project was part of the process for Primary Care Trusts to transfer commissioning responsibility to Clinical Commissioning Groups (CCGs) and it covered the PCT clusters across County Durham and Darlington and Tees Valley.

3. The overall objective of the project was to enhance the commissioning of acute hospital services by reaching consensus on the key clinical quality standards in acute hospital care that should be commissioned by CCGs. The project aimed to produce a report that would describe the agreed clinical quality standards in the context of the financial and workforce resources that are expected to be available to support implementation of the standards.

4. The project report was received at the final meetings of the PCT clusters in March 2013.

Acute Services Quality Legacy Project - Final Report - Summary of key messages and recommendations

5. Both commissioners and providers of acute services face a similar set of challenges over the next five to ten years. Our population will be older, with more long term conditions being treated by a state funded NHS that is ultimately tied to the performance of the national economy. These services will also be operating as part of a wider system with social care which itself faces significant challenges related to national financial constraints.

6. We are fortunate however to start from a strong starting position. Our current main providers consistently deliver high quality services, meet

national performance targets related to waiting times and cleanliness and operating efficiently within their means. Having said that, we know that we can do better. In this process we have looked to our clinical community to define what the best possible care should look like in our hospitals and begin to outline the next steps of how we should go about delivering them, given the likely financial future and the workforce that will be available to us.

7. The findings and recommendations set out in the report have implications that range from potential changes to be made to provider contracts through incorporating the agreed clinical quality standards, to potential service reconfiguration across County Durham and Tees Valley.

Key Messages from ASQL Project

8. The main key messages are as follows:

- Following years of growth, demand for acute services is currently high for both elective and non-elective care.

- There will be a significant increase in prevalence across the major long term conditions over the next ten years and a greater proportion of the population will be over the age of 65.

- This will have an impact on the utilisation of acute services to a varying degree in the different service areas.

- This growth will put pressure on commissioners' allocations over the next ten years as an older population with more co-morbidity will consume more health resource, unless effective demand and long term condition management are implemented. This analysis does not take into account potential increased spend on high cost drugs and new medical technologies in the acute setting that may require further investment from commissioners.

- Forecasts show that providers can maintain a financially stable position over the next five years as long as cost improvement plans deliver to target. Failure to deliver these targets will have implications for Trusts' operating surplus/deficit position and ultimately the length of time they can rely on cash savings to keep them solvent.

- This means that new funding is unlikely to be available to expand the access to services of the very highest quality as providers look to maintain the current levels of quality within the resources they have access to.

- Even if commissioners were to receive increases to their allocations and providers had efficiency requirements at pre-Comprehensive Spending Review levels, national and regional workforce constraints may have more impact on the ability to deliver higher quality standards.

- These national and regional workforce considerations are further compounded by supply and demand of particular grades and skills of the current and future workforce within the acute sector in County Durham, Darlington and Tees.

Recommendations from ASQL Project

9. The overall recommendations for the ASQL project board from key clinical areas are set out below. These recommendations were identified in the context of the wider financial and workforce contexts, the underlying health data, views of the clinical advisory groups and the specific workforce risks and opportunities

Acute Paediatrics, Maternity and Neonatal Services

10. Endorse the Royal College of Obstetricians and Gynaecologists (RCOG) standard of 168 hours (24/7) consultant presence as the ultimate goal for maternity services across County Durham Darlington and Tees. This standard was supported by the majority of the Clinical Advisory Group (CAG) but there was a minority view that 98 hours consultant presence should be established as the standard for units with less than 4000 deliveries a year. The Project could not find enough evidence to inform a recommendation that goes against the Royal College standard, therefore the Project supports the RCOG standard and majority view of the CAG. Given the scale of this challenge however, there is a recognition that this needs to be delivered in a staged way, with 98 hours as an interim step for units with less than 4000 deliveries a year as part of a phased approach to implementation.

11. Endorse the key quality standard of 1:1 Midwife care for women in established labour.

12. Ask Clinical Commissioning Groups to consider the steps they may take in the next contracting round to address some of the gaps in quality standards through the use of CQUIN incentives and agreeing small scale service improvement work with individual trusts.

13. Agree to a further feasibility analysis to understand the implications of implementing the standards across County Durham, Darlington and Tees. This assessment should take into account the role of Midwife Led Units and how best to support an increase in home-births.

14. Agree to inform the LETB – Local Education and Training Board to adjust commissioning plans to increase the numbers of midwife training places to mitigate against risks in future workforce shortages.

Acute Care

15. Endorse the key quality standards recommended by the CAG as those that define high quality care, for example: Emergency admissions seen and

assessed by a relevant consultant within 4 hours (in hours) and 12 hours (out of hours); Emergencies to have access to key diagnostics 24/7: for critical cases – imaging and reporting within 1hour of request, for non-critical cases – imaging and reporting within 12 hours of request.

16. Endorse the recommendation for acute trusts to collaborate in establishing an interventional radiology service available 24/7.

17. Agree that the critical care element of the Acute Care CAG continue until final recommendations can be made.

End of Life Care

18. Endorse the key quality standards recommended by the CAG as those that define high quality care, particularly those that relate to the 24/7 availability of an appropriately trained nurse to provide practical support, responding within one hour, with access to necessary medicines and home equipment for End of Life cases. In addition the CAG recommends the appropriate use of the Liverpool Care Pathway in all care settings including the sharing of results

19. Endorse the recommendation for collaboration across the acute trusts to establish a 7 day per week service providing specialist palliative care advice.

Long Term Conditions

The overall recommendations of the Acute Services Quality Legacy Project in relation to long term conditions are as follows:

20. Given the scale of the likely challenge ahead due to the ageing population, the rising prevalence of LTCs and the wider membership of organisations involved, a new project focusing on LTC management should be initiated across health and social care. This project should include community services, mental health and primary care providers as well as acute trusts.

21. The project will add value to the existing work on long term conditions led by CCGs, by establishing a consensus on the scale of intervention needed and the quality standards to be achieved.

22. Further work in this area would include more detailed work on the financial and workforce challenges to provide a better understanding of the required scale of transformation and the development of concrete plans to achieve this, learning from success locally, regionally and nationally.

Planned Care

The overall recommendations of the Acute Services Quality Legacy Project in relation to planned care are as follows:

23. CCGs should review the Planned Care Briefing Paper to identify and continue to understand unexplained variations in referrals from Primary Care and clinical practice in secondary care

24. Where appropriate CCGs should look to use information to inform patient choice and commissioning levers to encourage competition to drive quality in Planned Care. This includes the introduction of new providers into the market to stimulate innovation

25. CCGs should however consider the financial implications for current providers that any movement of activity away from them may have (either to other current or new providers) when making changes to elective pathways.

Next steps:

26. CCGs have agreed to build on this legacy work and will take this work forward in line with the duty placed upon them to commission high quality sustainable services. It has been agreed that this work will continue to be a commissioning led process and as such, Darlington CCG will lead the work on behalf of the six CCGs across County Durham, Darlington, Tees and Hambleton, Richmondshire and Whitby(the latter CCG is involved due to the scale of their patient flows into the Tees Valley area). The project will also feed into, and be supported by, the work of the Area Team of NHS England.

27. The objectives for the next phase of work which is expected to be complete by the end of the summer 2013, are to assess the feasibility of, and options for, implementing the standards and progressing implementation.

Recommendations

28. It is recommended that the Health and Wellbeing Board:
    a. Accept the report for information
    b. Agree that further reports will be submitted to the Health and Wellbeing Board as the project progresses.

Contacts: Rosemary Granger, Project Director, NHS Darlington Clinical Commissioning Group. rosemary.granger@nhs.net

Background Documents
There are no background documents for this report.

Appendix 1 - Implications

Finance – There are no funding or financial implications at this time of Securing Quality in Health Services

Staffing – There are no staffing implications of Securing Quality in Health Services

Risk – There are no risks attached to Securing Quality in Health Services at this time

Equality and Diversity / Public Sector Equality Duty – Under provisions in the Health and Social Care Act, the Clinical Commissioning Groups will have a duty to reduce health inequalities and assess the impact of any potential service changes for protected groups.

Accommodation – There are no accommodation implications that need to be considered

Crime and Disorder – N/A

Human Rights – There are no direct implications.

Consultation – If the outcome of the feasibility analysis of the implications of implementing the standards leads to a decision by the CCGs to reconfigure services consultation with the public, staff, and Elected Members will be undertaken

Procurement – There are no direct implications

Disability Discrimination Act – There are no direct implications at this time

Legal Implications – There are no direct implications

Adults Wellbeing and Health Overview and Scrutiny Committee

3 July 2013

Reconfiguration of Emergency Medical and Critical Care services at North Tees and Hartlepool NHS Foundation Trust

Report of Lorraine O'Donnell, Assistant Chief Executive

Purpose of the Report

1 This report details proposals by Hartlepool and Stockton on Tees Clinical Commissioning Group, Durham Dales and Easington and Sedgefield Clinical Commissioning Group and North Tees to consult upon the reconfiguration of emergency medical and critical care services at North Tees and Hartlepool NHS Foundation Trust.

2 The report also details proposals to establish a Joint Health Scrutiny Committee under the provisions of the Health and Social Care Act 2012 involving all local authorities affected by the proposals and invites the Adults Wellbeing and Health Overview and scrutiny Committee to appoint a representative(s) to the Joint Committee.

Background

3 Members of the Adults Wellbeing and Health Overview and Scrutiny Committee have received regular updates from North Tees and Hartlepool NHS Foundation Trust regarding the progress of their "Momentum : Pathways to Healthcare/Service Transformation programme", most recently at its meeting held on 26 January 2013.

4 Members will recall that central to the Momentum project is the building of a new hospital at Wynyard to replace the University Hospital of Hartlepool and the University Hospital of North Tees. The government at the time offered public funding for the new hospital in March 2010. However the new government withdrew this funding in June 2010.

5 The government said it realised there was a need to build the new hospital but the organisations who buy services on behalf of local people and the trust needed to find a different way to pay for it. This meant that, instead of the new hospital being open in 2014 as planned, it is now expected to open in 2017.

6 Doctors providing emergency medical and critical care at North Tees and Hartlepool NHS Foundation Trust have told the commissioners that, whilst they could have made arrangements to keep the two hospitals' emergency medical wards and critical care open until 2014, they cannot do this up to 2017.

7 In view of these concerns, the CCGs invited the National Clinical Advisory Team to visit North Tees and Hartlepool NHS Foundation Trust to listen to the

doctors, nurses and managers, patient representatives, politicians and other stakeholders so they could give us an independent view of the situation and what we should do about it.

8 The National Clinical Advisory Team provide independent clinical expertise to support and guide the local NHS on service reconfiguration proposals to ensure safe, effective and accessible services for patients. The team was lead by Dr Chris Clough from Kings College Hospital, London.

9 The National Clinical Advisory Team report was received in May 2013 and a copy is attached to this report (Appendix 2).

10 The report said that Commissioners should:

- work with the trust to centralise emergency medical services and critical care to the University Hospital of North Tees as soon as possible;
- explain to the public what this means for them;
- ask their views about the things that they are concerned about, especially how they and their relatives get to hospital.

Hartlepool and Stockton on Tees Clinical Commissioning Group and Durham Dales, Easington and Sedgefield Clinical Commissioning Group – Consultation on "Providing safe and high quality care leading up to the opening of the new hospital"

11 As a result of the findings of the NCAT report, a public consultation was launched on 20 May 2013 by Hartlepool and Stockton on Tees Clinical Commissioning Group and Durham Dales, Easington and Sedgefield Clinical Commissioning Group upon the proposed reconfiguration of emergency medical and critical care services at North Tees and Hartlepool NHS Foundation Trust.

12 A copy of the consultation document is attached to this report (Appendix 3).

13 The consultation document states that "after much discussion with health professionals, a review of alternative options and receiving the report from the independent National Clinical Advisory Team, which agreed that there are no viable safe alternatives, we are now proposing to centralise emergency medical and critical care services at the University Hospital of North Tees from October 2013.

14 Bringing these services together would affect some other services such as other parts of the medical directorate, pathology, radiology, pharmacy and other support services such as facilities and catering. It would mean that patients with lots of medical problems will not be able to have planned operations like hip replacements at the University Hospital of Hartlepool.

15 We do not expect this would affect very many patients because modern anaesthetics are safer. We want to ensure that most health care in Hartlepool continues to take place locally so we will be looking at ways to provide more

low-risk operations and other treatments in the University Hospital of Hartlepool for local people.

16 However we always have to assess if this will be safe and it will be for that reason and that reason alone, that we would transfer high risk planned operations to the University Hospital of North Tees."

17 The consultation proposes that leading up to the proposed changes commissioners and the trust would:-

- open 120 beds at the University Hospital of North Tees to make sure we have enough beds and staff to look after patients from right across our area;
- make extra space in critical care so we can look after critically ill patients;
- then, gradually, close the beds in medicine and critical care at the University Hospital of Hartlepool, and
- transfer a number of staff from support services such as pharmacy, radiology and pharmacy and estates that need to come to the University Hospital of North Tees to support the new arrangements.

18 The consultation aims to get the views on these proposals and to understand concerns about the proposed changes. In attempting to do so it asks the following questions

1. What do you think are the advantages and the difficulties (or disadvantages) of the proposed changes?

2. If you still have concerns, what are you most concerned about and how could we help to reduce your concerns?

3. What do you think are the main things we need to consider in putting the proposed changes in place?

4. Is there anything else you think we need to think about?

19 The consultation runs from 20 May to11 August 2013 and a copy of the proposed consultation plan is also attached. (Appendix 4)

Provisions for Consultation and Engagement of Overview and Scrutiny Committees

20 The Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013 require the formation of a joint scrutiny arrangement, where an NHS body or relevant health service provider consults more than one local authority on proposals to make substantial variations or developments to services. They provide that all the local authorities whose residents receive such services must participate in the joint scrutiny arrangement for the purpose of responding to the consultation, using the method most appropriate to the areas and issues being considered.

21 A local authority can opt-out if, having considered the information provided by the NHS body or relevant health service provider proposing the service change, they determine that the proposal is not "substantial" for their residents. Where a local authority opts out in this way, they will relinquish the power to refer the proposed change to the Secretary of State for the purposes of that particular consultation.

22 Only the joint scrutiny committee may require the organisation proposing the change to provide information to them, or attend before them to answer questions. That organisation is under a duty to comply with these requirements. If a local authority has opted out of the joint arrangement, they may not request information or attendance from the NHS body or relevant health service provider proposing the change. Failure by an NHS body or relevant health service provider to provide information requested by a local authority who is not participating in the joint scrutiny process and who is therefore not entitled that that information does not constitute a failure to consult that authority and is therefore not a valid reason for a referral to be made to Secretary of State.

23 They may not participate further in the joint scrutiny arrangements, unless changes occur during the development of proposals that make the impact substantial for residents in the local authority's area. The local authority, in these cases, should not expect to revisit any matters that the joint committee has already considered.

24 In scrutinising the proposals, the joint committee should aim to consider the proposal from the perspectives of all those affected or potentially affected by that proposal. The provisions of co-option set out above apply, enabling the involvement of district councils in the scrutiny process.

25 Only the joint scrutiny arrangement can then make a report and recommendations back to the organisation proposing the change. The power to refer to Secretary of State should only be exercised once the NHS body or relevant health service provider proposing the service change has responded to the comments of the joint scrutiny committee and all forms of local resolution have been exhausted. However, it can be exercised by any of local authorities originally consulted or by the joint arrangement where the power to refer has been delegated to it.

Proposals for a joint Health Scrutiny Committee

26 The establishment of joint Health Scrutiny Committee has been proposed consisting of representatives Hartlepool Borough Council, Stockton-upon-Tees Borough Council and Durham County Council comprising equal representation from each Council.

27 In accordance with the regulations detailed above, the Joint Committee will be the vehicle through which the respective Local Authorities will respond to the consultation.

28 Accordingly, it will be for the Council's Adults Wellbeing and Health Overview and Scrutiny Committee to provide information and representations in respect of the consultation as it impacts upon the residents of County Durham to its nominated representatives.

29 A protocol and Terms of Reference have been drafted for the proposed Joint Health Scrutiny Committee. A copy of these documents are attached to this report (appendices 5 and 6).

30 The protocol proposes the nomination of three representatives from each constituent authority and, having taken advice from the Monitoring Officer, this representation from Durham County Council should be politically balanced and as, such 2 Labour representatives and 1 from the Durham Independents Group will be required.

31 Notwithstanding the appointment of a joint Health Scrutiny Committee to oversee the production of a response to the Consultation, it is proposed that a special meeting of the County Council's Adults Wellbeing and Health Overview and Scrutiny Committee be held on 23 July 2013, to receive evidence from representatives of the Commissioners (Hartlepool and Stockton CCG and Durham Dales, Easington and Sedgefield CCG) and North Tees and Hartlepool NHS Foundation Trust in respect of proposals and also to enable members of the Committee to identify their concerns to be fed into the Joint Committees final consultation response.

Recommendations and reasons

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

(a) note the proposed consultation by Hartlepool and Stockton on Tees Clinical Commissioning Group, Durham Dales and Easington and Sedgefield Clinical Commissioning Group and North Tees to upon the reconfiguration of emergency medical and critical care services at North Tees and Hartlepool NHS Foundation Trust;

(b) consider those questions raised within the consultation document and detailed in paragraph 18 of this report in light of the proposed reconfiguration and provide comment to the proposed Joint Health Scrutiny Committee;

(c) Agree the proposed protocol and Terms of Reference for the Joint Health Scrutiny Committee detailed within this report;

(d) Appoint 3 representatives from the Adults Wellbeing and Health Overview and Scrutiny Committee to sit on the aforementioned joint Health Scrutiny Committee;

(e) Note the proposed arrangements for a special meeting of the Adults Wellbeing and Health Overview and Scrutiny Committee on 23rd July 2013.

(f) agree that any representations and key issues which Councillors wish to be raised as part of the Consultation exercise be directed through

this Committee's nominated representatives to the Joint Health Scrutiny Committee referred to in (b) above.

Background papers

As appended to the report

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

Appendix 1: Implications

Finance - None

Staffing - None

Risk - None

Equality and Diversity / Public Sector Equality Duty - None

Accommodation - None

Crime and Disorder - None

Human Rights - None

Consultation – This report details the Council's statutory responsibilities in participating in the consultation.

Procurement - None

Disability Issues - None

Legal Implications – This report has been produced in response to the Council's statutory responsibilities to engage in health scrutiny consultations as detailed in the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013

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NCAT review

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To: North East NHS

North Tees & Hartlepool NHS Foundation Trust

Date of Visit: 29January 2013
Venue(s): Hartlepool and North Tees Hospitals

NCAT Visitors: Dr Chris Clough
Dr Mike Jones

1. Introduction

1.1. NCAT was asked to clinically assure reconfiguration proposals for North Tees and Hartlepool NHS Foundation Trust (NTHFT) involving the University Hospital of Hartlepool (UHH) and University Hospital of North Tees (UHNT). The request for clinical assurance was initiated by Hartlepool and Stockton-on-Tees Clinical Commissioning Group as part of their service change assurance process as the Trust and Clinical Commissioning Group move towards public consultation.

1.2. Information reviewed - list of information received is shown in Appendix 1

1.3. Agenda and list of people met is shown in Appendix 2

2. Background

2.1. The background to this reconfiguration is lengthy and complex starting with the Tees Service Review in 2003, followed by the acute services review for Hartlepool and Teeside in 2005, the recommendations of the Independent Reconfiguration Panel 2006 and the development of the strategic plan Momentum – pathways to healthcare 2007. The details of these various recommendations and strategic plans will not be summarised here, but the conclusion of the most recent Independent Review Panel (IRP) , the Momentum programme, is that there should be a single new hospital, built between Hartlepool and Stockton, to replace the current services provided at UHH and UHNT. Additionally there should be a number of other work-streams to ensure that health services were as near to patient homes as possible, with the development of community services.

2.2. As part of the health service reform/redesign in North of Tees and the shared vision originating from the recommendations of the IRP, the new hospital capital project was consulted on in late 2008, leading to a final draft of the outline business case. As part of the spending review undertaken by the new coalition government following the general election in May 2010, the approval for public dividend capital (£464m) was withdrawn in June 2010. The Trust, with support from the then PCT (NHS Tees) and now NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group, is exploring alternative options for securing the required finance and, by the end of 2013 hope to identify an appropriate financial partner. A new hospital at the Wynyard site is expected to be in service by 2017.

2.3. In advance of and as anticipated in the new NHS with a strive for greater quality and safety standards that move to the new hospital the Trust is experiencing clinical problems of sustainability to keep abreast of escalating standards with the continued provision of two site acute medical and critical care services. It is the case for change for these services that NCAT has examined, but we have also reviewed the overall strategic direction of the Trust plans. Within the accompanying paperwork, plans to close the stand alone midwife led birthing unit (MLBU) at UHH were advanced, but we understand these are being reconsidered in an overall assessment of the provision of midwife-led services that exist within the community, or are hospital based. Whilst NCAT can understand that there may be concerns about the affordability and sustainability of a small stand-alone MLBU (approximately 300 births per year) we have not addressed the issue of maternity services directly, and these are not further discussed within the following report.

3. Case for change

3.1. Presently acute medicine and critical care (intensive care and high dependency care) are provided on the two sites of UHH and UHNT. Whilst UHNT is the major provider of acute medical services and critical care, UHH continues to admit acutely ill medical patients. Patients suffering from a possible stroke are already taken to UHNT (patients identified by the FAST test are transferred by the ambulance services to UNHT, other patients can self-present or be referred by GPs), and secondly patients

with acute coronary syndromes (ie those so-called STEMI patients) are taken directly or transferred to James Cook University Hospital for percutaneous coronary intervention. About 30 patients a day present to the acute medical unit (emergency medical unit) at UHH and a significant proportion of these will be ambulatory.

3.2. UHH is supported by a small critical care service with two ITU beds and two high dependency beds. Over recent years the bed occupancy has been 50% on average. Most of the activity using this service is referred on by the acute medical team. It is supported by anaesthetists with intensive care skills who are able to do a once daily ward round but are not able to offer the full panoply of intensive care support such as haemofiltration and routine tracheostomy can only be performed on mornings when the consultant is there. Such services are available routinely on the UNHT site. Patients for surgical tracheostomy need to be transferred to UNHT. It has been difficult to recruit and retain anaesthetists and medical staff to the UHH. In addition the nurses feel isolated within the unit and insecure about the level of care they are practicing.

3.3. The acute medical unit does run well and there are plenty of beds to which patients may be admitted , but again is not supported by the full panoply of services one would expect in a modern AMU. Patients need to be transferred to UNHT for endoscopy or other specialist opinion or interventions.

3.4. Thus the case for change here is predominantly clinically based, driven by the need to close the critical care unit at UHH which may potentially be unsafe, and secondly to provide modern fully supported acute medical care which certainly could not function without on-site critical care facilities. In the present situation patients may be left at UHH following their admission when it would have been better to transfer them in the first place to UNHT.

3.5. The proposal is to create a larger acute medical unit at UHNT, which would then be supported by a larger group of medical staff and other clinicians with specialist skills. The intensive care/critical care unit at UHH would

close and the capacity at UHNT would be expanded to accommodate the increased activity. Again there are likely to be efficiencies of scale and quality dividends by bringing all the individuals with intensivists skills onto one site.

3.6. The proposal will mean that the number of beds at UHNT will need to be expanded, and the figure given was of 100 extra beds committed to acute medicine. Within this present move there would also be some movement of plain X ray and diagnostic services to support acute medicine and critical care but these services would also remain on the UHH site to support outpatient services. Patients requiring elective surgery on the UHH site would undergo appropriate assessment to ascertain their ASA grade. Low grade patients (ASA 1 and 2) would be deemed fit enough to undergo surgery at the elective care centre. Those with higher ASA grades would be treated at UNHT in case of the need for critical care.

4. Views expressed on the day

4.1. The Trust and the CCG both have clear and creditable plans to develop high quality care for the people of Stockton and Hartlepool. It is important that the plans that emerge are evidence based and can be supported by our clinicians.

4.2. The Trust took on community services some time ago and would like to deliver integrated care, but there has been less investment in the community services at the Stockton side to enable us to do this.

4.3. There are now three short-listed bidders which have emerged to compete for the development/funding of the new hospital, and we would expect a recommendation by the end of the year

4.4. There has been a renaissance in community services. The single point of access has been a great success with signposting of appropriate services for the first time. However staff working at the SPA centre can feel stressed when attempting to make a decision about what is the appropriate patient pathway to recommend, and the default position may well be to admit.

4.5. We need to plan for the future, particularly the management of the frail elderly. It will be important to have integrated services with social services. A large proportion of these patients will have dementia who require appropriate care.

4.6. These plans will mean that 97% of the healthcare contacts that occur presently will remain in Hartlepool. We recognise that transport needs to be a key project. We are suggesting there needs to be a shuttle bus between the two hospitals. We know the public is worried about transport and it will be important to enhance both public transport and ensure that the ambulance service has sufficient capacity to make swift transfers if need be.

4.7. We are an upper decile performer with regard to average length of stay (3.6 days) for the acute medical service. We are trying to run an 85% bed occupancy, but often the occupancy is over 90%, particularly at the Stockton end (UHNT). Surgery runs at much lower occupancy rates (77-78%). Overall there will be 100 extra beds at North Tees to accommodate the increase in medical activity and this can be provided by refurbishing wards as at present. Additionally it would be relatively easy to reprovide the intensive care beds by some creative utilisation of space within the present ITU.

4.8. We must try to concentrate our elective surgical activity on the UHH site. Out of hours there will be a resident medical officer supported by advanced care nurse practitioners.

4.9. There are problems treating patients safely in the present UHH ITU. The number of beds is small, with low bed occupancy, and the medical cover relies on general anaesthetists some with intensivist skills. There is no dedicated intensivist presence on the ITU.

4.10. There is a growing disparity between the two sites because of the increasing isolation of the acute medical service and supportive critical

care. This can lead to an unwillingness to transfer patients from UHH which may not be in the patients' best interests. It is difficult to get specialist advice re haemofiltration and other specialist interventions for the patients in ITU. We have difficulty recruiting anaesthetists because of the low ITU throughput and facilities at UHH.

4.11. It would be difficult to justify training of junior anaesthetists in the ITU, and it is unlikely that the Deanery would support this at the UHH site. Increasingly we rely on locums which are difficult to find, and locum behaviour is worrying. Whilst what we are doing is adequate, this is not the model of care we want to see in the future.

4.12. One of the biggest challenges we have is working with the social services. However we do think we can preserve the relationships that have developed at UHH with community and social services if the acute services were to transfer to UHNT.

4.13. We want to develop consultant-led surgical care and this plan would assist that direction of travel. In the main UHH, as a surgical elective centre, would be dealing with orthopaedics (lower limb arthroplasty, spinal anaesthesia), breast surgery and paediatric day case surgery. There have been rare occasions when it has been necessary to open up the theatre out of hours for a deteriorating surgical patient using the UHH team. In future this occurrence must be kept to a minimum but in an extreme case it may be necessary to stabilise patients on the UHH site before transfer to UHNT.

We must utilise the capacity at UHH because without those 3 operating theatres we would not have the capacity to deliver all the surgical activity at UHNT.

4.14. There are concerns about equipment transfer between the two sites, and this needs to be clarified. We also need to do further work about understanding what competencies the out of hours team must have to support the level of elective care we would predict.

4.15. The acute medical team is comfortable with the assumptions about the rising level of admissions. We would expect this to be no more than 1% per year if integrated care and management of the vulnerable patients is developed within the community. We have work streams in mental health, substance misuse which aim to look at those care pathways carefully to identify patients at risk and prevent them being admitted unless absolutely necessary.

4.16. The local GPs are happy with the quality of care presently delivered at the two hospitals. We recognise the challenges faced by the Trust and support the movement of acute care to one site at UHNT.

4.17. We are not happy with the numbers of patients presently attending the ambulatory care unit at the Trust, and think these numbers need to be reduced over time by better provision of primary and community care. We recognise that GP services need to be more accessible, with 7 day working and extended hours. Presently there are a lot of zero day admissions; these need to be prevented wherever possible.

4.18. We are not happy with the paediatric assessment unit at UHH. We expect our children who are identified as being sick to be assessed by a paediatrician, at best a consultant, and presently this is mainly being performed by a nurse practitioner. Hence many of us are diverting children to UHNT anyway.

4.19. Whilst we recognise that community care needs to be developed, we must accept there has never been sufficient investment in the community services. It is worrying that the Trust re-admission rate is high, better community provision would help improve that.

4.20. Transport issues are key factors for patients.

4.21. The local Hartlepool Council has passed a vote of no confidence in the Trust management. Many people in Hartlepool do not support the building of a new hospital at Wynyard.

4.22. We would like to challenge the logic of the Momentum proposals. Why it is necessarily Stockton is the acute site rather than Hartlepool?

4.23. Patients do have concerns about the interim plans. Many of us took some convincing about the Momentum plans but have come to the view that the plans are acceptable as long as we develop community plans, and we would strongly support all attempts to keep care close to home.

4.24. We think the staff on both sites are good, and when we access care it is generally of a good quality. There are problems with access to some of the GPs locally, with up to 48 hours wait for an urgent appointment.

5. Discussion

5.1. Prior to the NCAT visit, both visitors were provided with a good deal of information about the background to the reconfiguration and the considerable political and other difficulties that the Trust and Commissioners have had over the past few years in making change happen with the North East. Thus it wasn't always clear from the paperwork what the substance of the proposal was, and what operational steps had been taken to achieve that. We fully understand the political difficulties in making change happen. Nevertheless we think the supportive paperwork could be considerably simplified, and certainly this would be necessary for public consumption, so that everybody is clear exactly what the proposal is about, the clinical case for change and what are the objectives and hoped-for outcomes to be achieved.

5.2. The core of this reconfiguration proposal is relatively straight-forward and that is the consolidation of the acute medical service on one site at Stockton and the transfer of the critical care services (ITU and HDU) to the Stockton site. This is the proposal we have clinically assured. As above, we have not reviewed plans for any changes in maternity services but did express our concerns about the viability of small standalone midwife led birthing units. We have not clinically assured any plans for a single site for all services, as envisaged with the new hospital build. Nevertheless we would like to make some broad strategic comments about the movement to

a possible new hospital at Wynyard, as this needs to be seen in the context of a national movement to create hospitals able to deliver care 24/7 with round the clock working for the acute team and supportive diagnostics.

5.3. We recognise that the public see a linkage between the interim plans and the final plans, but we think there is a pressing need to do something about what is happening to the acute services presently, no matter what the plans are for the future. Thus we see no need to link our decision with the decision making processes required for the acute hospital.

5.4. The clinical case for change can be strongly supported. What we witnessed today was dedicated and hard-working clinical teams at both sites, endeavouring to create a first class service but hampered by the present configuration. The key to what must happen is the provision of critical care. The present critical care service at UHH is inadequate, poorly staffed and does not meet the standards required for a modern intensive care unit. Its size and level of use mean that it will never be able to achieve these standards, thus it is not surprising that anaesthetists feel uncomfortable about working there, and there are problems with recruitment of anaesthetists and support staff. We heard that at times the nursing staff, particularly at night, feel unsupported and concerned in case a clinical error occurs. Certain practices are unacceptable, for instance the level of support for tracheostomy, the lack of haemofiltration and the ability to call on other specialist services. It is difficult to envisage how these deficits may be corrected. Massive investment in the service is not justified on the level of patient use, and it would be unlikely to be supported by the local education and training board (previously deanery). Thus we can see no alternative other than to transfer this service to UNHT. We believe there is capacity at that site to accommodate the increasing activity, and there will be the opportunity to bring together all the available staff and develop a dedicated intensivist workforce at UHNT.

5.5. The inevitable consequence of decommissioning critical care at UHH is that acute medical care can no longer be provided. Acutely sick patients need the availability of on-site resuscitation and critical care facilities. This must trigger the movement of acute medical care to UNHT. Not only that,

the present service is relatively small and does not have the full panoply of acute specialist care that is required to deliver high quality acute medicine. The bringing together of the two units under a single roof will undoubtedly enhance the level of support required for acute medicine and ensure there are viable specialist rotas, for instance in gastroenterology, respiratory medicine etc. It should also enhance the ability of elderly medicine to play an important part in identifying the frail elderly who require a comprehensive geriatric assessment and subsequent multi-disciplinary management.

5.6. When we spoke to the public and to the Overview & Scrutiny Committee members there was a significant majority in favour of the clinical argument for reconfiguration of the service. Not surprisingly the strongest support did come from those members of the pubic residing within the Stockton end of the patch. Nevertheless there were others from Hartlepool who also supported the plans. Understandably there are great concerns from the Hartlepool population about any changes to the services at UHH. They had two main concerns; firstly, whilst recognising that only a small part of the hospital services were being transferred to UNHT, and that the majority of services were remaining, it was felt that this could be the beginning of the end for UHH. Secondly, there are considerable concerns about transport – this has two components, firstly the extra travelling that relatives and carers would have to make in order to see their loved ones at UNHT when they were admitted acutely, and secondly was there sufficient capacity within the ambulance services to absorb the increased activity that inevitably would result from this transfer. From a clinical standpoint, the potential for small increases in travel times does not pose a significant clinical risk.

5.7. The Trust and its partners need to explain clearly the clinical case for change here, which is strong and can be strongly supported, but also reassure the Hartlepool public in particular that there is a continuing future for their hospital as a centre for elective care and other cold site services such as diagnostics and outpatients. Indeed there is a potential within the plans to develop intermediate care at UHH which would improve the care pathway for patients and ensure that once Hartlepool patients in particular had been treated at UHNT, they would be rapidly stepped down to

appropriate intermediate care facilities at UHH. The development of intermediate care at UHH will be an important component in managing the throughput of patients at the acute end.

5.8. Not enough has been done to describe patient narratives which I tell the story of what happens now and what will happen in the future. Overall we would expect these changes to deliver better patient outcomes, and all the OSC representatives and members of the public we spoke to agreed that some increased travel times was a necessary price to pay for better quality of care.

5.9. We were concerned about the lack of clarity about capacity planning for the enlarged Stockton unit. The assumptions used to model the bed numbers need to be robustly challenged and risk-assessed. Whilst it is very commendable that the CCG is emphasising the importance of providing adequate community services, and are putting plans in place to enhance admissions avoidance, it would be unwise to make any great assumptions that this necessarily will result in lowering the rise in hospital admissions. The Trust does need to plan for worse-case scenarios and risk-assess appropriately. It is possible that levels of admissions continue to rise and the planned achievements or reduction in average length of stay are not realised. We think the public need to be reassured that capacity planning has been carried out rigorously and the new service will be able to run efficiently and provide beds when they are needed. It would be best practice for the acute medical unit to assume a bed occupancy of 75% rather than the higher levels it has been achieving presently. The proposed bed/ambulatory care spaces in the acute medical unit on the UHNT site must be carefully modelled on present numbers and the time of day when patents present to ensure that the high quality care provided at the moment will not be compromised by the introduction of patients queues

5.10. There is much to be gained by developing primary care services and utilising community care. A community approach that utilises case registers for elderly patients with multiple morbidities, who are then appropriately risk stratified, would hopefully identify those patients in danger of needing admission so that they can receive targeted care within the community. Whilst we cannot guarantee that this would drive down

hospital admissions, the health economy can only thrive in the future if it reduces the reliance on hospital services, where the majority of costs are; the approach must be to concentrate on provision of high value interventions and decommission those healthcare interventions that have low value.

5.11. Removal of the acute services and critical care services from UHH will mean the Trust is able to focus on the provision of elective care on the UHH site. This can have considerable advantages in improving efficiency , patient flows and lowering rates of hospital acquired infection. Elective sites should be run to maximally utilise those resources, ensuring high levels of bed occupancy and theatre utilisation with low rates of cancellation and short waiting times. Patients will need to be appropriately risk-stratified, we were pleased to hear that the surgeons and anaesthetists fully recognise this. Consideration should be given to all the specialties that could potentially provide services on the UHH site as part of an elective care centre to ensure maximal utility of this site.

5.12. So far there has been very little debate about what the clinical support will be like following reconfiguration, and the key clinical competencies that must be provided in and out of hours within the on-site clinical team. This will be an important issue to resolve in advance of the transfer, and will determine exactly what the case-mix of patients who will be treated at UHH should be. There are a number of modern practices which can significantly enhance post-operative care of patients within daytime and early evening hours to ensure safe post-operative recovery and identify those patients who need further care (ie if they deteriorate surgically or have medical complications). This will require that appropriate protocols are put in place with physiological tracking schemes which provide an early warning of those patients who might need further care or indeed transfer to UHNT.

5.13. We would suggest that the clinicians, i.e. the surgeons and anaesthetists, get together very quickly to discuss these issues and agree on what the protocols of care should be, and what this might mean for the design of the clinical services. A lot can be safely done out of hours with the provision of a clinical team consisting of advanced care nurse practitioners with

resuscitation skills (ALS) but we suspect, following the discussion of the proposed case-mix of patients, there will need to be a medical presence on site overnight. This was described as a resident medical officer, or alternatively as a surgical trainee. The key to unlocking this problem is to look at the competency base of the whole team required to be on site in and out of hours. This will identify the skills and competencies of the individuals required. For instance we have seen similar plans where it was thought the most appropriate individual was an anaesthetist in training. Senior level support can be via telephone, presumably the on-call team at UHNT. Further thought should be given to whether telemedicine connections have anything to offer; for instance a video link might enable a consultant at distance to see and evaluate a patient, and watch a clinical exam. Digital imaging information can be easily transferred between the two hospitals. Our conclusion was that more work needs to be done to define the level of clinical support which would reside in and out of hours at UHH.

5.14. Turning to the more strategic issue of the long-term future of acute hospital services within the North East. This is of course a very large question, but it is one we feel we must raise. Whilst we wouldn't want to hold up the planning that is moving at a pace for the new acute hospital at Wynyard, we would point out that, within the North East, there are probably too many small DGH style hospitals. It would be appropriate to consider the consequences of planning a new hospital as above, but also to recognise that there may be an opportunity to configure services advantageously for the North East which in this case we would define roughly as that area between the Tyne and the Tees. It is clear that the two fixed points for acute hospital services are the Royal Victoria Infirmary at Newcastle and the James Cook University Hospital Middlesbrough. These are both large tertiary and, secondary care style hospitals which provide most services. What then is the requirement for other acute care providers? Whilst we recognise that the Healthcare Act provides for more qualified providers coming into the marketplace, acute care is extremely complex and costly and requires a strategic plan with partnership working between commissioners and providers.

5.15. The challenges ahead are a health economy which will not be growing as in previous years, and a requirement for year on year significant efficiency

savings. The major brunt of this inevitably will fall on the acute services, especially as there is a drive to improve primary and community services and deliver more care closer to patients' homes. The inevitable result of this is that there will be a requirement for fewer acute hospitals, and that these will cater for larger populations. The other side of the coin is that clinical care is becoming increasingly specialised within the acute sector, and needs to be provided by larger teams of clinicians who are available around the clock to ensure that patients' conditions are diagnosed speedily, and that there is immediate access to diagnostics and treatment in order to improve clinical outcome and produce shorter stays in hospital. Other drivers to change include a coming together of more specific services, for instance paediatrics, with the drop in the need to admit children and a requirement to provide 24/7 high quality inpatient care from dedicated paediatricians. This inevitably means there will be fewer paediatric inpatient units in the North East. We are aware that there are discussions within the North East to determine where these may be placed. The inevitable consequence of fewer paediatric units is fewer neonatal intensive care units and that will define where obstetric units will be placed (unless the size of the maternity unit justifies having its own standalone NICU).

5.16. We raise these issues because we think that there needs to be a broader strategic assessment of the requirement for acute hospital services within this geographical area and that CCGs need to come together to future-proof any plans they may have for new capital investment in acute hospital services. In the case of the proposed new hospital at Wynyard for instance, there may be a critical cut-off level for the population catchment area which will mean that the business case is challenged. If for instance this geographic site means that more patients from Hartlepool, through choice, are drifting down to the James Cook University Hospital, that could reduce the patient catchment to about 300,000,which will lead to a potential fall in income to fund the complex acute hospital care we would envisage as above. We would estimate (and here the evidence base can be challenged) that a larger population base of 500,000 and above, would lead to a more sustainable and affordable model. Nevertheless there are many other factors to consider including geographical variation, population clusters, travel times and political factors. Despite this, we think that this issue must

be raised with the commissioners and addressed speedily prior to proceeding with the new hospital build.

6. Conclusions

6.1. The clinical case for change is accepted. NCAT can support the move of the acute medical services and critical care services to UHNT. The timescale, whilst challenging, is supported and necessary in view of the potential for clinical risk at the UHH site

6.2. Capacity modelling needs to be robust and ensure that the reconfigured acute medical service aims to operate with an average bed occupancy of 75%.

6.3. The Trust needs to describe clearly what these changes will mean for the public and what services can be expected on both sites. A number of clinical narratives describing patient journeys need to be put forward to explain the change.

6.4. The public needs to see action taken about their concerns regarding transport and availability of appropriate public services between the two sites. Additionally the North East ambulance service needs to ensure they have sufficient capacity to deliver the increased numbers of transfers that might arise.

6.5. The residual clinical support (including medical on call) needs to be described on the UHH site. The approach should be one whereby the clinical competencies for the out of hours and in hours teams are defined to support the acutely ill patient.

6.6. The CCG and Trust need to work together to define patient pathways which ensure the right patient is treated in the right place first time, the aim being to reduce the number of patients who are admitted to secondary care and to improve overall quality of care delivered to patients, particularly those with multiple morbidity and long-term care needs.

6.7. The bigger questions of acute hospital strategy for the North East need to be addressed (see above).

7. Recommendations

7.1. The Trust proceeds to public consultation regarding the changes described above as soon as possible.

7.2. The CCG and Trust working together to respond to the conclusions as above and gives a written response to NCAT and NHS North of England within 3 weeks.

7.3. The CCG and Trust consider the need for external clinical review of the plans for the new hospital beyond the element of review built into the next steps of commissioning the new hospital to ensure that the model of care and facilities proposed will meet the needs of the local population and wider strategic direction of healthcare in the North East.

Appendix 1 Documentation Received

1 Covering Letter

2 Strategic Options

2.1 Strategic Options – 4 May 2012
Previous versions available if required
2.2 Presentation Transition Plan Summary of Options 12 June 2012

3 Cases for Change

3.1 Transition Plan 17 October 2011
3.2 Transition Workshop outcomes

4 Project Management of Service Reconfiguration

4.1 Presentation Strategic Options for Future Configuration of Services – 24 April 2012

- Transition Board Agenda – 17 January 2012
- Transition Board Agenda – 17 October 2011
- Service Transformation Project Group – Agenda of 7 December 2012

4.2 Service Transformation Project Group – Terms of Reference
4.3 Service Transformation Project Group – Project Initiation Document
4.4 Service Transformation Project Plan
5 North of Tees Partnership Board Agenda 20 December 2012
4.5 North of Tees Partnership Board Terms of Reference
5 North of Tees Partnership Board Agenda 21 June 2012
4.6 Minutes of the North of Tees Partnership Board – 21 June 2012
4.7 Service Transformation Presentation to North of Tees Partnership Board – 21 June 2012

5 Communication and Stakeholder Engagement

5.1 Communications Strategy and Implementation Plan
5.2 £40 m Challenge / Transition Plan – Engagement Schedule
5.3 Report to Executive Team: future service model 28 August 2012
5.4 Report to Trust Board: future service model 13 September 2012
5.5 Presentation to Trust Directors Group 19 October 2012
Report to Trust Executive Team 27 November 2012
Audit Trail of Current Engagement relating to Service Transformation.

6 Overview and Scrutiny Committee

6.1` Presentation to demonstrate the Trusts' commitment to developing services in Hartlepool – February 2012
6,2 Presentation by NHS Hartlepool on the proposal to transfer Outpatient Services to One Life
Hartlepool – 23 August 2012
6.3 (a & b) Presentation by NHS Hartlepool and Stockton and Tees Clinical Commissioning
Group and North Tees & Hartlepool NHS Foundation Trust – October 2012
6.4 Report to outline the potential impact of Outpatient moves into Community settings –

December 2012

6.5 The Positive Moves discussed with Hartlepool OSC on 15 December 2011

7 Clinical Evidence

- Links to Clinical Evidence documents

8 Guidance and Service Reviews

8.1 Guide to Service Change – Incorporating the NHS Yorkshire and the Humber Service Change Assurance Process

8.2 Reconfiguration Proposals That Have Passed The Lansley Criteria (HSJ Online (19/11/10)

8.3 Tees Review Acute Services – Report by Professor Sir Ara Darzi 2005

8.4 Independent Reconfiguration Panel Report (IRP) – Advice of Proposals for changes to Maternity and Paediatric Services in North Tees and Hartlepool 2006

9 Clear and Credible Plans

9.1 NHS Hartlepool and Stockton-on-Tees CCG

9.2 NHS Durham Dales, Easington and Sedgefield CCG

10 Activity and Performance and Additional Information

10.1 Annual Report

10.2 Annual Plan

10.3 Operational Efficiencies Report 2011/12

10.4 Operational Efficiencies Report 2012/13 to date

10.5 Board of Directors Report – Operational Efficiencies – November 2012

10.6 Board of Directors - Winter Resilience Report – October 2012

Appendix 2

PROGRAMME FOR VISIT

Time	Subject	Venue
9.15 am 9.20 am 9.35 am 9.50 am	Introduction to NCAT by Dr Chris Clough Expectations of the Visit and NHS Hartlepool and Stockton-on-Tees Clear and Credible Plan – led by Dr Boleslaw Posmyk and Mrs Alison Wilson. Case for Change and the bigger picture – led by Trust Executive Team. Discussion	Board Room University Hospital of Hartlepool
10 am	Tour of facilities at the University Hospital of Hartlepool including ITU, Ward 7, EAU and Ambulatory Care	Visit General Medicine and Critical Care
11.45 am 12.15 am	Clinical Case for Change Discussion	Board Room University Hospital of Hartlepool
12.30 pm	**WORKING NETWORKING LUNCH** Trust consultants drop in	
1 pm	Meet with Local GPs and CCG Representatives	Board Room, University Hospital of Hartlepool
2pm	Meet with Representatives from Hartlepool, Durham and Stockton Overview and Scrutiny Committee	Board Room, University Hospital of Hartlepool
2.45pm	Meet with Representatives from Patient Carer Groups (LINKs, Hospital User Group)	Board Room, University Hospital of Hartlepool
3.15 pm	**TRAVEL TO UNIVERSITY HOSPITAL OF NORTH TEES**	
3.50 pm	Tour of facilities on the University Hospital of North Tees including EAU, Ambulatory Care, Short Stay Unit and Critical Care Unit.	Visit General Medicine and Critical Care
4.45 pm	Closing Session	Board Room, University Hospital of North Tees
5 pm	Depart the University Hospital of North Tees	

People Met

Julie Gillon	Chief Operation Officer/Deputy Chief Executive
David Emerton	Medical Director
Lynne Hodgson	Director of Finance & Information Management
Alan Foster	Chief Executive
Sue Smith	Director of Nursing and Patient Safety
Farooq Brohi	Consultant Anaesthetist & Critical Care
Kevin Oxley	Commercial Director
Narayanan Suresh	Clinical Director Anaesthetics
Cameron Ward	Acting CE NHS Tees Director (Durham, Darlington & Tees) Area Team of NHS Commissioning Board
Ben Clark	Assistant Director (Durham, Darlington & Tees) Area Team of NHS Commissioning Board
Katie Dixon	Strategic Planning Manager
Nick Roper	Clinical Lead, Acute Medicine and New Hospital
Jean Macleod	Clinical Director Medicine
Linda Watson	Clinical Director of Community Services
Peter Tindall	AD Strategic Planning & Development
Boleslaw Posmyk	Chair NHS Hartlepool and Stockton-on-Tees CCG
Ali Wilson	Chief Officer NHS Hartlepool and Stockton-on-Tees CCG
Paul Williams	Locality Lead (Stockton) NHS Hartlepool and Stockton-on-Tees CCG
Mike Smith	Locality Lead (Hartlepool) NHS Hartlepool and Stockton-on-Tees CCG
Paul Pagni	GP
Nick Timlin	GP
Paddy O'Neill	GP
S Findlay	GP, CCO DDES CCG
Graeme Niven	Chief Finance Officer, NHS Hartlepool and Stockton-on-Tees CCG
Jed Hall	Vice Chair, Hartlepool Health Scrutiny Forum
Louise Wallace	Director of Public Health, Hartlepool Borough Council/PCT
Keith Fisher	HBC – Member of Health Scrutiny Forum

G Lilley	HBC – Member of Health Scrutiny Forum
J Beall	Deputy Leader, Chair HWB Stockton Borough Council
M Javed	Chairman Health Committee Stockton Borough Council
Peter Kelly	Director of Public Health, Stockton Borough Council
Peter Meenear	Scrutiny Officer, Stockton Borough Council
Cllr Robin Todd	Chair, PWH OSC Durham County Council
Feizel Jassat	OSC Manager, Durham County Council
Chris Greaves	General Manager, Anaesthetics & Critical Care
Sue Piggott	General Manager Medicine & Emergency Care
Chris Tulloch	CD Trauma/orthopaedics
Pud Bhaskar	CD Surgery/urology

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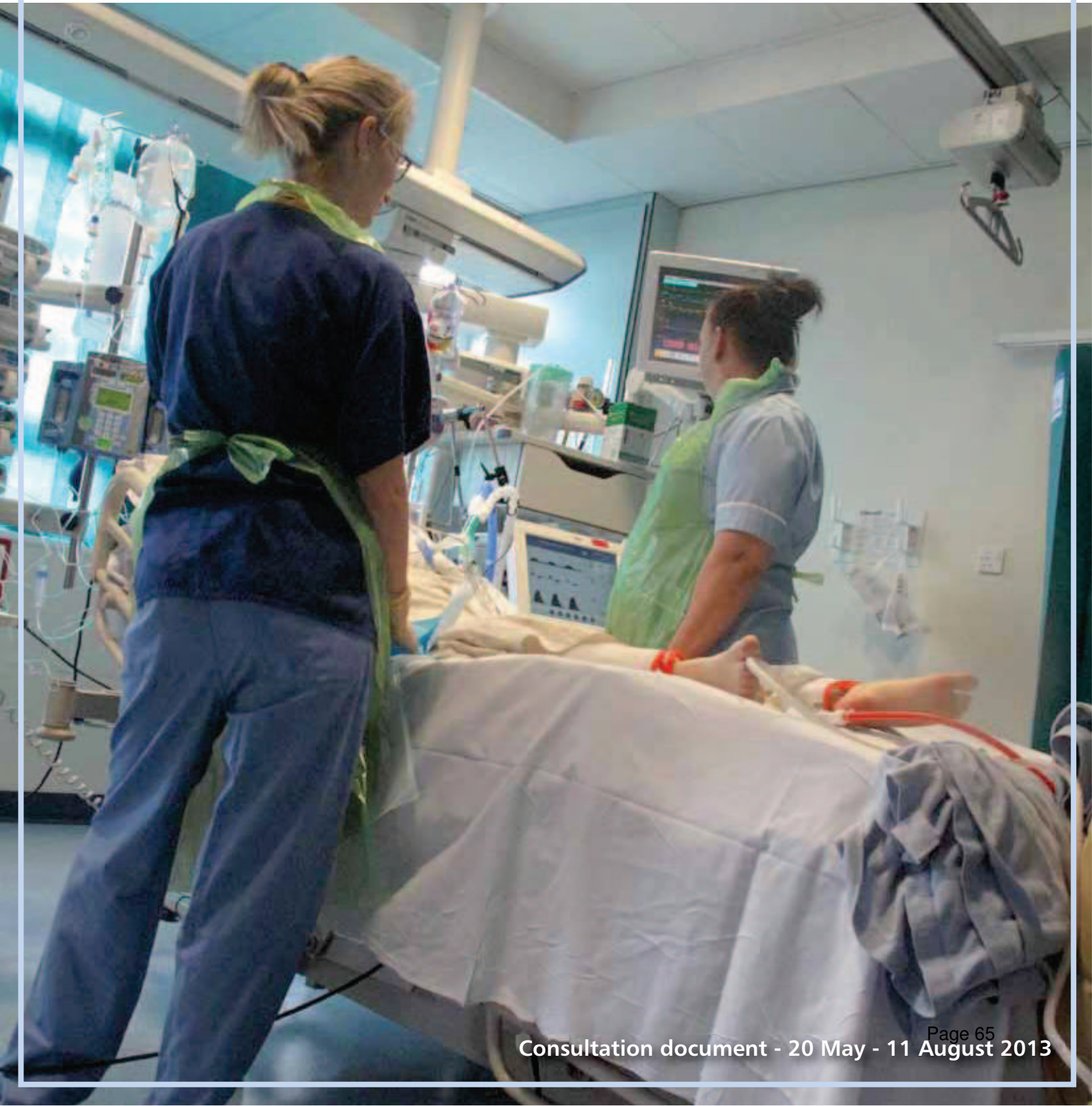
NHS
Durham Dales, Easington and Sedgefield
Clinical Commissioning Group

NHS
Hartlepool and Stockton-on-Tees
Clinical Commissioning Group

North Tees and Hartlepool NHS
NHS Foundation Trust

Providing safe and high quality care leading up to the opening of the new hospital



Consultation document - 20 May - 11 August 2013

Providing safe and high quality care leading up to the opening of the new hospital

A consultation on how best to ensure people have access to the safest and best quality, acute medical and critical care they need, in the lead up to the opening of the new hospital by:

Hartlepool and Stockton-on-Tees Clinical Commissioning Group

Durham, Dales, Easington and Sedgefield Clinical Commissioning Group

North Tees and Hartlepool NHS Foundation Trust

Consultation begins 20 May and ends 11 August 2013

If you require this information in another language or format please contact us on 01642 666815

Arabic 01642 666815 إذا احتجت لهذه المعلومات بلغة أخرى أو تنسيق آخر، فالرجاء الاتصال بنا على

যদি আপনি এই তথ্য যে কোনো ভাষাতে বা ফর্মেটে চান তাহলে, অনুগ্রহ করে 01642 666815 নম্বরে আমাদের সাথে যোগাযোগ করুন। Bengali

若您需要本資料的其他語言版本或格式，請與我們聯絡，電話 01642 666815 Cantonese

यदि आपको यह जानकारी किसी अन्य भाषा अथवा फॉर्मेट में चाहिए तो कृपया 01642 666815 पर हमसे सम्पर्क करें। Hindi

ਜੇ ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਜਾਂ ਫ਼ਾਰਮੈਟ ਵਿਚ ਚਾਹੀਦੀ ਹੋਵੇ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਡੇ ਨਾਲ 01642 666815 'ਤੇ ਸੰਪਰਕ ਕਰੋ। Punjabi

Urdu اگر آپ کو یہ معلومات کسی دیگر زبان یا شکل میں چاہئیں تو برائے مہربانی ہم سے 01642 666815 پر رابطہ قائم کریں۔

Why are we carrying out this consultation?

The commissioners' view

Dr Boleslaw Posmyk
Chair, Hartlepool and Stockton-on-Tees Clinical Commissioning Group (CCG)

Dr Paul Williams
Stockton-on-Tees locality lead, Hartlepool and Stockton-on-Tees CCG and governing body member

Dr Mike Smith
Hartlepool locality lead, Hartlepool and Stockton-on-Tees CCG

Dr Stewart Findlay
Chief clinical officer, Durham, Dales, Easington and Sedgefield Clinical Commissioning Group

We are carrying out this consultation because the doctors who provide emergency medical and critical care services at North Tees and Hartlepool NHS Foundation Trust have told us they cannot carry on providing these services safely and to the expected quality standards on two sites until the new hospital opens in 2017.

We buy these services from the hospitals for local people and we are responsible for their safety and quality. As commissioners we cannot wait until a problem arises before acting. Our job is to look forward and try to prevent problems from happening because this is in the interest of patients and everyone we serve.

We asked the National Clinical Advisory Team to visit us to listen to the doctors, nurses and managers, patient representatives, politicians and other stakeholders so they could give us an independent view of the situation and what we should do about it.

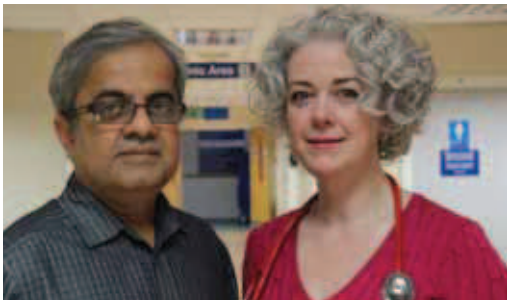
The National Clinical Advisory Team provide independent clinical expertise to support and guide the local NHS on service reconfiguration proposals to ensure safe, effective and accessible services for patients. Our team was lead by Dr Chris Clough from Kings College Hospital, London.

We now have a copy of the National Clinical Advisory Team report and this is why we are now holding this consultation.

The report said we should:

- work with the trust to centralise emergency medical services and critical care to the University Hospital of North Tees as soon as possible
- explain to the public what this means for them, which is why we are including a number of examples later in this document
- ask their views about the things that they are concerned about, especially how they and their relatives get to hospital

The provider's view



Dr Suresh Narayanan
clinical director for anaesthetics and critical care

Dr Jean MacLeod
clinical director for medicine

North Tees and Hartlepool NHS Foundation Trust

As the doctors who lead medicine and critical care in the trust, we are becoming increasingly concerned about our ability to provide safe services across our two hospital sites until the new hospital opens.

We are passionate about providing the safest, highest quality care possible and to meeting or exceeding the standards expected by the Department of Health, professional organisations, the deanery (which is responsible for organising the training of tomorrow's doctors) and most of all our patients.

While our services are safe and good quality today we want to ensure they will continue to be in the years to come. We want to ensure we can continue to provide excellent care for all our patients in the short, medium and long term – the type of care we would want for ourselves and our loved ones - but when our medical and nursing colleagues tell us they are concerned, then we have to act.

We raised these concerns at the highest level in the trust and, quite correctly, the trust raised these concerns with our commissioners who buy this care from our trust.

Together, as commissioners and provider, we are totally committed to ensuring that patients from the area we serve - Hartlepool, Stockton and parts of Easington and Sedgefield – can rely on the same standard of service regardless of where they live.

Had the new hospital opened its doors in 2014 as originally planned then we would have been bringing medical and nursing teams together now to be ready for the move to the new hospital. As things stand the new hospital is now expected to open in 2017 and we know things cannot stay as they are until then because:

- quite rightly, safety and quality standards continue to rise, but it is becoming increasingly difficult for us to keep pace with these requirement on two sites
- the way junior doctors are trained has changed and the deanery will not allow trainees to work in hospitals where they do not see enough patients to increase their learning and skills
- like the rest of the NHS we need to bring services together to ensure we can achieve the same standards of care for everyone living in the area served by our trust

Already, because of advances in medicine many patients from our area already go past their local hospital for their emergency medical care. For example:

- patients who have had a stroke are all taken to the University Hospital of North Tees where we can offer the latest treatments seven days a week, 365 days a year. We used to provide these services seven days a week at the University Hospital of North Tees but were only able to provide them Monday to Friday, 9am until 5pm, at the University Hospital of Hartlepool which was unfair on people from Hartlepool and Easington because strokes don't just happen in working hours. Because we have brought the skilled doctors who can carry out these treatments together we can now provide these services for everyone we serve.
- patients who have had certain types of heart attack are assessed at the scene and taken to The James Cook University Hospital in Middlesbrough to have the affected artery unblocked.

Both of these advances in medicine give patients a better chance of survival and recovery. As doctors we want local people to have access to the very best care available. This does mean this care cannot always be on the doorstep but in the modern NHS we have to accept that, while we can have most of our straightforward care provided locally, we have to travel for more specialist care.

It's also important to remember that most of the care provided by the health service is already provided in GP surgeries, local clinics and in people's homes and, under the *momentum: pathways to healthcare* programme, this will continue. We are beginning to take advantage of new technologies like telehealth where people can monitor their own health at home supported by a highly skilled team of community nurses. We already have many excellent examples of where this is working well and preventing people from having to be admitted to hospital. Medicine is advancing all of the time and we want to ensure we can offer the latest and best services and technologies to local people.

We are working closely with our commissioners because they, as the people who buy your care, and we, as the people who provide your care, have the same aim; that is to make sure your care is of the very best standard, wherever you live in the area we serve.

The important thing for you to know is, once the changes have been made, you do not need to do anything different. If you are unwell you will either contact your doctor or ring 999, just as you would today. Ambulance paramedics will assess you when they arrive and, if appropriate, begin treating you. They will make sure you get to the right place and to the right experts for any further treatment and care you need.

This is why we are joining Hartlepool and Stockton-on-Tees Clinical Commissioning Group and Durham, Dales, Easington and Sedgefield Clinical Commissioning Group to explain why things need to change but also to listen to any concerns you may have so we can address them.

How did we get to where we are now?

In 2008 what were then Hartlepool Primary Care Trust and North Tees Primary Care Trust and North Tees and Hartlepool NHS Foundation Trust began the *momentum: pathways to healthcare* programme.

The programme came about because the then Secretary of State for Health carried out a large national public consultation to ask people how they would like health care to be in the future. The results of this large national consultation became the White Paper *Our health, our care, our say*

People said they wanted:

- to be kept fit and healthy and for the health service to step in early if people start to become ill
- care given close to or in their own homes
- a health service that fits in with their lives, not the needs of the health service
- only to go to hospital if they couldn't be looked after nearer home or at home

There were other reasons too:

- people are, fortunately, living longer but they are often living with a number of health problems and the local health service has to change the way it works to ensure it can provide the type of care local people need
- the doctors, nurses and other health professionals want to continually improve care and that means they have to change the way they work to do this by:
  - making waiting times shorter
  - providing more services in GP practices and town centre clinics
  - making services safer
  - working in increasingly specialised teams to make the best use of their skills and resources
- the way doctors are trained has changed and the organisation responsible for training will only send their doctors to work and train in areas where they will get the right experience to improve their skills

The *momentum: pathways to healthcare* programme is made up of three things:

- changing and transforming the way the local health service works to provide better, safer care for patients
- providing a network of community and town centre facilities
- building a new hospital to replace the University Hospital of Hartlepool and the University Hospital of North Tees

The new hospital

The new hospital is the final piece of the *momentum* jigsaw

The government offered public funding for the new hospital in March 2010. However the new government withdrew this funding in June 2010. The government said it realised there was a need to build the new hospital but the organisations who buy services on behalf of local people and the trust needed to find a different way to pay for it.

This means that, instead of the new hospital being open in 2014 as planned, it is now expected to open in 2017.

Doctors providing emergency medical and critical care at North Tees and Hartlepool NHS Foundation Trust told the commissioners that, while they could have made arrangements to keep the two hospitals' emergency medical wards and critical care open until 2014, they simply cannot do this until 2017. They said they want to take the interim step of centralising emergency medical wards and critical care at the University Hospital of North Tees until the new hospital opens to keep services to the high standards we all want and expect.

As commissioners and providers of care our main concern is safety and quality and we are becoming increasingly uncomfortable with the current situation because we know the services in the two hospitals are increasingly unequal. This is making it impossible to provide the levels of safety and quality we would all want in the longer term

We are doing our very best to minimise these inequalities but, because of the increasingly high standards of care required, this is becoming a major challenge and we all know we cannot keep providing the type of care patients deserve with things the way they are.

This is because:

- it is becoming more and more difficult to staff medical rotas on two sites
- the standards of care required are, quite rightly, rising continuously

What we are proposing to do

After much discussion with health professionals, a review of alternative options and receiving the report from the independent National Clinical Advisory Team, which agreed with us that there are no viable safe alternatives, we are now proposing to centralise emergency medical and critical care services at the University Hospital of North Tees from October 2013.

Bringing these services together would affect some other services such as other parts of the medical directorate, pathology, radiology, pharmacy and other support services such as facilities and catering. It would mean that patients with lots of medical problems will not be able to have planned operations like hip replacements at the University Hospital of Hartlepool but we do not expect this would affect very many patients because modern anaesthetics are safer. We want to ensure that most health care in Hartlepool continues to take place locally so we will be looking at ways to provide more low-risk operations and other treatments in the University Hospital of Hartlepool for local people. However we always have to assess if this will be safe and it will be for that reason and that reason alone, that we would transfer high risk planned operations to the University Hospital of North Tees.

We know this proposal will worry and disappoint some people but as the organisations which are responsible for your services we cannot allow this situation to go on any longer and we know these changes should be made.

How it will work

Leading up to the proposed changes we would:

- open 120 beds at the University Hospital of North Tees to make sure we have enough beds and staff to look after patients from right across our area;
- make extra space in critical care so we can look after critically ill patients;
- we would then, gradually, close the beds in medicine and critical care at the University Hospital of Hartlepool and;
- transfer a number of staff from support services such as pharmacy, radiology and pharmacy and estates who need to come to the University Hospital of North Tees to support the new arrangements.

Patient stories

The National Clinical Advisory Team said we should set out how things would work in future if these proposals are implemented.

Here are some examples

Elsie's story

Elsie, 75, from Greatham is feeling unwell. She has had heart problems for a while but today she feels very short of breath, her daughter is worried about her and phones her GP. The GP calls at the house and decides Elsie needs to be in hospital. The GP tells the hospital he would like Elsie brought in during the next two hours. The ambulance arrives and takes Elsie to the emergency assessment unit at the University Hospital of North Tees where she is assessed by the doctor in charge. The doctors diagnosed an irregular heart beat and start Elsie on drugs to treat it. She is also put on a heart monitor and observed by nurses for the next 24 hours. The doctor says Elsie can go home and her daughter comes to collect her. The nurses make Elsie an appointment to see the heart specialist in outpatients at the University Hospital of Hartlepool the following week.

George's story

George, 80, from Hartlepool, has a painful swollen leg. He is worried about this and phones 999. The ambulance takes him to the ambulatory care unit which is part of the emergency assessment unit at the University Hospital of North Tees He is diagnosed with a deep vein thrombosis. While in the ambulatory care unit he is started on blood thinning drugs. A specialist nurse explains to George that he will have to take the drugs for several weeks. The doctor says George can go home. A nurse arranges for George to be taken home by ambulance. The district nurse visits George at home to see how is doing until he is fully recovered.

Jason's story

Jason, 45, from Easington, has diabetes had a fluttering feeling in his chest and was dizzy. He thought he was going to faint so he called 999. The ambulance paramedic carried out an ECG (a heart test) at Jason's house. The ECG showed that Jason wasn't having a heart attack but he did need medical attention so the ambulance brought him to the emergency assessment unit at the University Hospital of North Tees. Jason was put on heart monitoring equipment and was given drugs to stabilise his abnormal heart beat. The doctor said Jason could go home once he was stabilised on the treatment but he needed to see a heart specialist to get to the bottom of the problem so an appointment was made for him to see a heart specialist at the University Hospital of Hartlepool the following week.

John's story

John, 75, has diabetes. He was feeling ill because his diabetes was out of control and he phoned 999. The ambulance paramedic assessed him at home and then he was brought to the University Hospital of North Tees. A doctor specialising in diabetes was able to see him straightaway and he was given the appropriate drugs to stabilise his diabetes. He stayed in overnight for observation and was allowed home the next day. He saw the diabetes specialist in outpatients the following week to ensure his diabetes was stable.

Mary's story

Mary, 70, is taken ill and her son phones 999. The ambulance takes Mary to the University Hospital of North Tees where she is diagnosed with pneumonia. Mary becomes worse and she has to be transferred to critical care for intensive medical support. After two days Mary is improving and she is transferred back to the ward. After three days Mary is allowed to go home with support from the community team who give her intravenous (a drip) antibiotics every day for the next 10 days until she has fully recovered.

Sharon's story

Sharon, 47, from the Fens, Hartlepool, noticed her leg was red and sore. She also felt feverish. She went to her GP who said she needed to be seen by a hospital doctor. Her husband took her to the ambulatory care unit at the University Hospital of North Tees, part of the emergency assessment unit. A doctor assessed Sharon's leg and the soft tissue infection was diagnosed as cellulitis. She was started off on a drip of antibiotics while in the ambulatory care unit and after further observations she was allowed home four hours later. The unit arranged for the rapid response nurses to go to Sharon's home to give her intravenous antibiotics each day Three days later she came back to the ambulatory care unit to see the doctor who was happy with how the soft tissue infection was clearing up. He recommended intravenous antibiotics until the end of the week and the rapid response team came to Sharon's house daily to give the treatment until the infection cleared up. This saved Sharon and her husband several trips to hospital.

Betty's story

Betty, 90, from Easington ,was confused and unable to get out of bed and her son called the GP. The GP thought Betty should be in hospital and asked for her to be admitted in the next two hours. The ambulance brought Betty to the emergency assessment unit at the University Hospital of North Tees where she was assessed by doctors. Betty had a urine infection which was making her confused so doctors started her on antibiotics. Doctors arranged for Betty to be transferred to the step down ward at the University Hospital of Hartlepool in a ward staffed by highly skilled nurses and therapists. It was becoming clear that Betty was having difficulty managing in her own home and discussions began so Betty could move to a home specially set up to meet her needs. Her family were pleased that they could visit her easily in the two weeks she stayed in hospital.

Transport

When the new hospital is built

Looking on a map, the new hospital (signified by the red dot) is centrally located in the area we serve. At the moment it is a green-field site on what we know is a very busy junction off the A19/A689. But the plans for the new hospital are supported by a comprehensive public and private transport plan and we are committed to ensure the new hospital is easily accessible for all.

As things are now

We know people may not find it easy to get to the University Hospital of North Tees for emergency care or to the University Hospital of Hartlepool for a planned operation. We know it can be difficult for people to visit their loved ones.

North Tees and Hartlepool NHS Foundation Trust's council of governors has a transport committee which is already working on improving transport for patients, visitors and staff.

So far the trust has:

- set up joint working with Hartlepool Borough Council to improve transport
- recruited a team of volunteer drivers to help people with transport problems to access hospital services
- ordered two 17-seater buses so it can increase the cross-site shuttle bus service

Please tell us about your concerns and if there's anything else we could be doing so we can try to address them.

Publishing the report

On 15 May we shared the report of the National Clinical Advisory Team with all the people the independent experts met when they visited the area in January.

At that meeting we listened to the questions and comments and we have added them to this document so we can ensure that we address all of these issues.

- People were disappointed that services could not stay in two separate sites and the doctors explained why this was the case. They also explained that they had done many things to try and preserve services on two sites but that was becoming increasingly difficult to do.
- The main concern was transport and people told us that it was very difficult for people to get to the University Hospital of Hartlepool from Stockton and to the University Hospital of North Tees from Hartlepool and Easington, especially by public transport. There were issues about the ambulance patient transport service which does not start until 8.30am. This is a problem for people who have early appointments and makes it impossible for people to get to hospital on time when they are already worried and distressed about their treatment. We promise we will look into this urgently.
- People wanted to know if we would scrap the plans if the public consultation resulted in local people being unhappy about the changes. We said we were going into the consultation with an open mind and we were not prepared to say what we would do until we had heard everyone's views at the end of the consultation.
- People thought we didn't try hard enough to put things right in Hartlepool. We explained that we had done as much as we possibly could to put things right and we were left with no option but to centralise services to keep them safe for the future.
- People thought the North Tees and Hartlepool NHS Foundation Trust paid different rates of pay and gave shorter contracts to doctors working at the University Hospital of Hartlepool. This is not true. All doctors working at the trust have a trust-wide contract and are expected to work at either hospital.
- People thought the people of Hartlepool were being let down. The doctors explained that they would be letting people down if they allowed the current situation to continue.
- People thought that no more joint replacements would be done at the University Hospital of Hartlepool. This is not correct. The trust's doctors explained that they intend to continue carrying out joint replacement at the University Hospital of Hartlepool with the only exception being where patients had many medical problems because those patients need the back up of critical care so the operation can be carried out safely.
- People thought that the people of Stockton might suffer if all of the services were brought together. The trust's doctors said things would actually improve for everyone if the services were brought together.
- People thought the consultation is a done deal. The clinical commissioning group explained that, while they believe the changes need to go ahead, they do want to listen to people's views.
- People thought the National Clinical Advisory Team were the hatchet men. The National Clinical Advisory Team is a team of independent medical experts who do not know the organisations and who come in, look at the evidence in front of them and speak to doctors, nurses, managers, patient representatives, politicians and other stakeholders. No health organisation can persuade the National Clinical Action Team to say anything it doesn't want to say.

What this consultation is about

We want to get your views on our proposals and understand your concerns about the proposed changes and we would particularly like you to answer the following questions for us:

1. What do you think are the advantages and the difficulties (or disadvantages) of the proposed changes?
2. If you still have concerns, what are you most concerned about and how could we help to reduce your concerns?
3. What do you think are the main things we need to consider in putting the proposed changes in place?
4. Is there anything else you think we need to think about?

We know for example that people could be concerned about how they get to the hospital to visit their loved ones. We promise we will listen to these concerns and we will work with the local authorities and others to do whatever we can to help.

Please use the time in the 12 weeks of the consultation to tell us your views. You can do this by:

Writing us an email and send it to: **communications@tees.nhs.uk** or,

Writing to:

Hartlepool and Stockton-on-Tees CCG
FREEPOST NEA9906
Middlesbrough
TS2 1BR

or by coming to one of the meetings we have organised, see the website at:
www.hartlepoolandstocktonccg.nhs.uk for more details

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Reconfiguration proposals for emergency medical and critical care services in Hartlepool and North Tees

Draft Consultation Plan – 20th May 2013 v4

'Providing safe and high quality emergency medical and critical care.'

Introduction

This document outlines the plan for a consultation by NHS Hartlepool and Stockton on Tees (HAST) Clinical Commissioning Group (CCG), Durham Dales, Easington and Sedgefield (DDES) CCG (the commissioners) and North Tees and Hartlepool NHS Foundation Trust on how best to ensure people have access to the safe, high quality emergency medical and critical care they need.

Emergency medical services and critical care services work together closely to support patients who become critically ill.

The consultation will ask for views on our proposal to move emergency medical and critical care services from the University Hospital of Hartlepool to the University Hospital of North Tees and seek to understand concerns about the proposed changes so as to inform next steps.

Durham Dales, Easington and Sedgefield (DDES) CCG will be involved as a partner commissioner as their population will also be affected by these proposals.

This plan follows good communications and engagement practice and focuses on what will be meaningful to stakeholders. High quality communications and engagement must underpin any formal consultation to ensure it is as fair, robust and inclusive as possible. Adherence to Public Sector Equality Duties must also be demonstrated.

The approach will take into account the need for reconfiguration proposals to meet the four Tests for reconfiguration proposals to demonstrate:

- support from commissioners;
- strengthened public and patient engagement;
- clarity on the clinical evidence base; and
- consistency with current and prospective patient choice.

Section 244 of the consolidated NHS Act 2006 (which replaced Section 7 of the Health and Social Care Act 2001) requires NHS organisations to consult relevant Overview and Scrutiny Committees on any proposals for a substantial development of the health service in the area of the local authority, or a substantial variation in the provision of services.

A substantial variation is not defined in Regulations – Section 244 applies to any proposal where there is a major change to services experienced by patients.
It is important to understand the new legal framework for making service changes and the obligations both in statute and guidance over consultation. That is because the previous statutory obligations under s.242 of the Act will continue to apply to FTs and other NHS bodies, even though for commissioners they have changed to some degree, see below.

Obligations under the NHS Act 2006 (as amended) for CCGs and FTs

The duty placed on CCGs to promote public involvement and consultation is set out in section 14Z2, which states:

14Z2 Public involvement and consultation by clinical commissioning groups

(1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions ("commissioning arrangements").

(2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways)—
(a) in the planning of the commissioning arrangements by the group,
(b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and
(c) in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

(3) The clinical commissioning group must include in its constitution—
(a) a description of the arrangements made by it under subsection (2), and
(b) a statement of the principles which it will follow in implementing those arrangements.

(4) The Board may publish guidance for clinical commissioning groups on the discharge of their functions under this section.

(5) A clinical commissioning group must have regard to any guidance published by the Board under subsection (4).

(6) The reference in subsection (2)(b) to the delivery of services is a reference to their delivery at the point when they are received by users.

Context

North Tees and Hartlepool NHS Foundation Trust raised concerns with NHS HAST CCG that they could not sustain required quality and safety standards of emergency medical and critical care services at the University Hospital of Hartlepool, in either the medium or long

term. The trust put forward proposals to move emergency medical and critical care services from the University Hospital of Hartlepool to the University Hospital of North Tees.

NHS HAST CCG requested a review from the National Clinical Advisory Team (NCAT) in order to test the case for change and to provide clinical assurance for proposals. A review visit was undertaken on 29th January 2013 and the formal report launched on 15th May 2013.

The independent report from NCAT supported the trust's proposals and agreed with their concerns regarding sustainability and safety. Whilst NCAT are not recommending an emergency closure in their report, they acknowledge that the changes should be made as quickly as possible to ensure that local services are safe and of the required standard.

North Tees and Hartlepool NHS Foundation Trust have appraised potential options and concluded that the proposals to move these services to the North Tees site are the only viable option. The safety issues include isolation of working and access to appropriately trained staff, and therefore cannot be resolved through a financial solution.

Therefore, the scope of the formal consultation will ask for views and concerns about the proposal and how the impact of the proposed changes could be managed and implemented. It will be critical to explain the reasons for this option, and to make available supporting information which outlines how all options were appraised and evaluated. It will also be important to explain that the point of access for patients would not change as a result of these changes.

It should be noted that that approach and methodology for the consultation is proportionate to this scope. (See Appendix 1 – Communications and Engagement Implementation Plan.)

This proposal is set against the backdrop of the momentum: pathways to healthcare programme which was established in 2008 by North Tees and Hartlepool NHS Foundation Trust and the former PCT commissioners to transform the local healthcare system. (See Appendix 3)

A significant element of this programme is the capital project to build a new hospital to serve the people of Hartlepool, Stockton and parts of Easington and Sedgefield. Whilst some interim changes to services across the two existing sites are planned via the Momentum programme, this proposed change is not one of these as it has arisen due to concerns over quality and safety which are outwith the scope of Momentum.

Formal consultation

The formal consultation period will run for a 12 week period, beginning on Monday 20th May 2013.

In terms of governance and accountability, North of England Commissioning Support (NECS) will lead the formal consultation for the commissioners and North Tees and Hartlepool NHS Foundation Trust, and is therefore responsible for its successful delivery.

Support from the provider North Tees and Hartlepool NHS Foundation Trust will be essential in ensuring that the knowledgeable clinicians on the subject are able to both support and participate in the consultation process.

NHS Hartlepool and Stockton on Tees CCG and NHS Durham Dales, Easington and Sedgefield (DDES) CCG (the commissioners) and North Tees and Hartlepool NHS Foundation Trust (the provider) will jointly lead this plan.

Affected NHS provider organisations will take responsibility for consulting with their own staff.

A Task and Finish Group will be set up to plan and monitor the delivery of the consultation process.

The commissioners and Hartlepool NHS Foundation Trust will be accountable to Health Scrutiny Committees for Stockton-on-Tees, Hartlepool and County Durham on the consultation process. Local HealthWatch organisations will contribute to this consultation by representing the interests of patients and the public and will advise on consultation materials and contribute to discussion on the consultation proposals.

Key messages have been developed to communicate the scope of the consultation and case for change effectively to patients, the public, political and wider stakeholders and the media. A range of communications and consultation mechanisms will be utilised to ensure sufficient information and involvement opportunities are available to identified stakeholders.

Mapping of and planned engagement with hard to reach and protected groups is also underway as part of the commissioners' ongoing engagement plans.

NECS will commission independent specialist consultants to receive and independently analyse the responses. Respondents to the consultation will be able to feed back by email, freepost address, telephone or via the website.

NECS will produce a report on the consultation which will cover:

- stakeholders who have been consulted;
- what information was provided to those stakeholders;
- what matters those stakeholders were consulted about;
- the result of the consultation, including a summary of the differences expressed by those consulted; and
- details of the decisions or changes made following the consultation and the influence the results of the consultation had on that decision / change.

A Communications and Engagement Implementation Plan has been developed. (Appendix1).

Stakeholders

A list of stakeholders is attached at Appendix 2.

Objectives

A programme of activity will:

- Encourage responses to and involvement in the formal consultation
- Promote the consultation via all appropriate communications channels.
- Effectively manage and co-ordinate stakeholder engagement

Channels

The following communications channels will be utilised:

- A full consultation document which includes questions seeking views on the proposals to be distributed widely across the district, available online and on request.

- Public meetings in appropriate and accessible locations across the district and at a range of times to take account of the public's preferences.

- Presentations to a wide range of groups and audiences (pro-active and on request) including OSC, Healthwatch, patient groups, voluntary and community groups etc.

- Staff briefings and meetings as required.

- Information in prime community and health settings.

- The main website will be that of NHS Hartlepool and Stockton-on-Tees CCG. It will signpost people to online information/opportunities to comment, etc. There will be a link from NHS DDES CCG and North Tees and Hartlepool NHS Foundation Trust websites.

- Media – press release and paid-for advertorials and adverts.

- Posters in a range of community venues throughout the health economy including health settings, libraries etc.

- Information distributed and shared through public partners' publications and information points.

- Feedback forms and questionnaires.

- Local foundation trust members.

- Social media will be an important part of the process but there will need to be clear and robust mechanisms for monitoring, recording and responding to messages sent via social media.

- Appropriate commissioner and NTHFT representatives will meet with Overview and Scrutiny Committees, HealthWatch and any other appropriate groups identified to discuss the consultation document, respond to questions and facilitate consultation responses.

- Internal communications mechanisms such as staff newsletter and intranets will be used to ensure information is communicated to key staff groups.

- Opportunities for hard to reach, protected and under-represented groups, and all literature will be offered in alternative languages and formats.

- Third party distribution will be used where possible for economy, to encourage better dissemination and to demonstrate independent support e.g. articles for voluntary sector and local authority magazines.

- Consultations documents will meet accessibility guidelines.

- Web and online communication will provide access to all the information quickly and easily and enable people to have their say, and will meet accessibility guidelines.

Key messages

- Proposals to move emergency medical and critical care services from the University Hospital of Hartlepool to the University Hospital of North Tees have been validated for by national clinical advisors and are fully supported by the commissioners.

- The point of access for patients will not change i.e. people will not have to do anything different once the changes are put into place because the initial call will still be to 999 or the GP.

- The proposed changes are necessary and appropriate to support improvements in clinical quality and safety. An independent report has provided independent clinical assurance that these changes will result in better services for local people.

- Transferring services from the University Hospital of Hartlepool (UHH) to the University Hospital of North Tees (UHNT) is hoped to be an interim solution. In the longer term, both hospitals will close and until the new purpose-built hospital development receives final approvals.

- Investment has already been made in community services and intermediate care and towards reducing emergency admissions, and that this remains a priority.

- Commissioners and the trust are we are still all committed to moving to the new hospital because this will mean we can provide services in a more convenient geographical location. However, we need to take this interim step now to preserve and improve quality and safety.

- Acknowledging any short-term recommendations made and that proposals will be agreed across the health economy to address these and key stakeholders, including Overview and Scrutiny Committees, will be fully involved in this.

- As a result of the changes, 97 per cent of healthcare contacts will remain in Hartlepool. In the lead up to the opening of a new Hospital at Wynyard Business Park in 2017, the University Hospital of Hartlepool will become a centre for diagnostic tests, day case and low risk operations. There will also be an increase in the number of medical rehabilitation beds at the hospital.

Managing issues and risks

A rolling handling plan will be established at the start of the consultation and maintained by the NECS Communications and Engagement Team. This will include key lines and actions, and provide a core script with key messages, process detail, organisations' corporate lines and rebuttal messages to support all actions outlined.

It is vital that all the major partners are highly visible through this process, including clinicians from the trust. It will be important to provide adequate notice of meetings for clinicians in particular.

Appendix 1

Communications and engagement Implementation Plan

Area	Task	Who's responsible	Timescale
Stage 1 - consultation planning			
Task and Finish Group	Establish membership, agree scope and schedule meetings	MB/CY	By 3rd May
Finalise key messages and question areas	Develop: • Briefing paper • Presentation • Key messages and question areas		
Plan access to existing communications mechanisms	• Ensure/schedule upload to CCG and FT websites • Gather all supporting documentation e.g. ➢ Consultation document ➢ Relevant background information e.g. Momentum, Tees Review ➢ Options appraisal evidence • Prepare briefing via My NHS • Distribution of information to GPs, pharmacists • Prepare information – based on above – for communications teams within neighbouring NHS Trusts, local authorities, key relevant charities and groups	SJ/CY	By 10th May
Implement communications via mechanisms	• **All consultation materials and supporting information available on CCG and FT websites** • **Briefings and distribution above**	**SJ/CY**	**15th May** **By 17th May**
Brief FT PALS team	• Provide information and timetable	CY	By 10th May
Communications with staff	• FT mechanisms • NHS HAST CCG bulletin • NECS	CY SJ MB	By 10th May
Plan attendance at existing meetings and events	Agree schedule and attendance	T&F Group	By 10th May

Consultation planning	• Agree consultation timelines for: - Planning - Response mechanisms and handling - Questionnaire and document design and print - Advertising - Full handling of consultation meetings - Response handling, analysis and reporting	T&F Group	By 10th May
Prepare and finalise consultation document for agreement	• Ensure this meets four reconfiguration tests • Source case studies	CY – lead T&F Group	By 17th May
Agree final consultation document	• **Agree via extraordinary NHS HAST CCG Governing Body meeting**	**AW**	**16th May**
Further consultation materials	• Agree range of materials based on main consultation document • Draft and agree materials • Produce materials • Agree distribution	T&F Group	By 17th May
Map/schedule all meetings with key stakeholders	• Health and Wellbeing Boards • Scrutiny meetings – formal and informal		
Public meetings - preparation	• Set dates • Book venues • Confirm dates for attending representatives – well in advance for clinicians • Confirm lead/chair for each • Plan advertising • Plan media i.e. ongoing releases • Prepare presentation using available resources • Prepare facilitators' recording materials • Draft and issue press release with contact details	T&F Group	By 17th May

Prepare access and response mechanisms	• Source supplier of analysis • Freepost • Addresses	T&F Group	By 17th May
Liaison with Scrutiny	• Informal discussion with officers to determine formal presentation of plans • Determine presentation of Consultation Plan	SJ/CY	By 17th May
Media	• Arrange meetings with Hartlepool Mail and Evening Gazette (re NCAT report) • Issue NCAT media release to include consultation dates • Draft, agree and issue consultation launch release	SJ/CY	For 15th May 16th May By 17th May
Advertising	Schedule and organise paid advertisements in local print and broadcast media	SJ	By 17th May
Stage 2 - 12 week formal consultation – from Monday 20th May to Friday 16th August 2013			
Materials	• Commissioning production of consultation materials in alternative formats as required	T&F Group	Ongoing – as required
Consultation document available	• Upload document to CCG and NTHFT websites	SJ/CY	For 9am Monday 20th May
Send out consultation document to key stakeholders	• Prepare covering letter and response form • Identify list of stakeholders as key consultees • Indicate deadline for responses • Provide full list of consultees, stakeholders and contacts	T&F Group	By 24th May
Distribution	• Co-ordinate distribution of consultation materials e.g. to independent contractors and community based health locations	T&F Group	From 20th May
Media handling	• Production and distribution of press releases • Set up and maintain media handling plan	T&F Group	From 20th May
Public meetings	• Organise and manage consultation meetings, • Commission recording and transcribing	SJ T&F Group	By 17th May In sufficient time

	• Arrange BSL interpreting services		In sufficient time
Other meetings	• Manage and record outcomes from targeted meetings/focus groups with key stakeholder groups with a vested interest in consultation	T&F Group	Ongoing
Analysis, response handling and reporting	• Arrange and manage ongoing handling of postal responses • Log, collect and collate responses from web, mail, email letter and meetings (meeting summaries and notes) including a breakdown to show organisational and public responses. • Summarise and provide analysis of all of the responses received • Prepare final report - presentations, printed report in hard copy	T&F Group / external supplier	By 17th May
Post consultation – from 16th August 2013			
Collation of responses	• **Liaison with supplier re completion of report**	**T&F Group**	**19th August**
Reporting	• Make report available on CCG website • Identify stakeholders who should receive a copy of the report directly	T&F Group	By 30th August
Awareness-raising of the consultation outcomes through local media	• Issue press release reporting on outcomes and when final report will be available	T&F Group	By 30th August
Communications with staff	• NECS • CCG • NTHFT	MB AW CY	By 30th August
Feedback to stakeholders	• Provide feedback on outcomes of consultation and related involvement and how these have been used to inform the decision	MB – lead T&F Group	By 30th August
Decision making	• Prepare full paper (with report) for Board / Governing Body • Prepare messages re implementation	AW/MB/CY	By 30th August

Monitoring and evaluation

The evaluation process should ensure sufficient feedback is received to:

- Help steer the content of future communications by capturing the needs of the internal and external audiences
- Ensure that information being communicated is understood by the intended audience/s
- Gauge any misunderstanding or confusion about the project.

Appendix 2

Appendix A: Draft Stakeholder Map

Stakeholder Group	Stakeholder	Stakeholder Prioritisation Category	Communication Method(s)	Lead contact/spokespeople
Internal	Boards – North Tees and Hartlepool NHS Foundation Trust, South Tees Acute NHS Foundation Trust	**Key Player**	Face to face meetings	
Internal	Heads of Clinical Service	**Key Player**	Face to face meetings and briefings	
Internal	Senior clinical staff	**Key Player**	Face to face meetings and briefings	
Internal	Staff-side representatives	**Active Engagement and Consultation**	Face to face meetings/briefings	
Internal	Medical Staffing Committee	**Active Engagement and Consultation**	Meetings/briefings	
Internal	Staff affected by changes	**Active Engagement and Consultation**	Team and individual briefings/meetings with line managers/ Q&As/ existing internal comms tools	
Internal	All staff (including hospital volunteers)	**Active Engagement and Consultation**	Open staff meetings/Q&As/ existing internal comms tools	
Internal	NTH Governors			

Patients & Public (charities)	Charitable organisations and highly interested groups	**Active Engagement and Consultation**	Face to face meetings and briefings/engagement events and activities	
Patients & Public	General Public	**Keep Informed and Consult**	Public Meetings/ Media Releases/ Website/information stands/ posters/info distributed at prime settings/consultation documents	
Patients & Public	Affected Service User Groups	**Active Engagement and Consultation**	Meetings with identified service user groups/ Engagement events/ Focus groups/ Consultation events	
Patients & Public	GP Patient Participation Groups	**Keep Informed and engaged via practices**	Meetings/briefings	
Patients & Public	Local Involvement Network /HealthWatch	**Active Engagement and Consultation**	Meetings and presentations/ongoing briefings and updates/ Consultation documents	
Patients & Public	Protected groups, voluntary and community groups, third sector	**Active Engagement and Consultation**	Meetings with identified groups/ Engagement events/ Focus groups/ Consultation events	
Patients & Public	Foundation Trust members	**Keep Informed and Consult**	Briefings	

Patients &Public	MY NHS members	**Keep Informed and Consult**		
Political Audiences	Ministers	**Keep Informed**	Briefings through Ministerial Briefing Unit (via SHA)	SHA
Political Audiences	Local MPs	**Key Player**	Regular briefings/letters/ meetings / phone calls on urgent issues/ Consultation Documents	
Political Audiences	Area Committees	**Active Engagement and Consultation**	Meetings & presentations/ regular briefings	
Political Audiences	Local Councillors	**Active Engagement and Consultation**	Regular correspondence updating on progress /rep to attend meeting if necessary/ Consultation Documents	
Political Audiences	Overview and Scrutiny Panels and Joint Health Scrutiny Committee	**Key Player**	Meetings & presentations/ regular briefings	
Media	Local and regional media	**Keep Informed**	Pro-active and re-active press releases and statements/ interviews / briefings/ paid-for advertorials and supplements	
Partners	PCTs and Clinical Commissioning Groups	**Key Player**	Meetings/ Regular briefings/ Consultation Documents/ Website	

Partners	Local Medical Committee	**Active Engagement and Consultation**	Meetings & presentations/ regular briefings	
GPs	GPs	**Active Engagement and Consultation**	Meetings & presentations/ regular briefings	
Partners	Surrounding trusts -	**Keep Informed/ Active engagement where necessary**	Briefings as required/ Consultation Documents	
Partners	Deanery	**Keep Informed and Consult**	Briefing when required	
Partners	PFI partners	**Keep Informed**	Briefing when required/consultation document	
Partners	LHWB Boards	**Keep Informed**		
Governance & regulators	Department of Health	**Keep Informed**	Briefings via SHA	
Governance & regulators	Strategic Health Authority	**Key Player**	Meeting	
Governance & regulators	Care Quality Commission	**Keep Informed**	Regular Briefings/ Consultation Documents	
Governance & regulators	NCAT	**Key Player**	Visit	
Governance & regulators	National Reconfiguration Team	**Keep Informed**	Briefings	
Governance & regulators	Health Gateway Team	**Key Player**	Meetings/briefings	
Governance & regulators	Local health and Wellbeing Boards	**Key Player**	Meetings/briefings	

Appendix 3

momentum: pathways to healthcare

The programme was established by North Tees and Hartlepool NHS Foundation Trust and the former commissioners Stockton Teaching Primary Care Trust and Hartlepool Primary Care Trust.

The *momentum* programme has three elements:

Element one Transforming services – came as a result of the White Paper *our health, our care, our say*

Element two Primary and community care capital planning project designed to create a network of enhanced and improved community facilities to support the above changes

Element three The hospital capital planning project – building a new hospital to serve the people of Hartlepool, Stockton and parts of Easington and Sedgefield.

A condition of the outline planning permission granted by Hartlepool Borough Council was that the community facilities and services had to be in place by the time the new hospital opens. This is to ensure that all three elements of the programme fit together and are right for the future needs of the changing population while also allowing for advances in medical and surgical care. It follows that services would be moving and transforming into the lead up to the new hospital opening to enable this condition to be met.

The hospital programme is also supported by a £10.5m transport plan to ensure the hospital is accessible to patients, visitors and staff. An accessible transport system – a section 106 agreement - was also a condition of the outline planning permission for the new hospital.

However the hospital programme has been delayed until 2017 due to the withdrawal of capital project funding approval in 2010.

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APPENDIX 5

Protocol for the Health Scrutiny Joint Committee

Emergency Medical and Critical Care Review

1. This protocol provides a framework under the Local Authority (Public Health, Health and Wellbeing Boards and Public Health) Regulations 2013 for considering and providing a formal consultation response in relation to proposals affecting the population covered by North Tees and Hartlepool NHS Foundation Trust, in particular:

   (a) the proposed centralisation of emergency medical and critical care services at University Hospital of North Tees, as recommended by the National Clinical Advisory Team.

   (b) the development of services at University Hospital of Hartlepool in the period leading up to the opening of the new hospital.

2. The terms of reference of the Health Scrutiny Joint Committee is set out at Appendix 3.

3. The Health Scrutiny Joint Committee formed for the purpose of the consultation outlined at paragraph 1 will, following approval of this protocol at its first meeting, circulate copies of the same to:-

   Local Authorities
   Stockton-on-Tees Borough Council; Hartlepool Borough Council; Durham County Council

   Clinical Commissioning Groups (CCG)

   Hartlepool and Stockton-on-Tees CCG
   Durham Dales, Easington and Sedgefield CCG

   NHS Foundation Trusts
   North Tees and Hartlepool NHS Foundation Trust
   ("the relevant NHS Bodies")

   Health Scrutiny Joint Committee

4. A Health Joint Scrutiny Committee ("the Joint Committee") comprising Stockton-on-Tees Borough Council, Hartlepool Borough Council, and Durham County Council ("the constituent authorities") has been established in accordance with the Local Authority (Public Health, Health and Wellbeing Boards and Public Health) Regulations 2013 for the purposes of formal consultation by the relevant NHS Bodies in relation to the matters referred to at paragraphs 1(a) of this protocol, and in particular in order to be able to:-

   (a) make comments on the proposals consulted on, to the relevant NHS Bodies under the Local Authority (Public Health, Health and Wellbeing Boards and Public Health) Regulations 2013;

(b) require the relevant NHS Bodies to provide information about the proposals under the Regulations; or

(c) require an officer of the relevant NHS Bodies to attend before it under the Regulations to answer such questions as appear to it to be necessary for the discharge of its functions in connection with the consultation.

Membership

5. The Joint Committee will consist of equal representation from the health scrutiny committees of each of the constituent authorities.

6. The term of office for representatives will be for the period from the date of their appointment by their constituent authorities until their relevant authority's next annual council meeting. If a representative ceases to be a Councillor, or wishes to resign from the Joint Committee, the relevant council shall inform the joint committee secretariat and the replacement representative shall serve for the remainder of the original representative's term of office.

7. To ensure that the operation of the Joint Committee is consistent with the Constitutions of all the constituent authorities, those authorities operating a substitution system shall be entitled to nominate substitutes.

8. The Joint Committee may ask individuals to assist it (in a non-voting capacity) and may ask independent professionals to advise it for the purposes of the consultation process.

9. The quorum for meetings of the Joint Committee shall be a minimum of one member representative from each of the constituent authorities.

Chair and Vice-Chair

10. The Chair of the Joint Committee will be a Member representative from Hartlepool Borough Council and the Vice-Chair will be a Member representative from Stockton-on-Tees Borough Council. The Chair will not have a second or casting vote.

11. If the agreed Chair and Vice-Chair are absent from a meeting, the Joint Committee shall appoint a member to chair that meeting from the representatives present who are members of the same constituent Council as the Chair.

Terms of Reference

12. The Joint Committee will be the formal consultee under the Regulations and the Directions for the purposes of the consultation by the relevant NHS Bodies concerning those matters outlined at paragraphs 1(a) and will have the functions specified at paragraphs 4(a) - (c) inclusively of this protocol. Terms of reference are set out at Appendix 3.

Administration

13. Meetings shall be held at the times, dates and places determined by the Chair in consultation with each of the constituent authorities.

14. Agendas for meetings shall be determined by the secretariat (Hartlepool Borough Council) in consultation with the Chair.

15. Notice of meetings of the Joint Committee will be sent to each member of the Joint Committee at least 5 clear working days before the date of the meeting and also to the Chair of the constituent authorities' relevant overview and scrutiny committees (for information). Notices of meetings will include the agenda and papers for meetings. Papers "to follow" should be avoided where possible.

16. Minutes of meetings will be supplied to each member of the Joint Committee and to the Chairs of the constituent authorities' relevant overview and scrutiny committees (for information) and shall be confirmed at the next meeting of the Joint Committee.

Final Report and Consultation Response

17. The Joint Committee is independent of its constituent councils, executives and political groups and this independence should not be compromised by any member, officer or relevant NHS bodies. The Joint Committee will send copies of its final report and formal consultation response to the relevant NHS Bodies and the constituent authorities.

18. The primary objectives of the Joint Committee will be to reach consensus, but where there are any aspects of the consultation as regards which there is no consensus, the Joint Committee's final report and formal consultation response will include, in full, the views of all of the constituent authorities, with the specific reasons for those views, regarding those areas where there is no consensus, as well as the constituent authorities' views in relation to those matters where there is a consensus.

Principles for joint health scrutiny

19. The constituent authorities and the relevant NHS Bodies will be willing to share knowledge, respond to requests for information and carry out their duties in an atmosphere of courtesy and respect in accordance with their codes of conduct. Personal and prejudicial and/or disclosable pecuniary interests will be declared in all cases in accordance with the code of conduct and Localism Act 2011.

20. The Joint Committee's procedures will be open and transparent in accordance with the Local Government Act 1972 and the Access to Information Act 1985 and meetings will be held in public. Only information that is expressly defined in regulations to be confidential or exempt from publication will be able to be considered in private. Papers of the Joint Committee may be posted on the websites of the constituent authorities as determined by them.

21. Communication with the media in connection with the Joint Committee's views will be handled in conjunction with each of the constituent local authorities' press officers.

APPENDIX 6

HEALTH SCRUTINY JOINT COMMITTEE

TERMS OF REFERENCE

1. To consider the proposals affecting the population covered by North Tees and Hartlepool NHS Foundation Trust, in particular:

   a) the proposed centralisation of emergency medical and critical care services at University Hospital of North Tees, as recommended by the National Clinical Advisory Team.

   b) the development of services at University Hospital of Hartlepool in the period leading up to the opening of the new hospital.

2. The Joint Committee will as part of this process consider the following consultation questions as contained in the public consultation document, 'Providing safe and high quality care leading up to the opening of the new hospital':

   a) What do you think are the advantages and the difficulties (or disadvantages) of the proposed changes?

   b) If you still have concerns, what are you most concerned about and how could we help to reduce your concerns?

   c) What do you think are the main things we need to consider in putting the proposed changes in place?

   d) Is there anything else you think we need to think about?

3. In order to be able to formulate and provide views to the relevant NHS bodies on the matters outlined in paragraphs 1 and 2 above, the Joint Committee may:-

   a) require the relevant NHS Bodies to provide information about the proposals the subject of the consultation with the constituent local authorities and the Joint Committee; and

   b) require an officer of the relevant NHS Bodies to attend meetings of the Joint Committee, in order to answer such questions as appear to them to be necessary for the discharge of their functions in connection with the consultation.

4. To formulate a final report and formal consultation response to the relevant NHS Bodies on the matters referred to at paragraphs 1 and 2 above, in accordance with the protocol for the Health Scrutiny Joint Committee and the consultation timetable established by the relevant NHS Bodies.

5. To ensure the formal consultation response of the Joint Committee includes, in full, the views of all of the constituent authorities, with the specific reasons for those views, regarding those areas where there is no consensus, as well as the constituent authorities' views in relation to those matters where there is a consensus.

Adults Wellbeing and Health Overview and Scrutiny

3 July 2013

NHS Quality Accounts 2012-13 Adults Wellbeing and Health OSC Responses

Report of Lorraine O'Donnell, Assistant Chief Executive

1. Purpose of the Report

1.1 To inform members of the Adults Wellbeing and Health Overview and Scrutiny Committee of the responses made on behalf of the Committee in respect of NHS Partners' Draft Quality Accounts 2012/13.

2 Background

2.1 At its meeting held on 15 April 2013, the Adults, Wellbeing and Health Overview and Scrutiny Committee considered a report detailing proposals to respond to Draft Quality Accounts for 2012/13 from:-

- County Durham and Darlington NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust
- North East Ambulance Service

2.2 The Health Act 2009 requires the NHS Foundation Trusts to publish an annual Quality Account report. The purpose of the Quality Account report is for each of the Trusts to assess quality across all of the healthcare services they offer by reporting information on 2012/13 performance and identifying priorities for improvement during the forthcoming year and how they will be achieved and measured.

3 Draft Quality Accounts

3.1 Draft Quality Accounts documents were received as follows:-

Foundation Trust	Date Received
North East Ambulance Service NHS Foundation Trust	26 April 2013
County Durham and Darlington NHS Foundation Trust	24 April 2013
Tees Esk and Wear Valleys NHS Foundation Trust	19 April 2013

3.2. The Draft Quality Accounts' priorities for the three Trusts were considered at the Committee's meeting held on 15 April 2013 and it was agreed that, given that the County Council would hold all out elections on 2 May 2013 and would not appoint Committee members until the Annual Meeting of the Council to be held on 22 May 2013, comments made at that meeting be developed into formal responses to the Quality Accounts.

3.3 Responses to the documents were drafted on behalf of the Committee, signed off by the Chairman and sent to the respective organisations. A copy of each response is appended to this report.

3.4 All responses were submitted to the respective NHS Organisations within the statutory deadlines set out in legislation.

4. Recommendations

4.1 Members of the Adults Wellbeing and Health Overview and Scrutiny Committee are asked to note the report and endorse the responses to NHS Organisations' draft Quality Accounts contained therein.

Background Papers
NHS Quality Accounts Report to Adults Wellbeing and Health Overview and Scrutiny Committee – 15 April 2013

County Durham and Darlington NHS Foundation Trust Draft Quality Account 2012/13

Tees, Esk and Wear Valleys NHS Foundation Trust Draft Quality Account 2012/13

North East Ambulance Service Draft Quality Account 2012/13

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

Appendix 1: Implications

Finance – None.

Staffing - None

Equality and Diversity - None

Accommodation – None.

Crime and Disorder – None.

Human Rights – None

Consultation – The Adults Wellbeing and Health Overview and Scrutiny Committee have been invited to comment on the NHS Foundation Trust Draft Quality Accounts documents 2012/13 as outlined in this report.

Procurement – None

Disability Discrimination Act – None

Legal Implications – This report has been produced to reflect the requirements of the Health Act 2009.

APPENDIX 2

DURHAM COUNTY COUNCIL ADULTS WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

COMMENTS ON COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST QUALITY ACCOUNT FOR 2012/13

The Committee welcomes County Durham and Darlington NHS Foundation Trust's Quality Accounts and the opportunity to provide comment on it. This is the fourth year the Committee has provided comment and acknowledge progress by the Trust towards delivery of their priority areas for 2012/13.

The Committee welcomes the priorities linked to the improvement of the discharge process for patients including closer liaison between acute and community services, the timeliness of discharge summaries being completed and improved patient experience post-discharge to reduce avoidable re-admissions to hospital.

The Committee has engaged in the Trust's Review of Hyper Acute Stroke services and supported the recommendation to centralise all such services at UHND. The Committee has received update reports which set out the improvements that have been derived from the implementation of these recommendations. It is pleasing to note that this issue continues to be a priority for the Trust and that continued improvements in performance and patient experience will be sought in this respect.

The Committee also notes the Quality Account priority to reduce the length of time to assess and treat patients in Accident and Emergency departments. In undertaking this work, the Committee would seek assurances that the Trust will work closely with the North East Ambulance Service to improve performance in respect of accessing A/E services and to reduce the incidence of "ambulance stacking" outside A/E Departments that has been subject to recent adverse press coverage.

The Committee also notes the work that the Trust has undertaken in reviewing its Clinical Strategies and looks forward to continued engagement and joint working on this issue over the coming year.

To conclude, the Committee agree that from the information received from the Trust, including the identified priorities for 2013/14 are a fair reflection of healthcare services provided by the Trust and note the progress made against the 2012/13 priorities. In addition, the Committee request to receive a six monthly progress report on delivery of 2013/14 targets.

DURHAM COUNTY COUNCIL ADULTS WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

COMMENTS ON NORTH EAST AMBULANCE TRUST QUALITY ACCOUNT FOR 2012/13

The Committee welcomes North East Ambulance Service NHS Foundation Trust's Quality Account and the opportunity to provide comment on it.

Whilst the Committee acknowledges the Trust's desire to co-ordinate engagement of local authorities' responses to their Quality Account via the Regional Joint Health Scrutiny Committee, it wishes to place on record its views regarding issues around Accident and Emergency response performance and also waiting times/queuing at Accident and Emergency departments.

The Committee particularly welcomes the following priorities for the coming year :-

- Work with the acute trusts to reduce the impact of hospital turnaround delays. In order to ensure a positive, safe patient experience and prevent adverse effects on clinical outcomes due to delays to further hospital assessment and treatment,

- To introduce an appointment based Patient Transport Service through 2013/14, across entire NEAS area'.

The Committee have taken an active role in the Trust's consultation around Reconfiguration of the Accident and Emergency Ambulance Service and representations have been made around the proposals and their potential impact particularly on rural ambulance provision. County Durham is one of the areas where performance for Category A8 responses are below target and it is essential that this performance improves. These concerns within County Durham, particularly the Durham Dales continue and the Committee would seek assurances that any proposals to change existing arrangements within this area should not proceed without full and formal public consultation. The Committee awaits with interest the results of the recent evaluation activity undertaken within the Durham Dales to assess the effectiveness of current arrangements.

The Committee notes the proposed work to be undertaken in addressing hospital turnaround delays/ ambulance queuing at Accident and Emergency Departments and would support all steps taken in conjunction with relevant hospitals' Trusts to reduce the delays experienced by some patients being treated at Accident and Emergency Departments.

To conclude, the Committee agree that from the information received from the Trust that the identified priorities are a fair reflection of healthcare services provided by the Trust. In addition, the Committee request that a six monthly progress report on delivery of 2013/14 targets be provided.

DURHAM COUNTY COUNCIL ADULTS WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

COMMENTS ON TEES ESK AND WEAR VALLEY'S NHS FOUNDATION TRUST QUALITY ACCOUNT FOR 2012/13

The Committee welcomes Tees, Esk and Wear Valley's NHS Foundation Trust's Quality Accounts and the opportunity to provide comment on it. This is the fourth year the Committee has provided comment and acknowledge progress by the Trust towards delivery of their priority areas for 2012/13.

Durham County Council's Adults Wellbeing and Health OSC Chair and lead Scrutiny officer have attended stakeholder workshops during 2012/13 and engaged in the Quality Accounts process. To this end we welcome the early opportunity to examine key issues identified during 2012/13 and also consideration of draft priorities for 2013/14.

In considering the priorities for 2013/14, the Committee welcomes all of the identified priorities which seek to build on the work commenced by the Trust in reviewing its Care Programme approach, particularly those proposals to continue to engage with service users and carers/families. The Committee has previously emphasised the importance of service users and carers/families being actively engaged in this process, and it is encouraging that the way in which the Trust communicates services to these stakeholders remains a priority.

The Committee previously welcomed proposals "to develop broader liaison arrangements with Acute Trusts around physical health needs of mental health patients" and would seek the continuance of this work.

One area of concern identified by the Committee for consideration as part of its 2013/14 work programme is the incidence of suicides within County Durham. Members have noted a key action identified within the Durham County Council Council Plan to "develop and Implement a multi-agency Public Mental Health and Suicide prevention strategy for County Durham" and see the Tees Esk and Wear Valley NHS Foundation Trust as a key partner in this activity.

To conclude, the Committee agree that from the information received from the Trust, including the identified priorities for 2013/14 are a fair reflection of healthcare services provided by the Trust and note the progress made against the 2012/13 priorities. In addition, the Committee request to receive a six monthly progress report on delivery of 2013/14 targets.

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Adults, Wellbeing and Health Overview and Scrutiny Committee

3 July 2013

Quarter 4 2012/13 Performance Management Report

Report of Corporate Management Team
Lorraine O'Donnell, Assistant Chief Executive
Councillor Simon Henig, Leader

Purpose of the Report

1. To present progress against the council's corporate basket of performance indicators (PIs) for the Altogether Healthier theme and report other significant performance issues for 2012/13.

Background

2. This is the end of year corporate performance report of 2012/13 for the council. The report contains information on key performance indicators, risks and Council Plan progress.

3. The report sets out an overview of performance and progress by Altogether priority theme. Key performance indicator progress is reported against two indicator types which comprise of:
   a. Key target indicators – targets are set for indicators where improvements can be measured regularly and where improvement can be actively influenced by the council and its partners; and
   b. Key tracker indicators – performance will be tracked but no targets are set for indicators which are long-term and/or which the council and its partners only partially influence.

4. A summary of key performance indicators is provided at Appendix 3. More detailed performance information and Altogether theme analyses are available on request from performance@durham.gov.uk.

Developments since last quarter

5. Extensive work has been undertaken by all services to develop the draft 2013/14 corporate indicator set and 4-year targets. Appendix 4 sets out the proposed measures to be used to monitor progress towards achievement of the council's priorities as set out in the 2013-17 Council Plan. The proposed indicator set is based around our six Altogether priority themes and will be used to measure the performance of both the council and the County Durham Partnership. All Members have been invited to have input into this process through an Overview and Scrutiny Management Board (OSMB) workshop held on 14 March 2013 and their views have been incorporated in the final draft indicator set. The key outcomes from the OSMB workshop are provided at Appendix 5. The new basket of performance indicators together with targets will form the basis of the quarterly performance monitoring reports from quarter 1 2013/14.

6. Specific changes to note in respect to the proposed corporate indicator set include:

a. This year has seen a number of satisfaction indicators removed from the corporate indicator set mainly due to intervals that surveys are carried out. Options are being considered to report measures of satisfaction through another process.

b. The corporate indicator set contains a number of proposals for measuring the impact of welfare reform changes in County Durham as they are rolled out throughout the year. This will enable the effects to be reported through the quarterly performance reports. Some of these indicators are already measured but others are new proposals.

c. There will also be a stronger focus this year on input measures in our performance framework. This will allow us to better quantify productivity in the forthcoming year and to monitor the effects of reductions in resources and increases in volume driven by the economic situation and national policy changes such as welfare reform.

d. In setting targets for the forthcoming 4 years it is acknowledged that in some areas aspirations are less challenging for the forthcoming year compared to previous years. In these areas targets have remained static or are set below the previous year targets or performance rather than showing a continuing improvement trend. Services have advised that some targets have been set as a threshold and the focus is on maintaining performance in light of the economic climate and funding reductions.

7. An indicator specification document is available from the document library on the Councillors Intranet homepage at: http://intranet/sites/Councillors/default.aspx. The document details all definitions in relation to the performance indicators within the corporate set and highlights any known data quality issues.

Altogether Healthier: Overview

Performance indicators				
	Red	Amber	Green	N/A
Direction of travel	4 (24%)	4 (24%)	9 (53%)	5
Performance against target	5 (24%)	1 (5%)	15 (71%)	1

Actions				
	Red	Green	White	Deleted actions
Performance against target *1 blank	0 (0%)	5 (14%)	30 (83%)	1 (3%)

Council Performance

8. Key achievements this quarter include:

   a. A total of 3,468 people have stopped smoking between April and December 2012. This equates to 821 per 100,000 population, exceeding the target of 723 per 100,000 population (3,055 smoking quitters).

   b. Changing the Physical Landscape (CPAL) is a physical activity intervention project in support of the NHS Health Check Programme, which County Durham Sport was commissioned by NHS County Durham to develop, coordinate and manage. The total number of people commencing the CPAL programme was 13,292 against a target of 5,800. The main measure of success/effectiveness of the programme is that 60% of people sustained an increased level of physical activity after 6 months against a target of 58%.

   c. Move4Life replaces CPAL and will continue to deliver in 2013/14. Move4Life is an exciting programme aiming to get local people active through a range of activities tailored for those who are either not active enough, overweight or have a family history of cardiovascular disease and type 2 diabetes. Examples of activities include aqua classes and cycling.

   d. The number of adults aged 65 and over who were admitted on a permanent basis to residential or nursing care has decreased by 5%; from 826 admissions in 2011/12 to 782 in 2012/13. This equates to a rate of 840.7 per 100,000 population against a target of 879 per 100,000 population (818 admissions).

   e. At the end of March 2013, 56.7% of service users in receipt of community services had a personal budget, which compares to 53.5% at the same time last year and exceeds the 2012/13 target of 50%. This also exceeds the 2011/12 statistical neighbours average of 40.9% and England average of 43%.

   f. Of people who were discharged from hospital in 2012/13 into intermediate care, reablement or rehabilitation services, 87% were still living at home three months after their discharge. The nationally reported measure is based upon only those clients discharged between October and December 2012; this figure was 85.2% which exceeded the target of 85%. Latest benchmarking data for 2011/12 show performance is above the statistical neighbours average of 83.5% and England average of 82.7%

   g. Latest feedback from service user surveys highlights:

      - 93.7% of adult social care service users reported that they were satisfied with the care and support services they receive. This has exceeded the 2012/13 target of 92%, and

satisfaction reported last year (92.1%). This also exceeds the 2011/12 national Adult Social Care Survey England (90.1%) and North East (92.7%) averages.

- 94.9% of adult social care service users who had been assessed or reviewed stated that the care and support services they received had improved their quality of life. Additionally, 98% were happy with the way they were treated by their social worker during their assessment or review
- 79.3% of reablement service users reported that they achieved all or most of the goals they had set out to achieve at the start of their reablement service. This has exceeded the 2012/13 target of 75% and performance last year (75.6%). Additionally, 96% of reablement service users reported that they felt more confident following their package of reablement.

9. The key performance improvement issues for this theme are:

   a. A continued low level of breastfeeding rates. Overall, 27.6% of mothers were breastfeeding at 6-8 weeks between January and March 2013 (381 of 1380 mothers). Although this has increased from 23.5% for the same period last year, the rate has reduced from 30.6% in quarter 3 and has not achieved the target of 31.8%. Actions being taken in County Durham to encourage more mothers to breastfeed include:

      - A breastfeeding 'Buddying' pilot in East Durham where mothers who currently breastfeed give support and advice to new mothers who wish to breastfeed.
      - One Point Service Managers rolling out Baby Cafes across the county.
      - The Public Health Team working with the National Childbirth Trust to commission additional breastfeeding support in the most deprived localities in the county i.e. Easington, Derwentside and Sedgefield.
      - The Public Health Team commissioning services to improve uptake of breastfeeding in under 25 year olds.

   b. A total of 13% of people leaving drug treatment between July 2011 and June 2012 did so successfully (257 of 1975), against an annual target of 15%. This is slightly below latest benchmarking data; Durham's statistical neighbours average is 14% and national performance is 15%. The Drugs and Alcohol Community Team (DACT) is looking to encourage more non opiate/crack cocaine users (OCUs) into treatment to reflect changing patterns in drug use. This has included:

      - Meeting with staff and student union representatives at Durham University to discuss working with students who have been using drugs recreationally and are beginning to get into difficulties due to their drug use. Treatment workers will carry out short intense programmes with students on a self-referral basis
      - Carrying out recovery audits in all seven treatment centres to identify best practice, with the aim of improving performance around successful completions
      - Training seven service users who have been drug and crime free for over 6 months as ambassadors; to act as role models for both staff and other service users in treatment, showing that recovery is possible.

10. Tracker indicators for this priority theme (see Appendix 3, table 2) show:

    a. The under 75 mortality rate from all circulatory diseases has reduced from 71.6 per 100,000 population in 2010 to 70.6 in 2011. Although a reduction has been achieved the rate remains above the North East (68.6) and England (58) mortality rates.

b. The under 75 mortality rate from all cancers has increased from 115.6 per 100,000 population in 2010 to 120.7 in 2011. This equates to a 4.4% increase for County Durham, a trend which was replicated for the North East region (2.2% increase) but not nationally (1% reduction). This rate remains above the England (107) but below the North East (125.7) mortality rates.

11. There are no key risks in delivering the objectives of this theme.

Recommendation

12. That the Adults, Wellbeing and Health Overview and Scrutiny Committee receive the report and consider any performance issues arising there from.

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Appendix 1: Implications

Finance

Latest performance information is being used to inform corporate, service and financial planning.

Staffing

Performance against a number of relevant corporate health PIs has been included to monitor staffing levels and absence rates.

Risk

Reporting of significant risks and their interaction with performance is integrated into the quarterly monitoring report.

Equality and Diversity/Public Sector Equality Duty

Corporate health PIs and key actions relating to equality and diversity issues are monitored as part of the performance monitoring process.

Accommodation

Not applicable

Crime and Disorder

A number of PIs and key actions relating to crime and disorder are continually monitored in partnership with Durham Constabulary.

Human Rights

Not applicable

Consultation

Not applicable

Procurement

Not applicable

Disability Issues

Corporate health PIs and key actions relating to accessibility issues and employees with a disability are monitored as part of the performance monitoring process.

Legal Implications

Not applicable

Appendix 2: Key to symbols used within the report

Where icons appear in this report, they have been applied to the most recently available information.

Performance Indicators:

Direction of travel		Performance against target
Latest reported data have improved from comparable period	GREEN	Performance better than target
Latest reported data remain in line with comparable period	AMBER	Getting there - performance approaching target (within 2%)
Latest reported data have deteriorated from comparable period	RED	Performance >2% behind target

Actions:

WHITE	Complete. (Action achieved by deadline/achieved ahead of deadline)
GREEN	Action on track to be achieved by the deadline
RED	Action not achieved by the deadline/unlikely to be achieved by the deadline

Benchmarking:

GREEN	Performance better than other authorities based on latest benchmarking information available
AMBER	Performance in line with other authorities based on latest benchmarking information available
RED	Performance worse than other authorities based on latest benchmarking information available

Appendix 3: Summary of Key Performance Indicators

Table 1: Key Target Indicators

Ref	Description	Latest data	Period covered	Period target	Current performance to target	Data 12 months earlier	Performance compared to 12 months earlier	National figure	*North East figure **Nearest statistical neighbour figure	Period covered
Altogether Healthier										
26	Four week smoking quitters per 100,000 population (former NI 123)	821	Apr-Dec 2012	723	GREEN	913	RED	588 GREEN	814* GREEN	Apr - Dec 2012
27	% of the total eligible population screened for bowel cancer	61.8%	Apr-Jun 2012	60.0%	GREEN	58.1%	GREEN			
28	% of the total eligible population screened for cervical cancer	80.9%	Jul - Sep 2012	80%	GREEN	80.9%	AMBER	78.6% GREEN	79.8%* GREEN	2011/12
29	Number of health checks delivered to target population (aged 40-74)	8,206	Apr-Dec 2012	20,046	RED	15,714	RED			
30	Prevalence of breastfeeding 6-8 weeks after birth	27.6%	Jan-Mar 2013	31.8%	RED	23.5%	GREEN	47.2% RED	31.8%* AMBER	Oct - Dec 2012
31	Number of adult community health checks/health appraisals completed	2154	Apr-Sep 2012	1250	GREEN	New indicator	N/A			
32	Number of people in treatment with the Community Alcohol Service (CAS) as a percentage of the estimated drinking population**Also in Altogether Safer**	7.0%	Apr-Dec 2012	8.2%	RED	7.9%	RED			
33	% of all exits from alcohol treatment that are planned discharges **Also in Altogether Safer**	72%	Apr-Dec 2012	64%	GREEN	61%	GREEN	59% GREEN		Apr - Sep 2012
34	% of service users reporting that the help and support they receive has made their life “much” or “a little” better.	94.9%	Apr 12 - Mar 13	92%	GREEN	Not comparable	N/A			
35	Overall satisfaction rating of social care users	93.7%	Apr 12 - Mar 13	92%	GREEN	92.1%	GREEN	90.1% GREEN	92.7%* GREEN	2011/12

Ref	Description	Latest data	Period covered	Period target	Current performance to target	Data 12 months earlier	Performance compared to 12 months earlier	National figure	*North East figure **Nearest statistical neighbour figure	Period covered
36	Adults in contact with secondary mental health services in paid employment (former NI 150)	11.7%	as at 31 Dec 2012	9%	GREEN	10.7%	GREEN	8.0% GREEN	7.5%** GREEN	2011/12
37	Overall satisfaction rate of carers	83.6%	Oct 2012	81%	GREEN	New indicator	N/A	83% GREEN		2009/10
38	Adults aged 18-64 per 100,000 population admitted on a permanent basis in the year to residential or nursing care	13.4	Apr 12 - Mar 13	10	RED	11.0	AMBER	19.4 GREEN	17** GREEN	2011/12
39	Adults aged 65+ per 100,000 population admitted on a permanent basis in the year to residential or nursing care	840.7	Apr 12 - Mar 13	879	GREEN	907	GREEN	705.9 RED	804.1** RED	2011/12
40	% of service users that have had care needs reviewed	92.0%	Apr 12 - Mar 13	92%	GREEN	94.4%	RED			
41	Social care service users offered self-directed support (direct payments and individual budgets) (former NI 130)	56.7%	as at 31 Mar 2012	50.0%	GREEN	53.5%	GREEN	43.0% GREEN	40.9%** GREEN	2011/12
42	% of older people who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	85.2%	Oct-Dec 2012	85%	GREEN	86.0%	AMBER	82.7% GREEN	83.5%** GREEN	2011/12
43	Overall satisfaction rating for intermediate care services	93.0%	Apr 12 - Mar 13	95%	AMBER	95.2%	AMBER			
44	% of people completing reablement who had achieved their goals (regional indicator)	79.3%	Apr 12 - Mar 13	75%	GREEN	75.6%	GREEN			
45	Successful completions as a percentage of total number in drug treatment **Also included in Altogether Safer**	13%	Jul 11 - Jun 12	15%	RED	Not available	N/A	15% RED	14%** AMBER	Jul 2011 - Jun 2012

Ref	Description	Latest data	Period covered	Period target	Current performance to target	Data 12 months earlier	Performance compared to 12 months earlier	National figure	*North East figure **Nearest statistical neighbour figure	Period covered
46	Number of people from the cardiovascular disease (CVD) risk group, their families and others commencing Changing the Physical Landscape (CPAL) programme	13,292	Apr 12 - Mar 13	5800	GREEN	4682	GREEN			
47	Number of new referrals onto Improving Access to Psychological Therapies (IAPT) programme (interventions for treating people with depression and anxiety disorders)	2322	Oct-Dec 2012	TBC	N/A	Not available	N/A			

Table 2: Key Tracker Indicators

Ref	Description	Latest data	Period covered	Previous period data	Performance compared to previous period	Data 12 months earlier	Performance compared to 12 months earlier	National figure	*North East figure **Nearest statistical neighbour figure	Period covered
Altogether Healthier										
144	Mortality rate from all circulatory diseases at ages under 75, per 100,000 pop (former NI 121)	70.6	2011	71.6	GREEN	71.6	GREEN	58 RED	68.6* RED	2011
145	Mortality rate from all cancers at ages under 75, per 100,000 pop (former NI 122)	120.7	2011	115.62	RED	115.62	RED	107 RED	125.7* GREEN	2011
146	Male life expectancy at birth (years)	77	2008-10	76.9	AMBER	76.9	AMBER	78.58 RED	77.2* AMBER	2008-10
147	Female life expectancy at birth (years)	81	2008-10	80.7	AMBER	80.7	AMBER	82.57 RED	81.2* AMBER	2008-10
148	Alcohol related hospital admissions (per 100,000 population, former NI 39) **Also included in Altogether Safer**	2483	Apr 11 - Mar 12	2486	AMBER	2486	AMBER	1895 RED	2597** GREEN	2010/11
149	% respondents who feel that their health in general is good	67.4%	2009	69.2%	RED	69.2%	RED	75.80% RED	70% RED	2008
150	% of the adult population participating in at least 30 minutes sport and active recreation of at least moderate intensity on at least 3 days a week (Active People Survey) (former NI 8)	24.0%	Oct 2010-2012	23.3%	GREEN	23.3%	GREEN	22.6% GREEN	22.1%* GREEN	2012

Ref	Description	Latest data	Period covered	Previous period data	Performance compared to previous period	Data 12 months earlier	Performance compared to 12 months earlier	National figure	*North East figure **Nearest statistical neighbour figure	Period covered
151	Delayed transfers of care from hospital per 100,000 population (former NI 131)	10.7	Apr 12 - Mar 13	10.7	AMBER	4.9	RED	9.68 RED	7.92 RED	Apr 2012 - Feb 2013
152	Delayed transfers of care from hospital which are fully or partially attributable to adult social care per 100,000 population (former NI 131)	1.76	Apr 12 - Mar 13	1.86	AMBER	1.00	RED	3.4 GREEN	2.35 GREEN	Apr 2012 - Feb 2013
153	Mortality attributable to smoking per 100,000 population	275.1	2008-10	290.2	GREEN	290.2	GREEN	216 RED		2007-9
154	All cause mortality rate at ages under 65 per 100,000 population	247	2008-10	246	AMBER	246	AMBER	212.17 RED	246.36* AMBER	2008-10

2013/14 Corporate Basket of indicators

APPENDIX 4

Ref	Indicator type	PI Ref	Performance Indicator Definition	Service Grouping	Frequency	Welfare Reform	Performance		2012/13 Target	Proposed targets				National Comparison
							2011/ 12	2012/ 13 (YTD)		2013/ 14	2014/ 15	2015/ 16	2016/ 17	
Altogether Healthier														
68	Tracker	AWH AH9	Female life expectancy at birth (years)	CAS	Annual		81 (2008-10)	Not due						82.6 (2008-10)
69	Target	AWH AH10	Four week smoking quitters per 100,000	CAS	Quarterly		1,308	554 per 100,000 (2340 quitters) (Apr-Sep 2012)	1154 per 100,000 (4,875)	1193 per 100,000 (5,066)	Not set	Not set	Not set	944 (2011-12)
70	Target	AWH AH2	Percentage of eligible people who receive an NHS health check	CAS	Quarterly		73.5%	Not available	Not set	20% of eligible population	20% of eligible population	20% of eligible population	20% of eligible population	51.6% (2011-12)
71	Target	AWH AH3i	Percentage of people eligible for bowel cancer screening who were screened adequately within a specified period	CAS	Quarterly		81.2%	78.8% (2012)	80%	80%	Not set	Not set	Not set	75.3% (2012)
72	Target	AWH AH3ii	The percentage of women eligible for cervical screening who were screened adequately within a specified period	CAS	Quarterly		66.8% (Jan-Mar 2012)	61.8% (Apr-May 2012)	60%	60%	Not set	Not set	Not set	
73	Target	AWH AH4	Under 75 all cause mortality rate per 100,000 population	CAS	Annual		302 (2010)	Not due	Not set	296.8 (2011)	288 (2012)	279.5 (2013)	271.2 (2014)	272.8 (2010)

Ref	Indicator type	PI Ref	Performance Indicator Definition	Service Grouping	Frequency	Welfare Reform	Performance		2012/13 Target	Proposed targets				National Comparison
							2011/ 12	2012/ 13 (YTD)		2013/ 14	2014/ 15	2015/ 16	2016/ 17	
74	Target	AWH AH6	Under 75 mortality rate from cardiovascular diseases (including heart disease and stroke) per 100,000 population	CAS	Annual		70.6 (2011)	Not due	Not set	62.9 (2012)	58.8 (2013)	54.9 (2014)	51.3 (2015)	58.0 (2011)
75	Target	AWH AH7	Under 75 mortality rate from cancer per 100,000 population	CAS	Annual		120.7 (2011)	Not due	Not set	116.1 (2012)	113.9 (2013)	111.8 (2014)	109.7 (2015)	107.0 (2011)
76	Tracker	AWH AH8	Male life expectancy at birth (years)	CAS	Annual		77 (2008-10)	Not due						78.6 (2008-10)
77	Target	N/A	Under 75 mortality rate from liver disease per 100,000 population	CAS	Annual		18.1 (2009-11)	Not due	Not set	18.5 (2010-12)	18.8 (2011-13)	19.1 (2012-14)	19.4 (2013-15)	14.7 (2009-11)
78	Target	N/A	Under 75 mortality rate from respiratory diseases per 100,000 population	CAS	Annual		29.1 (2009-11)	Not due	Not set	28.5 (2010-12)	27.8 (2011-13)	27.1 (2012-14)	26.4 (2013-15)	23.8 (2009-11)
79	Target	N/A	The percentage of women eligible for breast screening who were screened adequately within a specified period	CAS	Quarterly		79.9%	79.3% (2012)	70%	70%	Not set	Not set	Not set	76.9% (2012)
80	Target	AWH AS5	Percentage of exits from alcohol treatment (Community Alcohol Service) that are planned discharges	CAS	Quarterly		64%	70% (Apr-Dec)	64.0%	2% above England average	Not set	Not set	Not set	58% (2011-12)

Ref	Indicator type	PI Ref	Performance Indicator Definition	Service Grouping	Frequency	Welfare Reform	Performance		2012/13 Target	Proposed targets				National Comparison
							2011/ 12	2012/ 13 (YTD)		2013/ 14	2014/ 15	2015/ 16	2016/ 17	
81	Target	AWH AS15	Percentage of successful completions of those in drug treatment	CAS	Monthly		11%	14% (Apr-Sep 2012)	15.0%	1% above England average	Not set	Not set	Not set	15% (2011-12)
82	Tracker	SL03	Percentage of the adult population participating in at least 30 minutes sport and active recreation of at least moderate intensity on at least 3 days a week	NS	6-monthly		23.3	24						22.6
83	Target	SL04	Number of adult community health checks / appraisals completed	NS	Quarterly		2490	3191	2500	2500	3000	3000	3000	
84	Tracker	N/A	Excess winter deaths (3 year pooled)	CAS	Annual		19.8 (2007-10)	Not due						
85	Target	AWH AH25ii	Adults aged 65+ per 1000 population admitted on a permanent basis in the year to residential or nursing care	CAS	Quarterly		9.1 per 1000	8.5 per 1000 (Apr-Dec)	8.8 per 1000	8.5 per 1000	Not set	Not set	Not set	7.1 (2011-12)
86	Target	AWH AH19	Proportion of people using social care who receive self-directed support, and those receiving direct payments	CAS	Quarterly		53.5%	53.2% (YE Dec)	50.0%	55.0%	60.0%	Not set	Not set	43.0% (2011-12)
87	Target	AWH AH21	The percentage of service users reporting that the help and support they receive has made their quality of life better	CAS	Quarterly		93.7% 92.2% (ASCS)	95.4% (local survey - Apr-Dec 2012)	92.0%	92.0%	92.0%	92.0%	92.0%	88.2% (ASCS 2011-12)

Ref	Indicator type	PI Ref	Performance Indicator Definition	Service Grouping	Frequency	Welfare Reform	Performance		2012/13 Target	Proposed targets				National Comparison
							2011/ 12	2012/ 13 (YTD)		2013/ 14	2014/ 15	2015/ 16	2016/ 17	
88	Target	AWH AH13	Proportion of older people who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services	CAS	Quarterly		86.0%	87.6% (Jan-Sep 2012)	85.0%	85.0%	85.0%	85.0%	85.0%	82.7% (2011-12)
89	Tracker	AWH AH20i	Delayed transfers of care from hospital per 100,000 population	CAS	Quarterly		4.9 per 100,000	10.7 per 100,000						9.8 per 100,000
90	Tracker	AWH AH20ii	Delayed transfers of care from hospital, which are attributable to adult social care, per 100,000 population	CAS	Quarterly		1 per 100,000	1.86 per 100,000						3.8 per 100,000
91	Target	N/A	Percentage of people who have no ongoing care needs following completion of provision of a reablement package	CAS	Quarterly		54.3%	59.6% (Apr-Dec 2012)	50.0%	55.0%	Not set	Not set	Not set	
92	Target	N/A	Percentage of adults receiving secondary mental health services known to be in settled accommodation	CAS	Quarterly	Y	81.8%	88.1% (Apr-Dec)	85.0%	85.0%	85.0%	85.0%	85.0%	57.8% (2011-12)
93	Target	N/A	Patient experience of community mental health services (scored on a scale of 0-100)	CAS	Annual		87.3	Not due	Not set	87	Not set	Not set	Not set	86.8 (2011)
94	Tracker	N/A	Number of suicides	CAS	Quarterly	Y	32 (2011 - 2 awaiting verdicts)	55 (2012 - 39 awaiting verdicts)						

OSMB workshop held 14 March 2013

APPENDIX 5

Ref	Member comment/query	Action to be taken/feedback for members
Adults, Wellbeing & Health Overview & Scrutiny Committee (Altogether Healthier)		
9	Target relating to smoking cessation should be increased as it impacts on the mortality and life expectancy indicators.	This has been raised with the Public Health Portfolio Lead. The target for smoking quitters has been increased by almost 200 for 2013/14. With a 52% quit rate this means an additional 400 people entering the service. The current contract is due for renewal on 31st March 2014 where targets over a longer period can be considered.
10	Targets for cancer screening should be increased to reflect levels of performance and need in County Durham.	This has been raised with the Public Health Portfolio Lead who has confirmed that this a nationally set target and is tightly performance managed and controlled.
11	Concern expressed over AWHAH20i/AWH AH20ii (delayed transfers of care from hospital). There was a possibility of a bottleneck which would affect future hospital admissions if delayed transfers are not addressed.	An indicator relating to Delayed Discharges from hospitals will be monitored as part of the Healthier basket.

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Adults Wellbeing and Health Overview and Scrutiny Committee

3 July 2013

Review of the Committee's Work Programme

Report of Lorraine O'Donnell, Assistant Chief Executive

Purpose of the Report

1. To provide for Members consideration an updated work programme for the Adults Wellbeing and Health Overview and Scrutiny Committee for 2013 - 14.

Background

2. At its meeting on 15th April 2013, the Adults Wellbeing and Health Overview and Scrutiny Committee considered the actions identified within the Council Plan 2012 – 2016 for the Altogether Healthier priority theme and agreed to refresh its work programme to include a number of these actions. In addition, topics have been identified that are in line with the Cabinet's Forward Plan of Key Decisions, the Sustainable Communities Strategy, forthcoming Government Legislation, outcomes form Quarterly Performance reports and other plans and strategies accordingly.

Detail

3. In accordance with this decision, a work programme for 2013 – 2014 has been prepared and is attached at Appendix 2.

Recommendation

4. Members of the Committee are asked to agree the new work programme.

Background Papers

Council Plan 2013 – 2017
AWH OSC Report 15 April 2013 – Council Plan 2013-17 – Refresh of Work Programme for Adults Wellbeing and Health Overview and Scrutiny Committee

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Appendix 1: Implications

Finance – The Council Plan sets out the corporate priorities of the Council for the next 3 years. The Medium Term Financial Plan aligns revenue and capital investment to priorities within the Council Plan.

Staffing – None

Risk - None

Equality and Diversity - None

Accommodation - None

Crime and Disorder - None

Human Rights - None

Consultation – None

Procurement – None

Disability Discrimination Act – None

Legal Implications – None

OVERVIEW AND SCRUTINY WORK PROGRAMME 2013 TO 2014

OVERVIEW AND SCRUTINY WORK PROGRAMME 2013 TO 2014 **Adults, Well-being and Health OSC** **Lead Officer**: Stephen Gwillym **IPG contact**: Peter Appleton	**Note:** **O/S Review** - A systematic 6 monthly review of progress against recommendations/Action Plan **Scrutiny/Working Group** – In depth Review **Overview/progress** – information on an issue; opportunity to comment, shape, influence, progress with a scrutiny review **Performance** – ongoing monitoring (quarterly) performance reports/budgets

Committee	When	Who	Outcome	Comment
1. Adults, Well Being and Health				
O/S Review				
Scrutiny/Working Group				

Overview/Progress				
Health and Wellbeing Strategy	January 2014	Health and Wellbeing Board	Review of Health and Wellbeing Strategy – AWH OSC informed of potential changes and impact on Work Programme	For comment and monitoring
Review of Joint Strategic Needs Assessment	January 2014	Peter Appleton	Review of Joint Strategic Needs Assessment – AWH OSC informed of potential changes and impact on Work Programme	For comment and monitoring
Social Care and NHS Reform	TBC	Peter Appleton	Progress report on the implications of the Social Care Reform/White Paper	Member Update
Safeguarding Adults	17 December 2013	Lee Alexander	Update on Annual Report	Member Update
Director of Public Health Report	17 March 2014	Anna Lynch	Overview of Impact of Report on Older Peoples Services	Member Update
Suicide Prevention Strategy	TBC	Anna Lynch	AWH OSC member input into the development of a Suicide Prevention Strategy. Also analysis of the incidence of Suicides in County Durham	Member Update
Dementia	TBC	Denise Elliott	Progress report on the implementation of the Dementia Strategy and potential implications for DCC	Member Update

NHS /Public Health Reform	3 October 2013 1 November 2013 17 March 2014 22 April 2014	Peter Appleton/Anna Lynch	Continued updates around the developing NHS/Public Health landscape following Reform	Member Update
Public Health Services	3 October 2013	Anna Lynch	Introduction to the Public Health Service following its Transfer to DCC	Member Update
Implications of the Francis Report for Health Overview and Scrutiny	3 October 2013	TBC	To report to AWH OSC the main issues arising from the Francis Report	Member Update
Performance and Budget Reporting				
Performance	Performance Quarterly update Reports 2012/13 Q4 Outturn – 3 July 2013 2013/14 Q1 – 3 October 2013 2013/14 Q2 – 17 December 2013	P. Appleton/K. Forster	Members using performance management information to inform the Work Programme and possible Review Activity	Summary information to members

Budget Outturn	2013/14 Q3 – 22 April 2014 2012/13 Q4 Outturn – 3 October 2013 2013/14 Q1 – 3 October 2013 2013/14 Q2 – 17 December 2013 2013/14 Q3 – 17 March 2014	Andrew Gilmore	Quarterly update key issues	Summary information to members

2. Health improvement & NHS commissioners (North Durham CCG; DDES CCG and NHS Commissioning Board/LAT) and provider organisations	When	Who	Outcome	Comment
Review of OS report/ recommendations and monitoring implementation				
Review of Hyper Acute Stroke Services	3 October 2013	County Durham and Darlington NHS FT	Further progress on the implementation of hyper acute stroke service changes	Member Update
Health Inequalities Review – Physical Activity	1 November 2013	Anna Lynch/Stephen Gwillym	Update on progress of Implementation of Review Recommendations	Member progress report
Regional Health Scrutiny Project (Ex-servicemen's project)	1 November 2013	Stephen Gwillym	Update on progress of Implementation of Review Recommendations	Member progress report
Scrutiny Review/Working Group				
To be Confirmed pending any service changes which AWH OSC are formally consulted upon	TBC	Stephen Gwillym	AWH OSC – Member engagement into Service Review changes	
Accident and Emergency Ambulance Service Review – Durham Dales	July 2013 onwards	NEAS/DDES CCG	Members engaged and input into potential service review of Accident and Emergency Ambulance Service provision in Durham Dales	Continued engagement of members and Community into Accident and Emergency Ambulance Service

2. Health improvement & NHS commissioners (North Durham CCG; DDES CCG and NHS Commissioning Board/LAT) and provider organisations	When	Who	Outcome	Comment
Overview/Progress				
Cancer Screening Services – Cervical, Breast and Testicular	1 November 2013	Anna Lynch	Overview of services and performance in early detection of Cancers and reduced incidence of Early Deaths by these cancers	
Single number for urgent care (111) – Rollout of new contract arrangements	TBC	Durham Darlington and Tees Area Tea	Progress report on the roll out of the 111 Service and issues arising therefrom	Member Update
Quality Accounts 2012/13 – Monitoring Updates	17 December 2013	County Durham and Darlington NHS Foundation Trust Tees Esk and Wear Valleys NHS Foundation Trust North East Ambulance Service	Monitoring Updates on 2011/12 Quality Accounts Priorities	Member Update
Quality Accounts 2012/13 – Preparation of Overview and Scrutiny Input and Commentary	24 April 2014	County Durham and Darlington NHS Foundation Trust Tees Esk and Wear Valleys NHS Foundation Trust North East Ambulance Service	Process of shaping and OSC commentary on 2013/14 Quality Accounts	For Member Information and comment

2. Health improvement & NHS commissioners (North Durham CCG; DDES CCG and NHS Commissioning Board/LAT) and provider organisations	When	Who	Outcome	Comment
Clinical Commissioning Groups – Clear and Credible Plans	3 October 2013	North Durham and DDES CCGs	Overview of CCG Commissioning Plans and Relationship building with CCG Progress of CCGs in delivering against their CCP Priorities	For Member Information and comment
"With you all the way" – Developing a Clinical Strategy	1 November 2013	County Durham and Darlington NHS Foundation Trust	Overview of recent CDDNHS FT engagement activity in developing their clinical strategy	For Member information and comment
County Durham HealthWatch	3 October 2013	HealthWatch Reps	To update members of the development of County Durham HealthWatch and to confirm their role with the AWH OSC	For member Information
Pharmaceutical Needs Assessment	17 December 2013	Anna Lynch/Public Health	To input into the Pharmaceutical Needs Assessment process.	For member information and comment

2. Health improvement & NHS commissioners (North Durham CCG; DDES CCG and NHS Commissioning Board/LAT) and provider organisations	When	Who	Outcome	Comment
Other – Regional				
Momentum	3 July 2013 and ongoing	NT&H NHS FT and Hartlepool CCG, Stockton CCG and DDES CCG	Member updates on:- • Wynyard Hospital project • Community Health Services development in South and East Durham • Hartlepool B.C. Scrutiny Input on Monitoring Groups • The £40m challenge	For services to meet needs of South and East Durham residents. This is an ongoing piece of work which sees NT&H NHS FT and Hartlepool CCG, Stockton CCG and DDES CCG consulting about the future of service provision at University Hospital Hartlepool and UH North Tees in advance of the development of a new DGH at Wynyard.
Securing Quality in Health Services	3 July 2013 and ongoing	Rosemary Granger, Project Director - Securing Quality in Health Services, Darlington Clinical Commissioning Group	Member update on Securing Quality in Health Services	For member information and Comment