Adults, Wellbeing and Health Overview and Scrutiny Committee

Date	**Tuesday 1 March 2016**
Time	**9.30 am**
Venue	**Committee Room 2, County Hall, Durham**

Business

Part A

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

1. Apologies
2. Substitute Members
3. Minutes of the meeting held on 19 January 2016 (Pages 1 - 10)
4. Declarations of Interest, if any
5. Media Issues
6. Any Items from Co-opted Members or Interested Parties
7. Durham Dales, Easington and Sedgefield Clinical Commissioning Group (DDES CCG) - Consultation in respect of a proposed review of Urgent Care Services - Joint Report of the Assistant Chief Executive and Stewart Findlay, Chief Clinical Officer, Durham Dales, Easington and Sedgefield CCG (Pages 11 - 106)
8. Better Health Programme (Formerly Securing Quality in Health Services SeQiHS) - Report of the Assistant Chief Executive and presentation by Dr. Boleslaw Posmyk and Edmund Lovell, Better Health Programme office (Pages 107 - 112)
9. Winter Plan and System Resilience - Report of Stewart Findlay, Chief Clinical Officer, Durham Dales, Easington and Sedgefield CCG (Pages 113 - 128)
10. Transformational Change of Adult Social Care - Eligibility Criteria - Presentation by Paul Copeland, Strategic Programme Manager, Care Act, Children and Adults Services

11. Regional Joint Health Scrutiny Committee Update - Report of the Assistant Chief Executive (Pages 129 - 148)

12. 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
22 February 2016

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

Councillor J Robinson (Chairman)
Councillor S Forster (Vice-Chairman)

Councillors J Armstrong, R Bell, P Brookes, J Chaplow, P Crathorne, M Davinson, K Hopper, E Huntington, P Lawton, H Liddle, J Lindsay, O Milburn, M Nicholls, L Pounder, A Savory, W Stelling, P Stradling and O Temple

Co-opted Members:

Mrs B Carr and Mrs R Hassoon

Co-opted Employees/Officers:

Dr L Murthy, Healthwatch

Contact: Jackie Graham **Tel: 03000 269704**

DURHAM COUNTY COUNCIL

At a Meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in Committee Room 2, County Hall, Durham on **Tuesday 19 January 2016 at 9.30 am**

Present:

Councillor J Robinson (Chairman)

Members of the Committee:
Councillors J Armstrong, R Bell, P Brookes, S Forster, K Hopper, H Liddle, J Lindsay, M Nicholls, A Savory and O Temple

Co-opted Members:
Mrs B Carr, Mrs R Hassoon and Murthy

Also Present:
Councillor L Hovvels

1 Apologies

Apologies for absence were received from Councillors J Chaplow, P Crathorne, M Davinson, E Huntington, P Lawton, O Milburn, L Pounder, W Stelling and P Stradling

2 Substitute Members

There were no substitute Members in attendance.

3 Minutes

The minutes of the meeting held on 4 November 2015 and of the special meeting held on 14 December 2015 were confirmed as a correct record and signed by the Chairman.

The Principal Overview and Scrutiny Officer referred to the Minutes of 4 November 2015 and gave updates as follows:-

- Item 7 (ii) – Emergency Department indicators had been received and circulated to the Committee on 8 January 2016.
- Item 9 – a written report had been received about Richardson Hospital and circulated to the Committee on 21 December 2015.
- Item 11 – the in-year reduction of the Public Health grant had been confirmed for 2015/16. The future Public Health funding consultation by the Advisory Committee for Resource Allocation had been concluded although the results were not yet known. However, he reported that within the recent MTFP 6 Cabinet report, there was an anticipated reduction in Public Health Grant totalling £8.9m across the next 4 years.

With reference to the 14 December 2015 minutes, he advised of the following update in respect of the TEWV/CCG Consultation on proposed reconfiguration of Organic Inpatient Wards serving County Durham and Darlington:-

- The formal consultation process included three engagement events in County Durham – Consett on 5 February, Bishop Auckland on 9 February and Murton on 29 February. Details would be circulated to the committee.

4 Declarations of Interest

Councillor S Forster declared an interest as former Chair of Malborough Patient Reference Group.

5 Media Issues

The Principal Overview and Scrutiny Officer provided the Committee with details of the following items which had appeared in the press:-

- English GP surgeries reach new patient 'breaking point' – BBC Website 6 January 2016
  Hundreds of GP surgeries in England have stopped taking on new patients or have applied to do so, a BBC investigation has found. The British Medical Association (BMA) says many are at "breaking point" as they struggle to fill staff vacancies. At least 100 surgeries applied to NHS England to stop accepting new patients in 2014-15, a Freedom of Information request revealed. This issue of GP Capacity is a real concern in respect of the URGENT Care proposals by DDES and something that members referenced in considering the Urgent Care Strategy.

- North East patients who call 999 for an ambulance could soon be treated by firefighters – Evening Chronicle 6 January 2016
  THE North-East's four fire and rescue services are to start providing emergency medical care as part of a six-month trial. The North East Ambulance Service (NEAS) says the scheme is need after demand on the ambulance service increased by nearly 20 per cent since 2007. At the same time firefighters nationally have been attending fewer fires, thanks to their successful programmes of community safety work. The trial is part of a review of the terms and conditions of firefighters by the National Joint Council for Local Authority Fire and Rescue Services, looking at the current and future demands on the service and profession. This links to the IRMP Item currently out for consultation by County Durham and Darlington Fire and Rescue Service

- Proposed changes to dementia services at two County Durham hospitals – Northern Echo 6 January 2016
  TEWV/DDES CCG Consultation commenced on 4 January 2016 as reported to the Committee's special meeting held on 14 December 2015. The issues raised by the Committee in respect of the consultation plan have been addressed in the revised document including the addition of an extra engagement session at Glebe Centre, Murton as well as inclusion within the consultation document of financial implications attached to the options.

- NHS could be facing a winter crisis – Northern Echo 12 December 2015

Hard-pressed hospitals may be unable to cope with a sudden cold snap this winter after new figures showed the NHS is already missing key targets. Only 92.3 per cent of patients attending emergency departments were seen within four hours in October against a target of 95 per cent - the lowest figure for the month since current records began in 2010 – A report on Winter pressures would be reported to the next meeting on 1 March 2016.

6 Any Items from Co-opted Members or Interested Parties

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

7 Durham Dales, Easington and Sedgefield CCG - Review of Urgent Care Strategy

The Committee received a report of the Assistant Chief Executive and presentation from the Chief Clinical Officer and Director of Commissioning, Durham Dales Easington and Sedgefield Clinical Commissioning Group (DDES CCG) that gave an update about the development of the Urgent Care Strategy within it's locality (for copy see file of Minutes).

The Chief Clinical Officer, DDES CCG informed the Committee that as contracts had lapsed there was a need to re-procure services. This action had been endorsed by this Committee and the Health and Wellbeing Board. It was necessary to improve access to general practices and provide more local services. Patients would be encouraged to use their GP practices and the 111 service. He advised that the CCG had to save £150m over the next few years and as it cost £86 per consultation at present for urgent care services compared to £35 across the region, it would be a more appropriate use of money.

The Director of Commissioning, DDES CCG gave a detailed presentation that highlighted the following:-

- Why have we reviewed urgent care services?
- What are Urgent and Emergency Care Services? Definitions:-
  - Accident and Emergency
  - Emergency Admission
  - Urgent Care Centre/ Walk in Centre
  - Minor Injuries Unit
  - GP Out of Hours Service
- Current Services:-
  - Three Urgent Care Centres and one Walk in Centre
  - No A&E Department in DDES
- Profiles for Bishop Auckland, Peterlee, Seaham and Healthworks
- Engagement with patients and other stakeholders
- Background – view of patients
- Further work to understand use
- Summary of Issues

The Director of Commissioning invited GPs from the Easington, Sedgefield and Durham Dales areas to discuss the potential future services within DDES.

The Committee received information from Dr Robin Armstrong, Dr Winny Jose and Dr Stewart Findlay in relation to in hours care, 6-8 p.m. care, weekends, out of hours and minor injuries for each area.

The Director of Commissioning went on to present information relating to:-

- Impact on provider sustainability
- Next steps and timelines

She concluded that there were work pressures in DDES with GPs taking on the additional demand. A recent workforce recruitment programme had been successful in recruiting 7 GPs. She said that the new proposals were about having services in the right place in an integrated way for Primary Care.

The Chief Clinical Officer advised that North Durham CCG would start the process shortly.

The Chairman said that he was surprised that 70% of patients could have had GP appointments. He asked if there had been an audit carried out at GP practices to ascertain why people did not go to their GP. The Director of Commissioning stated that this was looked at and GP practices were asked how many spare appointments they had had on a particular day. The Chief Clinical Officer added that patients want to be seen as soon as possible and therefore turn up at urgent care centres and many don't try to get a GP appointment first.

Councillor S Forster referred to a steering group set up in Seaham in the 1990s to establish a 24/7 building that would include X-ray facilities, dentist, doctor and a consulting room. This did not happen and the people of Seaham have to attend a confusing system of having a walk in centre and GP surgeries in the same building. She said that the X-ray facility was only available on a Tuesday and Friday and outside of that people could have up to three journeys to make, from Seaham to Peterlee to Sunderland. She agreed that patients information should be shared and available to all services. She referred to a system used at Malborough whereby a doctor rings a patient back to determine whether they need an appointment and who with. She had wrote a letter on behalf of Malborough PRG about the consultation as there were concerns about no cover at night or weekends. The Director of Commissioning said that this could be used as an example as to why there needed to be a change. There needed to be a robust triage in place where people could be directed to the right service.

Following on from that Councillor Forster reiterated her point that there was no weekend or night time opening, hence the reason that people go to the walk in centre. The Director of Commissioning said that the model proposed by Easington would address that as there was an understanding that longer hours and weekend provision was required.

Councillor J Armstrong thanked the representatives for their presentation but did have concerns that they would need to convince the general public of their plans, especially as people prefer to use walk in centre and urgent care. He was critical of the availability of GPs over an extended number of hours, as pointed out that they also needed time off. He looked forward to a follow up report coming back to Committee in March.

Councillor P Brookes welcomed the consultation. As Chair of the Sedgefield PRG he commented that no urgent care or walk in centres were available in the Sedgefield area which gave people a lot of travelling to do. He said that people go to urgent care due to the quality of their own GP service and added that patients struggled to get appointment to see their own GP. He hoped that any financial benefits to GP practices would be audited to ensure a quality of service, otherwise he feared that the pressure would transfer to A&E departments.

Councillor H Liddle referred to GPs in North Durham and informed Members that it was often problematic to get an appointment as reception staff were difficult at times. People would need to remember to ring before certain time to be able to get an appointment and therefore would use walk in centres instead. She added that people do not often have confidence in their GP as they use their computers for a diagnosis.

Referring to access to GPs, the Director of Commissioning said that this was measured nationally and that DDES perform well on this. She welcomed feedback about problems and access to GP appointments as they could be dealt with. She said that it was important to get the message across to patients about available appointments. She also recognised that people were unlikely to see their own GP but by seeing a GP at your own practice would ensure that your personal records were available.

In relation to funding, the Director of Commissioning advised that any service put in place would be robustly evaluated and if found not to be working right it would be changed.

The Chief Clinical Officer said that walk in centres and urgent care centres were vastly more expensive to run than a GP practice and evidence had shown that there was no impact on people visiting A&E departments. The opening of these centres in effect just created somewhere else for people to go.

Councillor R Bell referred to his own GP practice and the lack of available appointments. He said that there was nothing in the surgery about where you should go and for what, and added that if this was his perception then others may have the same view. The Chief Clinical Officer said that the surgery in Middleton-in-Teesdale provided a very good service including a minor injuries unit. He said that he was happy to talk through any issues with the surgery.

Referring to communication and technology, Councillor K Hopper said that the main issues were about what was available. She added that it was also frustrating when people did not turn up for appointments and time was wasted for the GP.

Councillor A Savory was interested in the appointments available that were not taken up and asked if a breakdown could be provided. The Chief Clinical Officer said that he would be happy to provide this information.

Dr L Murthy commented that the system was broken and not fit for purpose. He advised that the CCG should take into account and make sure they know what patients want. He suggested that the views of Patient Reference Groups be taken into account as they represent what people want and how services could be provided. He said that we should be proud to have a service that had this approach to its care.

The Chairman thanked the representatives for their presentation and would welcome a further report in March.

Resolved:

(i) That the report be received.

(ii) That those comments made by the Committee be fed back in respect of the proposed review of Urgent Care services within the DDES CCG locality.

(iii) That a further report be brought back to Committee in March 2016 detailing the proposed models for Urgent Care services within DDES and the associated consultation and engagement plan.

8 NHS England and DDES CCG- Review of APMS Contract - Easington Healthworks

The Committee received a report from the Assistant Chief Executive that gave an update about a recent consultation exercise carried out by NHS England and Durham Dales Easington and Sedgefield Clinical Commissioning Group (DDES CCG) in respect of a review of the Easington Healthwork's Alternative Provider Medical Services Contract (for copy see file of Minutes).

The Chief Operating Officer, DDES CCG gave an update on the consultation. She advised that the initial contract had been awarded in 2009 to Intrahealth and had been extended twice. Therefore as part of managing the end of time-limit contracts for primary medical services, the CCG propose to offer the service as a branch of an existing contract for the 1585 registered patients. She referred to the report from NHS England that sets out the community and engagement process and she informed the Committee that a further report would be brought back.

Councillor J Armstrong said that the consultation was comprehensive and he was pleased to see that other people had been added into it, including councillors.

The Chief Operating Officer confirmed that this would be shared with AAPs, following a question asked by Councillor P Brookes.

The Principal Overview and Scrutiny Officer informed the Committee that feedback had been given to NHS England around local councillors and parish councils being included in the consultation, and acknowledged that Easington Colliery Parish Council had been added as a consultee.

Dr L Murthy asked why weekends had been excluded and was informed by the Chief Operating Officer that this consultation was about the basic GP core service. She added that the hub model would provide weekend working.

Resolved:-

(i) That the report be received.

(ii) That comments be fed back to NHS England.

(iii) That a further report be brought back to Committee at the conclusion of the engagement exercise highlighting the decision of NHS England.

9 Integrated Risk Management Plan (IRMP) Action Plan 2016/17 Consultation

The Committee received a report from the Chief Fire Officer, County Durham and Darlington Fire and Rescue Authority that set out background to the Fire Authority's IRMP Action Plan consultation for 2016/17 (for copy see file of Minutes).

The Station Manager gave a detailed presentation that highlighted the following key points:-

- What is the IRMP consultation? – the process used by fire services nationally to ensure that risk to people and property was identified and reduced through the efficient use of available resources.
- Background and the current situation
- Where savings have already been made

He went on to explain about the 2016/17 consultation and the timeline involved:-

- Proposal one – strategic review of fire control
- Proposal two – extend the role of firefighters to assist public health services
- Proposal three – expand the emergency medical response (EMR) scheme
- Proposal four – explore further collaboration in the areas of support services, estates and fire stations
- Proposal five – extend the Young Firefighters' Association (YFA) and Fire cadets' schemes

Councillor J Armstrong fully endorsed the consultation and would welcome the feedback.

On answering a question from Dr L Murthy about what happened to the data collected from the safe and wellbeing forms, the Station Manager explained that their admin team receive them and send to the appropriate team. A disclaimer form was sent with it so that consent was given for any safeguarding issues that arose.

Resolved:

(i) That the report be noted.

(ii) That the Adults Wellbeing and Health OSC feedback on those health related issues identified within the IRMP consultation, namely proposals 2 and 3.

10 Joint Health and Wellbeing Strategy refresh

The Committee considered a joint report of the Corporate Director of Children and Adults Services and Director of Public Health which provided the key messages from the Joint Strategic Needs Assessment and information relating to the refresh of the Joint Health and Wellbeing Strategy 2016-19 (for copy of report see file of Minutes).

The Strategic Manager, Policy Planning and Partnerships gave a detailed presentation that covered the following key points:-

- National Context
- Engagement Process
- JSNA Key Messages

    - Demographics
    - Health
    - Social Care
- Proposed additional outcomes
- Strategic Objectives
- Next steps
- Consultation Questions

The Head of Planning and Service Strategy added that this was a top strategy that sought direction through an inclusive process, with appropriate input from Committee and the wider public. He informed the Committee that the direction of travel tied all agencies together. He was pleased to see the focus on mental health.

Councillor J Armstrong confirmed that Children and Young People's Overview and Scrutiny Committee had fully endorsed the report at their recent meeting.

Councillor P Brookes asked why there was nothing specifically relating to child sexual exploitation. The Head of Planning and Service Strategy advised that this report focused on health implications and would pick up on any health related issues relating to child sexual exploitation. He said that child sexual exploitation was being covered by a number of other bodies including the Safe Durham Partnership and the Local Safeguarding Children's Board

The Chairman thanked the Strategic Manager, Policy, Planning and Partnerships for her presentation and informed the Committee that any comments on the JSNA or the JHWS should be forwarded to the Principal Overview and Scrutiny Officer by 3 February 2016.

Resolved:-
That the reports be received and the comments made by the Committee be included in a response to the JSNA and draft Joint Health and Wellbeing Strategy, such response to be fed into the Health and Wellbeing Board meeting on 8 March 2016.

11 2015/16 Quarter 2 Performance Management Report

The Committee considered a report of the Assistant Chief Executive, presented by the Head of Planning and Service Strategy, Children and Adults Services, that updated on progress against the Council's corporate basket of performance indicators for the Altogether Healthier theme and reported other significant performance issues for 2015/16 covering the period July to September 2015 (for copy see file of Minutes).

The Head of Planning and Service Strategy highlighted that the NHS health check figures had shown an improvement although there was still a variation between GP practices. He added that the data for Lifeline was not available and targets for drug and alcohol treatment referred to the previous provider. The first official Lifeline data on drug treatment would be available in early 2016.

Resolved:
That the report be received.

12 Review of the Council Plan and Service Plans

The Committee considered a report of the Assistant Chief Executive which provided information contained within the Council Plan 2016-2019, relevant to the work of the Adults, Wellbeing and Health Overview and Scrutiny Committee, reflecting the four objectives and subsequent actions within the Council Plan for the Council's "Altogether Healthier" priority theme (for copy see file of Minutes).

The Corporate Scrutiny & Performance Manager highlighted the priorities within the current plan and the proposed changes, including the addition of a new outcome on 'Better Mental Health'.

Councillor Armstrong informed the Committee that a meeting with all Scrutiny Chairs and Vice Chairs would be held to discuss all of the performance indicators and trackers at the end of February/ early March.

The Chairman said that he was delighted to see the addition of better mental health but expressed concerns at the proposal to delete the three cancer performance indicators. Councillor Armstrong suggested that this could be discussed at the Chairs/Vice Chairs meeting.

Resolved:

(i) That the updated position on the development of the Council Plan and the corporate performance indicator set be noted.
(ii) That the draft objectives and outcomes framework be noted.
(iii) That the draft performance indicators proposed for 2015/16 for the Altogether Healthier priority theme be noted.

13 Forecast of Revenue Outturn Quarter 2, 2015/16

The Committee considered a joint report of the Head of Finance, Financial Services, which provided details of the updated forecast outturn position for the Children and Adults Services (CAS) service grouping, covering both revenue and capital budgets and highlighting major variances in comparison with the budget, based on spending to the end of September 2015. The Committee received a presentation regarding the Revenue and Capital Outturn Forecast for Quarter 2 of 2015/16 from the Finance Manager (for copy of report and slides see file of Minutes).

Councillor Armstrong congratulated the Finance Manager on presenting a clear, precise and concise report.

The Head of Planning and Service Strategy suggested that as the Member who had requested the presentation on the Consistent Application of Eligibility Criteria had left the meeting that it be deferred until the next meeting.

Resolved:

(i) That the financial forecasts included in the report, summarised in Quarter 2 of the forecast of outturn report to Cabinet in November, be noted.
(ii) That the presentation on the Consistent Application of Eligibility Criteria be deferred to the next meeting.

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Adults Wellbeing and Health Overview and Scrutiny Committee

1 March 2016

Durham Dales, Easington and Sedgefield Clinical Commissioning Group (DDES CCG) – Consultation in respect of a proposed review of Urgent Care Services

Joint Report of Lorraine O'Donnell, Assistant Chief Executive, Durham County Council and Stewart Findlay, Chief Clinical Officer, Durham Dales Easington and Sedgefield Clinical Commissioning Group

Purpose of the Report

1 To provide members of the Adults Wellbeing and Health Overview and Scrutiny Committee with details of the three proposed options for Urgent Care Services in Durham Dales, Easington and Sedgefield (DDES) from April 2017 and together with details of the proposed consultation and engagement process.

Background

2 At its meeting held on 9 October 2015, the Adults Wellbeing and Health Overview and Scrutiny Committee considered a report and presentation detailing the development of the County Durham and Darlington Urgent Care Strategy 2015-20.

3 At the meeting the Committee endorsed the County Durham and Darlington Urgent Care Strategy 2015-20 and also asked for further detailed reports from the Systems Resilience Group and CCGs outlining detailed proposals for implementation of the strategy and any service changes and associated consultation and engagement plans to be brought back to future meetings of this Committee.

4 On the 19th January, DDES CCG presented an overview of the issues that were being considered as part of the review of services and received questions and comments from this Committee. The presentation included:

- A summary of why DDES has reviewed its Urgent Care Services, providing a National and County Durham and Darlington context to this work;
- A definition of what Emergency and Urgent Care Services are;
- An explanation of the current service provision model for Urgent Care across the DDES locality including service profiles for the Bishop Auckland Urgent Care Centre; Peterlee Urgent Care Centre; Seaham

Urgent Care Centre and the Healthworks Urgent Care Centre, Easington;

- Details of the engagement activity undertaken with patients and stakeholders to date and the key messages from this activity and how this information was being used to inform the development of proposed future models for how Urgent Care services might be provided.

- The models for the future provision of Urgent Care services within the DDES locality including timeframes for public consultation and engagement together with the engagement of the Adults Wellbeing and Health OSC in accordance with the statutory requirements.

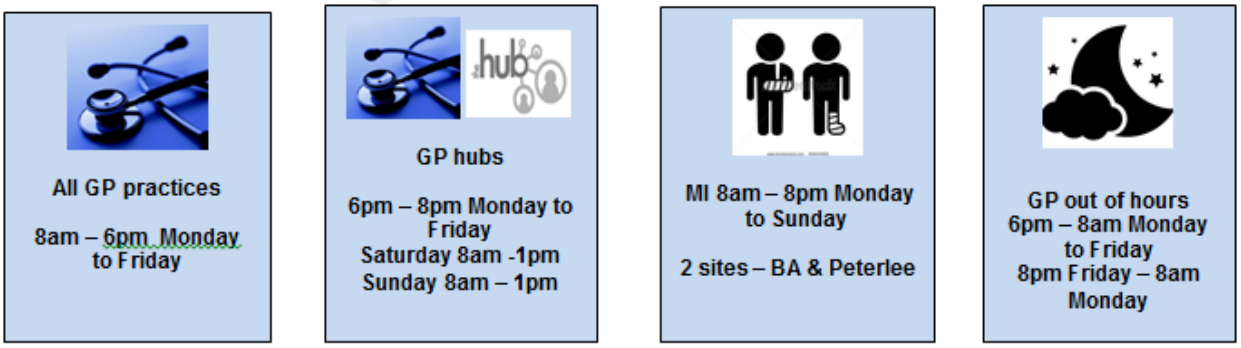
5 Following the presentation, the Chair of the Committee wrote to DDES CCG's Chief Clinical Officer highlighting a number of issues raised by the Committee and requesting further information. A copy of that letter is attached to this report together with a response from Sarah Burns, Director of Commissioning, DDES CCG. (Appendices 2 and 3)

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

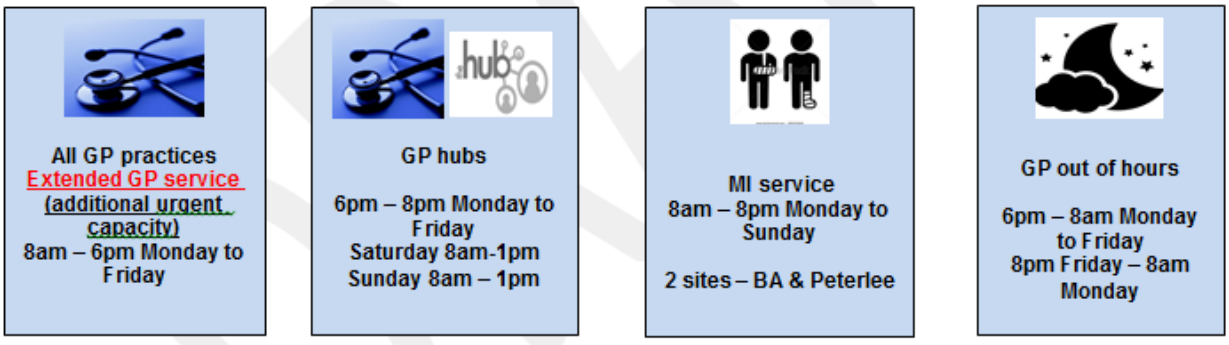
Proposed options for Urgent Care Service Delivery within the DDES CCG locality

7 The models for the future provision of Urgent Care services within the DDES are set out below:

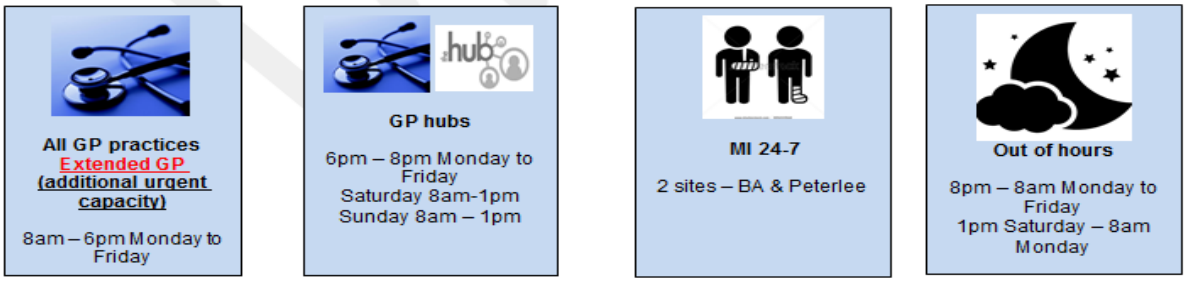
Scenario 1



Scenario 2



Scenario 3



8 DDES CCG has produced consultation documents (Long and abridged versions) in respect of the proposed Review of Urgent Care services across DDES CCG together with a Communications and Engagement Plan. Copies of these are attached to this report (Appendices 4,5 and 6) together with an options appraisal briefing paper (Appendix 7).

9 Members of the Adults Wellbeing and Health OSC will be able to question the CCG representatives on the service options and the consultation and engagement plan and consultation documents.

Next Steps

10 Following comments and input from the Committee, DDES CCG will commence a formal twelve week public consultation regarding the three proposed options for urgent care service delivery. DDES CCG will update the Committee regularly on progress and it is also proposed to hold an additional special meeting of the AWH OSC to allow for full consideration of the consultation documents to enable the Committee to respond to the proposals as part of the formal consultation process.

Recommendation

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

1. receive this report;

2. note and comment on the documents attached including the consultation and engagement plan and the consultation materials;

3. agree to hold an additional special meeting of the AWH OSC to allow for full consideration of the consultation documents to enable the Committee to respond to the proposals as part of the formal consultation process, receive regular updates through the consultation period and a final report once the consultation is complete.

Background papers

- Draft Communications and Engagement Plan (final to be provided 19/02/16)
- Draft Consultation and Engagement Document (Long) (final to be provided 19/02/16)
- Draft Consultation and Engagement Document (Short) (to be provided 19/02/16)
- Review of Options

- Response to letter from the Health Overview and Scrutiny Committee dated 19th January 2016

Contact: Stephen Gwillym, Principal Overview and Scrutiny Officer
E-Mail: stephen.gwillym@durham.gov.uk Tel: 03000 268140
Contact:Sarah Burns, Director of Commissioning, Durham Dales, Easington and Sedgefield CCG Tel: 0191 371 3234

Appendix 1: Implications

Finance - None

Staffing - None

Risk - None

Equality and Diversity / Public Sector Equality Duty – As part of the consultation approach, specific engagement work will be undertaken to ensure that specific engagement activities are undertaken with protected groups.

Accommodation - None

Crime and Disorder - None

Human Rights - None

Consultation – The supporting documents set out how statutory consultation and engagement will be undertaken in respect of the proposed future models of Urgent Care Services.

Procurement - None

Disability Issues - None

Legal Implications – None

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APPENDIX 2

Contact: Cllr John Robinson
Direct Tel: 03000 268140
e-mail:
Your ref:
Our ref:

Dr. Stewart Findlay,
Chief Clinical Officer,
Durham Dales, Easington and Sedgefield CCG,
Sedgefield Community Hospital,
Salters Lane,
Sedgefield,
County Durham.
TS21 3EE

19 January 2016

Dear Stewart,

Durham Dales, Easington and Sedgefield Clinical Commissioning Group – Review of Urgent Care Services

At a meeting of Durham County Council's Adults Wellbeing and Health Overview and Scrutiny Committee on 19 January 2016, members considered a report and presentation providing early information in advance of a proposed consultation exercise in respect of the development of options for the future provision of Urgent Care Services across the Durham Dales, Easington and Sedgefield CCG locality.

The Committee welcome the opportunity to participate in early discussions around this issue and have previously indicated, when considering the development of the County Durham and Darlington Urgent Care Strategy, the importance of early engagement in respect of the development of future options for Urgent Care service provision and associated consultation and engagement activity and plans.

The Committee would wish to highlight the following comments from the Committee in response to the report and associated presentation provided to the Committee:-

- The key principle within the development of a model for future Urgent Care Services appears to be focussed upon patients own GP practices where possible on an in-hours basis with provision between 6.00 p.m. and 8.00 p.m. weekdays to be sourced through a GP Practice hub based model. Furthermore, weekend provision would be provided via Primary care extended opening via a hub model. In view of this, members have

concerns about the ability of GP practices to meet the anticipated demand of such arrangements, given that GP capacity and access is an issue of concern nationally, regionally and locally.

- The Committee are keen to ascertain what steps GPs have taken to promote the availability of appointments within the current model of urgent care, given the assertion within the report presented to Committee that 70% of patients at walk in centres could have been seen within primary care. Furthermore, GPs need to demonstrate that they are examining why patients are bypassing their GP practices to attend an Urgent Care Centre/Walk-in Centre or Minor Injuries Unit when there are appointments available.

- There will undoubtedly be significant financial considerations arising from the remodelling of Urgent Care Services, with the potential redistribution of resources from existing providers to GP practices. What steps will be taken and how can the Adults Wellbeing and Health OSC and patients generally be assured that high quality, accessible and equitable services are being provided.

- A number of members relayed concerns around patients having to “get past” GP practice receptionists acting as gatekeepers to GPs and the importance of patient confidentiality being maintained at GP reception areas when often sensitive and personal information is requested in such publicly accessible areas.

- The Committee would like to be provided with an assessment of exactly where the 70% appointments available were located and whether these were available in the GP practices of the patients choosing.

- There will be potentially 2 periods of election purdah within the potential consultation period identified within the indicative timeframe, one for the Police and Crime Commissioner election on 5 May 2016 and in respect of a National Referendum on EU membership (potentially identified for June/July 2016). The Committee would wish to see the consultation period reflect these important periods of purdah.

Finally, the Committee welcome the DDES CCG’s desire to return to the Adults Wellbeing and Health OSC meeting scheduled for 1 March 2016 to update members further on the proposed service models to be consulted upon and the associated consultation and engagement plans.

Yours sincerely,

Cllr John Robinson
Chair of the Adults, Wellbeing and Health Overview and Scrutiny Committee
Durham County Council

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NHS
Durham Dales, Easington and Sedgefield
Clinical Commissioning Group

Our ref: SB/SL/UC/OSC001

18 February 2016

Councillor John Robinson
Chair
Adult Wellbeing and Health Overview
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Dear Councillor Robinson

Response in relation to Urgent Care

Thank you for your letter of 19th January 2016 outlining some concerns and questions from the Overview and Scrutiny Committee in relation to the review of urgent care across Durham Dales, Easington and Sedgefield (DDES) CCG.

I have outlined your specific queries below along with our response to each one.

1 *Members have highlighted concerns regarding the ability of GP practices to meet the anticipated demand on the future model, given that GP capacity and access is an issue of concern nationally, regionally and locally.*

It is recognised by the Centre for Workforce Intelligence that there is a shortage of GPs nationally, the numbers not having risen since 2009.

The GP ratio per 100,000 of population for DDES CCG is 67.3 compared to a North East average of 68.0 and an England average of 63.4, meaning we are above the national average. The GP workforce within DDES CCG is predominantly UK trained (65%). In addition, DDES CCG has a higher ratio of single-handed GP practices compared to both the North East and England figures.

In January 2015, NHS England announced £10m investment to expand GP recruitment. This is aimed at retaining GPs by establishing a new scheme to encourage GPs who may otherwise be considering a career break or retirement, to remain working on a part-time basis. It will also encourage doctors to return to general practice. Health Education England (HEE) and NHS England will publish a new induction and returner scheme, recognising the different needs of those returning from work overseas or from a career break.

The CCG has developed and implemented a Primary Care workforce plan within the CCG which is summarised below:

- Continued development of the Career Start GP scheme building on Phase I , which has seen seven newly trained GPs come to work in the area;
- Phase II will see the development of GPs with specific health interests, by providing access and support to development/courses in areas of interest;
- The CCG promotes the Career Start scheme as an employment route for aspirant/trainee GPs who are in their final stages of education (ST3);
- We are exploring portfolio opportunities with other providers as part of the GP career start development;
- HENE is developing schemes for return to practice and near retirement GPs;
- We are in the process of expanding a career start programme for practice nurses which will support the transition of nurses working in the secondary care setting who wish to work in primary care;
- Access to clinical leadership programmes for GPs. This will include building on the already developed clinical leadership programmes, where appropriate. Two of our GPs (Dr Satinder Sanghera and Dr Jonathan Smith) have previously both attended the North East Leadership Academy (NELA) clinical fellowship programme;
- Developing the pharmacy workforce by working with the HENE Pharmacy subgroup to ensure appropriate development of the pharmacy workforce in primary care. This will be in addition to the national pilot for expanding the pharmacy workforce in primary care where DDES federations are part of a national pilot.

The CCG has supported and developed federated working amongst GP practices across DDES. This enables practices to collaborate and share resources and has enabled us to offer weekend opening to whole DDES population for the last eighteen months.

The CCG has commissioned additional community services for the frail and vulnerable population that wrap around GP practices. These services provide additional resource to support some of the more complex patients both for patients at risk of admission to hospital or those that have been recently discharged from hospital. This is, in effect, an additional resource for GP practices which frees up or extends capacity across primary care.

We are collecting activity data from primary care which enables us to compare appointments provided across all of our practices. This will be implemented across the region of part of the Urgent and Emergency Care Vanguard, but DDES had already implemented this across all of its practices.

We have implemented direct booking from the 111 service into GP practices both during the week and on Saturdays. This enables 111 to book patients into a GP practice if their need can be met in primary care.

Finally, we are about to conduct an audit into access and booking across all of our practices. This will enable us to identify and share good practice.

2. *Outline steps that GPs have taken to promote the availability of appointments within the current model of urgent care, given the assertion that 70% of patients at walk in centres could have been seen within primary care.*

GP practices generally make contact with patients who inappropriately use urgent care services. These patients are encouraged to use the GP practices.

The CCG has incentivised practices this year to hold slots open daily for 111 to remotely book in patients who need to be seen. To date, these are not overly used and work will continue with this to encourage patients to contact 111 for signposting to appropriate services ensuring we utilise the capacity available.

Some practices across DDES now also do telephone appointment/triaging and this has proven successful.

A communications strategy is being developed to educate patients on the appropriate use of services, triaging and signposting. This will run alongside all consultation and development work and will be widely promoted by the CCG and practices.

The CCG has promoted weekend opening in Stewart Findlay's newspaper column and in the Stakeholder newsletter, as well as on the CCG's website.

Our GP federations (groups of practices working together), have carried out communication campaigns throughout the year to advise of capacity within GP practices on a weekend/ over the Christmas and Easter breaks and how to access which is proving very successful. This has included text messaging to patients to make them aware of availability.

We will continue to work with our GPs over the coming months on a patient education programme and acknowledge that promoting access to services needs to be improved to ensure any future model is successful.

3. *Demonstrate that GPs are exploring why patients are bypassing their GP practices to attend an urgent care / walk in centre or Minor Injuries Unit when there are appointments available.*

We have commissioned 'Care in the Chemist' so that patients can bypass urgent care and general practice.

We commissioned Healthwatch to undertake an audit of the reasons why patients had attended urgent care services and shared this with practices.

4. *Explain what steps will be taken with regards to financial considerations arising from the remodelling of the Urgent Care service, with the potential redistribution of resources from existing providers to GP practices.*

All financial modelling around the potential redistribution of resources is open and transparent. At the time of writing this response, we are not able to share this level of detail as it is commercially sensitive.

NHS England will review all financial considerations as part of the assurance of the CCG's business case both pre and post consultation.

Bespoke governance arrangements have been developed to protect confidentiality give the conflicts of interest. A sub-committee of the Governing Body and the Executive Committee of the CCG is being established which only includes non-conflicted members of both groups.

Additional legal advice is being obtained on commissioning of primary care services.

5. *Explain how the OSC and patients can generally be assured that high quality, accessible and equitable services are being provided.*

NHS England is part of the Urgent Care Project Group as a critical friend, and all the CCG's plans are measured for suitability against NHS assurance framework. The CCG needs approval from NHS England before it can proceed with any large scale service changes such as urgent care. We should be able to share feedback from NHS England about our plans at the next Overview and Scrutiny meeting.

NHS England would not approve plans that were of poor quality, inaccessible or inequitable.

6. *Concerns have been raised by OSC members around the difficulties experienced 'getting past' the receptionists/gate keepers and the importance to maintain patient confidentiality.*

As mentioned previously, we are about to conduct an audit into access and booking across all of our practices. This will enable us to identify and share good practice.

7. *How are the CCG ensuring that access to primary care is equitable?*

The CCG began recording the number of primary care contacts in May 2015, recording the number of face-to-face, home visit and telephone appointments for GPs, nurses and healthcare assistants. From May 2015 to December 2015 there were 1,178,000 contacts, and the forecast for 12 months using this figure is 1,765,000 primary care contacts (source: NECS Information Analysis team).

As mentioned previously, DDES CCG has been collecting activity data from all of the practices for some time and is able to compare and share activity rates.

GP access is challenging to assess as there are no established mechanisms to determine whether or not a practice has access issues. The metrics that are available relate to the information that is collected as part of the patient survey undertaken at practice level which focuses on:

1. Accessing GP services;
2. Making an appointment;
3. Opening hours;
4. Overall experience.

DDES practices perform very well in the GP National Patient Survey, achieving over the England average for the following measures:

Table 15: GP patient survey results, Jan-16 (Source: National Patient Survey: https://gp-patient.co.uk/)

Measure	DDES CCG	England
Ease of getting through to someone at GP surgery on the phone, % Easy	77%	70%
Frequency of seeing preferred GP, % always, almost always or a lot of the time	61%	59%
Impression of waiting time at surgery, % Don't normally have to wait too long	63%	58%

We will carry out a skills gap analysis with all member practices to establish the implications for future workforce. A full training and development programme will be developed and implemented within primary care in DDES. It is acknowledged that this will need to cover reception and administration to ensure that services are easy to access. Some practices are exploring GPs directly triaging patient calls and consulting if appropriate over the phone.

8. *Provide an assessment of exactly where the 70% of appointments available were located and whether these were available in the GP practices of the patients choosing*

The figure of 70% refers to when appointments were available in primary care when patients attended an urgent care centre.

The figures below relate to availability of appointments when the condition could be treated in primary care:
Durham Dales – 61%
Easington – 45%
Sedgefield – 50%

9. *OSC have highlighted 2 potential periods of purdah within the potential formal public consultation timescale.*

We have checked the information provided with NHS England and the view is that this will not affect our timescales.

I trust our response goes some way to alleviating your concerns about any potential services changes however should you require any more information, please do not hesitate to contact me.

Yours sincerely

Sarah Burns.

Sarah Burns
Director of Commissioning

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NHS Logo

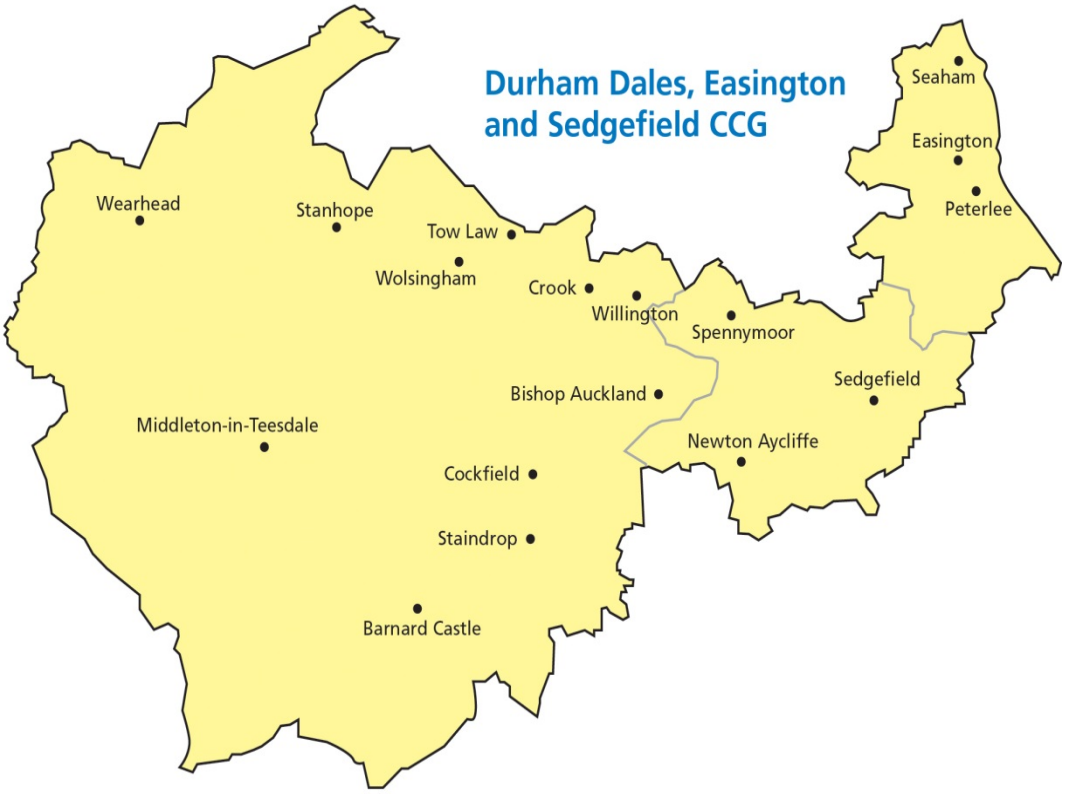
DDES logo

Getting Care Right for You

14th March 2016 – 6th June 2016

A photo/abstract image capturing the essence of the consultation plus consultation logo

CONTENTS



We are NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group, DDES CCG for short. We comprise 40 GP practices and cover a population of around 272.000 patients. We are a very big organisation, so we have got three localities as points of reference for what we do – the Dales area, Easington and Sedgefield.

What does this all mean?

Clinical: we are made up of GPs nurses and other health professionals who know your health needs and how to meet them.

Commissioning: we plan and buy health services that you need and use on your behalf.

Group: we are an organisation accountable to you, the taxpayers.

1. Getting Care Right for You

Welcome and Introduction

Welcome to our public consultation about urgent care services in Durham Dales, Easington and Sedgefield (DDES). We look forward to tell you what we have done, how we have done and why we believe that changing urgent care services will improve your experiences of local health care services.

By urgent care we mean 'the range of health services available to people who need urgent advice, diagnosis and treatment quickly and unexpectedly for needs that are not considered life-threatening'. Excluded from this is emergency care, which is defined as 'immediate or life threatening conditions, or serious injuries and illnesses'. Examples of urgent care services are:

- NHS 111
- Pharmacy
- Local GPs, during and outside normal working hours
- Walk-in centres
- Minor injuries unit
- Urgent care centres

The aim of the proposed changes is to commission (buy)urgent care services that people find simple to understand and provide people prompt treatment or advice for their urgent care needs, making best use of the medical workforce and without additional pressure on A&E.
In particular, the consultation will focus on:

- Current day-time urgent care services
- Proposal for extended GP practice until 8pm weekdays and weekends
- Out of Hours Urgent Care
- Rapid access to diagnostics (i.e. x-ray facilities) Minor Ailments and Minor Injuries

We are consulting on a range of options in your area which will look to deliver better services from April 2017:

- **Urgent Care from your GP practice and extended GP Access** – working with GP Practice to recruit more GPs and other health professionals to create more

appointments and improve access during the day from 8am to 8pm and on a weekend and greater use of 111 for appointment bookings

- **GP Out of Hours** - From 8pm – 8am weekdays and from Friday 8pm to Monday 8am (i.e. the times your GP practice will be closed) as we are required to put out to tender (purchase) a new service
- **Removing the need to walk in** to urgent care services and replace with triage and booking from 111
- Providing **rapid access diagnostics (x-ray etc) and assessment** from specific centres, minor ailments and injuries from your GP practice or aligned to diagnostic centres.

We began a review of urgent care services in 2014 and from January 2015 to December 2015 we asked local people about their experience of using services and for their views on how they could be improved. In summary, people told us that the current system is confusing and needs to be much simpler. This feedback has helped us to develop a range of options for the future. These options have also been informed by key national policy which directs us to further develop the NHS 111 telephone service and to also increase GP surgery opening hours to cover weekends and evenings. In order for us to make these improvements, we will need to change the way we deliver services.

Now we are asking for your views on proposals we have developed as a result of both public feedback and this national policy. The views of local people are extremely important to us. No decision will be made until the end of the consultation.

This document summarises our proposals and informs you about the many ways in which you can have your say. We look forward to hearing your views.

Photos/names of Chair and Chief Operating Officer within the CCG?

2. What is urgent care?

Urgent Care is care that is needed when you have an illness or injury that does not appear to be life – threatening, but also cannot wait for a routine appointment.

Urgent care is for minor injuries such as:

- bruises, strains and sprains
- minor burns, cuts and wounds
- skin complaints, rashes, bites and stings
- small eye injuries
- wound infections
- minor head injuries
- injuries to the back, shoulder and chest
- minor wounds to hands, limbs and feet.

Urgent care is also for minor illnesses such as:

- coughs, colds and flu-like symptoms, sore throats and earache
- stomach ache, constipation, vomiting and diarrhoea.

Services to assess and treat these injuries and illnesses are currently provided in a variety of places, including minor injury units and through most GP surgeries. You do not need to have an appointment or referral to go to a minor injury unit or urgent care centre. It's probably just as important to understand what urgent care is not. Urgent care is not when something is life threatening or an emergency, at which point accident and emergency services should be used.

This is how urgent care services are currently delivered across DDES:

Self-Care
Around 80% of adults can manage common illnesses like coughs and colds using medicines that can be easily bought in shops or at the local pharmacy.

Pharmacy
Local pharmacies prepare and supply prescription and non-prescription treatments and offer advice and support to people to manage long-term conditions. Most provide contraception and flu vaccination services.

NHS 111
NHS 111 is an easy to remember national NHS non-emergency Freephone number that has been in place across Durham since April 2011. Available 24 hours a day, 365 days a year, users speak to a highly trained adviser, supported by healthcare professionals. Advisors ask questions to assess symptoms and immediately direct users to the best medical care.

GP Practice (usually open 8am to 6pm)
We have 40 GP practices providing NHS services. They are the only service to hold a complete patient health record. They work closely with community health and social care teams.

Emergency Dental Services
DDES patients have provision to secure urgent dental treatment within Durham Dales, Easington and Sedgefield. When a patient has a severe dental pain, advice should be secured through your local Dental Practice. Where you do not have a dentist you can secure advice, support and information regarding how to access urgent dental care services from within the DDES area by contacting NHS 111.

Ambulance Service
The ambulance service receives and responds to 999 calls, assesses patient need and provides an appropriate response. This includes the 'hear and treat' service where trained staff provides advice and guidance over the telephone.

The table below helps to understand what services, where and when are currently available across County Durham.

	North Durham CCG		DDES CCG				Darlington CCG	
General Practices	GP practices open 8am-6pm Mon to Fri plus extended opening some evenings Additional weekend opening		GP practices open 8am-6pm Mon to Fri plus extended opening some evenings Additional weekend opening				GP practices open 8am-6pm Mon to Fri plus extended opening some evenings Additional weekend opening	
	University Hospital of North Durham	**Shotley Bridge**	**Seaham Primary Care Centre**	**Easington Healthworks**	**Peterlee Community Hospital**	**Bishop Auckland General Hospital**	**Darlington Memorial Hospital**	**Dr Piper House**
Urgent Care Centre	6pm – 8am Mon to Fri and 24 hours at weekends	6pm – 8am Mon to Fri and 24 hours at weekends	8am to 6pm, Monday to Friday		24/7	24/7	6pm – 8am	8am – 6pm
Minor Injuries Unit		24/7			24/7	24/7		
Walk in Service				8am to 8pm, 7 days a week				
A&E department	24/7						24/7	
GP Out of Hours Service	6pm – 8am Mon to Fri and 24 hours at weekends	6pm – 8am Mon to Fri and 24 hours at weekends			6pm – 8am Mon to Fri and 24 hours at weekends	6pm – 8am Mon to Fri and 24 hours at weekends	6pm – 8am Mon to Fri and 24 hours at weekends	
Key Points	No day time urgent care		No A&E department in geography Range of day time urgent care				Integration between UCC and A&E	

3. Why urgent care services need to change?

Local NHS healthcare needs are increasing as people live longer lives. More and more people are using NHS services every year, increasing the pressure on an already overloaded system.

We believe that urgent care services should:

- Provide consistently high quality and safe care, seven days per week
- Be simple, ensuring the urgent care system works together rather than pulling apart
- Provide the right care according to people's needs

- Acknowledge that prompt care is good care
- Deliver care closer to home where appropriate and safe to do so
- Be efficient and effective in delivery of care for patients

Services are complex and confusing

The changes that we are proposing to make to the current urgent care system are based on your views and your practical experiences of the services. In 2014-2015 we engaged with a number of local people who told us how confused they were about where to go for advice and treatment for problems that were not a life threatening emergency, but needed the advice of a skilled clinician urgently – minor illnesses and injuries. Local people also told us that because they don't know where to go and for what conditions, they often choose to visit A&E instead.

Demand

In County Durham there has been a continued rise in demand for Urgent and Emergency Care across the whole system, from increasing attendances at Emergency Departments to increased demand on the GP In and Out of Hours Services. County Durham has an increasingly ageing population, and there is a continued rise in all long term conditions. In the future, managing this demand may become unsustainable within the current configuration of health and social care systems. As technology and clinical techniques advance, so do the expectations of the public in being able to access health and social care services in more convenient and flexible ways.

Continuing to work to refine the already stretched hospital centric and urgent care systems will only have limited success in meeting the growing demands. There is a strong need to reduce the overall demands through addressing the reasons for the patient accessing an urgent and emergency care service.

Duplication in the system

There is currently duplication with services providing similar treatments within a close proximity, often at the same time, leading to confusion for patients as to where to seek care. This adds to duplication, not only for the patient but also for the local health system. This duplication is also impacting on the availability of the current workforce. Nationally and locally there is a shortage of GPs and other health professionals involved in urgent and emergency

medicine. There is recognition that current service duplication is diluting this scarce workforce resource and our options take this into account.

Cost of urgent care is high

The current cost of delivering the urgent care system in DDES is approximately £10.5m and whilst our proposals are not about cost savings, we want to ensure that we use our money much more effectively to the benefit of our local people, recognising the growing health care demand, an ageing population and the need to sustain services for the future. In order to deliver 7 day access to GP practices, as per national policy and public feedback, we cannot afford to duplicate services.

Existing contracts have expired

Contracts with our existing providers have expired and so we need to review the services being delivered to see if they are still meeting patients' needs. We also need to make sure that they represent value for the taxpayers.

National Policy

In response to increasing pressure on the health care system, the government carried out a comprehensive review of the NHS urgent and emergency care system in England. The overall objective of the review was to consider how to improve services for patients across the spectrum of urgent and emergency care, and to identify potential solutions. It made a number of recommendations including working towards a 7 day NHS service. National policy requires us to deliver 7 day GP services by 2020. Clearly our proposals need to take this into account and build upon the work already being piloted by our local GPs to increase access over 7 days.

In September 2015, NHS England published further direction for CCGs - *'Integrated Urgent Care Commissioning Standards'*. This document describes improvements for the NHS 111 service that must be adopted by all CCGs. It outlines NHS England's vision for urgent care which has also been taken into account when drawing up our proposals. This includes:

- Access to a summary patient record
- Increased telephone access to a range of clinical professionals working within the NHS 111 service
- An expanded directory of services in order to signpost more people to

appropriate support
• The ability to book appointments into GP practices and other relevant services.

4. What have you told us?

Engagement has been undertaken with a range of stakeholders to better understand the services delivered and the needs and preferences of the population. This engagement helped us to:

• Understand the experience of using current, local urgent care services
• Understand how urgent care services could be improved

The following groups of people were involved in a number of engagement events and activities in 2014:

- Parents of young children (under five years)
- People living with long term health issues
- People with mental health issues
- People in good health
- Front-line teams in urgent care settings

These events focused on:

- Patients experience of urgent care services
- How urgent care could be improved
- How urgent care services could continue to meet the needs for the future.

Both members of the public and front line staff said that urgent care centres were mainly used because people couldn't get an appointment to see their GP during the day. Front line staff added that during the day, the majority of patients attended urgent care centres with problems that could have been resolved at their GP practice, and that during the out of hours period urgent care services were used more appropriately.

The conclusions from the engagement work were that people in DDES said:

- The process for making GP appointments should be improved
- Direct access to X-ray and fracture clinics would improve services

- Having the ability to request diagnostic tests for non-urgent needs should be considered
- There is a need for more joined-up thinking around
    - Triage (across urgent care centres, GP practices and NHS 111)
    - Policies and procedures
    - Access to clinical records
    - Accessing specialist advice (a second opinion)
- NHS 111 needs to be joined-up and part of any new system thinking
- What matters to people and delivers a 'great' urgent care experience would be if services are
    - Welcoming
    - Supporting
    - Reassuring
    - Building confidence
    - Informing and educating people how to self-care
    - Listening and understanding
- Would like to have more knowledge and be educated, who to call, where to go when they have specific health needs or condition. "Being in the right place, at the right time, seeing the right person, who can support their needs"
- Would like to receive health education in the community to self-care and by receiving training would give them more confidence

The key message was that patients would prefer to see their own GP where possible and that they would like new and innovative ways of contracting their GP.

Planning Alternative Tomorrows with Hope (PATH event)

In June 2014, DDES CCG invited its community to come together with them to describe a positive possible future for the whole health and care system around urgent care in Durham in June 2017 and beyond. The group worked with a facilitated visual planning process called PATH (Planning Alternative Tomorrows with Hope) to describe a positive possible future to support people to keep well and live life to the full.

The planning process asked participants to consider for urgent care in Durham:

- What is our ambition for urgent care?
- What is a positive possible future we want to achieve by 2017?
- What is happening now?
- What are the bold steps that will accelerate our progress?
- What are our personal commitments and next steps?

People told us:

- **People** lack confidence and there is a lot of confusion around future of urgent care services and those over 80 are excluded from screening and not helped to "self-care"
- **Services** - too much money is being spent on "in hours" 8am – 8pm Urgent Care Centres and there is a culture of misuse of services and 111 needs to be improved!
- **Communication** - there is a total breakdown in communication between GP's, nurses and pharmacists with an inappropriate allocation of GP appointments.
- **National standards** for Urgent Care are coming but there is a Wellbeing for Life workforce in place and Prime Minister (PM) Pilots have a lot of learning

5. How we developed our options for improvement

We started by developing a large number of potential scenarios that we thought might make urgent care services better. These were informed by the engagement activities that we described above, as well as input from local doctors, the CCG and stakeholders such as our Local Authority and NHS England.

An in-depth discussion around urgent care services took place at our GP Locality meetings in July and August 2015. The discussion included the GP

Commissioning Leads (every practice has a lead GP that represents them) from each practice and the Patient Reference Group Chair for that locality. A follow up workshop took place in October 2015 with the GP clinical locality leads and proposed new service models were considered. A summary of the discussion is below:

- There are multiple services for patients to access in DDES, particularly during the day
- There are peaks in demand for services (mid-morning and 4-8pm)
- Patients would prefer to see their GP where possible
- Appointments are available in a large proportion of cases where patients have attended Urgent Care Centres/Walk In Centres services
- Services must be more closely linked and integrated (including 111 services)
- Patients perceive the Urgent Care Centres/Walk In Centres to be between A&E and GP services when this is not always the case
- Patients want care closer to home

In developing a forward plan for urgent care, DDES CCG developed scenarios about how services could be improved by utilising patients and key stakeholders feedback along with all the information gathered through the engagement activities carried out in 2014 and 2015.
The scenarios were assessed using best practice, national strategies and standards. Six scenarios were taken forward; these were then evaluated using the following factors as appraisal criteria:

- Affordability
- Sustainability
- Safety
- Access for patients

Option	Affordable	Sustainable	Safe	Convenience of Access for Patients	Overall Rating	Summary

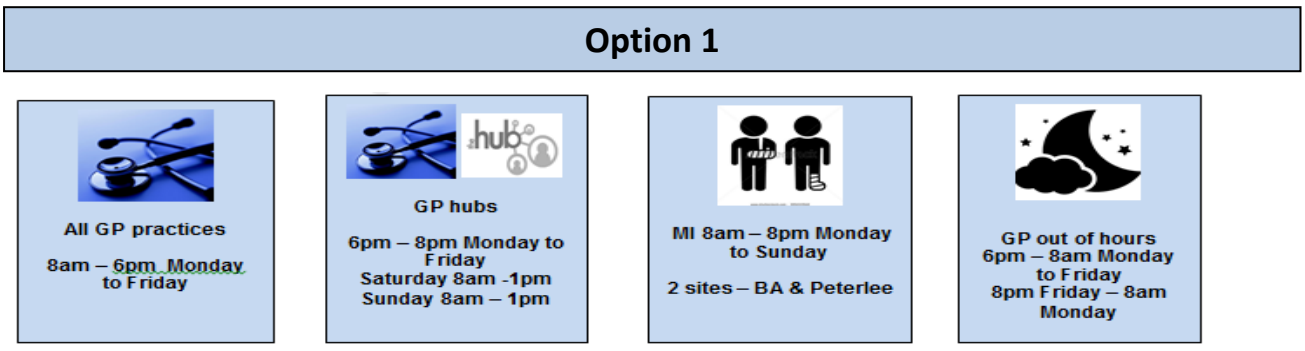
1	No	No	Yes	Yes	Non-viable	This model involves re-procuring the existing services in their current configuration and does not involve any change.
2	No	No	Yes	Yes	Non-viable	Increase the number of minor injury/urgent care/out of hours services to three, retain all other services.
3	Yes	Yes	Yes	Yes	Viable	Retain two MIUs for 12 hours per day, retain the number of out of hours hubs, existing primary care services to manage demand for minor ailments during the day.
4	Yes	Yes	Yes	Yes	Viable	Retain two MIUs for 12 hours per day, retain the number of out of hours hubs, enhanced primary care services to manage demand for minor ailments during the day.

5	**Yes**	**Yes**	**Yes**	**Yes**	**Viable -**	Retain two MIUs for 24 hours per day, retain the number of out of hours hubs, enhanced primary care services to manage demand for minor ailments during the day.
6	**No**	**No**	**No**	**No**	**Non-viable**	Standard primary care services during the day, no minor injury units, GP out of hours service in two locations.

Scenarios 3, 4 and 5 met all the criteria and were taken forward as options for consultations.

Scenarios 1, 2 and 6 were not taken forward as they did not meet the criteria.

Options Selection



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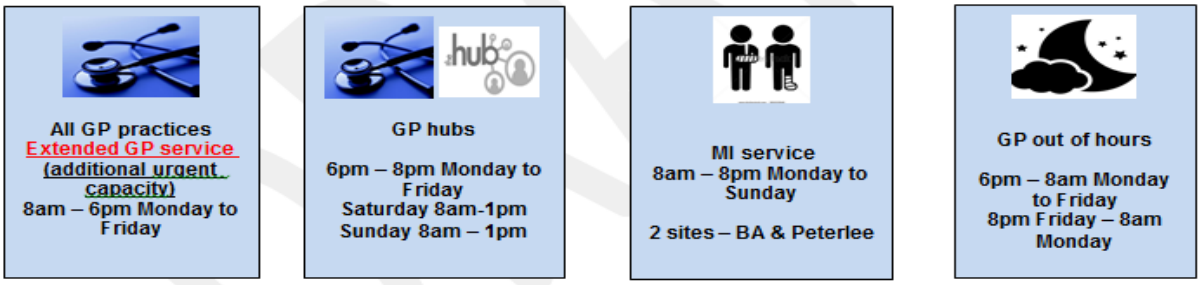
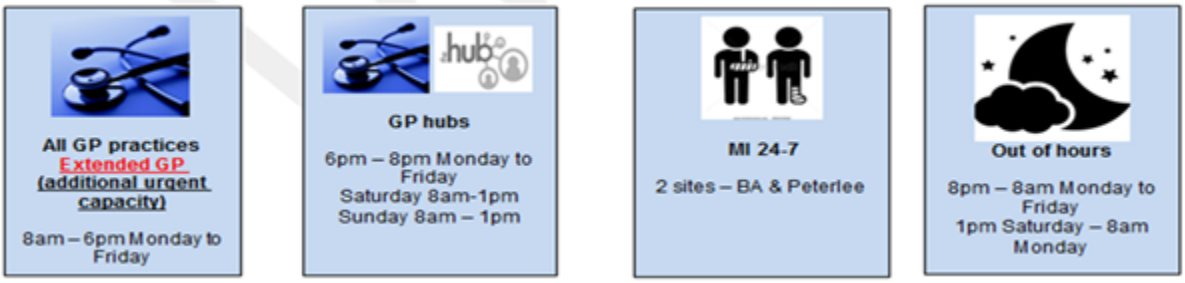


Option 3



6. How you can have your say

We are keen to hear your views, experiences and ideas about how we can improve urgent care services across DDES. To make sure your voice is heard, you can share your views in the following ways:

Online survey: add link when it is agreed upon

A paper version is also available by calling
AGREE ON NECS ENGAGEMENT TEAM

Email us: AGREE ON NECS ENGAGEMENT TEAM

Twitter: @ddesccg

Write to us: AGREE ON NECS ENGAGEMENT TEAM

Public Consultation events
3 X Sedgefield
3 X Easington
3 X Dales

FAQs
What is a Hub?
What does extended GP Hours mean?

7. How we will use your feedback

We know it is really important to keep you updated, especially when you have taken the time to share your thoughts and views with us. At the end of the consultation, we will write a report. The CCG Governing Body will look at the report and use the information and views to decide how best improve urgent care services across DDES. We will share the report with you and make sure it is available on our website. We will also share it through our Community Newsletter, our Facebook and Twitter profiles, the online platform MyNHS.
Please remember to leave your contact details with us if you would like a copy.

The CCG recognises that the consultation relates to complex services, options and issues. If you need more information to help you respond to the consultation, or have any further questions please contact XX
Telephone XX
Email XX

8. Public consultation questionnaire

Please read the accompanying consultation information before completing the questions below. Please send the completed questionnaire (no stamp required) to **NECS** or contact us at ? to receive an electronic copy.

The Case for Change

1. Do you agree that the changes we are proposing reflects what the public told us during our period of pre-engagement?

Agree Unsure Disagree (please state why)

2. We have given an outline of how urgent care services could look in the future. Do you agree that this will best meet the urgent care needs of patients in the future?

Agree Unsure Disagree (please state why)

3. Do you think the proposals will reduce confusion and provide a simpler service for patients?

Agree Unsure Disagree (please state why)

The Options

4. Which of the options do you feel would best meet the needs of the local population?

Option 1: retain two Minor Injuries Unit for 12 hours per day, retain the number of out of hours hubs, existing primary care services to manage demand for minor ailments during the day

Option 2: retain two Minor Injuries Unit for 12 hours per day, retain the number of out of hours hubs, enhanced primary care services to manage demand for minor ailments during the day

Option 3: retain two Minor Injuries Unit for 24 hours per day, retain the number of out of hours hubs, enhanced primary care services to manage demand for minor ailments during the day

5. What is it about the option you have chosen that is important to you?

Feedback

6. Do you have any other feedback about our proposals for urgent care services?

7. Where have you heard about this consultation

□ Local radio

□ Local television

□ Local newspaper

□ Email

□ Twitter/Facebook

□ Word of mouth

The consultation

8. Overall, how do you feel about the way you have been consulted and the level of information that you have been given?

☐ Very satisfied

☐ Quite satisfied

☐ Very dissatisfied

☐ Quite dissatisfied

What do you think of the consultation process? Please use this space if you wish to give us more feedback

About You

Additional Information (optional) The CCG has a duty to ask for data monitoring information, so we can meet our equality duties. You do not have to answer all the questions if you do not want so.

Please state your gender

Male Female Prefer not to say

Has your gender changed since you were born?

Please state your age range

Under 25 25-35 36-45 46-55 56-65 66-75 75 and over

What is your marital status?

Married
Single
Divorced
Widowed
Separated
Civil Partnership
Other

Please state which ethnic group you consider yourself to be?

Please tell us your religion? (If you prefer not to say, please leave blank)

Do you consider yourself to have a long standing illness or disability?

How would describe your sexuality?

Heterosexual or straight
Gay or lesbian
Bisexual
Other
Prefer not to say

Please tell us if you are pregnant or have a child under 2 years of age

Please tell us the first 4 or 5 characters of your postcode (please note this does not identify a street or house).

9. Do you need more help?

We can provide versions of this document in other languages and formats such as Braille and large print on request. Please contact NECS?

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NHS logo

NECS logo DDES Logo

'Getting Care Right for You' public consultation on changes to urgent care services in Durham Dales, Easington and Sedgefield

Welcome to our public consultation about urgent care services in Durham Dales, Easington and Sedgefield (DDES). We look forward to tell you what we have done, how we have done it and why we believe that changing urgent care services will improve your experiences of local health care services.

By urgent care we mean 'the range of health services available to people who need urgent advice, diagnosis and treatment quickly and unexpectedly for needs that are not considered life-threatening'. Excluded from this is emergency care, which is defined as 'immediate or life threatening conditions, or serious injuries and illnesses'. Examples of urgent care services are:

- NHS 111
- Pharmacy
- Local GPs, during and outside normal working hours
- Walk-in centres
- Minor injuries unit

The aim of the proposed changes is to commission (buy) urgent care services which people find simple to understand and gets people prompt treatment or advice for their urgent care need, making best use of the medical workforce and without additional pressure on A&E.

In particular, the consultation will include:

- Current day time urgent care services
- Proposal for extended GP practice opening until 8pm weekdays and at weekends
- Out of hours urgent care

- Rapid access to diagnostics, minor ailments and injuries

We will consult on a range of options in your area which will look to deliver better services from April 2017:

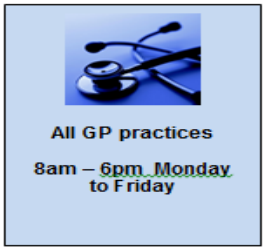
- **Urgent Care from your GP practice and extended GP Access** – working with GP Practice to recruit more GPs and other health professionals to create more appointments and improve access during the day from 8am to 8pm and on a weekend and greater use of 111 for appointment bookings
- **GP Out of Hours** - From 8pm – 8am weekdays and from Friday 8pm to Monday 8am (i.e. the times your GP practice will be closed) as we are required to put out to tender (purchase) a new service
- **Removing the need to walk in** to urgent care services and replace with triage and booking from 111
- Providing **rapid access diagnostics (x-ray etc) and assessment** from specific centres, minor ailments and injuries from your GP practice or aligned to diagnostic centres.

We began a review of urgent care services in 2014 and from January 2015 to December 2015 we asked local people about their experience of using services and for their views on how they could be improved. In summary, people told us that the current system is confusing and needs to be much simpler. This feedback has helped us to develop a range of options for the future. These options have also been informed by key national policy which directs us to further develop the NHS 111 telephone service and to also increase GP surgery opening hours to cover weekends and evenings. In order for us to make these improvements, we will need to change the way we deliver services. Now we are asking for your views on proposals we have developed as a result of both public feedback and this national policy. The views of local people are extremely important to us. No decision will be made until the end of the consultation.

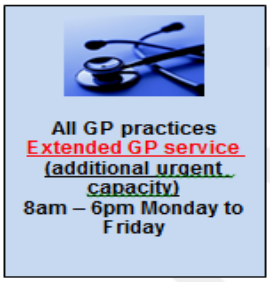
This document summarises our proposals and also informs you about the many ways in which you can have your say. We look forward to hearing your views.

Options the CCG is consulting the public on

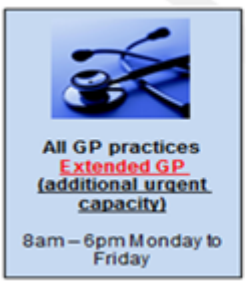
Option 1



Option 2



Option 3



More information is available on the DDES CCG website

(http://www.durhamdaleseasingtonsedgefieldccg.nhs.uk/) including an online questionnaire about the consultation. Paper copies are also available by contacting 0191-3713222 or emailing ddesccg.enquiries@nhs.net

Public consultation meetings

A number of public meetings have been arranged as part of the consultation. These are detailed below. To book a place at one of the events, please call 0191-3713222 or email ddesccg.enquiries@nhs.net

3 X Sedgefield
3 X Easington
3 X Dales

Do you need more help?

Want to talk to someone about how this consultation has been run?

If you would like to talk to someone about how this consultation has been put together and delivered, please contact DDES CCG

Other languages and formats

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NHS
Durham Dales, Easington and Sedgefield
Clinical Commissioning Group

Urgent Care Consultation
Communications and Engagement Plan

February 2016
Version 7

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

Contents

1. Introduction

NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group (DDES CCG) is reviewing urgent care services to ensure patients are treated in the right place at the right time and by the right health care professional wherever possible. This is part of their five year strategy to review the urgent and emergency care system to develop a patient centred vision and is in line with NHS England's review of urgent and emergency care services. The CCG has an overarching Communications Strategy in place and an Engagement Strategy but it recognises that certain transformation projects require bespoke communications/engagement plans to be in place. The aim of this communications and engagement plan is to inform the development of a new model of urgent care services in the DDES area that will appropriately meet the needs of the population now and into the future.

For the purposes of defining 'urgent care', this includes the following services:

- Self-care
- GP Practice
- Pharmacy
- Walk-in-centres
- GP out-of-hours services
- NHS 111

2. Setting the context of the consultation

The CCG engages extensively and regularly through Patient Reference Groups (PRGs), Health Networks, Area Action Partnerships (AAPs) and various community groups. Building on its commissioning intentions and the CCG's strong beliefs and commitment to put local communities at the heart of everything they do.

An initial period of pre-engagement was conducted between May and July 2014 to help the CCG to understand the experience of people using urgent care services. DDES CCG worked in partnership with Experience Led Commissioning (ELC), an external company, formed a local team to carry out an engagement exercise in order to explore in-depth local people's perceptions of urgent care, and what matters to them when they access these services.

In addition, members of the Executive Committee, Commissioning Team and some members of the Governing Body visited all four of the relevant services in order to observe the context of

delivery and talk to staff members. Furthermore, two audits were undertaken in 2015: the first one was carried out by DDES GP Practices of Urgent Care Centre and Walk in Centre attendances, whereas the second one was conducted by Healthwatch.

More detailed information about the engagement carried out by the local ELC Team's work and the Audits can be found in Appendix One of this document.

PATH (Planning Alternative Tomorrows with Hope)

In June 2014, Durham Dales, Easington and Sedgefield (DDES) CCG invited its community to come together with them to describe a positive possible future for the whole health and care system around urgent care in Durham in June 2017 and beyond.

The group worked with a facilitated visual planning process called PATH (Planning Alternative Tomorrows with Hope) to describe a positive possible future to support people to keep well and live life to the full.

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

Importantly, throughout the pre-engagement, and development of potential new models to deliver urgent care services, an on-going dialogue was maintained with the Overview and Scrutiny Committee (OSC). In particular, the rationale for the proposed changes to urgent care were presented at a meeting on 19th January 2016, and a full consultation plan (including Communications and Engagement Plan and briefing documents) will be shared and discussed at the OSC meeting on 1st March 2016.

3. The case for change

Benefits of the proposed change include:

- Patients and the public will know how to access information and guidance in the event of needing urgent or emergency care;
- Patients, public and carers will be able to access the most appropriate services for their needs;
- The patient will not experience any unnecessary delay in receiving the most appropriate interventions;
- The urgent and emergency care services will be simpler to understand for patients
- There will be less duplication of services in the health system

- Due to less duplication of services, a reconfigured service will represent value for money for the taxpayer

4. Urgent and Emergency Care Task and Finish group

An 'Urgent and Emergency care' Task and Finish Group has been established to manage and oversee the development and implementation of the consultation process and related consultation dialogue activity with the public. This group is an internal group made up of CCG employees.

Terms of reference were developed for this Group, defining it's:

- Membership
- Purpose, scope and frequency of meetings
- Confidentiality

This Task and Finish Group has developed links with NHS England and the Consultation Institute as part of its assurance and quality function. In addition, the Engagement Strategy Task and Finish Group will provide regular feedback in relation to ways to engage meaningfully with diverse local communities. Furthermore, the CCG Engagement Steering group will review the proposed consultation plan and we will take their feedback on it, into consideration.

5. Pre-engagement and options development

Two stages of pre-engagement activities were planned, developed and implemented to inform and underpin:

- the development of a proposed new model of urgent care services in DDES;
- the outline business case relating to the proposals and;
- the development of a full public consultation on the proposals.

These pre-engagement activities were carried out at different stages, and they have successfully achieved the following objectives in relation to understanding:

- the experience of people using current urgent care services;
- the ways in which those people, and the wider general public, think urgent care services could be improved in DDES.

Stage 1 Engagement

At an early stage (2014) engagement was carried out to help DDES CCG understand what local people thought about urgent care services; what worked well and what needed to be improved. The aim was to develop an understanding of how urgent care services could continue to meet appropriately the needs of the DDES population in the future.

Objectives of this early stage engagement:

- to develop communication and engagement activity to engage meaningfully with local people;
- Listen to, and understand, the experiences of local people using existing urgent care services
- In doing so, ensure that the views of those who do not always have the opportunity to engage are reflected in the decision-making of DDES CCG
- Analyse feedback to understand relevant themes, priorities, challenges and issues identified by local people in relation to urgent care services
- Report back findings to DDES CCG, with recommendations on how the feedback should be used and developed to inform the new urgent care strategy
- Make recommendations for further communications and engagement activity to take place to inform development of the new model of urgent care services, including the future public consultation

DDES CCG is proud of the relationships developed with key voluntary sector organisations. To ensure that as many local people, groups and organisations as possible were given the opportunity to become involved in the development of its urgent care proposals, the CCG Communications and Engagement Team worked closely with an Experience Led Commissioning (ELC) Team. A description of activities undertaken is outlined below.

Approaches to Stage 1 Engagement

ELC activities took place from May 2014 to May 2015. The following table contains an overview of this form of engagement along with a number of methods that were utilised to increase the potential for public engagement at these sessions.

Stage One Engagement Activity

Engagement Activity	Overview
ELC sessions	The National ELC team analysed data collected by The North East England ELC team at eleven ELC Co-Design outreach events held in DDES CCG between May and June 2014. Young families, people living with long term conditions and older people participated and shared their current and desired experiences of seeking help with unexpected or unfamiliar health issues (urgent care). They also told us: • What they understand by urgent care • What builds their confidence to self-care (including existing service or individuals) • What triggers their use of urgent care services

PATH Event	PATH (Planning Alternative Tomorrows with Hope) In June 2014, Durham Dales, Easington and Sedgefield (DDES) CCG invited its community to come together with them to describe a positive possible future for the whole health and care system around urgent care in Durham in June 2017 and beyond. The group worked with a facilitated visual planning process called PATH (Planning Alternative Tomorrows with Hope) to describe a positive possible future to support people to keep well and live life to the full. People told us: • **People** lack confidence and there is a lot of confusion around future of urgent care services and those over 80 are excluded from screening and not helped to "self care" • **Services** - too much money is being spent on "in hours" 8am – 8pm Urgent Care Centres and there is a culture of misuse of services and 111 needs to be improved! • **Communication** - there is a total breakdown in communication between GP's, nurses and pharmacists with an inappropriate allocation of GP appointments. • **National standards** for Urgent Care are coming but there is a Wellbeing for Life workforce in place and Prime Minister (PM) Pilots have a lot of learning
Open Access Engagement, communications and public relations	Development and distribution of a press release. Articles in stakeholder e-newsletter Northern Echo newspaper Raising awareness via social media – Twitter and Facebook, as well as encouraging key partners

Who was engaged?

Those engaged came from a variety of different backgrounds, experiences, groups and communities. As well as engaging people who may not always have the opportunity to have their say on health issues, the combination of open access and targeted engagement also ensured that DDES CCG was fully compliant with its public equality duty, defined by S.149 of the Equality Act 2010.

Summary of Key Stage 1 Findings

The conclusions from the ELC work were that people in DDES said:

- The process for making GP appointments should be improved
- Direct access to X-ray and fracture clinics would improve services
- Having the ability to request diagnostic tests for non-urgent needs should be considered

- There is a need for more joined up thinking around;
    - Triage (across urgent care centres, GP practices and NHS 111)
    - Policies and procedures
    - Access to clinical records
    - Accessing specialist advice (a second opinion)
- NHS 111 needs to be joined up and part of any new system thinking
- What matters to people and delivers a 'great' urgent care experience would be if services are;
    - Welcoming
    - Supporting
    - Reassuring
    - Building confidence
    - Informing and educating people how to self-care
    - Listening and understanding
- Patients would like to have more knowledge and be educated, who to call, where to go when they have specific health needs or condition. "Being in the right place, at the right time, seeing the right person, who can support their needs'
- People would like to receive health education in the community to self-care and by receiving training would give them more confidence

The key message was that patients would prefer to see their own GP where possible and that they would like new and innovative ways of contacting their GP.

The outcomes of the ELC exercise underpinned DDES CCG's decision to carry out further work around integrating urgent care services.

Stage 2 Engagement

Two service audits were also undertaken in February 2015 to help understand:

- Numbers and demographics of those accessing UC and WICs by DDES CCG patients
- Proportion of symptoms and ailments that patients present at urgent care, that could be safely dealt with, assessed and treated in primary care
- Current capacity in primary care, to help understand or challenge public perception that patients are unable to access appointments and as a result feel they have no choice but go to A&E/UCC/WIC

Stage 2 Objectives

- To ensure that DDES CCG fully engages its local population in the development of its new urgent care model and give more people the opportunity to share their views and experience of urgent care services
- To inform the development of urgent care scenarios
- To balance clinical and public needs and priorities within the development of urgent care scenarios

Stage 2 included a focus on engaging people who are currently using urgent care services in DDES.

Stage Two Engagement Activity

Engagement Activity	Overview
Clinical Audit of UCC and WIC attendances	The first audit was carried out by DDES GP Practices of UCC and WIC attendances *(Note: 'urgent care centre [UCC]' has been used to describe all activity whether at an UCC or a WIC)* • 36 out of 41 practices in DDES CCG took part in the audit • In total, 5,338 UCC attendances were reviewed (4.90% sample of the approximate 120,000 predicted UCC attendances) • The top reason for attending urgent care was due to an injury (15.5% of the total) and this was also the final or main diagnosis of the attendance (16.1% of the total) • Most patients had the symptoms for 0-1 weeks prior to their attendance at urgent care (63.0% of the total) • Prescribing of medicines was the top treatment stated by practices (44.3% of the total) • In total there were 394 cases where the patient had received an X-Ray • In 59.2% of UCC attendances no follow up was required • In 50.4% of cases appointments were available in primary care on the day that the patients
Audit carried out by Healthwatch regarding patients experience in an UCC or WIC	*Note: 'urgent care centre [UCC]' has been used to describe all activity whether at an UCC or a WIC)* • Healthwatch reviewed 151 patients, at Bishop Auckland, Peterlee, Seaham and Healthworks UCCs • 91.4% of these were from DDES CCG • The top reason for attending urgent care was patient choice: "I chose to come here" • 84.1% (127 patients) of patients stated they had used their own transport to get to the UCC • The top reason for attending urgent care was due to an injury (14.6% of the total) • 29.1% patients would have gone to A&E had the UCC been unavailable

Options Development

:

Multiple scenarios were considered following the pre-engagement work,. ongoing discussions and debates by DDES CCG executive members. These discussions and debates were also informed by the outcomes of the pre-engagement and six models were considered. These were evaluated by the non-conflicted members of the Executive Committee with the following factors used as appraisal criteria:

- Affordability

- Sustainability
- Safety
- Access for Patients

The scenarios that were deemed viable were then confirmed as options upon which to consult the public

Options upon which the public will be consulted

1. Retain two MIUs for 12 hours per day, retain the number of out of hours hubs, existing primary care services to manage demand for minor ailments during the day
2. Retain two MIUs for 12 hours per day, retain the number of out of hours hubs, enhanced primary care services to manage demand for minor ailments during the day
3. Retain two MIUs for 24 hours per day, retain the number of out of hours hubs, enhanced primary care services to manage demand for minor ailments during the day.

Equality Analysis

DDES CCG has a duty to meet its public sector equality duty, as defined by S149 of the Equality Act 2010.

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

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

Targeted engagement has ensured that people with all protected characteristics defined within the Equalities Act have had the opportunity to participate; however, to ensure that DDES CCG is fully meeting this duty, an equalities analysis has also been undertaken and is in the process of being validated and further informed through continuing engagement.

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

6 Engagement and consultation activity

As outlined in Section Two, the proposed approach for the consultation has been accepted by the Overview and Scrutiny Committee on 19th January 2016, therefore a second presentation will be made to the Committee on 1st March to outline the 12 week Public Consultation exercise which will begin on 14th March 2016. For the consultation exercise we will produce a consultation booklet and a briefing. These documents will also include the options we are consulting on.

Prior to this, Patient Reference Groups will be informed about the consultation timeline in February 2016, along with our other stakeholders. Views on the proposed service changes will be gathered and fed into the decision making process once the public consultation opens on 14th March 2016.

Meetings with staff who are currently employed within the Urgent Care Centres took place on Monday 11th January 2016 outlining the potential impact the proposed changes will have on their working arrangements.

In particular, the CCG has engaged with the Engagement Strategy Task and Finish group in order to identify appropriate locations and times for public meetings.
The CCG also communicates regularly with the Council of Members and with GPs through the Practice Managers meetings and the three Locality meetings. These mechanisms allow the CCG and the Engagement Team to receive meaningful input into the development of the consultation and to ensure that all members of staff are fully informed about the plans for change.

Appendix four and five of this document provide further details on the CCG's planned communications and engagement activities which will consider at all times guidance from NHS England which sets out the required assurance process that commissioners should follow when conducting service configuration.

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

7. Stakeholders

A stakeholder is anyone who is effected by or can affect, the project. The CCG needs the right information to inform decisions for its community. It continually strives to maintain and strengthen its strong working relationships with its stakeholders. A stakeholder map can be found at Appendix two which includes project specific stakeholders, both internal and external.

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

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

This enables the CCG to formulate a bespoke communications plan based on influence and impact, increasing the chances of the communications and engagement plan being successful. A stakeholder analysis template used for this purpose can be found at Appendix three.

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

8. Consultation briefing document

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

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

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

available on a dedicated section of the CCG's website and will be promoted via social media channels such as Facebook, Twitter and YouTube.

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

9. Dialogue development

A variety of communication and engagement activities will be used to ensure that the consultation dialogue activity is fully accessible to the diverse and varied population of DDES.

A detailed communications and engagement action plan can be found at Appendix eight and an overview of engagement activity at Appendix five.

10. Standard formats of information

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

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

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

11. Documentation and resources

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

- Consultation briefing documents and questionnaires
- Posters
- Website
- Booklet?
- Flyers
- Leaflets
- Stand-up banners
- Venues for public events

12. Communications and engagement objectives

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

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

- Communicating clearly, effectively and honestly with local communities in order to build trust and confidence in the NHS and health professionals;
- Engaging effectively with every segment of the population in order to ensure that local people are given the opportunity to consider and comment on the options for new models of urgent care services in the DDES area;
- Using the comments and feedback from the local communities to inform consideration by the CCG as to how it should provide urgent care services to best meet the needs of the population of the DDES area;
- Inform CCG commissioning responsibilities in relation to, and the procurement of, urgent care services.
- Ensuring that the CCG is complying with all its legal obligations in relation to public consultations and engagement (see Appendix 7 for further details of these specific requirements).

13. Risks and Mitigation

Risk and risk mitigation will be managed by the Urgent and emergency care task and finish group, Risks will be identified and regularly reviewed and assessed throughout the consultation development and implementation.

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

Lack of response / “buy in”	Ensure adequate publicity and support
Accessibility of activities and appropriate feedback mechanisms to those taking part	Ensure clear contact for translations or alternative format Include appropriate feedback mechanisms in plan that are accessible to people with varying needs and abilities
Managing expectations of members of the pubic	Ensure adherence to communications plan and advise CCG of any issues
The consultation and options may be perceived by members of the public as a “cost cutting” exercise	Ensure clear rational for change is communicated within the consultation briefing document
The consultation may be subject to challenge	Appropriate governance policies/standards will be put in place to ensure correct procedure and equality analysis are maintained throughout the consultation

14. Data analysis

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

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

14. Reporting and feedback

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

Following a period of consideration, the CCG will then make a decision on any changes to urgent care services. This decision will be published and communicated to stakeholders, along

with the rationale for making that decision and the reasons that other options were not taken forward.

15. Evaluation

Evaluation will be on-going throughout the consultation period and beyond, overseen by the Urgent and Emergency care Task and Finish Group.

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

Appendix 1
The work of the ELC team and audits

In July 2014, DDES CCG in partnership with an external Experience Led Commissioning (ELC) team, formed a local ELC team to carry out an engagement exercise to help understand how patients and the public use and perceive urgent care and what matters to them when they access these services.

Engagement work was undertaken in the DDES CCG area with the following groups of people:

- Parents of young children (under five years)
- People living with long term health issues
- People with mental health issues
- People in good health
- Front line teams (urgent care centres and primary care)

There were five main reasons that people said they use urgent care centres:

1) They want immediate reassurance
2) They perceive their condition as “in between GP and A&E”
3) They believe they can’t see their GP soon enough
4) It is out of hours
5) Because there is free transport to urgent care centres out of hours

Both people and front line staff said that urgent care centres are mainly used because people cannot get an appointment to see their GP during the day. Front line staff added that during the day, the majority of patients attend urgent care centres with problems that could have been resolved at their GP practice, and that during the out of hours period urgent care services are used more appropriately.

The outcomes of the ELC exercise were that:

- The process for making GP appointments should be improved
- Direct access to x-ray and fracture clinics would improve services
- Having the ability to request diagnostic tests for non-urgent care should be considered
- There is a need for more joined up thinking around;
    - Triage (across urgent care centres, GP practices and NHS 111)
    - Policies and procedures
    - Access to clinical records
    - Accessing specialist advice (a second opinion)

- NHS 111 needs to be joined up and part of any new system thinking
- What matters to people and delivers a 'great' urgent care experience would be if services are;
    - Welcoming
    - Supporting
    - Reassuring
    - Building confidence
    - Informing and educating people how to self-care
    - Listening and understanding

The key message was that patients would prefer to see their own GP where possible and that they would like new and innovative ways of contacting their GP.

The outcomes of the ELC exercise underpinned DDES CCGs decision to carry out further work around integrating urgent care services.

Service Audits

Audits were carried out in February 2015 to help understand:

- Numbers and demographics of those accessing urgent care and walk-in centres by DDES CCG patients
- Proportion of symptoms and ailments that patients present at urgent care, that could be safely dealt with, assessed and treated in primary care
- Current capacity in primary care, to help understand or challenge public perception that patients are unable to access appointments and as a result feel they have no choice but go to A&E

Clinical Audit of UCC and WIC attendances

The first audit was carried out by DDES GP Practices of UCC and WIC attendances

(Note: 'urgent care centre [UCC]' has been used to describe all activity whether at an urgent care centre or a walk-in centre)

- 36 out of 41 practices in DDES CCG took part in the audit
- In total, 5,338 UCC attendances were reviewed (4.90% sample of the approximate 120,000 predicted UCC attendances)

- The top reason for attending urgent care was due to an injury (15.5% of the total) and this was also the final or main diagnosis of the attendance (16.1% of the total)
- Most patients had the symptoms for 0-1 weeks prior to their attendance at urgent care (63.0% of the total)
- Prescribing of medicines was the top treatment stated by practices (44.3% of the total)
- In total there were 394 cases where the patient had received an x-ray
- In 59.2% of UCC attendances no follow up was required
- Appointments were available in GP practices when the UCC attendances took place in 51.5% of cases

Audit carried out by Healthwatch regarding patients experience in an UCC or WIC

(Note: 'urgent care centre [UCC]' has been used to describe all activity whether at an urgent care centre or a walk-in centre)

- Healthwatch reviewed 151 patients, at Bishop Auckland, Peterlee, Seaham and Healthworks UCCs
- 91.4% of these were from DDES CCG
- The top reason for attending urgent care was patient choice: "I chose to come here"
- 84.1% (127 patients) of patients stated they had used their own transport to get to the UCC
- The top reason for attending urgent care was due to an injury (14.6% of the total)
- 29.1% patients would have gone to A&E had the UCC been unavailable

Appendix 2 – Stakeholder Map

Appendix 3 – Communication Plan

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

		Briefings Joint communications developed between CCG and existing provider for existing staff
Local Authority (incl. AAPs, HWBB, Public Health)	Public	Briefings News (stakeholder) Consultation plan Updates at regularly attended meetings
Executive Committee	CCG Committee	Briefings
Governing Body	CCG Committee	Briefings
Overview and Scrutiny	External committee	Briefings News (stakeholder) Consultation plan
General public/patients	Public	Consultation plan Public meetings Pre-consultation information Patient education programme
Existing providers	Health service providers	Briefings News (stakeholder) Joint communications developed between CCG and existing provider for existing staff
Urgent Care Task and Finish Group	CCG internal operational group	Meetings briefings
Third sector organisations	Public/link organisations	News (stakeholder) Briefings
CCG Staff	CCG internal group	News Briefings
Carers	Public	Briefings News (stakeholder) Public meetings
Neighboring CCGs	Health Commissioner	Briefings News (stakeholder)
Hard to Reach Groups	Public	Focus Groups – 1 per locality with East Durham Trust Briefings News (stakeholder)
NHS England		Briefings News (stakeholder) Task and finish attendance
Healthwatch		Briefings News (stakeholder)
Pharmacies		Briefings News (stakeholder)
Opticians		Briefings News (stakeholder)

Dentists		Briefings News (stakeholder)
LDC		Briefings News (stakeholder)
LPC		Briefings News (stakeholder)

Appendix 4 – Engagement activities

An overview of proposed engagement activity is contained within the table below.

Engagement Activity	Overview
Locality based events	A number of local based events will be attended by relevant CCG staff to raise awareness about the start date and timeline of the consultation, provide relevant information as to how, where and when people can have a say about the proposed plans. In particular, discussion will take place at the following meetings: Dales PRG 5th February 2016 Sedgefield PRG 17th February 2016 Easington PRG 24th February 2015 Easington Practice Manager meeting March 2016 Sedgefield Practice Manager meeting March 2016 Durham Dales Practice Manager meeting march 2016
Hard to reach groups	The CCG will work with hard to reach groups with East Durham Trust and will run at least one focus group session in each locality area with these members of the public to ensure their views are heard and are considered as part of the engagement process.
Formal public events	Public events will take place across the consultation dialogue period. There will be a combination of weekday evening and daytime events as well as weekend daytime

	events in each locality. The weekday events will each be held on different days of the week to maximise the opportunity for people to attend who may be able to attend on specific weekdays due to other commitments such as work. The proposed venues may be Peterlee, Seaham, Spennymoor, Bishop Auckland and Barnard Castle. Further advice will be provided by the members of the Engagement Strategy Task and Finish group. A Public Meeting plan is being developed and we will involve our PRG members and locality leads.
Existing Provider Staff Information sessions at urgent care centres across the DDES CCG area	Informal visits by the CCG to the urgent care centres will be arranged. These will include 'Meet the Staff' sessions to discuss issues and concerns. Two of these sessions have already taken place at Bishop Auckland hospital and Peterlee Community Hospital on 11th January 2016. All feedback will be logged in the activity log and used by the Communications Lead to devise a joint communication for staff with the Communications Lead at the Existing provider organisation.
Consultation Roadshows	Target public places such as shopping centres, supermarkets
Public drop-in information sessions at public venues across DDES	Libraries, leisure centres
Discussion groups	Targeted discussion groups with stakeholders with an interest in the protected characteristics defined in the Equality Act 2010. Facilitated and self-directed discussion groups with community and voluntary organisations For example this will include the following groups, amongst others: Investing in Children – 10 March 2016 The CCG engagement lead will introduce the Urgent Care consultation to young

	people so that they can organise at least two Agenda Days ('adult-free events') in the second half of March. Generally, at these events the young people will discuss the consultation document and some issues that the proposed changes may pose to young people. However, the details will be discussed in the March session to ensure that the young people's voice is included meaningfully in planning the Agenda days. Learning Disability People's Parliament - 1 March 2016 The CCG engagement lead will have an introductory meeting with the People's Parliament in order to discuss how partnership working could be developed in the future. The Urgent Care consultation will be discussed. In particular, there will be a discussion around holding mini-consultation sessions with the Parliament in order to provide them with a safe and non-threatening forum where they can receive information, ask questions and have a say. Gypsy Roma Travellers (GRT) Practitioners Forum – 1 February 2016 The GRT Practitioners Forum was set up in 2015 as a means to bring together practitioners who work with the GRT community in County Durham (both on site and in housing). The purpose is for practitioners to share and disseminate information about their services and way to seek opportunity to work together on specific issues. Through this Forum, SS will try to disseminate information about the consultation, to understand the impact that the proposed changes may have and to get the GRT community's views on the consultation.

	Waddington Centre – 25 February 2016 The CCG engagement lead will have an introductory meeting with the Manager of Waddington Centre in order to discuss how partnership working could be developed in the future. The Urgent Care consultation will be discussed. In particular, there will be a discussion around holding mini-consultation sessions with service users with mental health issues in order to provide them with a safe and non-threatening forum where they can receive information, ask questions and have a say.
Information stall and presence at local public events	Key local public events will be identified and, where possible, information stalls will be set up at events containing information about the consultation. Those attending the event will have the opportunity to participate in the consultation, or to do so later at home or online.
Engagement using social media	A programme of social media communication will be developed including mechanisms such as Facebook, Twitter, You Tube etc
Information and consultation briefing documents / questionnaires provided online and in public places	Information and consultation documents will be available online and will also be distributed across a variety of public buildings and places in the DDES area.

Appendix 5: Media Handling Strategy

NHS Durham Dales, Easington and Sedgefield CCG
Urgent Care Consultation "Getting care right for you"

Pro-active media plan

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

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

- **Press**

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

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

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

    This column is monthly.

- **Social Media**

    Facebook and Twitter will be utilised to push key messages throughout the consultation. Highlighting events, surveys and opportunities to get involved.

Using Facebook and Twitter effectively will allow the CCG to stay ahead of any press coverage and release messages both proactive and re-active.
The use of social media will coincide with the press plan outlined above.

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

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

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

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

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

"Getting care right for you" consultation media handling plan – January 2016

1. Background

Since 2014 residents who live close to urgent care centres told us about their experiences of urgent care services across the Durham Dales, Easington and Sedgefield. They told us what they think needs to happen so that planned changes in urgent care services help support people to deal successfully with unexpected health issues.

This feedback, as well as the views of patient reference groups, local health networks, area action partnerships and community groups has helped the CCG to develop five options that form the basis of a formal public consultation that will be launched on 14 March 2016. We are consulting with local people about what they want urgent care services to look like including, in hours urgent care, out of hours urgent care and minor injuries.

2. Objectives

- To ensure a collaborative approach to proactive and reactive media handling;
- To reassure the public around the future of urgent care services;
- To reinforce key messages and how the public can get involved and influence the consultation;
- To protect the reputation of the CCG and reinforce its role in the local health economy.

3. Key messages

- Urgent care is a CCG priority. We are not reducing our budget or cutting services. Government has told CCGs that 7 day GP access must be introduced by 2020. In Durham Dales, Easington and Sedgefield we are ahead of the game;
- NHS 111 will play a crucial role in ensuring people are seen by the right health care professional, in the right place, at the right time;
- Through our engagement activity, local people have told us that they value access to a GP; they want to be seen straight away, cannot wait for a GP appointment and they want care out of hours.
- There is real need to communicate better with the public about what constitutes an 'emergency', what common conditions can be treated at home and what signposting is needed to direct people to appropriate urgent care services in hours, out of hours and for minor injuries;
- Our proposals reduce duplication;
- Our proposals will simplify services and reduce confusion, ensuring people are seen in the *'Right place, first time'*.

4. Strategy

- NECS communications and engagement team will:
- Co-ordinate proactive and reactive media statements / press releases and ensure the appropriate approval processes are adhered to;
- Co-ordinate media interviews with the CCG, identifying appropriate spokespeople and providing support/briefing in advance of media interviews;
- As appropriate, liaise with communication leads at neighbouring trusts, including NHS England;
- Monitor media coverage and provide regular updates to the CCG and urgent care project team;

Key contacts

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

NECS communications and engagement: Judith McGuinness 07785601944; (alternative numbers 01642 745401/01642745019) judith.mcguinness@nhs.net; Sarah Murphy - 07793 522838 sarah.murphy24@nhs.net Rachael Milligan rachaelmilligan@nhs.net 01642 745455

NECS project manager: Johnathan Kelly: 07899 086357 johnathan.kelly@nhs.net

CCG: Sarah Burns: 0191 371 3217 sarahburns3@nhs.net, Gail Linstead: 0191 371 3232 gail.linstead@nhs.net Sarah Lambert: 0191 371 3222 sarah.lambert1@nhs.net

CDDFT comms: Gillian Curry: 01642 854343; gillian.curry@cddft.nhs.uk
NHS England comms: Sophie McDougall: 07795 666368; sophiemcdougall@nhs.net

Appendix 6: Legal requirements

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

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

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

6.2 S.244 NHS Act 2006 (as amended)

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

6.3 S.149 Equality Act 2010

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

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity

- Race
- Religion or belief
- Sex
- Sexual orientation.

6.4 S.3a NHS Constitution

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

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

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

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

6.6 Mental Capacity Act 2005

The MCA says:

- Everyone has the right to make his or her own decisions. Health and care professionals should always assume an individual has the capacity to make a decision themselves, unless it is proved otherwise through a capacity assessment.
- Individuals must be given help to make a decision themselves. This might include, for example, providing the person with information in a format that is easier for them to understand.
- Just because someone makes what those caring for them consider to be an "unwise" decision, they should not be treated as lacking the capacity to make that decision.

Everyone has the right to make their own life choices, where they have the capacity to do so.

- Where someone is judged not to have the capacity to make a specific decision (following a capacity assessment), that decision can be taken for them, but it must be in their best interests.

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

6.7 Human Rights Act 1998

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

6.8 The Gunning Principles

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

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

The principles are as follows:

1. When proposals are still at a formative stage

Public bodies need to have an open mind during a consultation and not already made the decision, but have some ideas about the proposals.

2. Sufficient reasons for proposals to permit 'intelligent consideration'

People involved in the consultation need to have enough information to make an intelligent choice and input into the process. Equality Assessments should take place at the beginning of the consultation and be published alongside the document.

3. Adequate time for consideration and response

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

4. Must be conscientiously taken into account

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

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

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

The four tests are:

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

As a proposal is developed and refined commissioners should ensure it undergoes a rigorous self-assessment against the four tests

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

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

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

6.11 Transforming Participation in Health and Care – NHS England Guidance

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

Equality Analysis

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

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

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

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

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

The equality analysis has considered potential impacts that any change to urgent care services may have on people from groups with protected characteristics.

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

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

Appendix 7

Consultation Communications and Engagement Action Plan

Activity	Detail	Who is responsible	Timescales
Pre-engagement	Stage 1 pre-engagement activity Stage 2 pre-engagement activity	ELC/CCG CCG/Healthwatch	May 2014 February 2015
Governance	Urgent and Emergency Care Task and Finish Group • Terms of reference • Identify members • Schedule weekly meetings The group will manage and oversee consultation, as outlined in their terms of reference	Delivery team	January 2016 Ongoing
Stakeholder Mapping	Develop stakeholder spreadsheet - contacts Establish existing stakeholder mapping from pre-engagement Conduct additional stakeholder mapping to ensure complete stakeholder list for consultation Review and update stakeholder list throughout consultation	SL - complete SS/SL	Jan/Feb 2016 Ongoing review Ongoing review

Supplier and Resources	Identify suppliers and obtain quotes Plan and confirm timescales and turnaround for resources and suppliers Procure required resources and suppliers with agreed deadlines and arrangements to provide each resource	Task & Finish Group/JMcG/NG SL	w/c 15 Feb - ongoing
Identify and Branding	Develop project branding and identity, share with PRGs Develop marketing material – flyers, newsletters, posters, leaflets, pull up banners, power point presentations etc	Task&Finish Group/JMcG/NG	w/c 15 Feb – 22Feb Ongoing
Communications Key Messages	Development of key messages, FAQs	JMcG	w/c 15 Feb
Consultation briefing document	Develop consultation briefing document Consider different languages and formats that may be required, including large print, braille, audio, easy/read etc Determine number of each type of document Have documents produced by agreed supplier within agreed timescales Consultation video??	Task & Finish Group/JMcG/NG SS	w/c 15 Feb - ongoing
Consultation Dialogue	Plan content and format of required communications and engagement activity Develop, make arrangements for and publicise consultation activity,	Task&Finsh Group/SL/SS	w/c 15 Feb 15 March -

	including Radio advertising? Press / media 9 Formal public events across Durham Dales, Easington and Sedgefield	JMcG	ongoing 15 March (12 weeks)
	Targeted discussion groups with stakeholders with an interest in the protected characteristics defined in the Equality Act 2010/ Facilitated and self-directed discussion groups with community and voluntary organisations	SS/East Durham Trust SS/People's Parliament/ Investing in Children/Gypsy Roma Travellers Practitioners Forum/LGBT group/Macmillan	
	Discussion groups in public places Information stall and presence at local public events Consultation roadshows	SS/SL SS/SL SS/SL	
	Online and hardcopy consultation document and survey Information and surveys in public places	NECS/JMcG NECS	

Comment [NG1]: I;m aware that Silvia is doing some engagement with a few groups but this needs to cover all 9 protected characteristics. As detailed prior in the report it may be something you consider commissioning a comm/vol group to do

Comment [NG2]: This may be something you want to consider

Developing and supporting dialogue	Identify suitable venues for public events Visit venues to check suitability (disability access, parking, bus route, acoustics, large numbers) Arrange catering Promote events Send invites to all stakeholders, including those who took part in the pre-engagement Develop facilitator packs for facilitators at events Develop agendas and evaluation sheets for events Identify and confirm facilitators and scribes for events	SL/SS SL/NECS SL/NECS SL/NECS SL/NECS	w/c 15 Feb 15 March - ongoing
Online	Design dedicated section on CCG website Ask for partners and stakeholders to place on their websites and to cascade via their social media channels Develop content for social media Video?	JMcG SS/SL JMcG NG/JMcG	w/c 15 Feb 15 March w/c 15 Feb w/c 22 Feb
Public Relations and Advertising	See Appendix 6 media handling strategy		
Distribution of Consultation Materials	Develop distribution plan for flyers, posters and booklets to public places Identify and source a mailing house / distribution company to distribute all information	J McG/NECS/SLJ McG/NECS/SL	w/c 15 Feb w/c Feb
Recording	Develop and maintain consultation action log	Task & Finish Group	15 March ongoing
Analysis and Reporting	Ensure independent supplier identified and procured in good time to	NG	

	conduct analysis and reporting when the consultation closes		
Quality and risk assurance	Provide quality and risk assurance of the engagement process	Consultation Institute NHSE	

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Development and Review of Options for Urgent Care Services

Taking into account the feedback received from our member practices in DDES CCG and pre engagement consultation work with the public and key stakeholders a number of options for service configuration were considered. Any option proposed would need Any model for urgent care delivery in DDES CCG should be aligned to clearly defined expectations set out both nationally and regionally.

Any future model of care cannot be delivered in isolation. It must be aligned to the future direction of primary care, informed by national and local pilots for extending access over seven days. The future model of delivery will contribute to improving urgent and emergency care service delivery as will other primary care / out of hospital initiatives currently commissioned in the CCG.

Development of Scenarios

Over the past year through existing meetings, DDES CCG management executive, clinical leaders and member practices have been asked to consider future scenarios around the types and mix of models for urgent care services given what is known about current service configuration, future health needs, economic constraints and other relevant dynamics (eg, demographics, service user expectations, technology trends etc).

The commissioners have spoken to staff to understand implications of the changes proposed and to work with those more knowledgeable in the services to come up with ideas and alternative suggestions for a patient centred view/service that will also inform the consultation and give assurance that all eventualities have been considered by the commissioner.

Contributors were asked to consider best practice and the national strategies and standards therefore enabling an informed clinical model proposed. Multiple scenarios have been considered following the pre-engagement work and ongoing discussions and debates by DDES CCG executive members. Six models were considered and three robust models of care have been proposed.

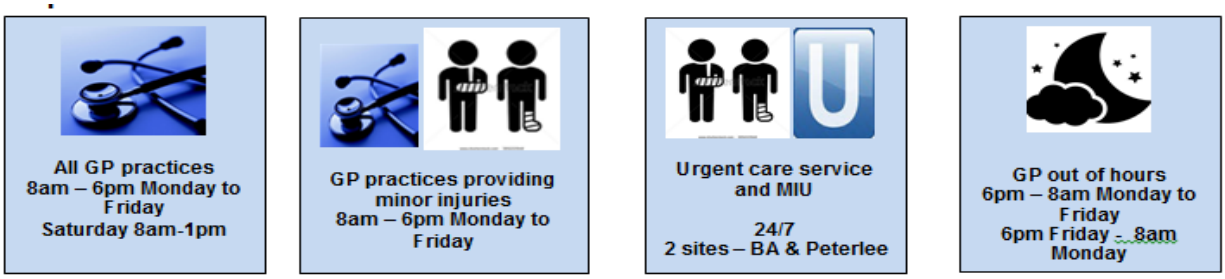
The following section sets out the six options, gives a robust appraisal of each option and sets out the rationale and framework used to select the final three options to be considered by the public as part of the consultation.

Scenario Appraisal

This section gives an appraisal of each of the six options considered.

Option 1 (current model)

This model involves re-procuring the existing services in their current configuration and does not involve any change.



When	Where	What
24/7 (X-Ray services open for 12 hours only)	Bishop Auckland and Peterlee	Minor Injury Service
24/7	Bishop Auckland and Peterlee	Urgent care service
8am-6pm to Friday	All GP Practices	Primary care minor injury service
8am-6pm to Friday 8am-1pm Saturday	All GP Practices GP Practice Hubs	GP services for both urgent and non-urgent conditions
6pm-8am Monday to Friday 6pm Friday – 8am Monday	Bishop Auckland and Peterlee	Out of Hours hubs

Advantages	Disadvantages
• Patients value the service • Offers patient choice • Offers an alternative to A&E • Provides access to services 24/7 in some parts of DDES • Convenient for people working full time	• Not affordable/financially sustainable • Duplication of payments for services • Service not equitable across DDES localities • Travel distance for some patients • Patients treated for presenting complaint only in UCCs – does not support management and prevention of long term conditions • System is complex and causes confusion for patients • Does not support seven day working in primary care • Limited access to patient records • Does not reflect outcome of ELC exercise • Potential risk of increased activity if services continue as they are

Option 2

Increase the number of minor injury/urgent care/out of hours services to three, retain all other services.

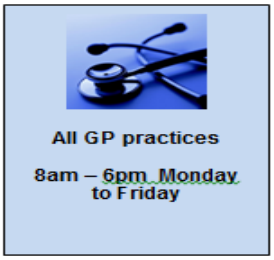
When	Where	What
24/7 (X-Ray services open for 12 hours only)	Bishop Auckland, Sedgefield and Peterlee	Minor Injury Service
24/7	Bishop Auckland, Sedgefield and Peterlee	Urgent care service
8am-6pm to Friday	All GP Practices	Primary care minor injury service
8am-6pm to Friday 8am-1pm Saturday	All GP Practices GP Practice Hubs	GP services for both urgent and non-urgent conditions
8pm-8am Monday to Friday 8pm Friday – 8am Monday	Bishop Auckland, Sedgefield and Peterlee	Out of Hours hubs

Advantages	Disadvantages

Advantages	Disadvantages
• Offers patient choice • Offers an alternative to A&E • Provides diagnostic in more locations • Less distance to travel for some patients in Sedgefield • Makes localities equitable • Maintains MIU as an alternative to A&E services	• Increases service duplication • Not affordable/financially sustainable • Cost of services is unsustainable • Patients treated for presenting complaint only in UCCs – does not support management and prevention of long term conditions • System is complex and causes confusion for patients • Does not support seven day working in primary care • Limited access to patient records • Recruitment issues • Lack of patient demand for a third service • Potential risk of increased activity patients if not educated properly • Services remain separate and not integrated • Does not reflect outcome of ELC exercise

Option 3

Retain two MIUs for 12 hours per day, retain the number of out of hours hubs, existing primary care services to manage demand for minor ailments during the day.

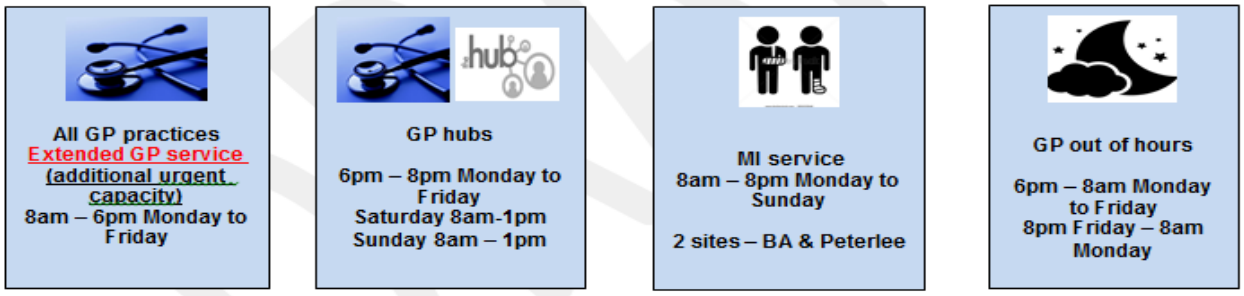


When	Where	What
8am-8pm, Monday to Sunday	Bishop Auckland and Peterlee	Minor Injury Service
8am-6pm 6pm – 8pm Extended opening via hubs 8am-1pm (via hubs) Saturday to Sunday	Normal GP service GP extended opening via hubs GP extended opening via hubs	Services for urgent ailments
8pm-8am Monday to Friday 8pm Friday – 8am Monday	Bishop Auckland and Peterlee	Out of Hours hubs

Advantages	Disadvantages
• Maintains MIU as an alternative to A&E services • Provides diagnostics in two locations • Reduces duplication of services • Reduces duplication of payments for similar services • Cost effective/financially sustainable • Patients treated in primary care will be treated more holistically • Primary care services are better for treating patients with long term conditions • Reflects outcome of ELC exercise • Releases significant savings that could be invested in other healthcare priorities • Ease of access to full patient record in primary care • Provides care closer to home – reduced travel time • Promotes opportunities to educate patients	• Not equitable for all localities • Potential increased activity at A&E if patients are not educated properly • Primary care may not be able to meet patient demand with existing capacity • Minor injury unit could be used for minor ailments • Impact on A&E performance target

Option 4

Retain two MIUs for 12 hours per day, retain the number of out of hours hubs, enhanced primary care services to manage demand for minor ailments during the day.

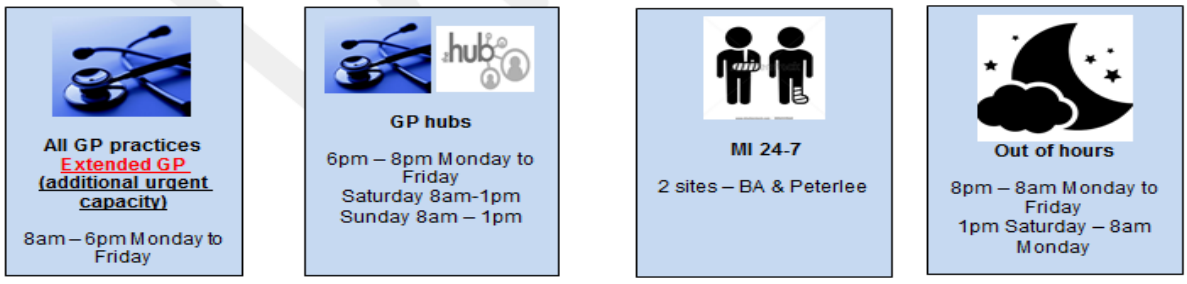


When	Where	What
8am-8pm, Monday to Sunday	Bishop Auckland and Peterlee	Minor Injury Service
8am-6pm 6pm – 8pm Extended opening via hubs 8am-1pm (via hubs) Saturday to Sunday	Extended GP service GP extended opening via hubs GP extended opening via hubs	Services for urgent ailments
8pm-8am Monday to Friday 8pm Friday – 8am Monday	Bishop Auckland and Peterlee	Out of Hours hubs

Advantages	Disadvantages
• Maintains MIU as an alternative to A&E services • Provides diagnostics in two locations • Reduces duplication of services • Reduces duplication of payments for similar services • Cost effective/financially sustainable • Patients treated in primary care will be treated more holistically • Primary care services are better for treating patients with long term conditions • Provides additional capacity in primary care • Reflects outcome of ELC exercise • Releases savings that could be invested in other healthcare priorities • Ease of access to full patient record in primary care • Provides care closer to home – reduced travel time • Familiar service for patients • Reflects outcome of ELC exercise • Promotes opportunities to educate patients • Patients have alternative service in place which will be delivered from across a number of Extended Hours GP Centres across more locations • Convenient for people working full time (patient-centred) • Increased choice of working pattern for GPs	• Not equitable for all localities • Potential increased activity at A&E if patients are not educated properly • Minor injury unit could be used for minor ailments • Impact on A&E performance target • More expensive than option 3

Option 5

Retain two MIUs for 24 hours per day, retain the number of out of hours hubs, enhanced primary care services to manage demand for minor ailments during the day.



When	Where	What
8am-8pm, Monday to Sunday	Bishop Auckland and Peterlee	Minor Injury Service
8am-6pm 6pm – 8pm Extended opening via hubs 8am-1pm (via hubs) Saturday to Sunday	Extended GP service GP extended opening via hubs GP extended opening via hubs	 Services for urgent ailments
8pm-8am Monday to Friday 8pm Friday – 8am Monday	Bishop Auckland and Peterlee	Out of Hours hubs

Advantages	Disadvantages
• Maintains MIU 24/7 as an alternative to A&E services • Provides diagnostics in two locations • Reduces duplication of services • Reduces duplication of payments for similar services • Cost effective/financially sustainable • Patients treated in primary care will be treated more holistically • Primary care services are better for treating patients with long term conditions • Provides additional capacity in primary care • Reflects outcome of ELC exercise • Releases savings that could be invested in other healthcare priorities • Ease of access to full patient record in primary care • Provides care closer to home – reduced travel time • Familiar service for patients • Reflects outcome of ELC exercise • Promotes opportunities to educate patients • Patients have alternative service in place which will be delivered from across a number of Extended Hours GP Centres across more locations • Convenient for people working full time (patient-centred) • Increased choice of working pattern for GPs	• Not equitable for all localities • Potential increased activity at A&E if patients are not educated properly • Minor injury unit could be used for minor ailments • Impact on A&E performance target • More expensive than options 3 and 4

Option 6

Standard primary care services during the day, no minor injury units, GP out of hours service in two locations.

When	Where	What
8am-6pm 6pm – 8pm Extended opening via hubs 8am-1pm (via hubs) Saturday to Sunday	Normal GP services GP extended opening via hubs GP extended opening via hubs	 Services for urgent ailments
8pm-8am Monday to Friday 8pm Friday – 8am Monday	Bishop Auckland and Peterlee	Out of Hours hubs

Advantages	Disadvantages
• Patients have alternative service in place which will be delivered from across a number of Extended Hours Hubs • Convenient for people working full time (patient-centred) • Reduces repeat attendees • Reducing duplication • Ease of access to patient notes	• Impact on A&E target achievement • Lack of alternative to A&E for minor injuries • Not equitable • Risk of patients migrating to A&E (although risk reduced with alternative GP seven day working) • Increased cost of A&E attendances make this an unaffordable option • Reduced access to diagnostic facilities locally • Risk associated with identifying an issue and not having facility to treat • Impact on A&E target • Stretches GP resource

7.3 Evaluation of options

The options were evaluated by the non-conflicted members of the Executive Committee with the following factors used as evaluation criteria:

- Affordability
- Sustainability
- Safety
- Access for Patients

Three options were rules out on that basis as below:

Option	Affordable	Sustainable	Safe	Convenience of Access for Patients	Overall Rating
1	No	No	Yes	Yes	Non-viable
2	No	No	Yes	Yes	Non-viable
3	Yes	Yes	Yes	Yes	Viable
4	Yes	Yes	Yes	Yes	Viable
5	Yes	Yes	Yes	Yes	Viable -Preferred
6	No	No	No	No	Non-viable

Of the three options being considered it was recognise that significant communication and engagement activities would need to take place with patients.

For options 4 and 5 it was recognised that new methods for patients to access primary care services would need to be implemented to ensure that patients are treated in the right service at the right time according to need.

The viable options are based on encouraging patients to seek advice and signposting to the most appropriate service through NHS 111, simplifying the system and enabling the patient to attend the right place, first time. They support primary care and local GP practices in offering enhanced accessibility over seven days which negates the need for walk in centres, reducing duplication and increasing affordability in the system.

In order to deliver a service which is responsive to actual patient need and times of greatest demand, a combined service model is recommended which incorporates GPs in and out of hours as well as minor injury services, with access to diagnostics.

The need for a communication drive and a patient education is not underestimated and a communication strategy for the new service/potential models is in development, which will commence alongside consultation and beyond. The strategy will enable staff to signpost patients as appropriate. All new specifications and contracts will include the need for 111 to predominately manage patients and signpost to appropriate services, and any new service to signpost appropriately.

The options above are preferred because:

- They are affordable and sustainable
- They reduce duplication when GP practices are open
- Patients with illnesses/ailments will be treated by a GP who will treat them holistically rather than for their presenting complaint

Adults Wellbeing and Health OSC

1 March 2016

Better Health Programme (Formerly Securing Quality in Health Services (SeQiHS))

Report of Lorraine O'Donnell, Assistant Chief Executive

Purpose of the Report

1 This report provides members with background information regarding the Better Health Programme (formerly known as the Securing Quality in Health Services (SeQIHS)) which includes an indicative timeframe for statutory public consultation. Representatives from the Better Health Programme office will be in attendance to provide members with a presentation which highlights additional information.

2 The report also details suggested 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 Better Health Programme and any associated service review proposals.

Background

3 The Adults Wellbeing and Health Overview and Scrutiny Committee have received a series of updates in respect of the Better Health Programme under its former guises of the Quality Legacy Project and Securing Quality in Health Services (SeQIHS), the last being received at the Committee's meeting held on 1 September 2015.

4 The Securing Quality in Health Services (SeQIHS) project was initiated by the former Primary Care Trusts and has now become the responsibility of the five Clinical Commissioning Groups, working together with the local NHS hospital foundation trusts in the County Durham, Darlington and Tees valley region.

5 The programme is about achieving and sustaining high quality care provided by hospital services in the Durham, Darlington and Tees (DDT) area as defined by agreed clinical quality standards and national expectations.

6 In the next ten years acute care for people will come under pressure that will challenge the capacity of acute care services, including:

- The changing health needs of the people, including an ageing population;
- Rising numbers of people with long-term conditions;
- Lifestyle risk factors in young people;

- Greater public expectations of NHS provision.

- Financial considerations, including the costs of new treatments, rising patient numbers, and finite budgets.

7 The commissioners and providers of acute care services across Durham, Darlington and Tees have to act now to make sure the acute care services can meet increasing demands over the next few years.

8 The drivers set out above, along with the requirement to ensure that the delivery of high quality clinical standards remains a priority for commissioners and providers alike, create the rationale and momentum for the Better Health Programme.

Better Health Programme

9 The Better Health programme is about meeting patient needs now and in the future with constantly improving health and social care delivered in the best place. Commissioners want to make sure that:

- We improve results for patients;
- Care is of the same high standard wherever, and whenever it is provided;
- Services have the resources to be sustainable for the next 10 -15 years;
- We can provide services across 7 days a week where necessary;
- We make services easier for patients to understand and use;
- We improve life expectancy and quality of life for everyone in Darlington, Durham and Tees.

10 The programme aims to continue improving the services available in Darlington, Durham and Tees but in doing so, key challenges have been identified including:

- The changing health needs of local people;
- Meeting recommended clinical standards;
- Availability of highly trained and skilled staff;
- High quality seven-day services;
- Providing care closer to home;
- Making the best use of our money.

11 Commissioners have worked with over 100 clinicians over several months, asking them to consider what the best possible care would look like for patients across Darlington, Durham and Tees. Specifically they were asked to look at the following hospital services:

- Acute Medicine
- Acute Surgery
- Accident and Emergency
- Critical Care

- Acute Paediatrics, Maternity and Neonatology (services for very small babies)
- Interventional radiology

12 They are also looking at care outside of hospital ("not in hospital care") including services and support which will help reduce the number of people who require hospital care, and help people maintain independent lives in their homes or normal places of residence.

13 Clinicians are agreeing a set of clinical standards for these services. These include standards recommended by national experts, for example

- London Quality Standards
- Royal College of Obstetricians and Gynaecologists
- Royal College of Physicians
- Royal College of Paediatrics and Child Health
- Royal College of Emergency Medicine
- National Confidential Enquiry into Patient Outcome and Death
- The National Institute for Health and Care Excellence (NICE)

14 Clinical standards cover issues like:

- Availability of consultant staff
- Staffing levels and availability during the day and at night or weekends
- Numbers of patients who should be seen and treated by a service to make sure skill levels are maintained
- Use of best practice and recommended treatments
- Access to diagnostic tests, where required
- Timescales for assessment by a senior clinician

Better Health Programme Timeline for 2016

15 Commissioners have stated their desire to work with stakeholder organisations and public representatives during the Programme and an indicative timeline for 2016 has been shared with stakeholders indicating that public consultation will commence around November 2016.

Provisions for consultation and engagement with Overview and Scrutiny Committees

16 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.

17 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.

18 Only the joint scrutiny committee can 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.

19 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. Only the joint scrutiny arrangement can then make a report and recommendations back to the organisation proposing the change.

Establishment of a Joint Health Scrutiny Committee

20 The establishment of joint Health Scrutiny Committee has been proposed consisting of representatives from Darlington Borough Council, Durham County Council, Hartlepool Borough Council, Middlesbrough Borough Council, Redcar and Cleveland Borough Council and Stockton-upon-Tees Borough Council.

21 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.

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

23 A protocol and terms of reference would be drafted by health scrutiny officers across the respective local authorities for the proposed Joint Health Scrutiny Committee setting out the role and function of the joint Committee as well as the proposed representation required from each Council. Early discussions on the issue of representation recommend three Councillors from each local authority to be appointed and that these reflect the political balance of each constituent Council.

Recommendations and reasons

24 The Adults Wellbeing and Health Overview and Scrutiny Committee are recommended to:-

(a) Receive and comment upon the information detailed within the report and accompanying presentation in respect of the Better Health Programme;

(b) Agree in principle with the establishment of a joint Health Overview and Scrutiny Committee under the terms of the Health and Social Care Act 2012 as set out in this report;

(c) Agree to a further report coming back to the Adults Wellbeing and Health OSC detailing the proposed protocol, Terms of Reference and membership of the Joint Health Scrutiny Committee that will be set up to scrutinise the Better Health Programme and associated consultation and engagement plans.

Background papers

Better Health Programme Stakeholder event information – 27 January 2016

Reports and Minutes from the Adults Wellbeing and Health OSC - 1 September 2015

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

Appendix 1: Implications

Finance - None

Staffing - None

Risk - None

Equality and Diversity / Public Sector Equality Duty - None

Accommodation - None

Crime and Disorder - None

Human Rights - None

Consultation – This report details the Council's statutory responsibilities in respect of any proposed consultation and engagement activity in respect of the Better Health Programme.

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 and associated Department of Health Guidance.

Adults Wellbeing and Health Overview and Scrutiny Committee

1st March 2016

Winter Plan and System Resilience

Stewart Findlay, Chief Clinical Officer, Durham Dales Easington and Sedgefield Clinical Commissioning Group

1. Purpose of the Report

1.1 The purpose of this report is to provide an update on the management of winter pressures and how the County Durham and Darlington Systems Resilience Group is going to evaluate what the schemes funded over winter to inform planning for 2016/17.

2. Background

2.1 The County Durham and Darlington System Resilience Group (SRG) has overall responsibility for the capacity planning and operational delivery of urgent and emergency care across the health and social care system.

2.2 A number of schemes were funded by the SRG monies to support the healthcare system in its management of pressures. A full list was given to the Health and Wellbeing Board in November 2015. These schemes are all up and running and have given the health economy more robustness over a time of great pressure which is continuing.

3. SRG Resilience Funding 2015/16

3.1 In planning for winter 2015/16 the SRG has taken into account a number of elements:

- learning from local resilience project evaluations;
- outcomes from the regional Winter Debrief event;
- national learning from winter 2014/15;
- current local urgent and emergency care system priorities;
- available resilience funding; and
- contingency arrangements to enable the potential funding of additional capacity, or innovation.

3.2 There was some slippage identified late in 2015 and this was allocated to two schemes. One was a brokerage service which would support the

speedy discharge of patients into a care home. This scheme started in February 2016 and the impact on delayed transfers of care will be monitored via the SRG monthly. The second scheme was to support handovers at the hospitals A&E departments to allow the ambulances to be turned around within 15 minutes. This scheme should be up and running by mid to late February, depending on recruitment of nurses and again will be monitored via the SRG. The total resilience funding available for 2015/16 is £4,681,000 and of this County Durham and Darlington Foundation Trust were given over £2 million. Primary Care received over £1.3 million to provide additional services to target vulnerable patients to prevent admissions.

3.3 In addition, from learning from winter 2014/15 around the Country, NHS England issued eight High Impact Interventions (**Appendix 2**) which are must do's for urgent and emergency care, the achievement of which all SRG's are now being monitored on as part of NHS England's SRG assurance process. The County Durham and Darlington SRG is showing as "implementation underway" for all of these and a more detailed update on progress is due at the February 18th SRG meeting. The winter schemes funds were asked to link to these so progress with implementation is expected and providers will be held to account on this point.

4. Monitoring and Accountability

4.1 The SRG has implemented a monthly monitoring template that providers in receipt of resilience funding, are required to complete and update on a monthly basis to provide the SRG and CCG's with assurance in terms of delivery of planned resilience schemes, actual spend against planned spend and progress towards achievement of key performance indicators. This has been working well and has helped identify slippage as well as give assurance.

4.2 A full and robust evaluation of each scheme will be completed in April 2016 to give the SRG valuable data to support decision making for 2016/17. Key Performance Indicators were agreed for all schemes to ensure that there was a measure of success. A summary of the evaluations can be brought back to a future Board.

5. Management of Winter Surge and Pressures

5.1 All providers were asked, by the NECS Surge Management Team, to revise and review their winter plans, business continuity plans and North East Escalation Plans (NEEP) and these were robustly tested on the 8th of October at a region wide event 'Getting Ready for Winter'.

In addition an SRG level escalation plan was developed which is used at times of surge to ensure all partners are aware of actions that others

are taking at times of pressure. This will be further refined over the coming months to take account of what more primary care can offer but the current working version is attached as **Appendix 3**.

5.2 The NECS Surge Management Team opened the Winter Hub from 1st of November 2015 until 31st March 2016 to provide co-ordination and communication to the health economy over the winter period. This proved very successful last year and has received good feedback from providers and commissioners this year. Consideration will be given to keeping it open to cover the Easter period in 2016.

5.3 The Surge Team co-ordinate and lead daily calls that CCGs and providers dial into to discuss the current pressures, a daily "sit rep" is circulated (**Appendix 4**) which gives an idea of the level of operational escalation each Trust is reporting. The scale of escalation is communicated via a "NEEP" level which is the North East Escalation Policy. This is an agreed unified system of reporting pressures. Actions are taken at each level to help prioritise urgent cases and keep patients safe.

6. Recommendations

6.1 The Adults Wellbeing and Health Overview and Scrutiny is recommended to:

- Accept this report for information

Contact: Helen Stoker, Senior Commissioning Support Officer, North of England Commissioning Support Unit, 0191 374 2751

Kathleen Berry, Commissioning Manager, North of England Commissioning Support Unit, 0191 374 2751

Background papers: None.

Appendix 1: Implications

Finance – Additional funding resource has been provided to support all the projects via SRG

Staffing – Providers in receipt of additional funding to support the projects listed in have been expected to ensure appropriate safe staffing arrangements are in place to support each of their projects

Risk – Contract variations have been put in place to ensure contractual accountability for appropriate use of the allocated funding

Equality and Diversity / Public Sector Equality Duty

Accommodation

Crime and Disorder

Human Rights

Consultation

Procurement

Disability Issues

Legal Implications

APPENDIX 2 – Eight High Impact Interventions for Urgent and Emergency Care

No.	High Impact Interventions
1	No patient should have to attend A&E as a walk in because they have been unable to secure an urgent appointment with a GP. This means having robust services from GP surgeries in hours, in conjunction with comprehensive out of hours services.
2	Calls to the ambulance 999 service and NHS 111 should undergo clinical triage before an ambulance or A&E disposition is made. A common clinical advice hub between NHS111, ambulance services and out-of-hours GPs should be considered.
3	The local Directory of Services supporting NHS 111 and ambulance services should be complete, accurate and continuously updated so that a wider range of agreed dispositions can be made.
4	SRGs should ensure that the use of See and Treat in local ambulance services is maximised. This will require better access to clinical decision support and responsive community services.
5	Around 20-30% of ambulance calls are due to falls in the elderly, many of which occur in care homes. Each care home should have arrangements with primary care, pharmacy and falls services for prevention and response training, to support management falls without conveyance to hospital where appropriate.
6	Rapid Assessment and Treat should be in place, to support patients in A&E and Assessment Units to receive safer and more appropriate care as they are reviewed by senior doctors early on.
7	Consultant led morning ward rounds should take place 7 days a week so that discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend.
8	Many hospital beds are occupied by patients who could be safely cared for in other settings or could be discharged. SRGs will need to ensure that sufficient discharge management and alternative capacity such as discharge-to-assess models are in place to reduce the DTOC rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance.

Appendix 3 - SRG Level Escalation Plan

County Durham and Darlington SRG Whole System Escalation Action Plan – 2015/16 Draft 1.2 8th January 2016

Level	1 Normal	2 Concern	3 Pressure	4 Severe Pressure	Critical Incident
Definition	Represents a situation where health and social care service are working as normal	Represents a situation where flow issues are being detected in the health and social care economy. Services are starting to implement active management of issues being experienced	Represents a situation where increased flow issues are being detected in the health and social care economy. Management plans are in place with regular review	Reflects the fact that demand for health and social care services is outstripping supply or patient flow is serious impeded by blockages in the system	Any localised incident where the level of disruption results in two organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions
Threshold	Normal operating	• Achievement of NHS constitutional standards at risk – above 95% A&E standard • Surge of activity is above baseline – moderate • Patient flow through the system affected - moderate	• NHS constitutional standards are compromised – above 90% A&E standards • Surge of activity above baseline – significant • Patient flow through the system affected – significant	• NHS constitutional standards are compromised – below 90% A&E standard • Surge of activity above baseline – severely • Patient flow through the system affected – severely	
Clinical Commissioning Group response and actions:					
Teleconference frequency	No call required	As necessary	Daily	Daily/ Twice Daily	NHS England assume control
Teleconference participants	As required	Operational level managers	**Senior Operational managers**	Director level	CEO and Director level
Command and control	CCG	CCG	CCG	CCG	NHS England
Communications	Business as usual	Refer to CCG communication plan	Refer to CCG communication plan	Refer to CCG communication plan	NHS England communications plan

Support Required from Partners

Levels	1 Normal	2 Concern	3 Pressure	4 Severe Pressure	Critical Incident
Action/Support	**Normal multi-agency working**	**Normal multi-agency working but with increased risk**	**Significant risk of services not being able to cope with demand:** ***NB: Support requested at level 2 should be carried forward when at level 4***	**Extra Support required from partners** ***NB: Support requested at level 2 should be carried forward when at level 4***	
Acute	**Communications** • Contribute to Flight Deck as per Regional policy • SitRep reporting • Liaise with NEAS / YAS if a build-up of ambulances is occurring	**Implications for others** • Some GP referrals may be routed via A&E • Trust may be able to offer limited mutual aid **Communications** • Liaise with TEWV to expedite mental health assessments • Liaise with community and	**Implications for others** • The Trust will be unable to offer mutual aid • There will be an impact on NEAS from handover delays and if border control and diverts are required. • It is likely the QE will be approached for assistance. • More GP referrals might have to go via A&E • Increased pressure on TEWV to	**Implications for others** • Ambulance handover delays will affect NEAS • Operational managers may have to cancel attendance at scheduled meetings to deal with operational pressures • Direct access to hospital beds for GP referrals will be impaired • Diverts will be in place	**Implications for others** • Support may be required from other partners, the nature and extent of which to be determined using Major Incident communications processes. **Communications** • Executive lead to communicate

	CDDFT Actions • Majors and minors streams in operation • Robust plans for all patients waiting more than 2 hours to avoid breaches of the 4-hour standard. • Triage appropriate patients to Urgent Care, AMU, Ambulatory Care or Clinical Decision Units • Diagnostics requested at triage or as soon thereafter as possible • Paediatric patients to go straight to paediatrics for assessment when paediatric front of house is operating • Liaise with Specialties to obtain Specialty assessments. • Maintain infection control of cubicles • S - senior review of all patients before mid-day • A - all patients have an expected date of discharge • F - flow of patients, wards to pull patients from assessment unit to wards before 10am • E - early discharge, 33% of patients from base wards to be in discharge lounge with to-take-out (TTO's) and letter before midday. This requires prescriptions to be issued the previous	social care services to expedite discharges. • Liaise with the QE/NEAS if seeking a divert to the QE. **CDDFT Actions** • Flex staffing to patient stream most under pressure and escalate any patient safety risks • Senior Decision Maker to work down line of ambulances waiting, in collaboration with Nurse Coordinator/ Practitioner to check if patients need to be in ambulance, moving patients to waiting room wherever suitable to reduce backlog/ handover breaches. • Heightened level of liaison with Specialties to obtain Specialist assessments, transferring medical patients direct to AMU if a bed is available on the authorisation of an ED Consultant or Registrar. • In the event of Specialty beds coming under pressure identify patients who can be guested if the need arises. • Ensure up-to-date medical review of all patients who might be suitable for discharge or transfer out of an acute bed. • Ensure patients identified for discharge are taken to the discharge lounge as soon as possible. • Delays with discharge letter and pharmacy to be identified and to be given priority. • Consider whether it is necessary to open a limited number of escalation beds or keep some Assessment unit beds open overnight. • Porters prioritise the movement of patients between A&E, AMU, wards and	expedite mental health assessments; and on community, social and intermediate care services to discharge patients with support. • NECS to facilitate mutual aid **Communications** • Liaise with NEAS if requesting "border control" or internal CDDFT diverts; or if transport delays are holding up patient transfers. • Heightened liaison with other services to ensure discharge of all suitable patients **CDDFT Actions** • Liaise with relevant POD/SOW/Specialty to expedite a medical / surgical assessment for patients who might be discharged direct from A&E, but who need Specialty assessment. • For patients who are more likely to need admission, undertake necessary investigations and contact POD/SOW/Specialty to agree action including time-scales. If in doubt about whether a patient is "fit to transfer" to AMU/SAU, the ED doctor should discuss it with the POD/SOW/Specialty Consultant. If the latter is prepared to take responsibility for the decision to transfer, the patient should be transferred. • Heightened liaison with Intermediate Care to prioritise ED patients who could be discharged direct with support; and to effect transfers of appropriate patients to Urgent Care and Ambulatory Care. • Move low risk patients to waiting room/ corridor to free up cubicle space • No more than in 3 resus at any time- Additional patients requiring resuscitation to be diverted to theatre recovery- contact Theatre Coordinator by switch/ bleep. • Prioritise all patients who may	affecting NEAS • Other Trusts may be asked for mutual aid • TEWV to expedite mental health assessments to avoid unnecessary delays in A&E • Increased pressure on community, social care and intermediate care services to discharge patients and provide alternatives to Acute admission. • Social Services and CHC staff to participate in Conference Calls **Communications** • Liaise with NEAS if requesting "border control" or internal CDDFT diverts. • If electives are to be cancelled: In-hours: Liaise with booking team to review lists of TCIs for the following day.Out of hours: Liaise with patients directly • If mutual aid is required in-hours notify NECS to advise GPs of pressures. • Request mutual aid from other Trusts • Seek Social Services and CHC staff participation in Conference calls. **CDDFT Actions** • Robust plans to avoid all potential 12-hour trolley waits • Deflect appropriate incoming patients to Ambulatory Care, Urgent Care, Surgical CDU. • For patients who might be discharged direct from A&E, but who need Specialty assessment, ask relevant POD/SOW/Specialty for early assessment • For patients who are more likely to need admission,	with CCG/NECS Executive lead or Director on Call. • Use communications procedures in the major incident procedure • Trust external communication not to attend ED unless there is a threat to life or limb and to make use of walk in centres, urgent care and 111 wherever possible. • Conference Calls with Neighbouring Trusts as required. **CDDFT Actions** • Implement Business Continuity Plans as necessary, keeping apprised of situation and redistributing resources as required • Authorise transfer of staff to areas under most critical pressure • Consider cessation of non-urgent work (to liberate staff to assist in the critical areas) including: • Electives • teaching to allow teaching fellows/ and students to support in the ED • Consultants on SPA time or undertaking non-critical tasks. • Review possibility of higher thresholds for GP referrals to A&E or for acute admission and lower thresholds for discharge. • Discuss with NEAS implementation of NEAS Extreme Measures • Agree Mutual aid from other Trusts • Ensure rigorous data collection/SitReps • Request divert of GP referrals or treat and transfer to neighbouring hospitals via CCG

	evening.
	• R - review of all patients with extended length of stay (10-14 days) to have a management plan
		diagnostics to maintain optimum patient flow, as agreed with PFT, A&E and Ward managers.
		• Porters promptly transfer deceased patients to mortuary
		• Domestics prioritise cleaning as directed by Patient Flow and Ward staff
		• In hours, line managers and out of hours Patient Flow authorise additional nurse staffing and Silver Command authorise additional Doctor staffing.
			potentially become 12-hour trolley waits to prevent any breach occurring, escalating to Silver Command if necessary.
			• Pharmacy to prioritise TTOs for dispensing, particularly for patients requiring discharge by hospital transport
			• Consider the need to open more escalation beds, if possible.
			• Consider requesting NEAS to implement "border control" between CDDFT sites
			• Consider and co-ordinate Specialty-level diverts to other CDDFT Sites. Provide details of the divert to NEAS, specifying the Specialty affected and the likely length of time the divert might last
			• Ensure medical teams review all patients thought to be appropriate for early discharge by nurse in charge of ward.
			• Identify and co-ordinate the transfer of patients suitable for guesting.
			• Pharmacy
			  • Advise on appropriate use of FP10 out of hours to support discharge
			  • Out of hours: the on call Pharmacist may be called in on the authority of Silver Command to dispense TTOs for urgent discharges.
			• Commission additional transport if needed
			• Staffing for escalation beds to be sought from less pressured CDDFT sites, from off duty staff , from Bank or, as a last resort, Agency staff.
				undertake necessary investigations and contact POD/SOW/Specialty for advice, agree action including time-scales. If in doubt about whether a patient is "fit to transfer" to AMU/SAU, the ED doctor should discuss it with the POD/SOW/Specialty Consultant. If the latter is prepared to take responsibility for the decision to transfer, the patient should be transferred.
				• Agree internal CDDFT ED diverts and advise NEAS; and seek further assistance from the QE.
				• Open all agreed escalation beds.
				• Ensure up-to-date senior review of all potential discharge patients
				• Ask suitable patients aged 16 - 18 not already in a Paediatric Ward to transfer to paediatrics (patient choice must be respected).
				• Review with DMT/ward staff/matrons potential discharge patients and put in place necessary actions.
				• All Pharmacy prescriptions for discharge patients dispensed expeditiously and transport in place.
				• Liaise with Intermediate Care Plus and RIACT to put urgent care packages in place
				• Transfer all suitable patients to Community Hospitals
				• Agree with Obstetrics which pregnant patients not already on an Obstetrics Ward can be transferred there.
				• Consider with the Director on Call a reduction or cancellation of some or all elective admissions for the following day other than Category 1 (urgent or cancer) cases. NB: The Regional NEEP requires Trusts to have
					• Facilitate increased use of voluntary staff/ chaplaincy staff with suitable pre-employment screening/ e-DBS to support on the transfer of patients to wards and transport home
					• consider where additional space can be opened and staffed to extend the ED outwith the immediate department if necessary
					• Co-ordinate a review and recovery phase after step down
					• Determine if Status Black has been reached.

				taken this step before seeking mutual aid from other Trusts (the QE excepted). In-hours, liaise with booking team to review TCI list for the following day. • Agree with Director on Call whether to seek mutual aid from other Trusts (the QE excepted) or to request regional Conference Calls.	
Community	**CDDFT Actions** • Operation of services prioritised as necessary by operational managers. • Provide routine assistance to "pull" patients from Wards and ED into community hospitals, Intermediate Care or community services.	**CDDFT Actions** • Liaise with acute matrons and Patient Flow to expedite discharge • Review, focus on and implement plans for patients in Community Hospitals who could be discharged to promote timely discharge.	**CDDFT Actions** • Communicate and manage staff shortages and manage supplies. • Consider temporary changes to access criteria and protocols to services. • Plan for possible redeployment of staff and communicate to partners. • Consider / assess availability to open more capacity • Determine with other FT divisions if a major incident of certain aspects of it need to be implemented	**CDDFT Actions** • Prioritise essential services to be maintained and which services can be restricted or suspended. • Additional capacity from cancelled services redeployed in line with competency matrix • Proactive supply requirements identified and ordered • Critical suppliers continue to be checked • Support requirements of acute services. • Discuss mutual aid from external partners	**CDDFT Actions** • Daily briefings with acute services and staff. • Individual patient priority in operation • Mitigation strategies are in place covering deferred services • Communications with patients at risk and not receiving treatment • Resource provision being more channelled towards the requirements of acute services but essential complex community care calls need to be met • All mutual aid will be utilised • Patients will be diverted outside the health economy • Increased reliance on telephone support and the virtual ward • Only critically ill patients will be admitted
Adult Social Care	• All Trusts provide timely comms on potential delays, risks and issues. • Strategic commissioners managing market and ensuring sufficient capacity	• All Trusts provide timely communication on potential delays, risks and issues • Strategic commissioners managing market and ensuring sufficient capacity • Weekly winter pressures call	• Intermediate Care + to allocate more Social Worker to discharge management function • Increase usage of IC+ Time To Think function • Daily/twice weekly winter pressures call	• Teleconference as required • Additional SW in locality teams will support IC+ if needed	BUSINESS CONTINUITY PLAN ACTIVATED
Out of Hours	• Services operating normally to national standards	• Services operating normally but with increased pressure • If 111 is generating unnecessary demand, we will work with commissioners and NEAS to address this. • The shift co-ordinator on	• Less busy Centres accept telephone calls and manage the home visiting to allow busier sites to focus on walk-in patients. • Where walk-in waits are lengthening, following triage, patients to be offered the choice to either wait to be seen, or	As NEEP 3	As NEEP 3

		every site has delegated authority to take corrective actions to maintain performance • Urgent Care GPs will review home visit requests and work with 111 to ensure that home visits are only agreed if essential.	to return later in the day for a planned appointment.		
Primary Care	• Service operating as normal	• Communications between organisations via teleconference and other channels as needed **<u>North Durham CCG Actions</u>** Additional services implemented to support winter pressures include: • Saturday morning opening • Vulnerable peoples service across North Durham (weekends) supporting hospital discharge • GP's to increase in same day appointments (to be discussed with Federations) • NHS 111 DOS updated • CCG on-call rota including emails and contact details in place • Intermediate Care + • Community Matron Service (7 days per week) **<u>DDES CCG Federation Actions:</u>** • Practices to discuss with other Federation lead Practice Managers (Jennifer Wood and Antony White) • Additional Services implemented over winter to support pressures including extra opening times and VWAS service and community matrons • CCG on-call rota including	• CCG to Communicate pressures to GPs in and out of hours via agreed form of words • Contact Practice Managers Council and advise Federation Board • Actions from NEEP 2 carried over to NEEP 3 and 4	• NECS to initiate system wide calls • CCG to initiate public communications as per communications plans • CCG to communicate excessive pressures to GP's and out of hour's with red colour code Other actions to consider • Escalate to Federation Board. • Practice, to notify local FTs of issues of concerns via Surge team • Join Surge calls as requested • Discuss and seek support from neighbouring federations	Actions for discussion with Primary care and Federation Leads, considered as suggestions at this point • Notify local A&Es, DDES and NHS England. • Explore possibility of redirection of patients to A&E or UCC • Possible re-direction of all patients to UCC or A&E • Practice may be closed by CCG/NHS England • GP's to consider stopping all pre bookable appointments and undertake home visiting all day (for further discussion)

		emails and contact details in place • Intermediate Care + **Primary Healthcare Darlington** • Saturday clinic: A&E & UCC both have mobile number to contact the clinic to book on the day appts where appropriate, specific slots are set aside for this. The community matrons and district nurses have also been given the mobile number should they require advice. • Evening Telephone Advice: All non-emergency calls transferred to UCC via 111 between 6pm-10pm Mon-Fri could be picked up by the service. • Hospital to Home: Community matrons and district nurses are able to contact the service GP via DMH switchboard or directly on ward rounds for any advice required.			
Mental Health	• Register for Heat-Health Watch Alerts • Identifying vulnerabilities through Joint Strategic Needs Assessments	• Identification of vulnerable individuals • Work with voluntary organisations to identify at risk • Support care homes to identify vulnerable people and	• Daily/twice weekly surge conference calls reporting by exception • Refer to Trust NEEP Surge level • Support community staff to maintain home visits • Consideration to be given to phoning/contacting high risk	• All existing emergency policies and procedures will apply. • Recovery working group established • Individual organisations operation rooms established 24/7	

	• Identification of vulnerable individuals/communities • Working with at risk individuals' families, and communities to support and put in place protective measures. • Supporting people and young children • Liaise with community groups and voluntary organisations • Pro-active communications education, winter warmth, • Cold weather alerts to be distributed • Working with partners and staff on risk reduction awareness, e.g. flu jabs, information and education	maintain room temperatures • Check vulnerable individuals have enough supplies of medication and food • Weekly surge conference calls reporting by exception • Maintain surge/escalation watch	vulnerable individuals/families on a daily basis • Support care homes to identify vulnerable persons and maintain room temperatures		
Ambulance Service	• Normal operating procedure for PTS and ambulance service	• Awaiting input from NEAS as per email	•	•	

Appendix 4 - Example of Daily Sit rep report

Daily Hospital SitRep Summary - Cumbria and the North East

Monday 8 February 2016

Friday 5 February 2016 08:00 to Monday 8 February 2016 07:59

NHS England

North East Ambulance Service REAP Level 3 - Pressure		Northumbria Healthcare	The Newcastle Upon Tyne Hospitals	Gateshead Health	South Tyneside	City Hospitals Sunderland	County Durham And Darlington	North Tees And Hartlepool	South Tees Hospitals	North Cumbria	Morecambe Bay
	Manually Enter NEEP Level (if required)										
Escalation level	NEEP Level Escalation level	Level 3 Pressure	Level 3 Pressure	Level 4 Severe Pressure	Level 2 Concern	Level 2 Concern	Level 4 Pressure	Level 4 Severe Pressure	Level 3 Pressure	Please Manually Enter NEEP Level	Please Manually Enter NEEP Level
Serious operational problems	Serious operational problems during previous 24 Hours	Yes	No	No	No	No	Yes	Yes	No	No	No
	Remedial Actions being taken	NEEP3 - General pressures, ED waits and bed capacity.	NEEP LEVEL 3	NEEP Level 4 - Bed pressures	NEEP 2	NEEP 2	Neep Level 4. Escalation beds are open. UHND assessement area and Day Surgery open overnight. Appropriate patients moved to Community Hospitals, paediatric 16-18yrs and obstetrics patients moved into specialty beds. POD/SCMs/Intermediate Care Staff focussed on urgent review of patients in ED to avoid admissions. We had 3 A&E diverts:UHND to DMH & South Tyneside and Dmh to UHND	NEEP level 4 - significant pressures experienced through both A&E and admissions, additional beds opened (outside winter plan) Full escalation plans in place. 06/02/2016 The Trust accepted A&E diverts for 1 hour	South Tees Foundation Trust NEEP LEVEL 3	0	0
A&E	A&E closures *Duration (minutes)*	0 -	0 -	0 -	0 -	0 -	0 -	0 -	0 -	0 -	0 -
	A&E diverts *Duration (minutes)*	0 -	0 -	0 -	0 -	0 -	3 480	0 -	0 -	0 -	0 -
	A&E - site 1 (All types) *Attendances* *Patients waiting over 4 hrs* *A&E performance (95% standard)*									Cumberland Infirmary 446 101 77.4%	
	A&E - site 2 (All types) *Attendances* *Patients waiting over 4 hrs* *A&E performance (95% standard)*									West Cumberland 290 39 86.6%	
	Trust A&E performance (95% standard)									81.6%	
	A&E attendances (All types)	1710	1225	1009	230	1153	1054	770	1627	736	816
	Emergency Admissions (Via A&E and other)	272	451	211	44	320	591	159	420	169	250
Operations cancelled in previous 24 hours	Urgent operations for second/subsequent time Urgent operations Elective operations									0 0 0	
Non-clinical critical care transfers	Out of an approved critical care transfer group Within approved critical care transfer group									0 0	
Ambulances queuing for longer than 30 minutes	Total *30 - 60 mins* *60 - 120 mins* *> 120 mins*									27 20 7 -	
General & Acute beds - as at Mon 8 Feb 09:00hrs	Total beds available *of which core stock* *of which escalation beds* Total beds occupied	1,134 1,089 45 94.9%	1,816 1,809 7 89.2%	469 425 44 99.8%	337 315 22 89.0%	761 736 25 82.9%	897 861 36 90.2%	607 559 48 92.3%	1,054 1,039 15 98.2%	398 391 7 98.7%	896 896 0 98.7%
	Closed/Affected due to D&V/norovirus like symptoms *of which unoccupied*	0 -	22 100.0%	0 -	0 -	4 25.0%	0 -	8 37.5%	0 -	10 20.0%	0 -
	Unavailable due to delayed transfers of care % of total beds available occupied by DTOC									47 11.8%	
Critical Care beds	Adult Critical Care beds available *of which occupied*	17 70.6%	69 73.0%	12 83.3%	6 83.3%	18 66.7%	21 81.0%	16 81.3%	62 90.3%	9 88.9%	14 100.0%
	Paediatric Intensive Care beds available *of which occupied*	0 -	29 75.6%	0 -	0 -	0 -	0 -	0 -	4 100.0%	0 -	0 -
	Neonatal Intensive Care beds available *of which occupied*	0 -	12 83.3%	0 -	0 -	8 87.5%	0 -	4 50.0%	14 78.6%	0 -	2 0.0%
		Northumbria Healthcare	The Newcastle Upon Tyne Hospitals	Gateshead Health	South Tyneside	City Hospitals Sunderland	County Durham And Darlington	North Tees And Hartlepool	South Tees Hospitals	North Cumbria	Morecambe Bay

[redacted] Rep Return
[redacted].net
Printed on Monday 8 February 2016 11:02

Daily Ambulance/Community Services SitRep Summary - Cumbria and the North East

Monday 8 February 2016

Friday 5 February 2016 08:00 to Monday 8 February 2016 07:59

NHS England

[redacted] Services/NEAS Daily SitRep Return
[redacted]@nhs.net
Printed on Monday 8 February 2016 11:52

		North East Ambulance Service FT
REAP	REAP Level	Level 3
Serious operational problems	Serious operational problems during previous 24 Hours	No
	Remedial Actions being taken	05/02/16,19:30-20:26UHND diverting to DMH(d2)21:15-22:22UHND deflecting to SGH(d2)UHND diverting to RVI(s2)UHND deflecting to STGH,22:26--00:45UHND diverting DMH(d2)01:25--02:02UHND diverting to DMH(d2).06/02/16,14:00STGH CT scanner down,diverting to SGH(s1),15:51DMH diverting to UHND(d2),16:20DMH diverting to N.Tees(s1),19:00DMH diverting to UHND(d2),19:00UHND diverting to STGH(d2),QEH diverting to STGH(s1)07/02/16,07:20QEH diverting to STGH(s1),16:50UHND deflecting to SGH(d2),STGH(d2)N.Tees(s1)
Calls Answered	Total 999 calls answered	3,956
Total Incidents (emergencies and GP urgents)	North of Tyne & Gateshead	1,085
	South Tyneside, Sunderland, County Durham and Darlington	1030
	Tees	1110
Cat. Red Performance	Total Category Red Incidents attended	1,992
	of which receiving a response within 8 minutes	56.4%
	Year to Date Category Red 8 min Performance	69.6%
Cat Green	Total Category Green Incidents attended	1,012

Handover Delays		> 30 mins	> 60 mins	> 120 mins
	Northumberland SEC	24	0	0
	Royal Victoria Infirmary A&E	1	0	0
	Queen Elizabeth A&E	34	0	0
	South Tyneside A&E	1	0	0
	Sunderland Royal A&E	6	0	0
	Uni Hospital of North Durham A&E	22	9	0
	Darlington Memorial A&E	22	16	3
	James Cook A&E	2	0	0
	Uni Hospital of North Tees A&E	0	0	0

111 (from 111 daily sitrep - CAD data)	Total 111 calls	7,529
	Ambulance Dispatches	1,115
	Ambulance dispatch as % of calls triaged	16.3%
	Total Calls Referredto ED	438
	Recommended to attend ED as % of total calls triaged	6.4%
Further comments	Media Interest	None
	Patient Transport Service	None
	Staffing	None

		Northumbria Healthcare FT Community services	Newcastle hospitals FT community services	South Tyneside FT community services	County Durham and Darlington FT community services	North Tees and Hartlepool FT community services	South Tees FT community services
NEEP	NEEP Level	Level 1 Normal	Level 1 Normal	Level 2 Concern	Level 1 Normal	Level 2 Concern	Level 3 Pressure
Serious operational problems	Serious operational problems during previous 24 Hours	No	No	No	No	No	No
	Remedial Actions being taken	NEEP 1	NEEP Level 1	None	The answer as to 'is there capacity available in District Nurse Teams?' is due to the DN teams being very stretched and therefore there is limited capacity at the present time.	None	None
Community beds - as at Mon 8 Feb 09:00hrs	Total beds available	No community beds	30	No community beds	66	No community beds	67
	Total beds occupied		100.0%		77.3%		92.5%
	Closed due to D&V/norovirus like		0		0		0
	of which unoccupied		-		-		-
	Unavailable due to delayed transfers of care		0		9		3
	Number of beds closed due to staffing issues		0		0		0
Community Services Capacity	Is there capacity available in community intensive assessment	Yes	Yes	Yes	Yes	Yes	Yes
	Is there capacity available in virtual wards or equivalent?	Yes		Yes			Yes
	Is there capacity available in District Nurse Teams?	Yes	Yes	Yes	No	Yes	Yes
Further comments	Media Interest	None	None	None	None	None	None
	Staffing	None	None	None	None	None	None

		NDUC - North of Tyne & Gateshead	NDUC - Tees	NDUC - S Tyneside, Sunderland, County Durham and Darlington	GatDoc - North of Tyne & Gateshead		CDD FT OOH services - County Durham and Darlington
NEEP	NEEP Level	Level 1 Normal			Level 2 Concern		Level 1 Normal
Serious operational problems	Serious operational problems during previous 24 Hours	No			No		No
	Remedial Actions being taken	None			Resilience standby called in on Sunday to Blaydon MIU.		None
Incidents in reporting period	Total Incidents	420	218	157	278		2,412
	Attendances - booked	220	102	44	47		498
	Attendances - walk in	0	0	0	79		1,445
	Home visits	48	36	22	35		75
	Telephone	152	80	91	117		394
	Admissions to secondary care ward	15	8	1	8		92
	Referrals to emergency department	19	4	22	10		70
Further comments	Media Interest	None			None		None
	Staffing	None			None		None

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Adults Wellbeing and Health Overview and Scrutiny Committee

1 March 2016

North East Regional Joint Health Overview and Scrutiny Committee - Update

Report of Lorraine O'Donnell, Assistant Chief Executive

Purpose of the Report

1 This report updates members of the Adults Wellbeing and Health OSC on key issues that have been considered at the North East Regional Joint Health Overview and Scrutiny Committee (JHOSC).

Background

2 The North East Regional JHOSC was established in 2010 by the twelve local authorities within the North East Region in response to the Centre for Public Scrutiny's Health Inequalities programme. Its first major piece of Scrutiny work was an in-depth review which examined the health needs of the Ex-service community.

3 This Committee has received update reports in respect of the progress against the recommendations made as part of the Ex–service Community review.

4 The North East Regional JHOSC Terms of Reference and protocols are attached to this report for members information (Appendix 2)

5 The North East Regional JHOSC is currently chaired by Councillor Ray Martin Wells from Hartlepool B.C. and scrutiny support provided by officers from that authority as "host authority".

North East Regional JHOSC – Health Service Reviews

6 The North East Regional JHOSC has been engaged in the following two key areas of work which have an impact across the Region:-

- Review of Neonatal Services in the North East and Cumbria – Consultation;
- North East and Cumbria Learning Disability Fast Track Transformation Plan

Review of Neonatal Services in North East England and Cumbria

7 At the North East Regional JHOSC meeting on 17 December 2015, members received a report and presentation detailing recommendations and proposals from a Review of Neonatal services in North East England and Cumbria undertaken by the Royal College of Paediatrics and Child Health (RCPCH) on behalf of the Northern Neonatal Network and Specialist Service Commissioner for NHS England.

8 During consideration of the Review recommendations by the North East Regional JHOSC, members discussed the optimum clinical outcomes and the number of cots required for the provision of neonatal care across the North East region. A representative from the Northern Neonatal Network indicated that national and international evidence had shown that better clinical outcomes were delivered where such neonatal centres were high activity.

9 The North East Regional JHOSC also expressed concern at the effectiveness and clinical safety issues surrounding the existing neonatal transport arrangements across the region and suggested that improved transport arrangements should be an integral element of the existing consultation and subsequent future proposals for neonatal services within the region.

10 NHS England had confirmed that in view of the implications arising from the Neonatal review upon the existing Better Health Programme (formerly SeQIHS), there had been no commissioning decision made in respect of neonatal services. Accordingly any further consultation in respect of the neonatal service within the North East region would be undertaken alongside future Better Health programme consultation.

11 The North East Regional JHOSC subsequently decided that:-

i) The Committee noted that the consultation in relation to the review of neonatal services in the North of England and Cumbria will now be considered as part of the wider Better Health Programme (formerly SeQIHS) consultation exercise and looked forward to its involvement in the consultation process;

ii) The Committee welcomed indications that, pending completion of the consultation, there will be no significant changes to the current neonatal services provided at University Hospital of North Tees, with services to be provided as follows (subject to clinical discretion/need):

- Babies born at 23 to 26 weeks to be treated at the RVI and James Cook hospitals; and

- Babies born at 26 weeks plus to be treated in individual units (as currently provided).

iii) The Committee emphasised the importance of resolving issues regarding the effectiveness/safety of neonatal transport arrangements prior to the implementation of <u>any</u> proposals for the provision of restructured services and requested a further report from NHS England

detailing proposals, and associated timescales, for the provision of improved transport arrangements.

North East and Cumbria Learning Disability Fast Track Transformation Plan

12 At its meeting held on 1 October 2015, the North East Regional JHOSC was informed of the North East and Cumbria Learning Disabilities Fast Track Transformation Plan. This followed NHS England's announcement on 12 June 2015, that the North East and Cumbria would be one of five national Fast Track areas for Transforming Care for people with a learning disability.

13 NHS England's Transforming Care programme looks to ensure that more services are provided in the community and closer to home rather than in hospital settings. This is as a direct result of the Department of Health's investigation and report into the events at Winterbourne View hospital, Gloucester and subsequent commitment to transform services so that vulnerable people no longer live inappropriately in hospitals and are cared for in line with best practice.

14 As part of the national fast track transformation programme the North East and Cumbria were required to produce an in-depth transformation plan focusing on five key areas:

15 The work that had already been undertaken in the North East and Cumbria has supported the development of a comprehensive transformation plan, with involvement of a wide range of stakeholders, despite the challenging national timescales.

16 The North East and Cumbria Transformation Board agreed that the plan would be developed at a regional level, and would feature locality specific plans which would describe the changes required at a locality level (Including service redesign, shifting resources, piloting of new models of care and any proposals for the use of the national transformation funds).

17 The proposed model of care would focus on 7 key strands, which are aligned to the draft national service model:

- Choice and control at the heart of ALL service provision and planning
- Systematic, early identification and intervention
- Planned, proactive and coordinated care in the community
- Effective prevention and management of Crisis
- Helping people to stay out of trouble and supporting people who enter the Criminal Justice System
- A consistently highly skilled, confident and value driven workforce

- Equitable service provision and high quality evidence based care

18 The North East and Cumbria Learning Disability Transformation Board supported the Fast Track Plan and made a commitment to take the plan through the formal governance arrangements of each of the statutory organisations involved including Health and Wellbeing Boards of Local Councils. Given the system wide involvement, and differing governance arrangements in place for each CCG and Local Authority partner, it was suggested that the Plan be brought to the North East Regional JHOSC for consideration.

19 The North East Regional JHOSC agreed that the North East and Cumbria Learning Disabilities Fast Track Transformation Plan should be considered at a special meeting on the 6 January 2016. The Committee noted that the proposals within the plan could have a significant negative impact on the number of available Learning Disability inpatient beds and associated wider community services across the Region.

20 The meeting was attended by representatives of the North East and Cumbria Learning Disability Transformation Board, which included Commissioners and providers, the Northern Clinical Commissioning Forum and local authority Adult/Children's social Care professionals.

21 Members were advised that the aim of the Programme was to reduce learning disability beds from 277 in 2014/15 to 173 in 2018/19 with an enhanced provision of appropriate support for people with learning disabilities within their own home or a community based setting. It was proposed that dowries would be available to Local Authorities for the care and support of each individual with learning disabilities discharged into their own home or a community based setting, although the detail of this provision had yet to be finalised.

22 In conclusion, it was noted that there was always the intention to maintain a limited number of in-patient learning disability beds within the region for cases where this was the most appropriate care for an individual.

23 There was some concern expressed by Members that there was no Elected Member representation on the North East and Cumbria Learning Disability Transformation Board. A discussion ensued during which it was considered appropriate to appoint two Elected Member representatives to the Board, one from the Northumbria and Tyne and Wear NHS Foundation Trust area and one from the Tees, Esk and Wear Valley NHS Foundation Trust area and this was welcomed by the health representatives in attendance. A Member questioned whether learning disability in-patient beds occupied by patients from out of the area were limiting the use of patients from within the north east area. The representative from the South Tees Clinical Commissioning Group confirmed that the majority of beds in the north east region were occupied by patients from within this region but support was provided to people from outside the region when this was appropriate.

24 Members sought reassurance that the proposed 'dowry' funding would follow patients and that Local Authorities would not be faced with additional costs for

these patients when their budgets were already under considerable strain. The Senior responsible officer for the Transforming Care Programme, David Hambleton, who chairs the Northern CCG Forum, reassured Members that Clinical Commissioning Groups fully supported the principle of the dowry following the patient to fund their care and were not looking to Local Authorities to take on these costs. Further reassurance was provided that the provision of care and support to people with learning disabilities was monitored and regulated by the Care Quality Commission. It was highlighted that further Government guidance was awaited on the provision of individual dowries and whether they would fund part or all of the individual's ongoing care as there remained the need to provide further investment in future service provision.

25 In response to a question from a Member, a representative from Tees, Esk and Wear Valley NHS Foundation Trust reassured Members that this Transformation Plan was not about moving to zero beds, there was always the intention to have a limited number of beds available within the north east to meet that particular need and demand.

26 A Member sought clarification on the rationale for the implementation of these changes and whether it was due to financial reasons or the best interests of the patients. A representative from Tees, Esk and Wear Valley NHS Foundation Trust indicated that this was an opportunity to make system wide transformational change whilst recognising that this may not be the most appropriate solution for everyone, given that some people will continue to need Inpatient treatment services. In view of this, any care packages put in place would be led by the individual and their needs and preferences from a range of choices. To support this process it was highlighted that there would be enhanced Community Teams to visit people living in their own homes and within the community to provide support and ensure an individualised and appropriate approach to their care and support package.

27 The North East Regional Joint HOSC resolved that:-

1) In acknowledging that this was a complex piece of work the Committee supported the principles within the North East and Cumbria Learning Disability Transformation Programme.
2) Further updates on the progress of the Programme be submitted to this Committee on a regular basis providing details of:
    a) The development of proposals and any associated consultation/engagement plans;
    b) Financial aspects of the project, including the proposed dowry arrangements for the care and support of individuals with learning disabilities within their own home and in community based settings; and
    c) Statistics in respect of Learning Disability bed occupancy rates throughout the lifespan of the project proposals.

3) That the Chair liaise with the Vice Chair to progress Member observer representation from the Northumberland, Tyne and Wear NHS Foundation Trust and Tees, Esk and Wear Valley NHS Foundation

Trust areas on the North East and Cumbria Learning Disability Transformation Board.

28 In view of the region-wide implications for all North East Local Authorities in respect of the aforementioned reviews, further reports will be taken to future meetings of the North East Regional Joint HOSC.

29 Members are assured, however that where there are specific implications for residents of County Durham arising from any subsequent service review proposals and associated consultation and engagement plans, the views of the Adults Wellbeing and Health OSC will be sought and submitted to the North East Regional Joint HOSC.

Recommendations

30 The Adults, Wellbeing and Health Overview and Scrutiny Committee receive this report, note the information contained therein and agree to further progress reports being brought back to the Committee as part of ongoing consultation and engagement activity.

Background papers

North East Regional Joint Health OSC – Agenda and papers from 1 October and 17 December 2015 and 6 January 2016

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

Appendix 1: Implications

Finance - None

Staffing - None

Risk - None

Equality and Diversity / Public Sector Equality Duty - None

Accommodation - None

Crime and Disorder - None

Human Rights - None

Consultation – The statutory consultation arrangements are referenced within the report. The report provides members of the Adults Wellbeing and Health OSC with an opportunity to feed into the deliberations of the North East Regional Joint Health OSC through the Chair of the Committee as the Council's appointed representative on that body.

Procurement - None

Disability Issues - None

Legal Implications – None

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Joint Health Overview and Scrutiny Committee of:

Darlington Borough Council, Durham County Council, Gateshead Council, Hartlepool Borough Council, Middlesbrough Council, Newcastle upon Tyne City Council, North Tyneside Council, Northumberland County Council, Redcar and Cleveland Borough Council, South Tyneside Council, Stockton-on-Tees Borough Council and Sunderland City Council

TERMS OF REFERENCE AND PROTOCOLS

Establishment of the Joint Committee

1. The Committee is established in accordance with section 244 and 245 of the National Health Service Act 2006 ("NHS Act 2006") and regulations and guidance with the health overview and scrutiny committees of Darlington Borough Council, Durham County Council, Gateshead Council, Hartlepool Borough Council, Middlesbrough Council, Newcastle upon Tyne City Council, North Tyneside Council, Northumberland County Council, Redcar and Cleveland Borough Council, South Tyneside Council, Stockton-on-Tees Borough Council and Sunderland City Council ("the constituent authorities") to scrutinise issues around the planning, provision and operation of health services in and across the North-East region, comprising for these purposes the areas covered by all the constituent authorities.

2. The Committee will hold two full committee meetings per year. The Committee's work may include activity in support of carrying out:

   (a) Discretionary health scrutiny reviews, on occasions where health issues may have a regional or cross boundary focus, or

   (b) Statutory health scrutiny reviews to consider and respond to proposals for developments or variations in health services that affect more than one health authority area, and that are considered "substantial" by the health overview and scrutiny committees for the areas affected by the proposals.

   (c) Monitoring of recommendations previously agreed by the Joint Committee.

For each separate review the Joint Committee will prepare and make available specific terms of reference, and agree arrangements and support, for the enquiry it will be considering.

Aims and Objectives

3. The North East Region Joint Health Overview and Scrutiny Committee aims to scrutinise:

   (a) NHS organisations that cover, commission or provide services across the North East region, including and not limited to, for example, NHS North East, local primary care trusts, foundation trusts, acute trusts, mental health trusts and specialised commissioning groups.

   (b) Services commissioned and/or provided to patients living and working across the North East region.

   (c) Specific health issues that span across the North East region.

   Note: Individual authorities will reserve the right to undertake scrutiny of any relevant NHS organisations with regard to matters relating specifically to their local population.

4. The North East Region Joint Health Overview and Scrutiny Committee will:

   (a) Seek to develop an understanding of the health of the North East region's population and contribute to the development of policy to improve health and reduce health inequalities.

   (b) Ensure, wherever possible, the needs of local people are considered as an integral part of the commissioning and delivery of health services.

   (c) Undertake all the necessary functions of health scrutiny in accordance with the NHS Act 2006, regulations and guidance relating to reviewing and scrutinising health service matters.

   (d) Review proposals for consideration or items relating to substantial developments/substantial variations to services provided across the North East region by NHS organisations, including:

(i) Changes in accessibility of services.
(ii) Impact of proposals on the wider community.
(iii) Patients affected.

(e) Examine the social, environmental and economic well-being responsibilities of local authorities and other organisations and agencies within the remit of the health scrutiny role.

Membership

5. The Joint Committee shall be made up of 12 Health Overview and Scrutiny Committee members comprising 1 member from each of the constituent authorities. In accordance with section 21(9) of the Local Government Act 2000, Executive members may not be members of an overview and scrutiny committee. Members of the constituent local authorities who are Non-Executive Directors of the NHS cannot be members of the Joint Committee.

6. The appointment of such representatives shall be solely at the discretion of each of the constituent authorities.

7. The quorum for meetings of the Joint Committee is one-third of the total membership, in this case four members, irrespective of which local authority has nominated them.

Substitutes

8. A constituent authority may appoint a substitute to attend in the place of the named member on the Joint Committee. The substitute shall have voting rights in place of the absent member.

Co-optees

9. The Joint Committee shall be entitled to co-opt any non-voting person as it thinks fit to assist in its debate on any relevant topic. The power to co-opt shall also be available to any Task and Finish/Working Groups formed by the Joint Committee. Co-option would be determined through a case being presented to the Joint Committee or Task and Finish Group/Working Group, as appropriate. Any supporting information regarding co-option should be made available for consideration by Joint Committee members at least 5 working days before a decision is made.

Formation of Task and Finish/Working Groups

10. The Joint Committee may form such Task and Finish/Working Groups of its membership as it may think fit to consider any aspect or aspects within the scope of its work. The role of any such Group will be to consider the matters referred to it in detail with a view to formulating recommendations on them for consideration by the Joint Committee. The precise terms of reference and procedural rules of operation of any such Group (including number of members, chairmanship, frequency of meetings, quorum etc.) will be considered by the Joint Committee at the time of the establishment of each such Group. The Chair of a specific Task and Finish Group will act in the manner of a Host Authority for the purposes of the work of that Task and Finish Group, and arrange and provide officer support for that Task and Finish Group. These arrangements may differ if the Joint Committee considers it appropriate. The meetings of such Groups should be held in public except to the extent that the Group is considering any item of business that involves the likely disclosure of exempt information from which the press and public could legitimately be excluded as defined in Part 1 of Schedule 12A of the Local Government Act 1972 as amended by the Local Government (Access to Information) (Variation) Order 2006.

11. The Chair of the Joint Health Overview and Scrutiny Committee may not be the Chair of a Task and Finish Group.

Chair and Vice-Chairs

12. The Chair of the Joint Committee will be drawn from the membership of the Joint Committee, and serve for a period of 12 months, from a starting date to be agreed. A Chair may not serve for two consecutive twelve-month periods. The Chair will be agreed through a consensual process, and a nominated Chair may decline the invitation. Where no consensus can be reached then the Chair will be nominated through a ballot system of one Member vote per Authority only for those Members present at the meeting where the Chair of the Joint Health Overview and Scrutiny Committee is chosen.

13. The Joint Committee may choose up to two Vice-Chairs from among any of its members, as far as possible providing a geographic spread across the region. A Vice-Chair may or may not be appointed to the position of Chair or Vice-Chair in the following year.

14. If the Chair and Vice-Chairs are not present, the remaining members of the Joint Committee shall elect a Chair for that meeting.

15. Other than any pre-existing arrangements within their own local authority, no Special Responsibility Allowances, or other similar payments, will be drawn by the Chair, Vice Chairs, or Tasking and Finish Group Chairs in connection with the business of the Joint Committee.

Host Authority

16. The local authority from which the Chair of the Joint Committee is drawn shall be the Host Authority for the purposes of this protocol.

17. Except as provided for in paragraph 10 above in relation to Task and Finish Groups, the Host Authority will service and administer the scrutiny support role and liaise proactively with the other North East local authorities and the regional health scrutiny officer network. The Host Authority will be responsible for the production of reports for the Joint Committee as set out below, unless otherwise agreed by the Joint Committee. An authority acting in the manner of a Host Authority in support of the work of a Task and Finish Group will be responsible for collecting the work of that Group and preparing a report for consideration by the Joint Committee.

18. Meetings of the Joint Committee may take place in different authorities, depending on the nature of the enquiry and the potential involvement of local communities. The decision to rotate meetings will be made by members of the Joint Committee.

19. Documentation for the Joint Committee, including any final reports, will be attributed to all the participating member authorities jointly, and not solely to the Host Authority. Arrangements will be made to include the Council logos of all participating authorities.

Work planning and agenda items

20. The Joint Committee may determine, in consultation with health overview and scrutiny committees in constituent authorities, NHS organisations and partners, an annual work programme. Activity in the work programme may be carried out by the Joint Committee or by a Task and Finish/Working Group under the direction of the Joint Committee. A work programme may be informed by:

    (a) Research and information gathering by health scrutiny officers supplemented by presentations and communications.

    (b) Proposals associated with substantial developments/substantial variations.

21. Individual meeting agendas will be determined by the Chair, in consultation with the Vice-Chairs where practicable. The Chair and Vice-Chairs may meet or conduct their discussions by email or letter.

22. Any member of the Joint Committee shall be entitled to give notice, with the agreement of the Chair, in consultation with the Vice-Chairs, where practicable, of the Joint Committee, to the relevant officer of the Host Authority that he/she wishes an item relevant to the functions of the Joint Committee to be included on the agenda for the next available meeting. The member will also provide detailed background information concerning the agenda item. On receipt of such a request (which shall be made not less than five clear working days before the date for despatch of the agenda) the relevant officer will ensure that it is included on the next available agenda.

Notice and Summons to Meetings

23. The relevant officer in the Host Authority will give notice of meetings to all Joint Committee members, in line with access to information rules of at least five clear working days before a meeting. The relevant officer will send an agenda to every member specifying the date, time and place of each meeting and the business to be transacted, and this will be accompanied by such reports as are available.

Attendance by others

24. The Joint Committee and any Task and Finish/Working Group formed by the Joint Committee may invite other people (including expert witnesses) to address it, to discuss issues of local concern and/or to answer questions. It may for example wish to hear from residents, stakeholders and members and officers in other parts of the public sector and shall invite such people to attend.

Procedure at Joint Committee meetings

25. The Joint Committee shall consider the following business:

    (a) Minutes of the last meeting (including matters arising).
    (b) Declarations of interest.
    (c) Any urgent item of business which is not included on an agenda but the Chair agrees should be raised.
    (d) The business otherwise set out on the agenda for the meeting.

26. Where the Joint Committee wishes to conduct any investigation or review to facilitate its consideration of the health issues under review, the Joint Committee may also ask people to attend to give evidence at Joint Committee meetings which are to be conducted in accordance with the following principles:

    (a) That the investigation is conducted fairly and all members of the Joint Committee be given the opportunity to ask questions of attendees, and to contribute and speak.

    (b) That those assisting the Joint Committee by giving evidence be treated with respect and courtesy.

    (c) That the investigation be conducted so as to maximise the efficiency of the investigation or analysis.

Voting

27. Any matter will be decided by a simple majority of those Joint Committee members voting and present in the room at the time the motion is put. This will be by a show of hands or if no dissent, by the affirmation of the meeting. If there are equal votes for and against, the Chair or other person chairing the meeting will have a second or casting vote. There will be no restriction on how the Chair chooses to exercise a casting vote.

Urgent Action

28. In the event of the need arising, because of there not being a meeting of the Joint Committee convened in time to authorise this, officers administering the Joint Committee from the Host Authority are generally authorised to take such action, in consultation with the Chair, and Vice-Chairs where practicable, to facilitate the role and function of the Joint Committee as they consider appropriate, having regard to any Terms of Reference or other specific relevant courses of action agreed by the Joint Committee, and subject to any such actions being reported to the next available meeting of the Joint Committee for ratification.

Final Reports and recommendations

29. The Joint Committee will aim to produce an agreed report reflecting a consensus of its members, but if consensus is not reached the Joint Committee may issue a majority report and a minority report.

    (a) If there is a consensus, the Host Authority will provide a draft of both the conclusions and discursive text for the Joint Committee to consider.

    (b) If there is no consensus, and the Host Authority is in the majority, the Host Authority will provide the draft of both the conclusions and discursive text for a majority report and arrangements for a minority report will be agreed by the Joint Committee at that time.

    (c) If there is no consensus, and the Host Authority is not in the majority, arrangements for both a majority and a minority report will be agreed by the Joint Committee at that time.

    (d) In any case, the Host Authority is responsible for the circulation and publication of Joint Committee reports. Where there is no consensus for a final report the Host Authority should not delay or curtail the publication unreasonably.

    The rights of the health overview and scrutiny committees of each local authority to make reports of their own are not affected.

30. A majority report may be produced by a majority of members present from any of the local authorities forming the Joint

Committee. A minority report may be agreed by any *[number derived by subtracting smallest possible majority from quorum: e.g. if quorum is 4, lowest possible majority is 3, so minority report requires 1 members' agreement]* or more other members.

31. For the purposes of votes, a "report" shall include discursive text and a list of conclusions and recommendations. In the context of paragraph 29 above, the Host Authority will incorporate these into a "final report" which may also include any other text necessary to make the report easily understandable. All members of the Joint Committee will be given the opportunity to comment on the draft of the final report. The Chair in consultation with the Vice-Chairs, where practicable, will be asked to agree to definitive wording of the final report in the light of comments received. However, if the Chair and Vice-Chairs cannot agree, the Chair shall determine the final text.

32. The report will be sent to *[name of the NHS organisations involved]* and to any other organisation to which comments or recommendations are directed, and will be copied to NHS North East, and to any other recipients Joint Committee members may choose.

33. The *[name of the NHS organisations involved]* will be asked to respond within 28 days from their formal consideration of the Final Report, in writing, to the Joint Committee, via the nominated officer of the Host Authority. The Host Authority will circulate the response to members of the Joint Committee. The Joint Committee may (but need not) choose to reconvene to consider this response.

34. The report should include:

    (a) The aim of the review – with a detailed explanation of the matter under scrutiny.

    (b) The scope of the review – with a detailed description of the extent of the review and it planned to include.

    (c) A summary of the evidence received.

    (d) An evaluation of the evidence and how the evidence informs conclusions.

(e) A set of conclusions and how the conclusions inform the recommendations.

(f) A list of recommendations – applying SMART thinking (Specific, Measurable, Achievable, Realistic, Timely), and how these recommendation, if implemented in accordance with the review outcomes, may benefit local people.

(g) A list of sources of information and evidence and all participants involved.

Timescale

35. The Joint Committee will hold two full committee meetings per year, and at other times when the Chair and Vice-Chairs wish to convene a meeting. Any three members of the joint committee may require a special meeting to be held by making a request in writing to the Chair.

36. Subject to conditions in foregoing paragraphs 29 and 31, if the Joint Committee agrees a report, then:

    (a) The Host Authority will circulate a draft final report to all members of the Joint Committee.

    (b) Members will be asked to comment on the draft within a period of two weeks, or any other longer period of time as determined by the Chair, and silence will be taken as assent.

    (c) The Chair and Vice-Chairs will agree the definitive wording of the final report in time for it to be sent to *[name of the NHS organisations involved].*

37. If it believed that further consideration is necessary, the Joint Committee may vary this timetable and hold further meetings as necessary. The *[name of the NHS organisations involved]* will be informed of such variations in writing by the Host Authority.

Guiding principles for the undertaking of North East regional joint health scrutiny

38. The health of the people of North East England is dependent on a number of factors including the quality of services provided by the NHS, the local authorities and local partnerships. The success of joint health scrutiny is dependent on the members of the Joint Committee as well as the NHS and others.

39. Local authorities and NHS organisations 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 interests will be declared in all cases in accordance with the Members' Code of Conduct of each constituent authority.

40. The scrutiny process will be open and transparent in accordance with the Local Government Act 1972 and the Freedom of Information Act 2000 and meetings will be held in public. Only information that is expressly defined in regulations to be confidential or exempt from publication will be considered in private. The Host Authority will manage requests and co-ordinate responses for information considered to be confidential or exempt from publication in accordance with the Host Authority's legal advice and guidance. Joint Committee papers and information not being of a confidential nature or exempt from publication may be posted on the websites of the constituent authorities as determined by each of those authorities.

41. Different approaches to scrutiny reviews may be taken in each case. The Joint Committee will seek to act as inclusively as possible and will take evidence from a wide range of opinion including patients, carers, the voluntary sector, NHS regulatory bodies and staff associations, as necessary and relevant to the terms of reference of a scrutiny review. Attempts will be made to ascertain the views of hard to reach groups, young people and the general public.

42. The Joint Committee will work to continually strengthen links with the other public and patient involvement bodies such as PCT patient groups and Local Involvement Networks, where appropriate.

43. The regulations covering health scrutiny allow an overview and scrutiny committee to require an officer of a local NHS body to

attend before the committee. This power may be exercised by the Joint Committee. The Joint Committee recognises that Chief Executives and Chairs of NHS bodies may wish to attend with other appropriate officers, depending on the matter under review. Reasonable time will be given for the provision of information by those asked to provide evidence.

44. Evidence and final reports will be written in plain English ensuring that acronyms and technical terms are explained.

45. Communication with the media in connection with reviews will be handled in conjunction with the constituent local authorities' press officers.

Conduct of Meetings

46. The conduct of Joint Committee meetings shall be regulated by the Chair (or other person chairing the meeting) in accordance with the general principles and conventions which apply to the conduct of local authority committee meetings.

47. In particular, however, where any person other than a full or co-opted member of the Joint Committee has been allowed or invited to address the meeting the Chair (or other person chairing the meeting) may specify a time limit for their contribution, in advance of its commencement which shall not be less than five minutes. If someone making such a contribution exceeds the time limit given the Chair (or other person chairing the meeting) may stop him or her.

48. The Chair (or other person chairing the meeting) may also structure a discussion and limit the time allowed for each agenda item and questioning by members of the Joint Committee.