Public Document Pack

Health and Partnerships Scrutiny Committee

Supplementary Agenda

DARLINGTON
BOROUGH COUNCIL

9.30 am Thursday, 29 August 2019
Committee Room No 2, Town Hall,
Darlington. DL1 5QT

(a) Improving Stroke Rehabilitation for the People of Darlington –
Report and Presentation by Director of Commissioning Strategy and Delivery
(Pages 1 - 106)

REASON FOR URGENCY – To enable Members to consider at the earliest possible date.

(b) Review of Inpatient Rehabilitation in County Durham and Darlington –
Report and Presentation by Director of Commissioning Strategy and Delivery
(Pages 107 - 204)

REASON FOR URGENCY – To enable Members to consider at the earliest possible date.

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County Durham and the Tees Valley
Clinical Commissioning Groups

Improving Stroke Rehabilitation For the People of County Durham and Darlington

Health and Partnerships Scrutiny Committee

29 August 2019

Darlington Clinical Commissioning Group
Durham Dales, Easington and Sedgefield Clinical Commissioning Group
Hartlepool and Stockton-on-Tees Clinical Commissioning Group
North Durham Clinical Commissioning Group
South Tees Clinical Commissioning Group

Background

- In 2011 the local system moved to a single site model for hyperacute stroke
- Since this time there has been an improvement in outcomes for patients at the point of emergency
- It was recognised that a review of stroke rehabilitation was required as patient outcomes were not being fully realised

Vision

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

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

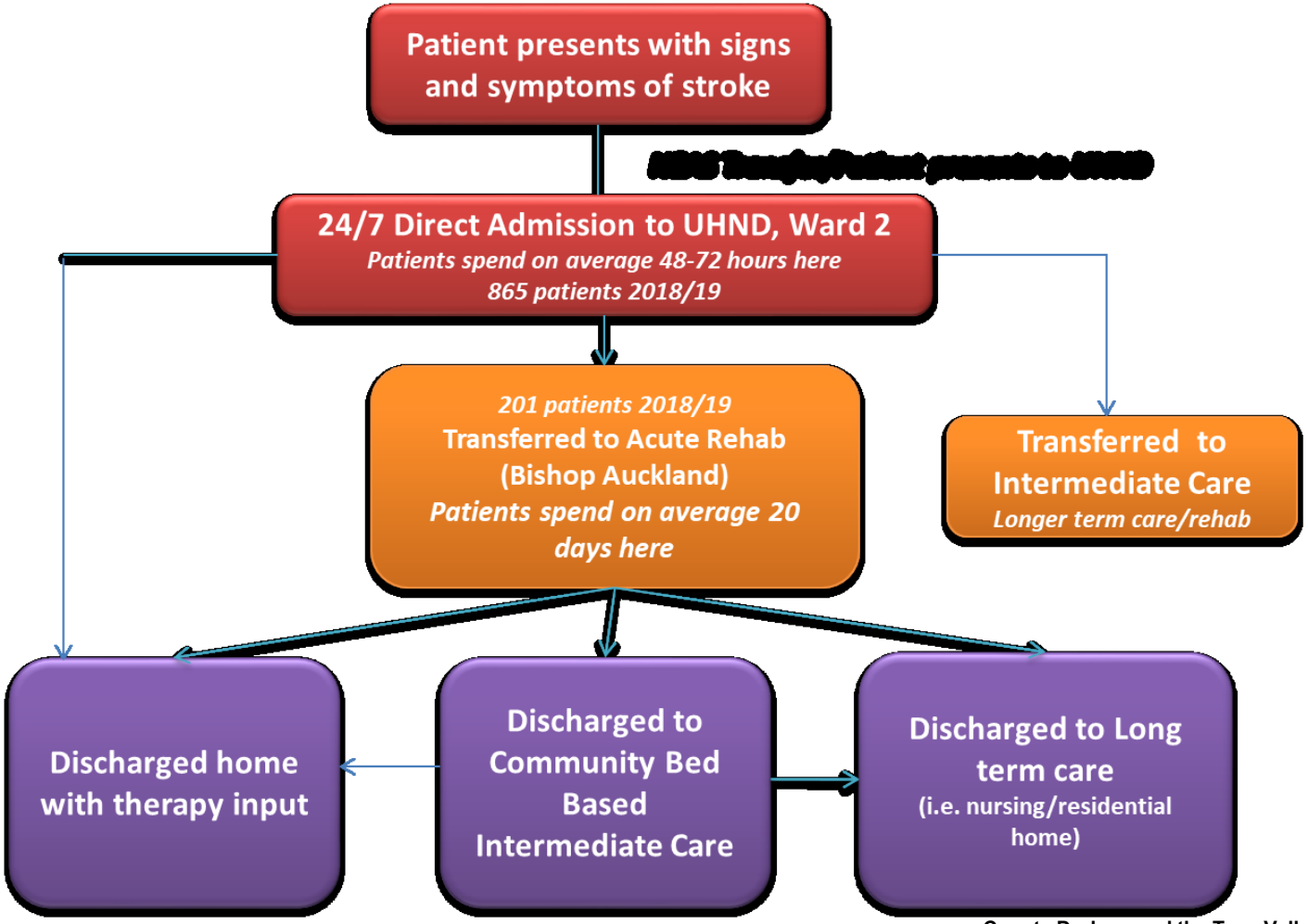
To ensure care is accessible and responsive to people's needs

To develop a service which retains and attracts an excellent workforce

Scope of Review

- The scope of this service review relates to the rehabilitation elements of the pathway following an acute episode due to stroke
- This includes:
    - Community based rehabilitation
    - Hospital based rehabilitation
- CCGs and CDDFT have a major emphasis on community services focussing on
    - Prevention and maintaining independence
    - Supporting patients with long term conditions
    - Managing crisis and supporting a return to independence

Current Pathway



Quality and Performance

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

Emergency Care Improvement Programme
Safer, faster, better care for patients

NHS Improvement

County Durham and the Tees Valley Clinical Commissioning Groups

NHS

Patient and Carer Feedback

Phase one

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

Phase two

Over 76% of patients or family were involved in setting their treatment goals

79 people shared their views

Letters were sent to over 190 current patients of the Stoke Association

79% of patients told us they were involved as much as they wanted to be in their discharge plan

72% of respondents said that they received continuity of care

Key Themes

- Positive experiences of hospital care
- People would value care closer to home
- Many people felt they would have benefited from more therapy input both in a hospital and community setting
- Many people felt a lack of support during discharge
- People didn't want to have to repeat 'their story' multiple times

Clinical Case for Change

Policy Context	Key Theme	Gap in Current Provision
Stroke Strategy 2007	Hand offs of care	The current pathway promotes multiple transfers of care
NHS England's Quick Guide: Discharge to Assess and benefits for older, vulnerable people.	Discharge to assess	Therapy assessment takes place within a hospital setting rather than in the person's home setting
Stroke Guidelines 2016	Equity of access to comprehensive specialist community rehabilitation	Current community based rehab services are inequitable across County Durham
SSNAP Audit 2016	Levels of recommended therapy input	Rehabilitation within the community doesn't provide the intensity required as detailed in national guidance
SSNAP Audit 2016	Levels of recommended therapy input	Patient based outcomes could be improved upon e.g. time for therapy based interventions
Stroke Specific Education Framework	Efficient use of clinical staff	Currently staff have to cover two sites, for example medical rotas for consultants are difficult to manage and sustain with limited workforce
NICE guidelines - continuity of care and relationships in adult NHS services	Continuity of care	Currently many patients are handed off to another team so patients don't have the familiarity of staff
Stroke Specific Education Framework	Effective recruitment and retention of staff	The expertise is diluted currently across two sites and staffing levels are limited – lack of contingency
Stroke Guidelines 2016	Early supported discharge	Currently not in place

GETTING IT RIGHT FIRST TIME

- **Therapy** - Increase therapy staffing on stroke unit and provision for Early Supported Discharge (ESD) to facilitate discharge and reduce Length of Stay (LoS)

- **Consider ring fenced stroke therapy or Combined Stroke unit (acute and rehab) at single site**

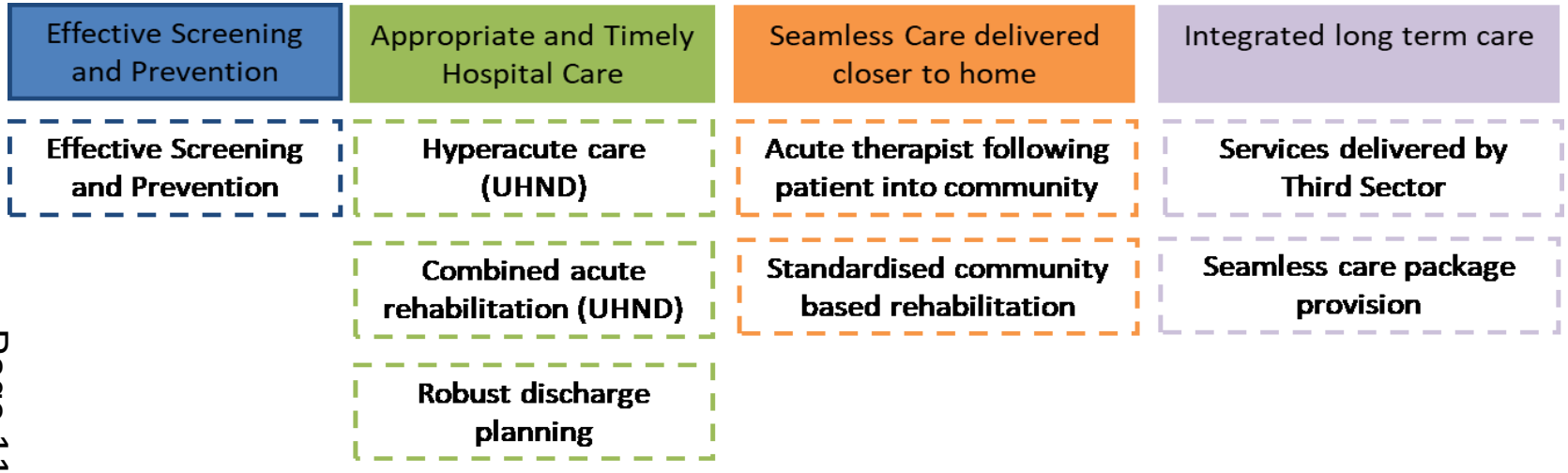
- **Consultant Cover** - Review of split site working to improve efficiency of medical workforce cover.

- **6 month reviews** - To ensure data is captured on the SSNAP system

Options Appraisal

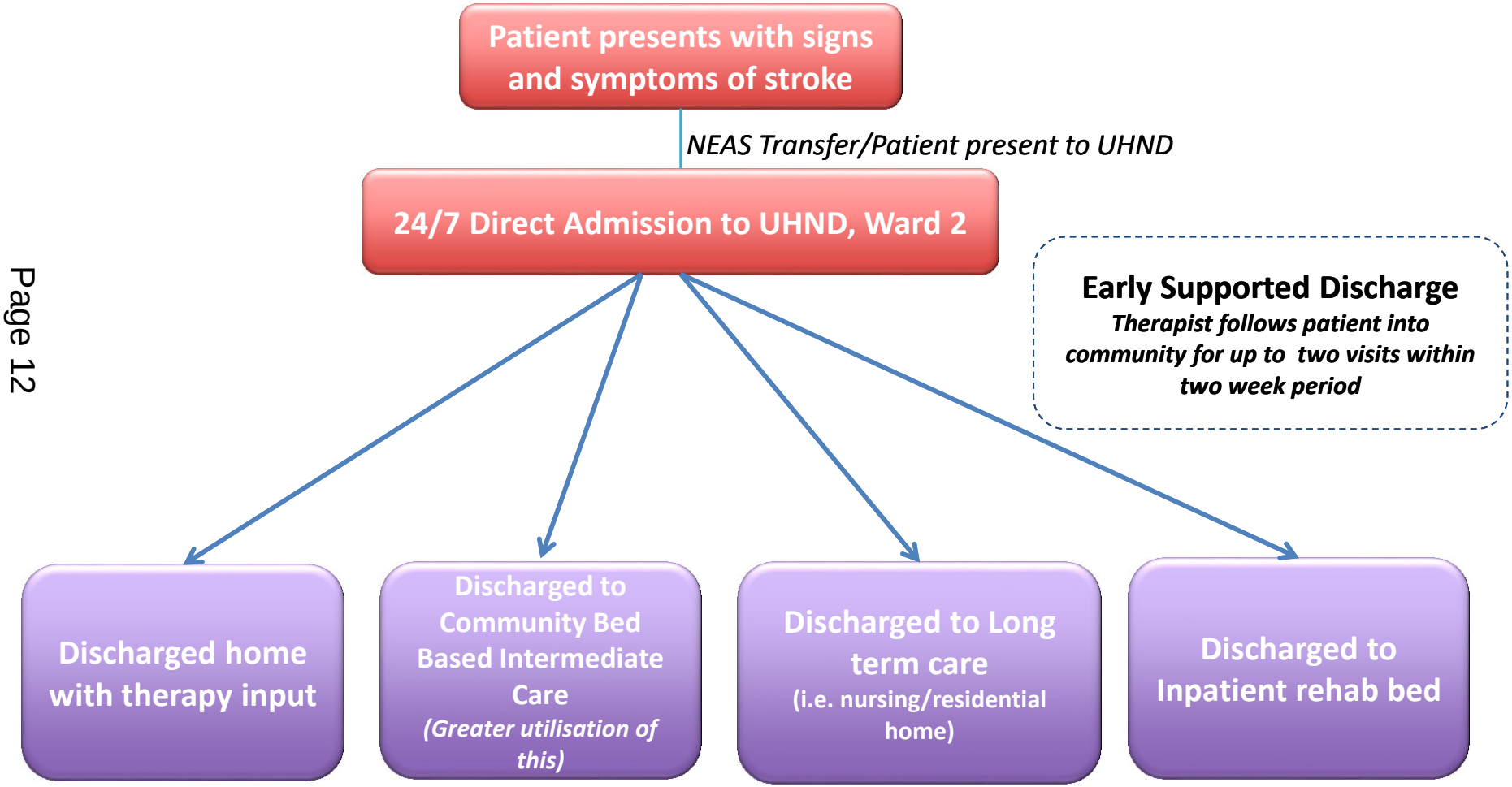
Clinical quality	Maintains or improves clinical outcomes; timely and appropriate services; minimises clinical risk	Patient, Public and carer Engagement – Experience and Feedback
Sustainability/flexibility	Ability to meet current and future demands in activity; ability to respond to local/regional/national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

Proposed Future Model



- To consolidate acute rehabilitation onto the Specialist Stroke Unit at UHND
- To provide robust discharge planning and implementation with seamless transition into the community
- Robust community rehabilitation services which are proactive and based on need

Proposed Pathway



What this would mean for patients in Darlington

- Equity of specialist inpatient stroke rehabilitation
- High quality and sustainable workforce available to deliver care in the the most appropriate setting
- A seamless transition into the community supported by Early Supported Discharge
- Community based services which are responsive to need
- Work in collaboration with the Stroke Association to ensure enhanced support for patients and carers is maximised as part of the pathway.

Next Steps

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

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

Improving Stroke Rehabilitation For the People of County Durham and Darlington

A review of stroke rehabilitation services within County Durham and Darlington

Pre-Consultation Business Case
Darlington

Contents

1.0 Executive Summary

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

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

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

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

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

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

2.0 Vision

Our vision and commitment is:

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

2.1 Scope

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

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

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

2.2 Aims and Objectives

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

3.0 Introduction and Background

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

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

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

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

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

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

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

3.1 Demographics and Prevalence

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

County Durham

The overall population of County Durham is growing and ageing, with an increase in population for those more vulnerable groups – children and older people. The 65+ age group is projected to rise by 36.8% (*n*37,300) between 2014-2030 and overall life expectancy for males and females is lower than the national average.

Stroke Specific prevalence – County Durham

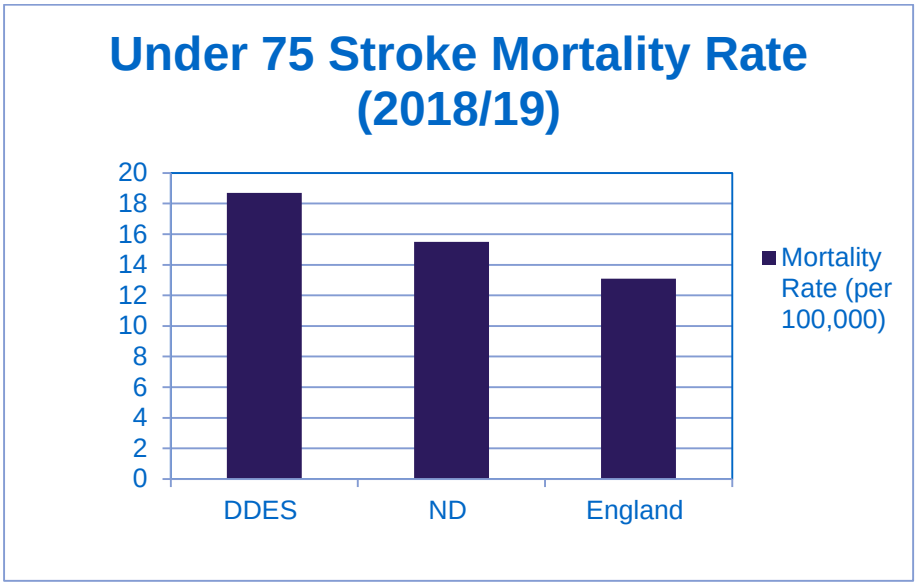


Figure one demonstrates that in both County Durham CCGs the under 75 mortality rate due to stroke is higher than the national average.

Figure 1

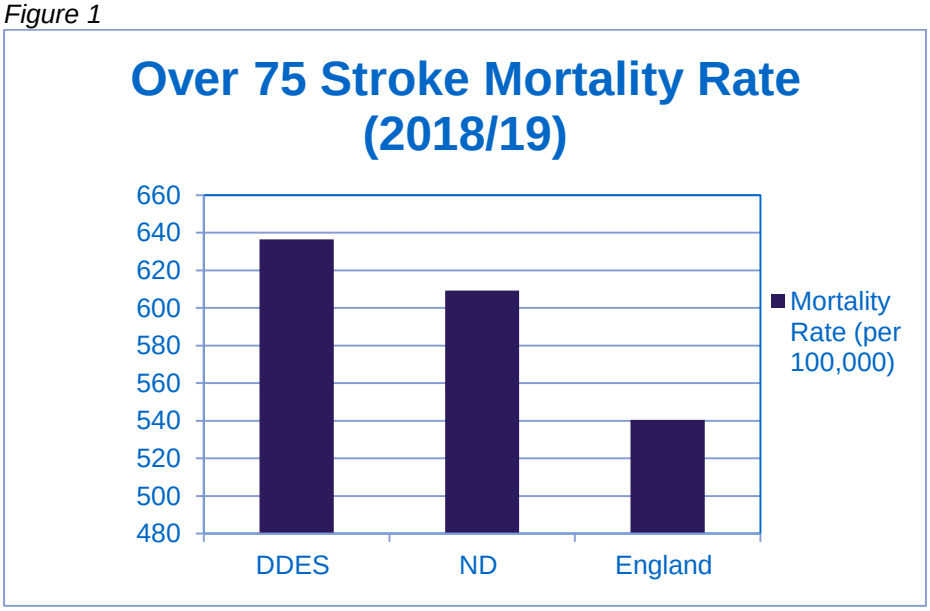


Figure two demonstrates that in both County Durham CCGs the over 75 mortality rate due to stroke is higher than the national average.

Figure 2

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

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

Figure 3

Darlington

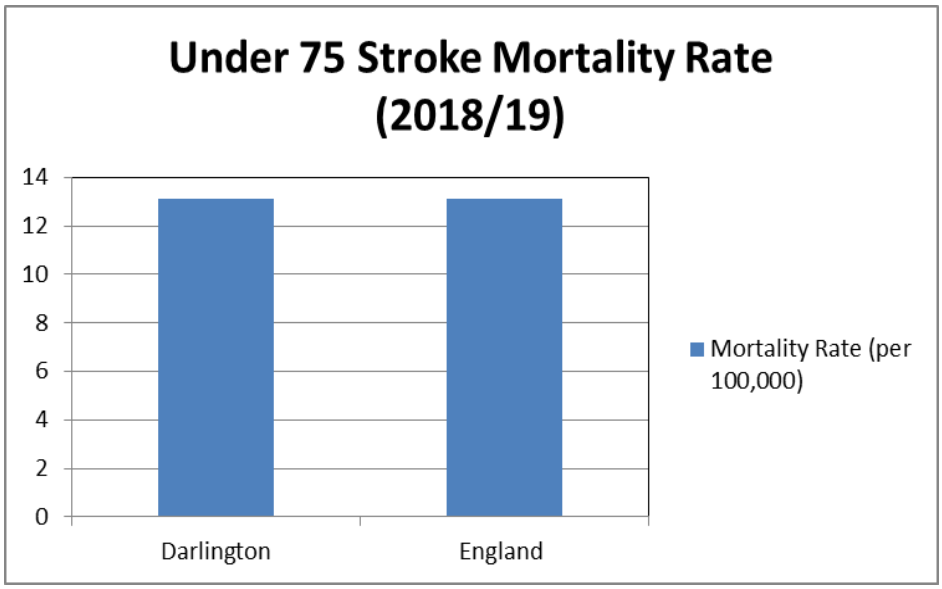


Figure 4

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

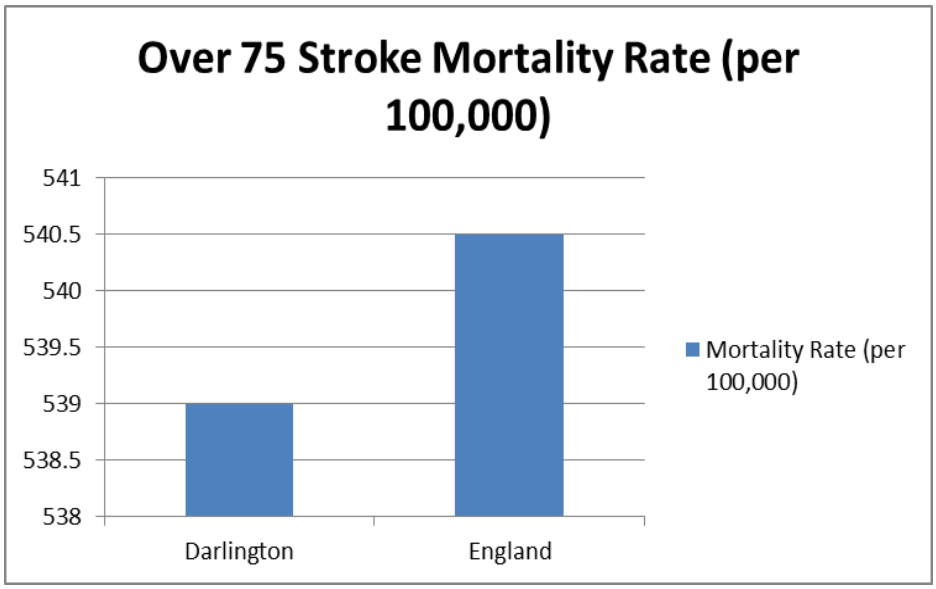


Figure 5

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

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

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

Figure 6

3.2 National Context & Evidence Base

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

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

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

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

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

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

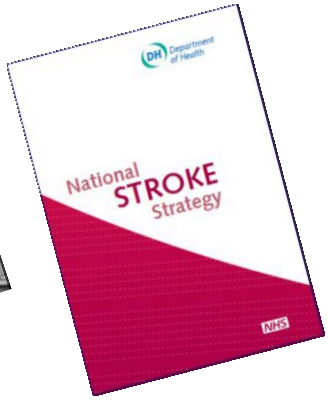
Stroke is a complex and devastating condition, the time needed for rehabilitation varies between people but will often need to continue long after leaving hospital, ideally in a person's own home.

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

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

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

3.3 Best Practice and National Guidelines



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

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

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

4.0 Local Context

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

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

Figure 8

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

Figure 8

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

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

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

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

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

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

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

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

Figure 9 – 2018/19

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

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

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

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

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

Figure 10

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

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

4.1 Quality and Performance

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

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

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

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

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

Figure 11

Hyperacute phase

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

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

Therapy provision

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

- ✗ According to SSNAP data and following the recent GIRFT review there is a potential improvement to be made in terms of the percentage of people who are identified as having an Occupational Therapy (OT) requirement. In addition, of those people identified as having a need for OT, the ability to deliver the average of 40 minutes per day is not achieved (currently 32 minutes).
- ✗ University Hospital of North Durham are currently assessing fewer than 65% of patients deemed applicable for physiotherapy, compared to the national average of 87%. The number of minutes of physiotherapy received per day by patients was also lower than the national average of 35 minutes per day.
- ✗ Those assessed as being suitable to receive Speech and Language Therapy (SALT) is lower than average at just 25% compared to 50% nationally. However the minutes of SALT per day is higher than the national rate of 32 minutes per day and is in fact performing at 36 minutes per day.
- ✓ Performance regarding nutrition screen, and patients being seen by a dietician before discharge, was achieved by CDDFT.

Rehabilitation and long term care

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

Bed occupancy

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

Figure 12

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

Length of stay

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

Figure 13

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

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

Stroke admissions by postcode

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

Figure 14

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

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

Further Recommendations from GIRFT Team

Therapy

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

Consultant Cover

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

6 month reviews

- To ensure data is captured on the SSNAP system

5.0 Patient Experience and feedback

CCGs and provider organisations have a duty to engage and consult on any potential major service change as described within the NHS Act 2006.[1]

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

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

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

[1] NHS Act 2006
www.legislation.gov.uk

Phase One

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

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

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

Key Themes from Phase One

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

What does good look like…patient engagement feedback

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

Phase Two

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

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

accompanying survey and pre-paid return envelope. During this engagement phase there were 79 responses.

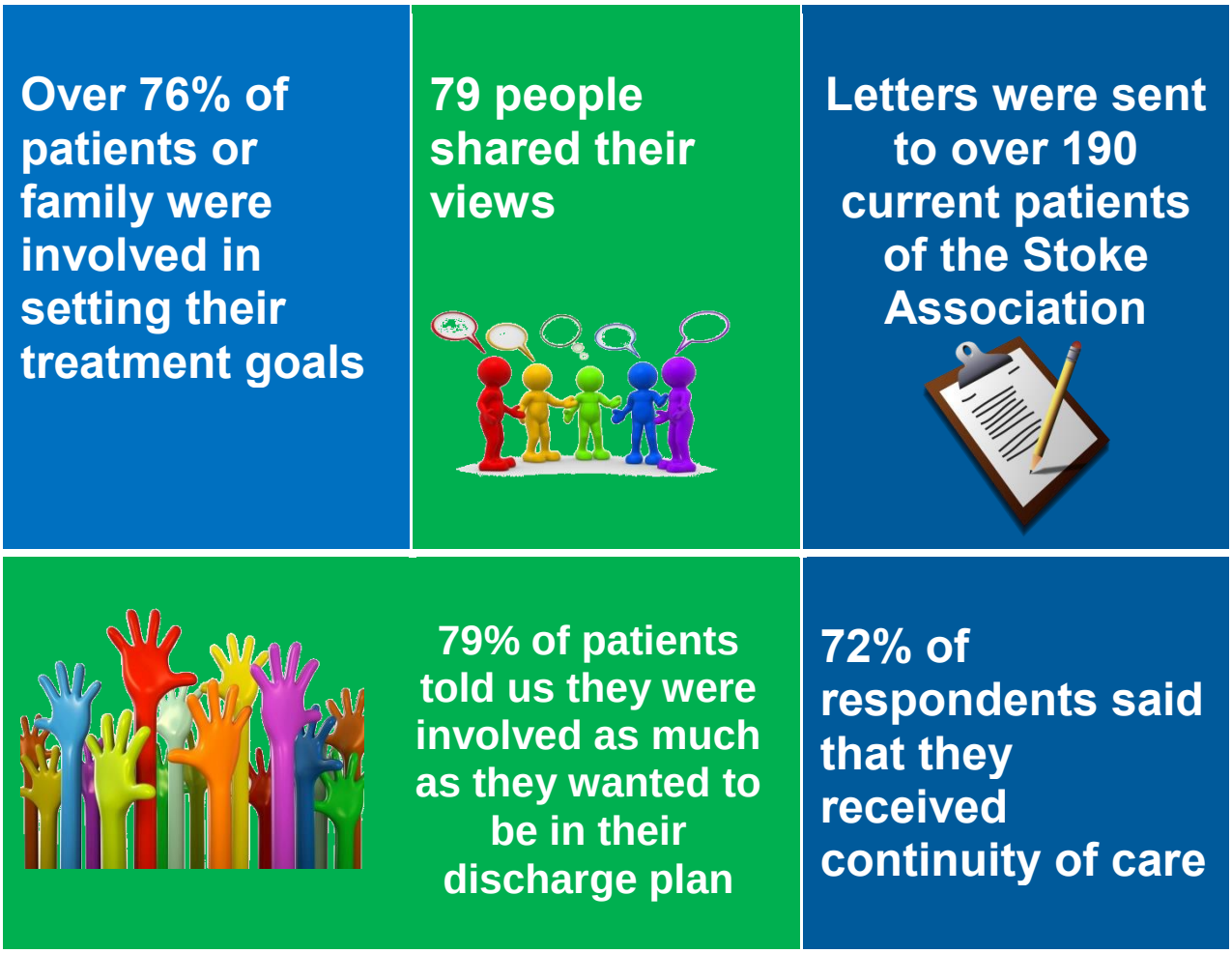


Figure 15

Key Themes from Phase Two

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

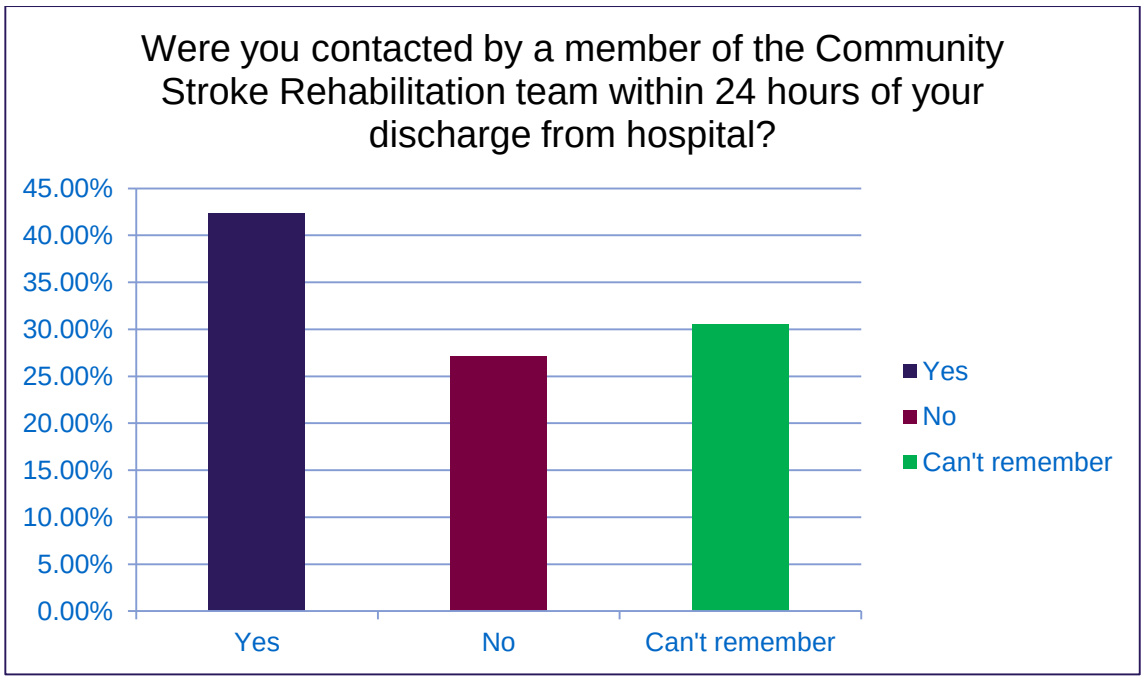


Figure 16

Some Comments

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

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

6.0 Staff Engagement

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

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

7.0 Current State

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

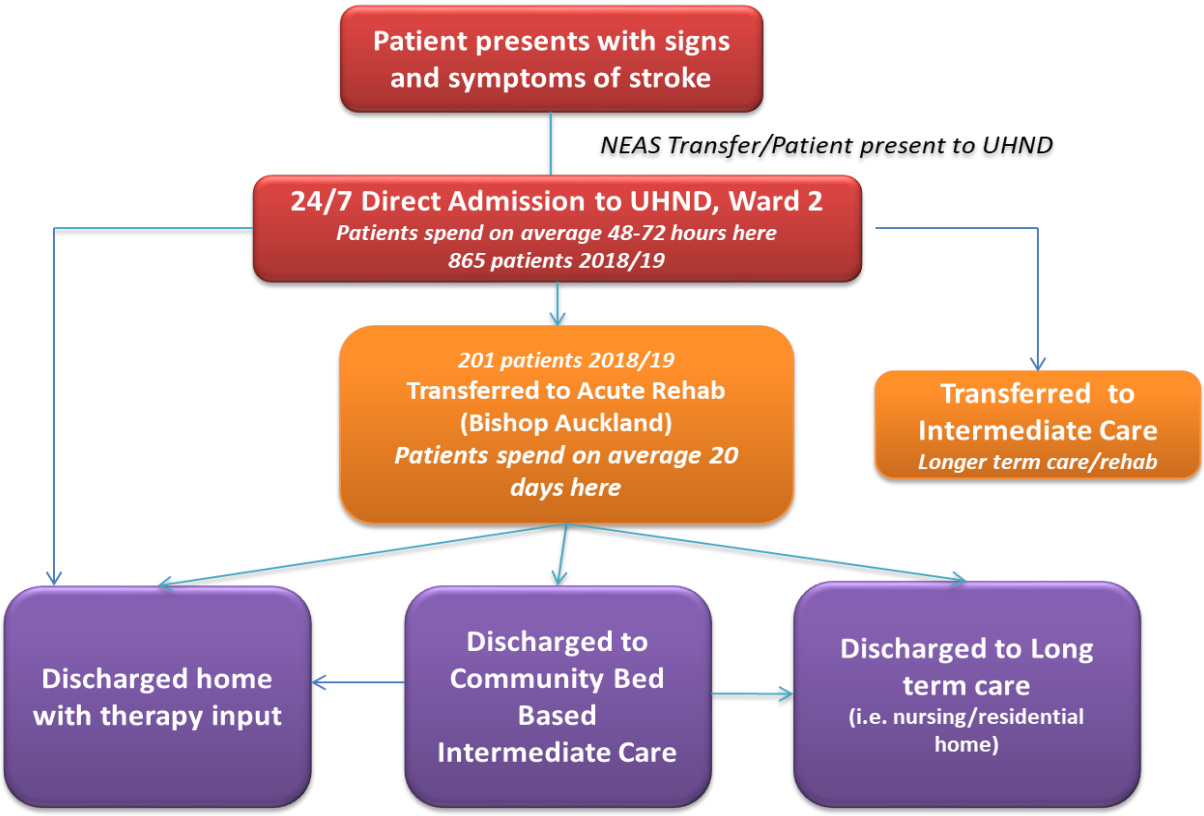


Figure 17

7.1 Stroke prevention

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

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

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

7.2 Hyperacute Model of Care

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

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

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

7.3 Stroke Rehabilitation

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

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

Figure 18

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

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

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

In Darlington, 198 people had a stroke in 2017/18 and 216 in 2018/19. Of these 93% were admitted to CDDFT in 2017/18 and 91% 2018/19. People who have had a stroke in Darlington can receive rehabilitation and support through a number of services:

- RIACT which provides nursing and therapy services including specialist stroke and neuro but supports a broader therapy based need also across the community
- Rehabilitation beds – commissioned in block at Ventress Hall nursing home
- Stroke association – stroke recovery service
- DBC – Exercise after stroke

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

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

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

Figure 19

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

	Total referrals to RIACT
2017	3302
2018	3605

2019 (up to 4th July 2019)	1837

Figure 20

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

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

Eligibility:

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

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

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

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

Figure 21

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

[1] March Admission figures for Eastbourne were not provided and are not included.
[2] Excludes March 2019 as Eastbourne LOS information was not provided.

	Total referrals to RIACT	Total referrals that were recorded as stroke/neuro	% of RIACT activity currently supporting stroke and neuro as coding does not go into more detail to allow detailed analysis
2017	3302	413 (average of 34 per month)	12.5%
2018	3605	434 (average of 36 per month)	12%
2019 (to 4th July)	1837	206 (average of 34 per month)	11.2%

Figure 22

7.4 Psychological Support

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

7.5 Stroke Recovery Service

NHS Darlington CCG commissioned the Stroke Association to deliver an Advice and Support service for people living in Darlington who had been diagnosed as having had a

stroke. This service was commissioned following the decommissioning of a joint collaboration between North Durham and DDES CCG's. The service offers information, emotional support and practical advice and signposting to stroke survivors, their families and carers and is delivered by a single Support Coordinator employed by the National Stroke Association. The service is funded non-recurringly (£20000) via the Better Care Fund, which ends on 31st March 2020

People remain open to the service for up to 12 months, and the service has been undertaking the 6 month reviews as part of this offer, at the request of CDDFT. NICE recommend that 6 months after a patient suffers a stroke their health and social care needs should be reviewed to ensure any additional needs the patient may have are identified. This is done by the Stroke Association as part of the Stroke Recovery Service, who use the Greater Manchester Stroke Assessment Tool (GM-SAT) to complete the assessment. Both Health and Social Care needs should be assessed during this review; therefore CDDFT would be best placed to carry these out, as opposed to the stroke recovery service.

Source of referral	Total referrals 2018/19
GP	2
Health (except GP or TIA)	135
Self-referral	4
Speech and language therapy	1
TIA Clinic	1
Total	**143 – represents 66% of those who have had a stroke in 18/19**

Figure 23

7.7 Exercise After Stroke

The Exercise After Stroke Programme, is provided by Darlington Borough Council and funded non-recurringly (£9000) via the Better Care Fund, which ends on 31st March 2020. The service provides access to safe and effective exercise for patients diagnosed with Stroke and TIA, with the aim of giving patients increased confidence and skills to be physically active and to carry out activities of daily living. This is provided in the form of group sessions which guide people through a variety of exercises. For the small number of people who are able to, there is an option to go through to the gym to use the equipment, but this is dependent on the availability of one of the two suitably qualified instructors.

Referrals into this service must be made via a health professional to ensure that the patient is medically fit to undertake the exercises. Once the referral is received, an assessment is undertaken with the patient which determines which service is suitable for their needs, the Exercise After Stroke Service or the Health Referral Scheme (The Health Referral Scheme may be more appropriate for patients who are able to carry out more exercise than the Exercise After Stroke service offers).

Measures for Exercise after stroke	Total activity 2018/19
No of new referrals into the service from Stroke Association	22
No of new referrals into the service from GP's/ Practices	6
No of new referrals into the service from RIACT	0
No of new referrals into the service from other sources	0
No of sessions of 12 week programme	104
Total attendances for the 12 week programme	1156
No completing the 12 week programme	26
No. of people who progress from the 12 week programme to ongoing regular exercise programmes.	20

Figure 24

Referrals into the service represent 13% of the overall number of people who had a stroke in Darlington in 18/19.

8.0 Case for change – Stroke Rehabilitation

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

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

8.1 Acute based rehabilitation

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

8.2 Community based rehabilitation

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

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

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

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

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

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

8.3 Gaps within current state vs. best practice

Policy Context	Key Theme	Gap in Current Provision
Stroke Strategy 2007	Hand offs of care	The current pathway promotes multiple transfers of care
NHS England's Quick Guide: Discharge to Assess and benefits for older, vulnerable people.	Discharge to assess	Therapy assessment takes place within a hospital setting rather than in the person's home setting
Stroke Guidelines 2016	Equity of access to comprehensive specialist community rehabilitation	Current community based rehab services are inequitable across County Durham
SSNAP Audit 2016	Levels of recommended therapy input	Rehabilitation within the community doesn't provide the intensity required as detailed in national guidance

SSNAP Audit 2016	Levels of recommended therapy input	Patient based outcomes could be improved upon e.g. time for therapy based interventions
Stroke Specific Education Framework	Efficient use of clinical staff	Currently staff have to cover two sites, for example medical rotas for consultants are difficult to manage and sustain with limited workforce
NICE guidelines - continuity of care and relationships in adult NHS services	Continuity of care	Currently many patients are handed off to another team so patients don't have the familiarity of staff
Stroke Specific Education Framework	Effective recruitment and retention of staff	The expertise is diluted currently across two sites and staffing levels are limited – lack of contingency
Stroke Guidelines 2016	Early supported discharge	Currently not in place

8.4 Workforce challenges

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

Within the current model there is a reduction in the levels of contingency in place across all staffing groups. The sense of "team" is somewhat lost, particularly in relation to training and team working. Ideally all staff groups would benefit from caring for people throughout their acute episode, learning from each other and creating development opportunities for staff. The service feels that the current model potentially inhibits their ability to effectively recruit and retain staff, particularly in relation to the therapies workforce.

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

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

8.5 Financial challenges

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

9.0 Options Criteria & Process

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

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

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

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

9.1 Options Appraisal

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

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

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

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

Option one – do nothing

Criteria	Score (out of 10)	Narrative
Clinical quality	5	• Majority of SSNAP indicators met • Issues in relation to therapy quality indicators unable to be met • Unnecessary hand-offs between teams on each site
Sustainability/flexibility	4	• As medical advances continue, length of stay reduces and there is an emphasis on care closer to home i.e. in the community • Operating two sites is not sustainable in terms of workforce • Loss of clinical time available due to travel
Equity of access	8	• BAH is closer for acute rehab for those who live in the South of County Durham and Darlington • Currently those in the North are travelling to BAH • All patients have access to same level of inpatient care
Efficiency	6	• Increased length of stay, which could be improved by more effective discharge processes and community provision • Transport required to transfer patients between sites

Criteria	Score (out of 10)	Narrative
Workforce	6	• Staff are diluted across two sites • Limited consultant workforce required to cover multiple rotas • Learning and development opportunities reduced • Workforce complement doesn't provide medical cover 24/7 at BAH
Functional suitability	6	• Facilities at BAH suitable for rehab • Where a patient becomes medically compromised there may be a need to transfer back to UHND
Acceptability	6	• The level of care experienced by patients and their families at both sites is good overall • People in the south of the county and in Darlington benefit from the location
Cost effectiveness	5	• Operating two stroke acute sites is not cost effective • The money could be better used to firm up staffing to enable contingency • The cost of transport in relation to transfers across sites needs to be taken into account
Total	46	

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

Criteria	Score (out of 10)	Narrative
Clinical quality	5	• Majority of SSNAP indicators met • Issues in relation to therapy quality indicators unable to be met • Unnecessary hand-offs between teams on each site
Sustainability/flexibility	4	• As medical advances continue, length of stay reduces and there is an emphasis on care closer to home i.e. in the community • Operating two sites is not sustainable in terms of workforce • Loss of clinical time available due to travel

Criteria	Score (out of 10)	Narrative
Equity of access	8	• BAH is closer for acute rehab for those who live in the South of County Durham and Darlington • Currently those in the North are travelling to BAH • All patients have access to same level of inpatient care
Efficiency	6	• Increased length of stay, which could be improved by more effective discharge processes and community provision • Transport required to transfer patients between sites
Workforce	6	• Staff are diluted across two sites • Limited consultant workforce required to cover multiple rotas • Learning and development opportunities reduced • Workforce complement doesn't provide medical cover 24/7 at BAH
Functional suitability	6	• Facilities at BAH suitable for rehab • Where a patient becomes medically compromised there may be a need to transfer back to UHND
Acceptability	6	• The level of care experienced by patients and their families at both sites is good overall • People in the south of the county and in Darlington benefit from the location
Cost effectiveness	5	• Operating two stroke acute sites is not cost effective • The money could be better used to firm up staffing to enable contingency • The cost of transport in relation to transfers across sites needs to be taken into account
Total	46	

9.2 Preferred Option

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

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

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

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

- Demonstrate that sufficient alternative provision, such as increased GP or community services is being put in place alongside or ahead of bed closures and that new workforce will be there to deliver it.
- Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions.
- Where a hospital has been using beds less efficiently than the national average, it has a credible plan to improve performance without affecting patient care for example Getting it Right First Time Programme (GIRFT)

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

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

The better values for stroke applied are based on:

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

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

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

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

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

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

CDDFT are currently reviewing the levels and location of all of their beds across County Durham and Darlington to ensure that they best meet the needs of the local population. The realignment of beds would mean that there are a higher proportion of people who require inpatient rehabilitation who would be treated within a community hospital closer to home.

9.2.1Community Stroke Rehabilitation

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

Darlington patients will utilise the community based service model as described in section seven.

10.0 Benefits Realisation

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

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

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

The benefits of a Combined Stroke Unit will include:

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

Workforce

- Team training, team building and so greater understanding of roles that will aid a patients care pathway.
- Easier to plan medical rotas and more efficient use of staff

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

Better use of resources

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

Quality and performance

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

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

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

Speech and Language Therapy (SALT)

- The Speech and Language Therapy workforce fully support this stroke service transformation. Centralising Stroke services on one site will have a number of patient experience/patient outcome benefits for communication and swallowing impaired patients. Communicating basic every day needs and consenting for treatments for this patient group can be a daily struggle where a patient has suffered both comprehension and verbal communication disabilities (dysphasia, dyspraxia, dysarthria, and dysphagia) in addition to other new disabilities.

- Transitioning to another hospital part way through the stroke pathway is less than ideal for this vulnerable population as both nursing and AHP staff will have built-up rapport with the patient and their families/ carers and begun to use effective communication strategies in the hyper-acute phase. If the patient is then

transferred this all needs to be re-established with a new MDT team on a different site which can be very frustrating for a patient with word-finding difficulties.

- Consolidating existing SALT staffing from both sites will help to increase the amount of available SALT provision to the combined unit, improving SNAPP scores from a consistent poor grade E mark so that those patients who require 5 x 45 minutes will receive a higher intensity of Speech Therapy which complies with National RCP Guidelines. This will improve patient outcomes in both communication and swallowing function, reducing the risk of social isolation, depression, long-term tube-feeding costs as well as reducing the burden on the overall healthcare economy and social care costs.

Occupational Therapy (OT)

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

Dietetics

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

Physiotherapy

- The preferred model enables the ability for the same staff to be involved for the patient's whole pathway.
- Improved familiarity with staff as rehabilitation progresses aiding acceptance of change due to condition and preparing for discharge home.
- Improved relationships for families with medical team as no change between sites.

- Team training can occur, team building and so greater understanding of roles that will aid a patients care pathway.
- Improved relationship between community team and social care ensuring the patient remains at the centre of the pathway from one discharging site.

Estates benefits

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

11.0 Risks

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

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

12.0 Testing out the Preferred Option

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

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

What this means for patients

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

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

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

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

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

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

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

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

That alternative is a choice of community hospitals, wherever possible, for their rehabilitation care but it must be noted that this does not comply with best evidence

(reference). BAH is one of the hospitals that will be offered as a possible place for rehabilitation as described.

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

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

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

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

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

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

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

13.1 Service Model

Patients will be discharged home with care and support for a period of time by the acute therapy teams before being transferred to the community stroke rehabilitation team. The proposed service model (figure 25) outlines the need to shift the emphasis of stroke rehabilitation care from an inpatient setting into the community – delivering care closer to home.

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

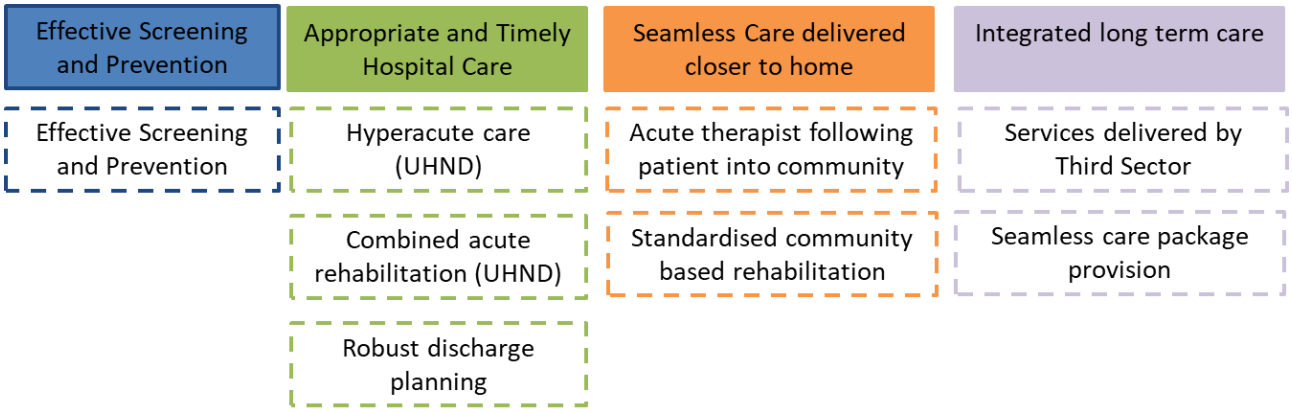


Figure 25 - Stroke Proposed Model of Care

13.2 Referral and Access

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

13.3 Specific Measurable Outcomes

Focusing on outcomes is one way of enabling the transformational change required in the healthcare system. Outcomes need to be meaningful to people who use rehabilitation services and enable them to maximise their potential, manage their healthcare themselves and promote independence. The Government's Mandate to NHS England for 2016-17[3] has an expectation that improvements will be demonstrated against the NHS Outcomes Framework[4] so as to provide evidence of progress and enable comparison of services locally.

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

[3] The Government's Mandate to NHS England for 2016-17
www.gov.uk/government/publications/nhs-mandate-2016-to-2017
[4] NHS Outcomes Framework
Department of Health (2014) The NHS outcomes framework 2015/16
www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015

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

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

Nationally, two large groups of rehabilitation teams, the UK Rehabilitation Outcomes Collaborative (UKROC)[5] and Sentinel Stroke National Audit Programme (SSNAP)[6], have already established systems to record service level, patient dependency level and individual patient function and ability. This now allows national benchmarking and comparisons of both care and rehabilitation pathways.

The following key areas will be covered:

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

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

Where are we now? (BASELINE)	Where do we want to be? (OBJECTIVE)	How will we know if we have got there? (MEASURES)
Admissions to Ward 2 / Transfers to BAH Ward 4	Reduce patient transfers / handoffs to improve patient care.	Admission data - Weekly
Average LoS for rehabilitation is 23.2 days	Reduce average LOS to 9.09 days	LoS data - Weekly
Two site MDT approach to assessment and management for all patients with stroke.	Develop a single MDT approach to assessment and management for all patients to the stroke unit	Admission data Occupancy figures Single site model implemented SSNAP data

[5] UK Rehabilitation Outcomes Collaborative
www.ukroc.org/NCASRI
[6] Sentinel Stroke National Audit Programme
www.strokeaudit.org

Where are we now? (BASELINE)	Where do we want to be? (OBJECTIVE)	How will we know if we have got there? (MEASURES)
Multiple pathways based upon 2 site approach and services available at the site specific.	Review and revise the Streamlined patient pathway to deliver improved outcomes and equitable service for all patients	SSNAP data
No alternative to in-patient rehabilitation.	Implement supported discharge and community based care	SSNAP data
Need to ensure any change to model doesn't have a negative impact on quality of care	Readmission rates reduced	Trust data
Limited therapy input throughout pathway	45 minutes of stroke rehabilitation therapy for a minimum of 5 days a week	SSNAP data

13.4 Performance Management

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

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

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

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

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

The following key areas will be covered:

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

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

14.0 Project Plan

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

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

The governance arrangements in place to deliver this project are below (figure 25). The Systems Assurance Group meets on a regular basis with senior teams from both CCGs and CDDFT on the membership.

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

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

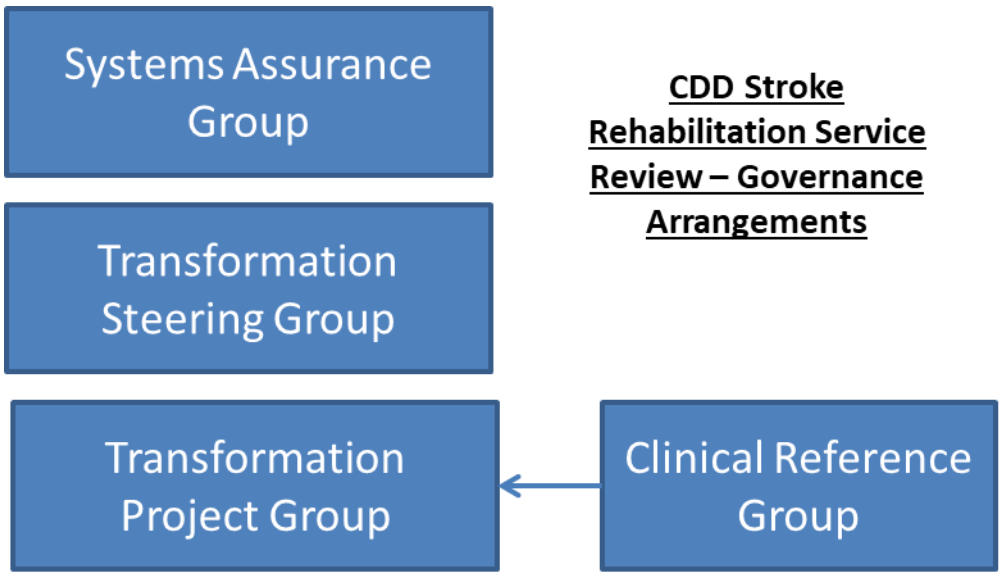

Systems Assurance Group
Transformation Steering Group
Transformation Project Group
Clinical Reference Group
CDD Stroke Rehabilitation Service Review – Governance Arrangements

Figure 26

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

PHASE 2

Acute and Community Stroke Rehabilitation Service Review - Patient Engagement

May and June 2019

Tina Balbach, Engagement Lead

Contents

Introduction

Any successful service change benefits from a period of sustained engagement with members of the public, patients, carers and stakeholders. Indeed one of the four key tests of any proposed service change is to ensure robust patient and public engagement has taken place.

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

It is extremely valuable to receive views on what is important to the local population, as the CCGs can use this information alongside clinical opinion to determine how future service provision may be commissioned. By engaging with those who have used services, the CCGs can begin to understand how the decisions they make have an impact on those using the services.

At this stage of the review the engagement needs to focus on people's experiences of services at the University Hospital of North Durham (UHND) Bishop Auckland Hospital (BAH) (if applicable) and within the community. Once we understand any future options for the service model we will undertake a consultation exercise which will be open to members of the public. During this time we will outline the current service and the proposal for future stroke rehabilitation services and seek their views on this.

The following report details the feedback received within phase one (as an executive summary) and phase two of the engagement process; highlighting key themes. This information will be used to inform the overall decision making process regarding future provision for stroke rehabilitation across County Durham and Darlington.

Executive summary

The information below is a summary of phase one and phase two of engagement.

Phase one

During November and December 2018, across County Durham and Darlington, a period of eight weeks of engagement was undertaken by North Durham (ND), Durham Dales, Easington & Sedgefield (DDES) and Darlington Clinical Commissioning groups (CCGs) with past and current service users, families and local stakeholders to gather views about stroke rehabilitation services.

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

Key points emerging from the online survey are;

- Over 67% (67.24%) of people who responded to the survey were patients, 25% were a family member/carer and 8% were 'other', which incorporated a partner, nurse and a stroke survivor
- Most respondents (20.88%) were at University Hospital of North Durham for one to two days
- Nearly 58% (57.95%) of patients felt that they were discharged from University Hospital of North Durham at the right time
- Over 41% (41.38%) of patients felt they or their carer / family member were involved as much as they wanted to be in their discharge, whereas the same amount (41%) felt they were not involved as much as they wanted to be
- The majority of patients (55.29%) felt they did not receive enough information in relation to the Community Stroke Rehabilitation Service before they were discharged from University Hospital of North Durham
- Three quarters of patients (77.38%) were transferred to Bishop Auckland Hospital following their stay at University Hospital of North Durham.

  The more negative comments included:
  - being on their own after discharge
  - the lack of information given
  - didn't receive any community service once left Bishop, you are on your own

- When asked about what could be improved, respondents said:
  - counselling should be offered at the end of the treatment,
  - more blocks of speech and language therapy are needed
  - giving out consistent information
  - More information in general around coping after stroke

- When asked about if they had any further comments on their experience of the service, respondents said:
    - “Amazing, if I didn't have this service I wouldn't be where I am”
    - “Excellent. I didn't need therapy as I had a small TIA which didn't affect my speech, movements or cognitive functions”
    - “In the hospital I was left to my own devices, as it was only a mini stroke, they didn't seem to bothered, stroke team contact was weeks and weeks apart with regards to visits to the house or a phone call every three weeks”
    - “The therapies team are amazing and fantastic. I wish there was a service - something to go to after the therapy has finished”

- The majority of patients (73.96%) said that they received continuity of care – seem mostly but the same team of therapists

Key points emerging from the qualitative feedback are in relation to;

- Communication challenges
- Emotional wellbeing and support
- Inconsistency of community rehabilitation provision
- People would appreciate a longer period of therapy once discharged from a hospital setting

Phase two

During May, June and July 2019, across County Durham and Darlington, a period of seven weeks of engagement was undertaken by CCGs with current service users, carers and families to gather views about their experiences and stroke rehabilitation services. This was done to further enhance the information already collected and to ensure that we targeted particularly those who had recently suffered a stroke to understand their experiences.

On behalf of the CCGs, the Stroke Association sent a letter with an accompanying survey to over 150 individuals within County Durham and 45 in Darlington who had been offered a six month review. The survey was also available online through a SurveyMonkey link. The letter also detailed contact details for patients / carers who needed support with completing the survey.

A summary of the key points emerging from the online survey are;

Over 76% of patients or family were involved in setting their treatment goals	**79 people shared their views** 	**Letters were sent to over 190 current patients of the Stoke Association** 
	**79% of patients told us they were involved as much as they wanted to be in their discharge plan**	**72% of respondents said that they received continuity of care**

- Nearly eighty (79) people completed the survey with the majority 94% (73) being patients and 6% (5) being a family member or carer
- When asked if they had any other comments on their experience of the service at UHND over 37 patients / carers responded:

Positive

- "They were very caring and friendly"
- "I was treated with gentle care and respect even when I fell behind the toilet door. The understanding even extended over the nights."
- "I received the best of care by courteous professional staff, I can't commend them highly enough"
- I have nothing but praise for ward 2 stroke ward"
- "Exceptionally well cared for".
- I hope the stroke unit continues to be ay UHND as it is easily accessed by public transport to all the outlying areas which makes visiting and follow up appointments much easier if only one bus is required".

Negative

- "Rushed to move on"
- "lacked any rehab, next steps were not discussed"
- "No therapy, sat for 2 hours waiting to go home because a nurse on duty didn't give me the paperwork"

- “I am still waiting for the therapy, both speech and physical it would be better if someone gave you a clue on what to do on the physical instead of leaving you to wait”
- “
- “I saw a physiotherapist once whilst I was in hospital. No speech therapy or explanation or other support groups”.

Key points emerging from the qualitative feedback are in relation to;

- Good care and compassion of staff
- Communication challenges
- Information
- Inconsistency of community rehabilitation provision
- Timespan of therapy
- Emotional wellbeing and support

Purpose of engagement (phase two)

Phase two of the engagement took place between May and June 2019. This engagement was in addition to the 2018 work carried out to hear views from patients/carers and families around their experience following a stroke. The 2019 engagement focused more on those patients who had experienced a stroke more recently i.e. in the past year.

Engagement methodology (phase two)

The engagement work was carried out in conjunction with the Stroke Association who were instrumental in pulling together patient details.

CCGs commission the Stroke Association to deliver six month reviews to patients who have suffered a stroke. As a result they have a wealth of information regarding patients who have recently had experience of stroke services in County Durham. They also deliver the stroke recovery service in Darlington which again gives them the advantage of having access to a rich source of data.

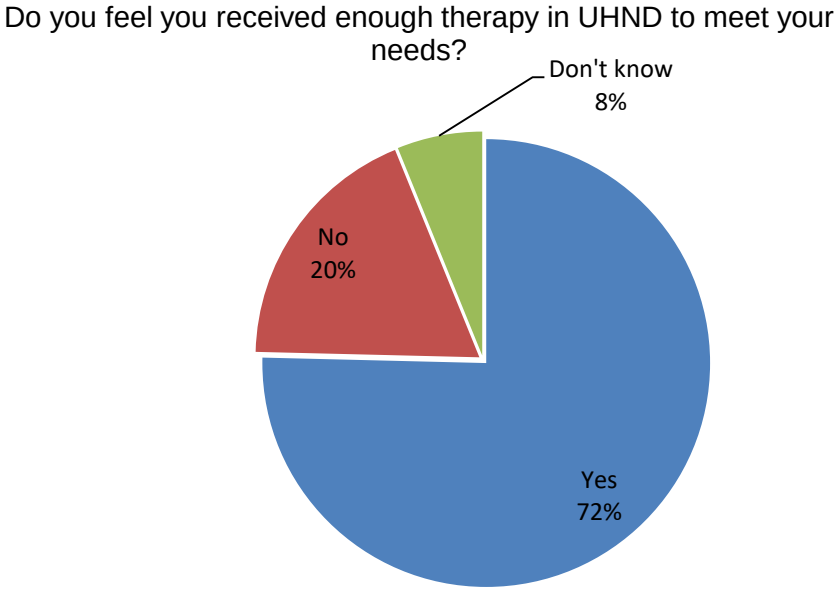
The Stroke Association sent out a letter and questionnaire with an offer of support for people for people who needed it to complete the questionnaire.

The questionnaire focused on their experience during the hospital stay in the acute ward at UHND it also focused on peoples discharge in terms of the destination and their level of care following their inpatient stay. This included those people who were cared for at Bishop Auckland Hospital as part of their pathway as well as those who went straight home from UHND. There was a specific focus on the level of therapy input as well as being involved in care planning and self-care to manage their condition. The engagement exercise also offered the opportunity for people to outline any other feedback as part of their experience.

Phase 2 engagement findings – May / June 2019

University Hospital of North Durham experience

- ***Discharge planning*** - over 79% (62) of patients/family member/carer were involved as much as they wanted in planning their discharge from the University Hospital of North Durham (UHND). Whereas 15% (12) said they were not as involved as they wanted to be and 5% (4) saying they didn't know.
- ***Discharge destination*** - On discharge from UHND the majority of patients 64% (49) patients went home, 33% (25) went to Bishop Auckland Hospital and 3% (2) went to intermediate care eg: a community hospital / residential home or another service.
- ***Therapy input -*** when asked if they received enough therapy to meet their needs at UHND, 72% (54) said yes they had, 20% (15) said no they hadn't and 8% (6) said they didn't know.



- ***Other comments re: UHND -*** When asked if they had any other comments on their experience of the service at UHND over forty (41) patients / carers responded:

  Positive
  - "They were very caring and friendly"
  - "I was treated with gentle care and respect even when I fell behind the toilet door. The understanding even extended over the nights."
  - "I received the best of care by courteous professional staff, I can't commend them highly enough"
  - I have nothing but praise for ward 2 stroke ward"
  - "Exceptionally well cared for".

- I hope the stroke unit continues to be ay UHND as it is easily accessed by public transport to all the outlying areas which makes visiting and follow up appointments much easier if only one bus is required".

Negative

- "Rushed to move on"
- "lacked any rehab, next steps were not discussed"
- "No therapy, sat for 2 hours waiting to go home because a nurse on duty didn't give me the paperwork"
- "I am still waiting for the therapy, both speech and physical it would be better if someone gave you a clue on what to do on the physical instead of leaving you to wait"
- "I saw a physiotherapist once whilst I was in hospital. No speech therapy or explanation or other support groups".

Bishop Auckland experience

For those people who were discharged to Bishop Auckland Hospital, we asked they received enough therapy to meet their needs, 35 people responded and the majority, 21 people said yes. Others gave their views detailed below:

Other comments re: Bishop Auckland Hospital (BAH) - When asked if they had any other comments on their experience of the service at BAH people commented:

"I was well looked after in both Durham and Bishop Auckland on both occasions and the help has helped me to remain positive".

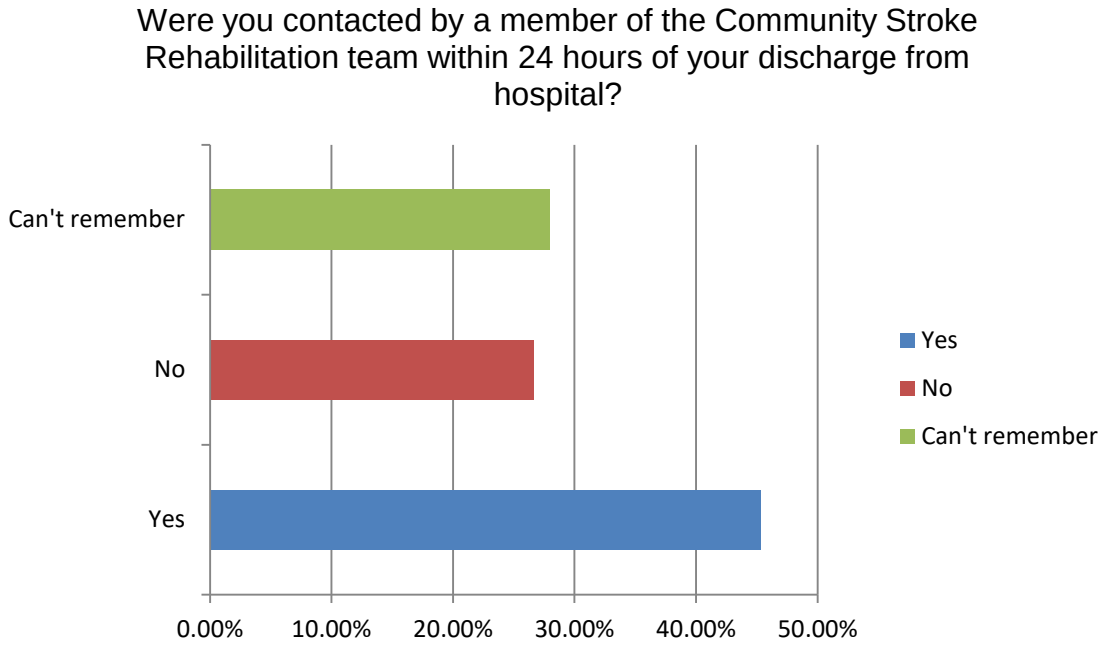
"I received a lot more (therapy) at Bishop Auckland than at UHND".

"I was able and encouraged in use of equipment (parallel bars, stairs and traffic crossing)".

"Excellent therapy at Bishop Auckland".

Community Stroke Rehabilitation Team

- Out of the 75 respondents, over 45% (34) said that they were contacted by a member of the Community Stroke Rehabilitation team within 24 hours of their discharge from hospital. Whereas 27% (20) said they were not and 28% (21) said they couldn't remember.

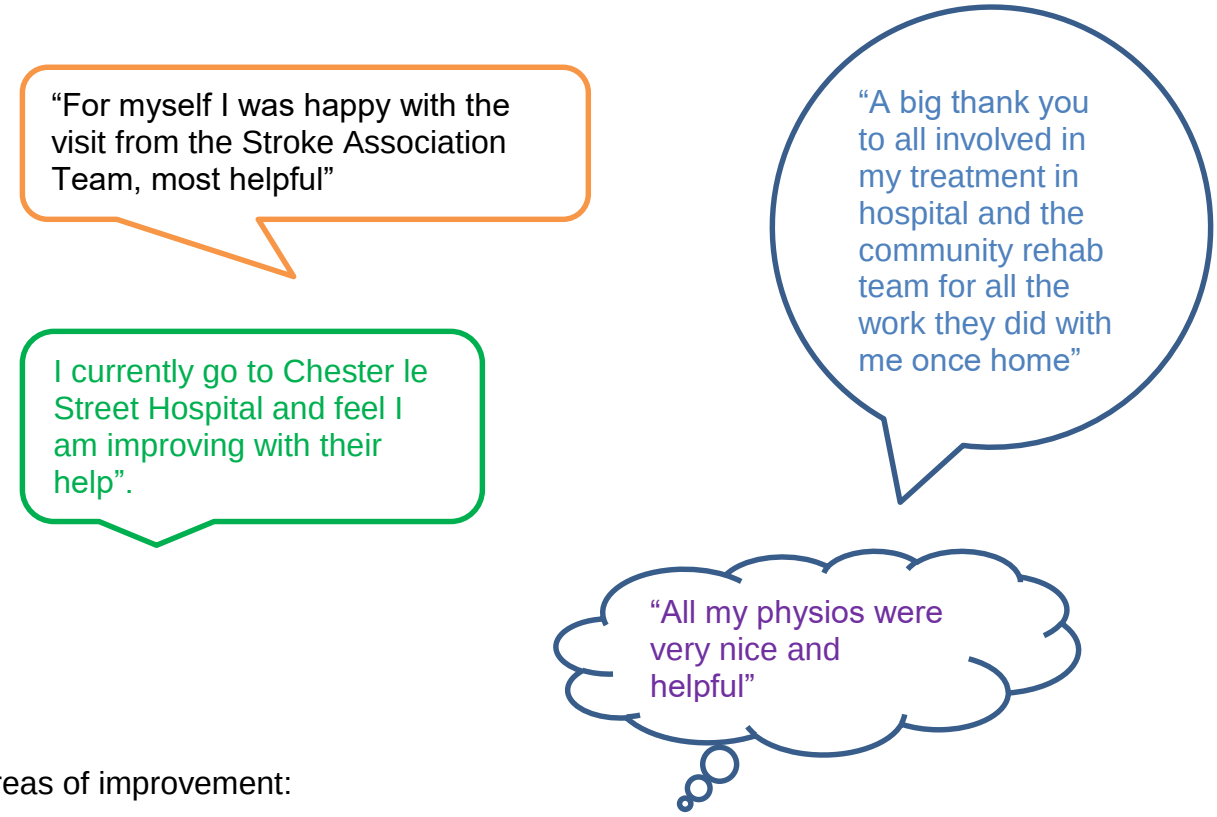


- When asked if members of the Community Stroke Team arrived as planned for visits over 83% (60) respondents stated always, 7% (5) saying usually or rarely and 10% (7) don't know or other.

- Out of the 69 respondents, almost three quarters of patients / carers / family 72% (50) said that they received continuity of care eg: seen mostly by the same team of therapists. 13% (9) said no they hadn't and 14% (9) said they didn't know.

Comments received included:

Positive

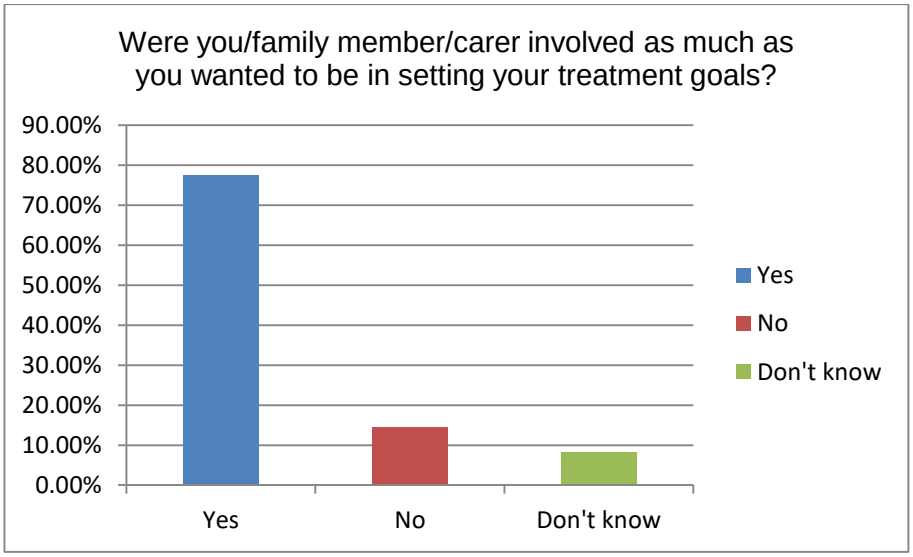


Areas of improvement:

- "It was about four months before I received help from a very good speech therapist after returning home from Bishop Auckland Hospital".
- "I think I should have been referred to physio. I did a self-referral"
- "Only had one visit"
- "Need more rehab"
- "The quickness of therapy (still waiting)"
- "general attitude of some nurses would be a great help"
- "A better understanding after discharge of what the rehab programme is and the goals that are trying to be achieved within a certain timeframe".

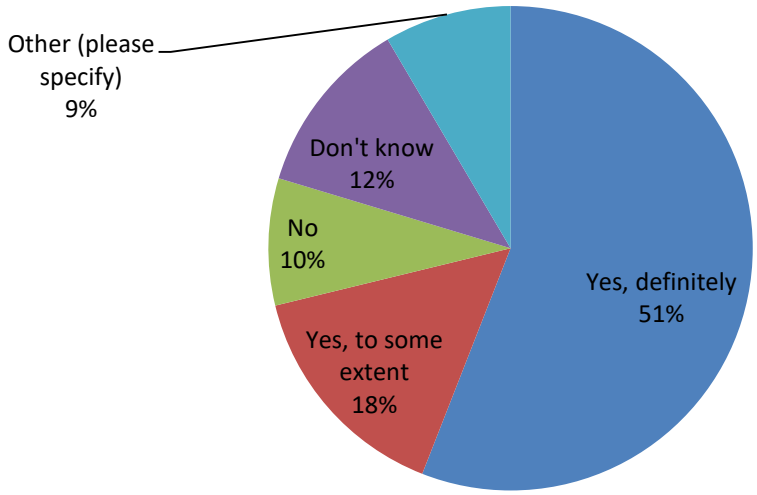
Care planning

- Nearly 77% (52) of respondents said that they felt involved as much as they wanted to be in setting their treatment goals. Fourteen per cent (10) said no and 9% (6) said they didn't know.



- When asked about whether respondents felt that they received enough therapy/rehabilitation to meet their needs over 67% (47) said yes they had, 20% (14) said no they hadn't and 13% (9) said they didn't know.
- Almost half of respondents 46% (32) said that they felt supported in managing their condition, 41% (28) said that they did to some extent and 7% (5) said no and 6% (4) said they didn't know.
- Out of 68 responses, over half of respondents 51% (35) said that they found it beneficial to receive their therapy at home and 18% (12) said yes to some extent. Over 10% (7) said no, they did not and 12% (8) said they didn't know and of the 9% (6) who stated other gave reasons such as did not need therapy at home and having therapy at a centre.

Did you find it beneficial to receive your therapy at home?



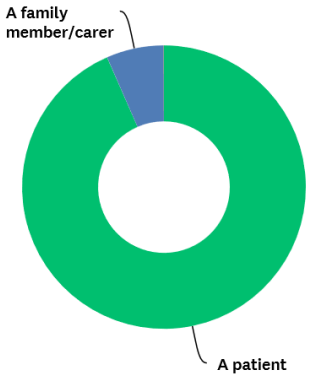
When asked if there was anything we could improve on, 41 people responded with a range of suggestions such as:

- Improved communication with patient and family members especially if there are other health conditions
- Training and supervision of staff
- Patients felt they were well looked after
- Getting more rehabilitation
- Quicker therapy
- More information required from staff

Demographics

Detailed below are the demographics of the 71 people who completed the survey.

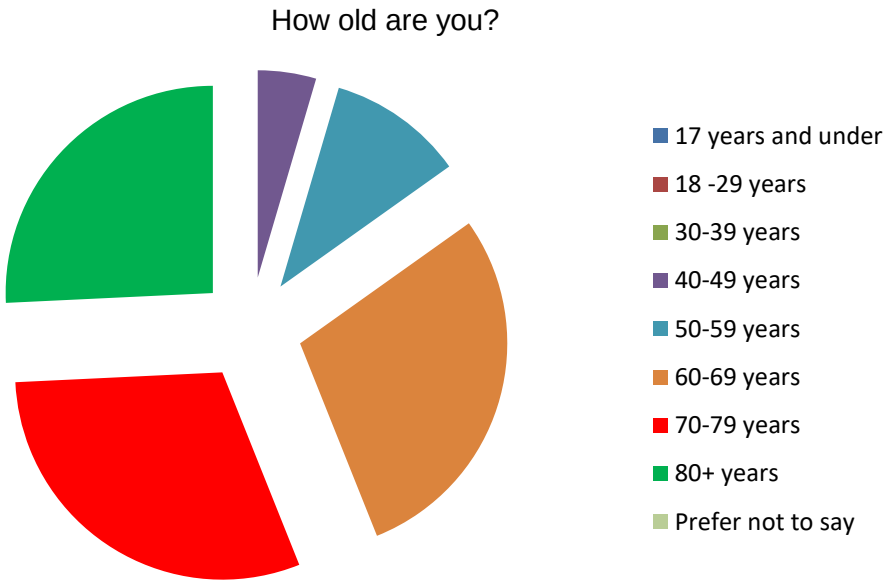
- Most people who completed the survey were the patient 94% (73) and 6% (5) were a family member/carer (Q1).



- Out of the 71 who responded to the question about their gender, over half (56%) of respondents were males with (44%) being female.

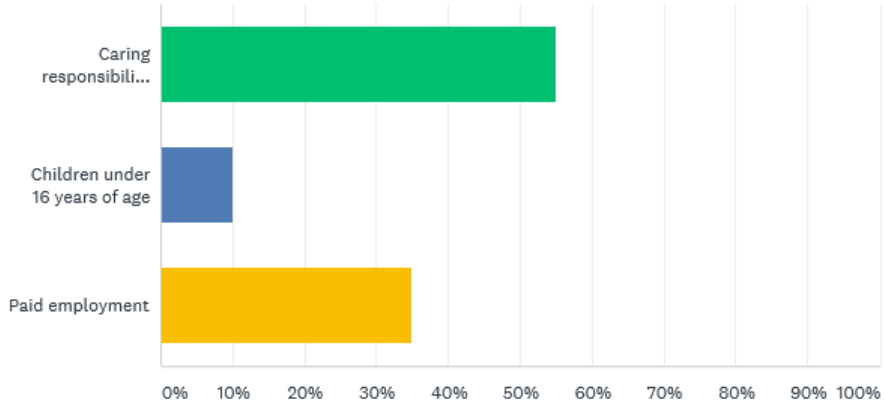
Age range of patients

- The majority of respondents, 30% (21) were between 70-79 years of age, closely followed by 28% (20) who were between 60-69 years of age. Just over 27% (19) were 80-89 years of age, with 15% (11) being between 40 – 59 years of age



Caring responsibilities

Twenty people responded to the question about caring responsibilities. Over 50% (55) said they had caring responsibilities for a family member, friend or neighbour, 10% said they had children under 16 years of age and 35% had paid employment.



Disability, long term illness or health condition

Over sixty five people (67) answered the question around whether they had a physical or mental impairment, which has lasted or will last at least 12 months and affects your ability to carry out normal day-to-day activities. Over fifty (57%) said that they did whereas over 43% said that they did not.

The people who said they did have a disability, long term illness or health condition told us that they had problems with their memory, eye sight, Chronic, Obstructive, Pulmonary Disorder (COPD), problems with their mobility, back problems, unsteadiness, shaking and loss of confidence, mental health problems, suffered a stroke and arthritis.

Most respondents, 89%, said they were White British, 94% said they were heterosexual and 86% said they were Christian and 9% said they had no religion.

Postcodes

The table below highlights, by postcode, where the 60 respondents who answered this question live.

CCG	Postcodes	Count	Percentage %
North Durham CCG	DH1, DH1 5,DH2, DH3, DH7 9, DH7 6, DH7 7, DH7 8, DH8 6, DH8 7, DH9 7	23	38%
DDES CCG	SR8, TS21, DH6, DL12, DL12, DL13, DL14, DL15,DL16, DL17, DL4 2, DL5 7	25	42%
Darlington CCG	DL1 4, DL2 1, DL3 6, DL3 8, DL3 9, DL11	12	20%

Thank you

On behalf of Durham Dales, Easington and Sedgefield and North Durham and Darlington Clinical Commissioning Groups, we would like to thank all of those who have contributed to this engagement including:

- The stroke patients, their families and carers who took the time to share their experiences with us or completed the survey

- The Stroke Association

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

STROKE Consultation and Communications Plan

Tina Balbach, Engagement Lead, County Durham CCGs

Rachel Rooney, Commissioning Manager, County Durham CCGs

Project Title:	Stroke Rehabilitation Services - consultation
Authors:	Tina Balbach – Engagement Lead
Owner:	Rachel Rooney
Date:	7 August 2019

Version	Date	Author	Changes Made	Status
1	23.07.19	Tina Balbach	Initial draft - incomplete	DRAFT
2	01.08.2019	Tina Balbach		DRAFT
3	07.08.2019	Tina Balbach	Amends to formatting of report, adding and removing informaiton	DRAFT
4				
5				
6				
7				

Contents

Introduction

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

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

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

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

Background

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

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

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

Policy and legislation

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

- Section 242, of the Health Act 2006
    - *Places a duty on the NHS to make arrangements to involve patients and the public in planning services, developing and considering proposals for changes in the way services are provided and decisions to be made that affect how those services operate.*
- Section 244, of the Health Act 2006
    - *Requires NHS bodies to consult relevant OSCs on any proposals for substantial variations or substantial developments of health services. This duty is additional to the duty of involvement under section 242 (which applies to patients and the public rather than to OSCs).*
- Section 14Z2 of The Health and Social Care Act 2012,

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

Other specific considerations have related to:

The ‘four tests’:

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

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

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

I. Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
II. Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
III. Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).

The Gunning Principles

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

The Equality Act 2010

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

The NHS Constitution

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

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

Aims and objectives

Generic CCG Consultation and Communication Objectives

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

- To communicate the recommended service model for each CCG area clearly and effectively with all identified stakeholders
- To consult the local population on the development of further services to be delivered as part of the provision outlined
- To ensure that all voices are heard and that views are used to inform future service delivery
- To ensure messages from the local community are heard and used to inform decision making. Feedback will be given in a timely manner based on the 'you said, we did' methodology.
- To ensure that all key stakeholders are aware of the consultation, surveys and events and have the opportunity to get involved should they wish to do so.

Stroke Consultation and Communication Objectives

For this stroke rehabilitation services consultation, the objectives are as follows;

- To consult with patients and carers/families who have used stroke services to gain an understanding of their experiences and their views on a different approach to their care
- To outline a range of options for the provision of stroke rehabilitation within a hospital setting as well as the community
- To outline a preferred option for a new model of care which assesses impact on the system and individual patient care
- Communicate clearly, effectively and honestly with local communities in order to build trust and confidence in the NHS and health professionals;
- Engaging effectively with every segment of the population, especially those seldom heard and from protected characteristic groups, in order to ensure that local people are given the opportunity to consider and comment on the options for the proposals around a new model of stroke rehabilitation in County Durham and Darlington areas;
- Using the comments and feedback from the local communities to inform consideration by the CCG as to how it should provide the Stroke Rehabilitation Services to best meet the needs of the local population
- Ensuring that the CCG is complying with all its legal obligations in relation to public consultations and engagement
- Arrange our meetings so they cover the local geographical areas

- Arrange meetings in accessible venues and offer interpreters, translators and hearing loops if required
- Inform partners of out consultation activity and share plans

Scope of the Consultation

The purpose of this plan is to describe our process for formal consultation and how we will reach stakeholders including patients, their carers, families and members of the public across County Durham and Darlington. This process will ensure that our methods and approaches are inclusive and tailored to the people we want to reach so that they can have their say. These include:

- Public, patients, carers and their representatives
- Key stakeholders including partner organisations
- Voluntary and community sector organisations
- Staff of affected partner organisations
- Local Councillors and MPs
- County Durham Health Overview and Scrutiny Committee
- Darlington Health Overview and Scrutiny Committee
- Healthwatch County Durham and Healthwatch Darlington
- Particular interest groups, including seldom heard groups

The plan sets out the activity which will take place and the timelines involved, including the resources required to deliver the plan. The intention of the plan is to help people understand what to expect from the formal consultation, how they can be involved and how long the process will take.

The purpose of the consultation, communications and engagement activity is to:

- Raise awareness of and provide information on the changes being proposed
- Involve stakeholders in discussions about the proposed changes and closures and to draw out any issues and concerns
- Work with stakeholders to consider potential solutions to any issues raised
- Gather feedback which will inform the decision about the future model of this service
- Ensure we meet our statutory duties as set out later in this document.

Pre-engagement

As part of the review a patient engagement exercise took place with patients that have recently had a stroke.

A period of engagement was carried out in autumn 2018 and then again in May, June and July 2019.

An extensive period of pre-engagement was carried out with patient, carer and public engagement to help the CCGs to understand the experience of people using Stroke Rehabilitation Services.

Views and feedback were gathered via and online and paper survey and also from focus groups where people, who have suffered a stroke, were invited to attend to tell us about their care.

This engagement gave us rich feedback around what patients thought of their stay in hospital and the treatment they received, the discharge process, rehabilitation and on-going care.

More recently we have worked with the Stroke Association who supported the CCGs with engagement. The Stroke Association carries out a six month review with patients, and assesses their progress six months after their stroke.

The CCGs engagement team wrote a survey and covering letter in conjunction with the Stroke Association. The Stroke Association then sent a letter and accompanying survey to patients who had signed up to a six month review and live in County Durham and Darlington. The feedback received gave a clear view from patients/carers and family of their recent experiences.

A copy of the full report can be found on the CCGs websites.

Stakeholder Mapping

A stakeholder is anyone who is effected by or can affect, the project. The CCG needs the right information to inform decisions for its community. It continually strives to maintain and strengthen its strong working relationships with its stakeholders.

The key stakeholders that need to be considered by this process include:

Patients and the public	Healthcare professionals / providers	Partner organisations and Voluntary and Community Groups	Political / Governance
Patients who access these services	CDDFT staff teams at Bishop Auckland Hospital	Local Authority directors of Social Care / Adults services	Local MPs
Family members and carers	CDDFT staff teams at other hospital sites	County Durham Healthwatch, Darlington Healthwatch	Health Overview and Scrutiny Committees
Patient Reference Groups (PRGs)	Community staff and teams	Voluntary and Community sector providers	Local Councillors and elected members
MY NHS members with an interest in stroke	Physiotherapists / Orthopeadic staff	Area Action Partnerships	Health and well-being boards
People who have responded or taken part in stroke rehabilitation engagement	Ambulance Service / Patent Transport	Durham County Carers Support	CCG Governing Body
	GPs and Primary Care	Housing organisations	NHS England
	Primary Care Networks	Health networks	
	CCG Staff	Neighbouring CCGs	
	NHS Improvement		
	Staff Unions		
	Local Medical Committee		

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

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

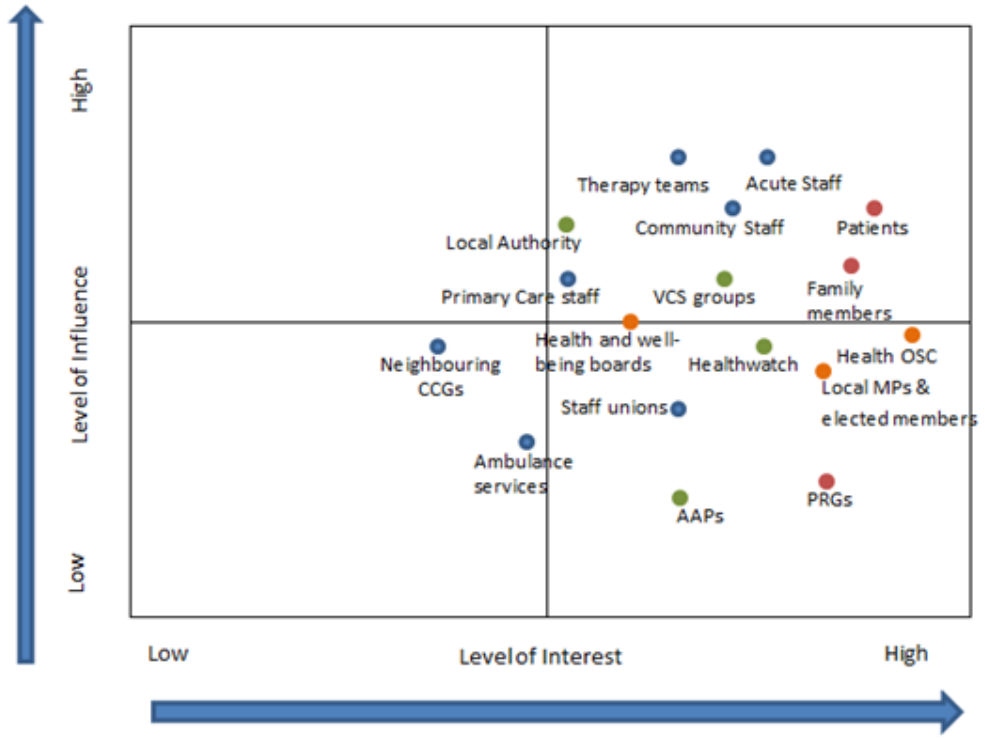
This enables the CCG to formulate a bespoke communications plan based on influence and impact, increasing the chances of the communications and engagement plan being successful.

The communications engagement process will also 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 County Durham and Darlington areas due to high levels of deprivation and health inequalities, as well as the diverse make-up of the local population. The engagement team will work to establish links with these groups.

Healtwatch and Patient Reference Groups (PRGs) will be key partners in supporting the CCG with the communications and consultation work to ensure that we simplify messages and don't use jargon and to act as critical friends throughout the process.

Stakeholder Mapping

This map shows the levels of interest of identified stakeholders have alongside the scope to influence as part of this process.


High
Level of Influence
Low
Therapy teams
Acute Staff
Community Staff
Patients
Local Authority
Primary Care staff
VCS groups
Family members
Health and well-being boards
Neighbouring CCGs
Healthwatch
Health OSC
Local MPs & elected members
Staff unions
Ambulance services
PRGs
AAPs
Low
Level of Interest
High

What we already have in place

The CCG already engages and communicates extensively with a range of key stakeholders and regularly through Patient Reference Groups (PRGs), Health Networks, Area Action Partnerships (AAPs), community council and various community groups.

The Health and Wellbeing Boards and Adults Overview and Scrutiny Committees are also regularly kept up to date. This is important as it engages on its commissioning priorities and the CCGs strong beliefs and commitment to put local communities at the heart of everything they do.

There are dedicated pages on the CCGs websites which contain a range of information including evidence of pre-engagement. Social media will continue to be a pro-active communications tool to promote the consultation but more traditional methods will also be utilised

More detailed information and the findings of the engagement carried out around Stroke Rehabilitation can be found in on the DDES, North Durham and Darlington CCG websites.

The engagement activities helped to inform the development Stroke Rehabilitation ‘options’. These options are ideas on how services could be further developed or delivered differently to best meet the needs of local people.

Importantly, throughout the pre-engagement, an on-going dialogue was maintained with the local health Overview and Scrutiny Committees (OSC) for both County Durham and Darlington.

In particular, the rationale for the proposed changes to Stroke Rehabilitation Services were presented at a meeting in November 2018.

Methodology

These intended methodologies will be used to enable the CCGs to deliver effective and meaningful consultation with the identified stakeholders. This will be a working document and may alter slightly depending on feedback and suggestions.

A consultation document will be written which will be available for people to access online and as a paper version. This will give people full information and informa them to able them to complete a survey which will be available on line and as a paper version.

We will hold a small number of public events to give the public the opportunity to hear from staff at the CCGs and CDDFT about the proposals and the background information. This will also be an opportunity for attendees to share their experiences and thoughts to help to inform their own decisions.

The CCG Engagement Teams will attend already established meetings with local groups and community organisations with the intention of speaking to as many people as possible to gather views from patients themselves and families / carers.

Consultation Communications and Engagement Action Plan

Pre-engagement activity

Activity	Detail	Additional information
Pre-engagement	Stage 1 pre-engagement activity 2018 Stage 2 pre-engagement activity 2019	
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	
Communications Key Messages	Development of key messages, FAQs	
Developing and supporting dialogue – programme of events and activities	Identify suitable, accessible venues for public events. Four formal public events across North Durham, Durham Dales, Easington and Sedgefield and Darlington Visit venues to check suitability (disability access, parking, bus route, acoustics, large numbers) 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	
Consultation briefing document	Develop Communication and consultation document Consider different languages and formats that may be required, including large print, braille, audio, easy/read etc. Work with expert partners to ensure documents meet best practices requirements and communication needs Determine number of each type of document *Have documents produced by agreed supplier within agreed timescales*	
Stakeholder briefings	Briefing prepared stakeholders about the consultation and what we want to do, the events and any other information	NECS comms to support
Consultation Dialogue	Plan content and format of required communications and engagement activity Develop, make arrangements for and publicise consultation activity, including: Press / media 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 Additional meetings - People's Parliament/ Investing in Children/Gypsy Roma	

	Travellers Practitioners Forum/LGBT group/Macmillan Information stall and presence at local public events Online and hardcopy consultation document and survey Information and surveys in public places	
Development of survey questions	Confirmation of the agreed questions and key feedback that is required	
Development of animation / video for consultation messages	Summary of key information and issues to help inform people with feedback. Work with PRG / Healthwatch members to help review content and language to ensure that key messages and issues being proposed are clear and in plain English	
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 and schedule for social media	
Confirm freepost address responses and identified information collection points	Work with partners to help ensure a variety of methods and locations are available for stakeholders to share feedback	
Public Relations and Advertising	Press release prepared for circulation at launch of consultation	
Distribution of Consultation Materials	Develop distribution plan for flyers and posters to public places	

Recording	Develop and maintain consultation action log	
Analysis and Reporting	Ensure independent supplier identified and procured in good time to conduct analysis and reporting when the consultation closes	
Quality and risk assurance	Provide quality and risk assurance of the engagement process	

Consultation activity

Activity	Detail	Additional information
Public events	Deliver the public events, likely to include presentation to set out scenario and proposals, table discussions for participants to share comments and gather group feedback. Open opportunities for questions	
Presentations	Attend AAPs, Parish councils or other local groups requesting presentations on issues and consultation options	
Targetted outreach sessions	Meetings with specific and identified audiences from stakeholder list Visit open public events and space; farmers markets, community evets etc.	

PR Activity	Updates on events and activities on the websites and social media. Continued promotions of ways to respond and contribute.	

Post consultation activity

Activity	Detail	Additional information
Data input and collection	Ensure all feedback from surveys and events is gathered and appropriately complied and recorded for analysis	
Analysis of feedback for key themes and preferred options	Key themes and preferred options identified.	
Consultation summary briefing	In conjunction with the NECS Communications Team and provide to stakeholders	
Update website pages	Ensuring information is continuously updated and reflects what is happening at that current time and to mark that the consultation is closed	
Draft full consultation report	Written in conjunction with Communications Department	
Consultation report published	Document shared with all stakeholders including OSC, Governing Body and ensure the document is available through CCG websites	

Standard formats of information

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

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

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

Documentation and resources

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

- Consultation briefing documents and questionnaires
- Posters
- Video?
- Website
- Surveys – online and paper
- Flyers
- Leaflets (including leaflet drop)
- Stand-up banners
- Venues for public events

Key messages for consultation

Key messages to be used:

- There is an opportunity to improve both the quality and efficiency of the care we commission and provide for stroke rehabilitation in County Durham and Darlington. If we are to have safe, sustainable stroke services that are set up to facilitate greater advances in care and outcomes we need to address three key factors:
  - Changing patterns of need;
  - Improving clinical standards of care;
  - Making the best use of an expert workforce;

- Currently stroke rehabilitation care is not compliant with the national model which recommends inpatient rehabilitation should provide a multi-disciplinary approach to care with dedicated and adequate therapy input with supported discharge into the community.

- People should be further assessed in their home through early supported discharge with as few handoffs of care as possible

- The transition between inpatient and community care should be seamless

- Community based services should provide the right level of therapy input to improve individual patient outcomes.

- Evidence to show that people especially older and frailer people benefit from timely discharge from hospital – to promote independence and the right environment for effective rehabilitation

- We want to secure the right services in the right place at the right time and delivered by a skilled, multi-disciplinary workforce

- We want to manage resources effectively - through reducing lengthy stays in secondary care providing a more efficient use of resources and promoting care closer to home where possible

- Deliver a standard, equitable and appropriate stroke rehabilitation pathway.

- Make services more accessible and responsive to the needs of our communities

Questions for consultation

As a structure for the engagement that will take place, the following questions will be included as part of all of the conversations undertaken during the consultation process. To enable appropriate analysis of the feedback from the information

provided, these are a mixture of closed and open-ended questions. This format enables analysis to include direct measurement of responses as well as more qualitative feedback.

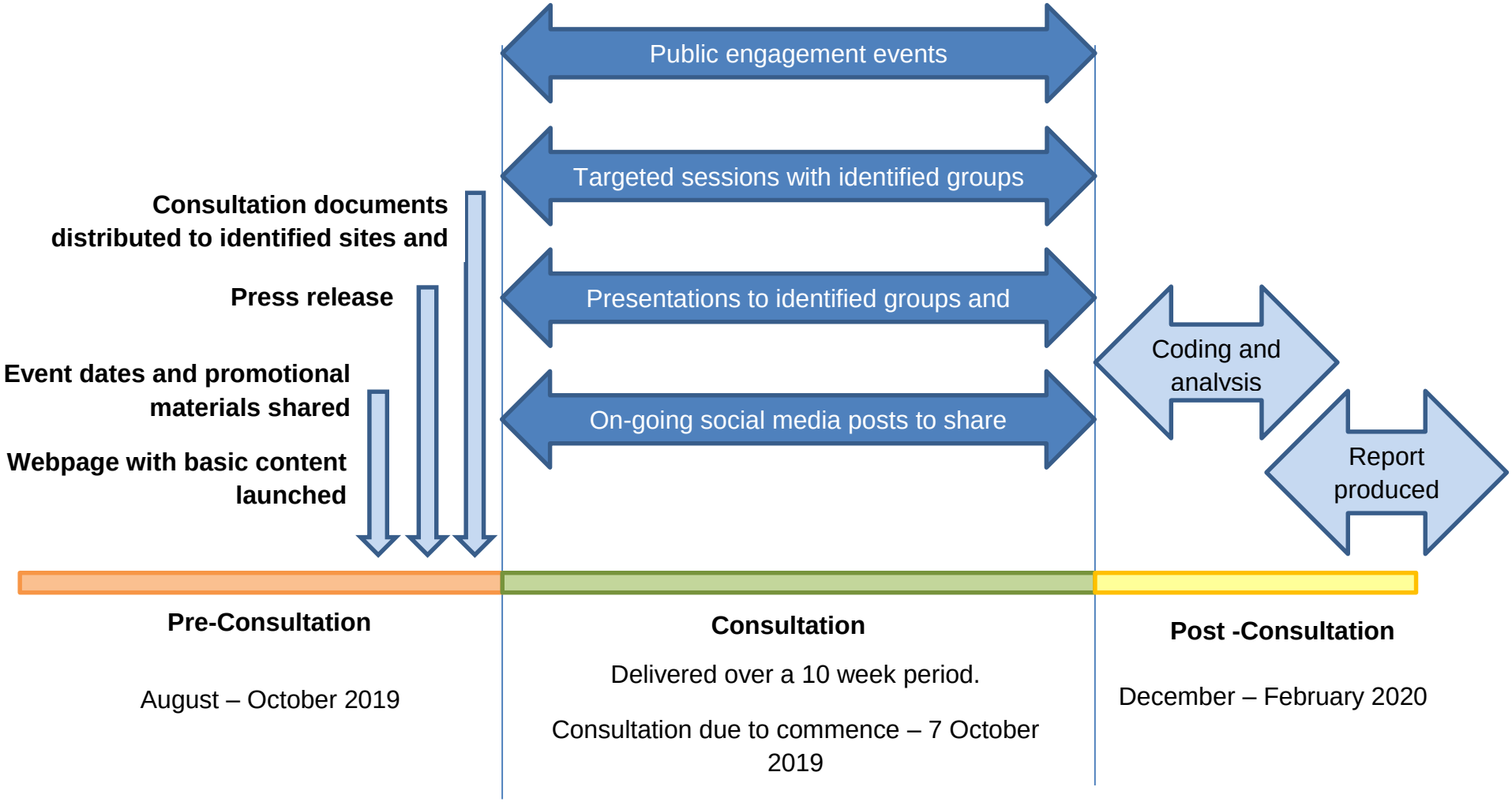
The proposed questions are as follows:

1. Have you been a stroke patient within County Durham and Darlington?
2. Have you had a family member utilising stroke services within County Durham and Darlington?
3. Do you understand the proposals outlined?
4. Based on the information available what is your preferred option?
5. What do you think are the benefits of the preferred option?
6. Are there any barriers associated with the preferred option?
7. Is there anything that we haven't considered?
8. First four digits from postcode

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

Timeline

Included below is an overview of some of the key activities and at what points in the process these will be completed. The timing of the consultation will be dependent on receiving assurance from NHS England and NHS Improvement.



Reporting and Feedback

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

Following a period of consideration, the CCG will then make a decision on any changes to stroke rehabilitation services. This decision will be published and communicated to stakeholders, along with the rationale for making that decision and the reasons that other options were not taken forward.

This will be assured and signed off by NHS England.

Equality Impact Assessment

STEP 3 - FULL EQUALITY IMPACT ASSESSMENT
The Equality Act 2010 covers nine 'protected characteristics' on the grounds upon which discrimination and barriers to access is unlawful. **Outline what impact (or potential impact) the project/service review outcomes will have on the following protected groups:**
Age A person belonging to a particular age
The service benefits the local population of County Durham and Darlington CCGs. There are no foreseen negative consequences for people accessing the services due to age. All attendances may include particular protected groups but these would be reviewed in line with the CCGs Equality and Diversity Strategy.
Disability A person who has a physical or mental impairment, which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities
The service benefits the local population of County Durham and Darlington CCGs. There are no foreseen negative consequences for people accessing the services due to age. All attendances may include particular protected groups but these would be reviewed in line with the CCGs Equality and Diversity Strategy.
Gender reassignment (including transgender) Medical term for what transgender people often call gender-confirmation surgery; surgery to bring the primary and secondary sex characteristics of a transgender person's body into alignment with his or her internal self perception.
The service benefits the local population of County Durham and Darlington CCGs. There are no foreseen negative consequences for people accessing the services due to gender reassignment. All attendances may include particular protected groups but these would be reviewed in line with the CCGs Equality and Diversity Strategy.
Marriage and civil partnership Marriage is defined as a union of a man and a woman (or, in some jurisdictions, two people of the same sex) as partners in a relationship. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must be treated the same as married couples on a wide range of legal matters
The service benefits the local population of County Durham and Darlington CCGs. There are no foreseen negative consequences for people accessing the services due to marriage or civil partnership. All attendances may include particular protected groups but these would be reviewed in line with the CCGs Equality and Diversity Strategy.
Pregnancy and maternity Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context.
The service benefits the local population of County Durham and Darlington CCGs. There are no foreseen negative consequences for people accessing the services due to pregnancy or maternity. All attendances may include particular protected groups but these would be reviewed in line with the CCGs Equality and Diversity Strategy.

Race It refers to a group of people defined by their race, colour, and nationality, ethnic or national origins, including travelling communities.
The service benefits the local population of County Durham and Darlington CCGs. There are no foreseen negative consequences for people accessing the services due to race. All attendances may include particular protected groups but these would be reviewed in line with the CCGs Equality and Diversity Strategy.
Religion or belief Religion is defined as a particular system of faith and worship but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.
The service benefits the local population of County Durham and Darlington CCGs. There are no foreseen negative consequences for people accessing the services due to relgion or belief All attendances may include particular protected groups but these would be reviewed in line with the CCGs Equality and Diversity Strategy.
Sex/Gender A man or a woman.
The service benefits the local population of County Durham and Darlington CCGs. There are no foreseen negative consequences for people accessing the services due to sex/gender. All attendances may include particular protected groups but these would be reviewed in line with the CCGs Equality and Diversity Strategy.
Sexual orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes
The service benefits the local population of County Durham and Darlington CCGs. There are no foreseen negative consequences for people accessing the services due to sexual orientation. All attendances may include particular protected groups but these would be reviewed in line with the CCGs Equality and Diversity Strategy.
Carers A family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person
The service benefits the local population of County Durham and Darlington CCGs. There are no foreseen negative consequences for people accessing the services who are carers. All attendances may include particular protected groups but these would be reviewed in line with the CCGs Equality and Diversity Strategy.
Other identified groups relating to Health Inequalities such as deprived socio-economic groups, substance/alcohol abuse and sex workers
The service benefits the local population of County Durham and Darlington CCGs. There are no foreseen negative consequences for this group of people accessing the service. All attendances may include particular protected groups but these would be reviewed in line with the CCGs Equality and Diversity Strategy.

NHS

County Durham and the Tees Valley
Clinical Commissioning Groups

Review of Inpatient Rehabilitation in County Durham and Darlington

A review of ward 6 at Bishop Auckland Hospital

Health and Partnerships Scrutiny Committee

29 August 2019

Darlington Clinical Commissioning Group
Durham Dales, Easington and Sedgefield Clinical Commissioning Group
Hartlepool and Stockton-on-Tees Clinical Commissioning Group
North Durham Clinical Commissioning Group
South Tees Clinical Commissioning Group

Background

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

Vision

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

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

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

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

To ensure timely and supportive discharge is achieved consistently

Scope of Review

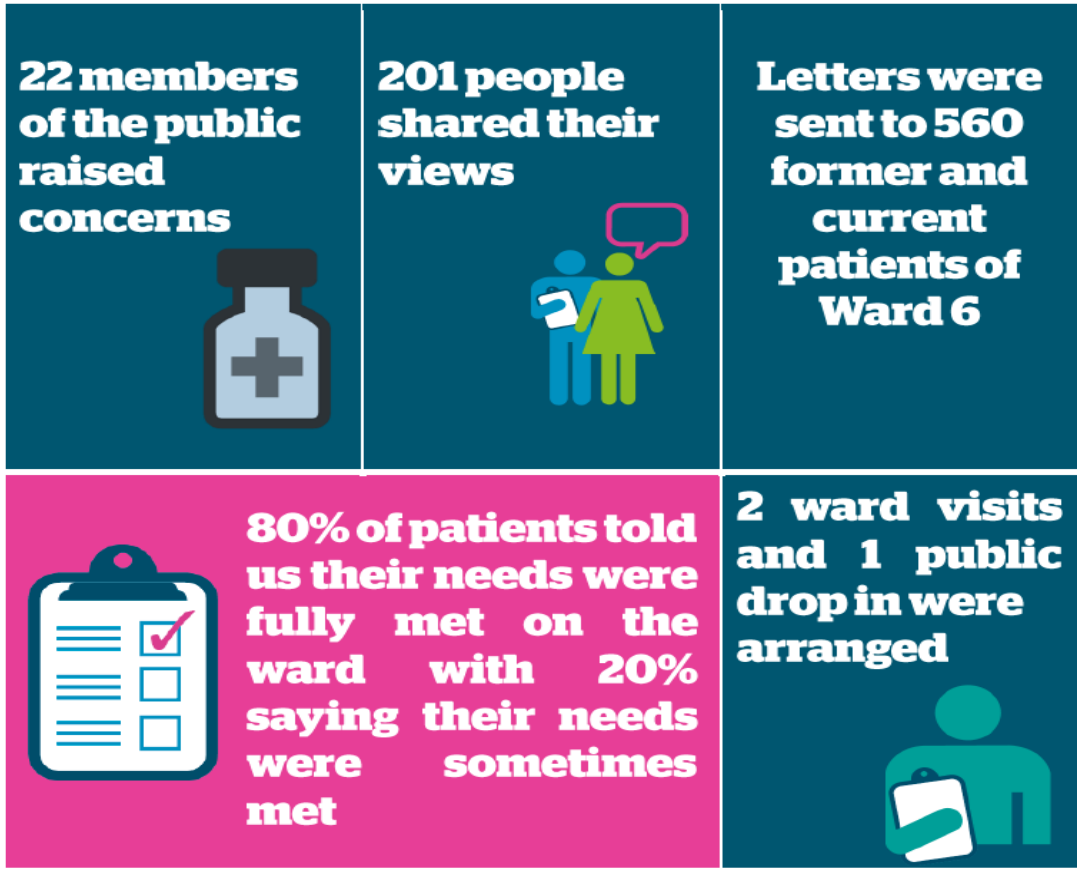
- The scope of this project relates to ward 6 at Bishop Auckland Hospital (BAH) which is a 24 bedded, nurse-led unit which currently delivers step down care.
- Although the project is specifically reviewing this ward at BAH, the wider context of delivering care closer to home has been taken into account

Current Service

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

Patient and Carer Feedback

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

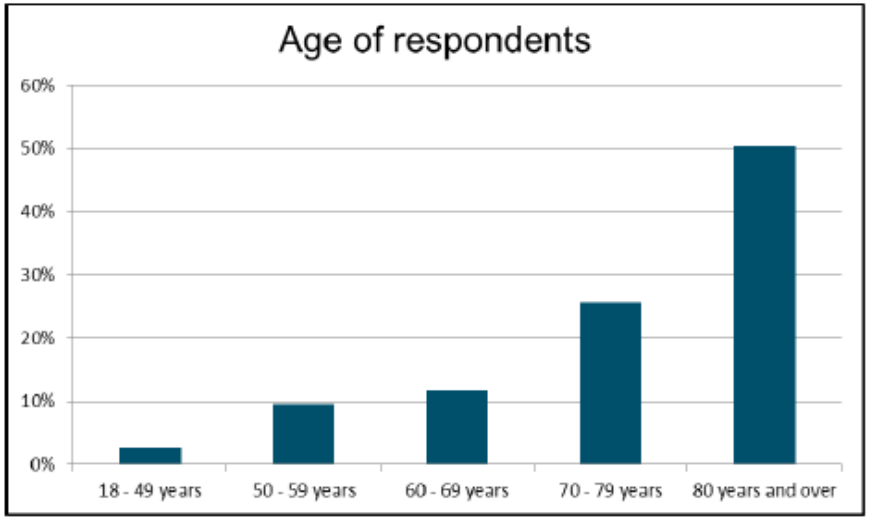


Patient and Carer Themes

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

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

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



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

Case for Change

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

Options Appraisal

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

Preferred Option

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

What this means for patients in Darlington

- Discharge planning will be start at the beginning of the patients inpatient pathway
- Robust inpatient rehabilitation will be provided from BAH
- Further inpatient rehabilitation will be available across community hospitals
- Enhnaced utilisation of intermediate care
- Community based services which are responsive to need

Next Steps

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

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

Review of Inpatient Rehabilitation in County Durham and Darlington

A review of ward 6 within Bishop Auckland Hospital

Pre-Consultation Business Case

Contents

1.0 Executive Summary

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

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

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

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

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

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

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

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

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

2.0 Vision

Our vision and commitment is:

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

2.1 Scope

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

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

2.2 Aims and Objectives

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

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

3.0 Background and Introduction

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.1 Demographics and Prevalence

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

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

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

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

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

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

3.2 National Context and Evidence Base

The World Health Organisation[3] states that rehabilitation intervention should be aimed at achieving the following broad objectives:

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

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

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

The 10 principles of good rehabilitation services:

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

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

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

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

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

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

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

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

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

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

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

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

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

4.0 Local Context

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

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

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

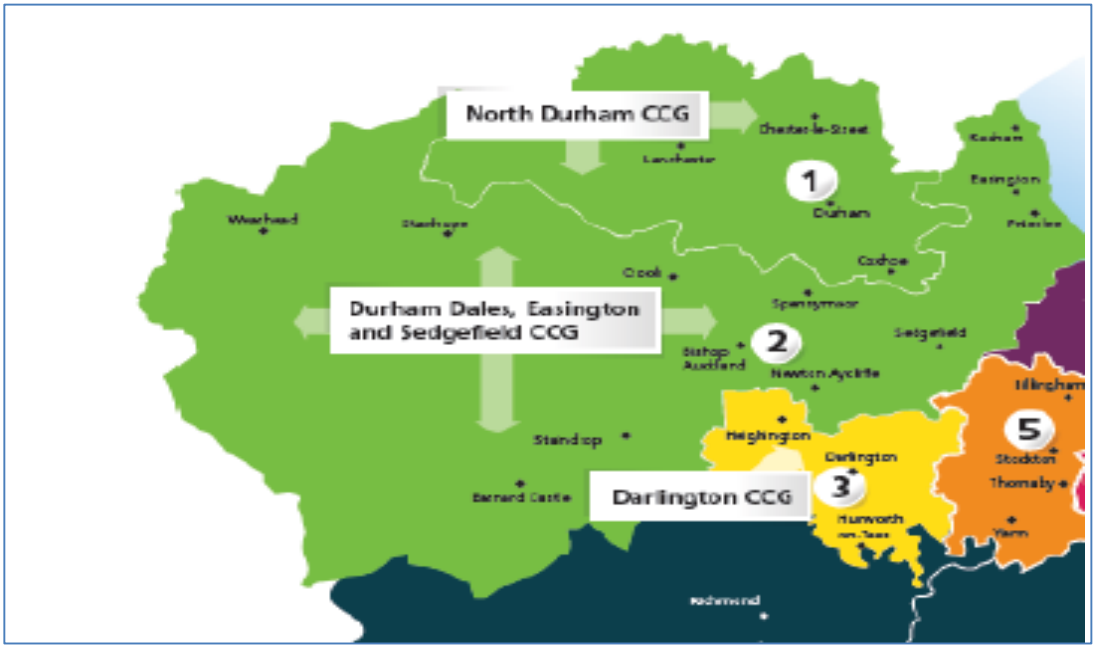


Figure 1 – geography of three CCGs within County Durham and Darlington

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

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

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

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

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

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

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

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

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

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

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

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

Figure 2 – PJ Paralysis campaign

4.1 Quality and Performance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Figure 6 change in admissions year on year by locality

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

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

Figure 7 current admissions into community hospitals by locality

5.0 Patient Experience and Feedback

CCGs and provider organisations have a duty to engage and consult on any potential major service change as described within the NHS Act 2006.[8]

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

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

[8] NHS Act 2006
www.legislation.gov.uk

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

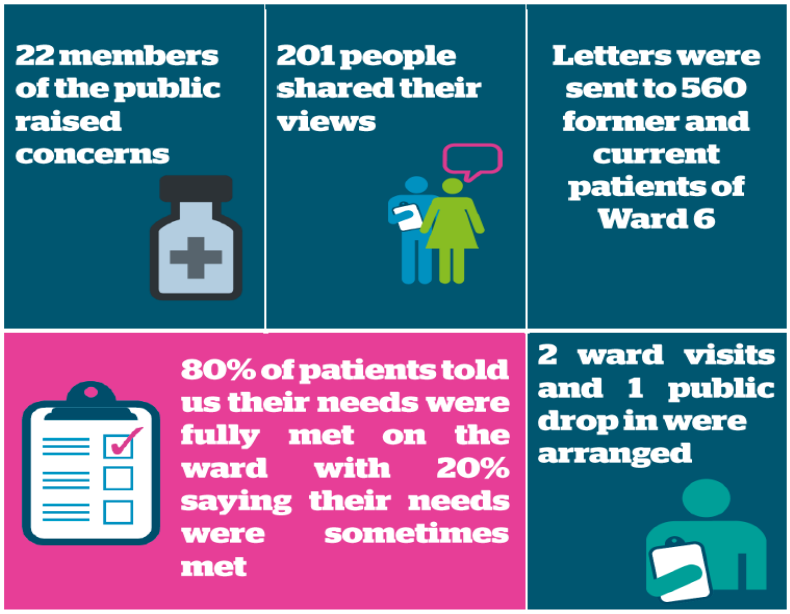


Figure 8 Overview of patient and carer engagement activity

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

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

The key recommendations from the report included:

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

6.0 Staff Engagement

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

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

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

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

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

7.0 Current State

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

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

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

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

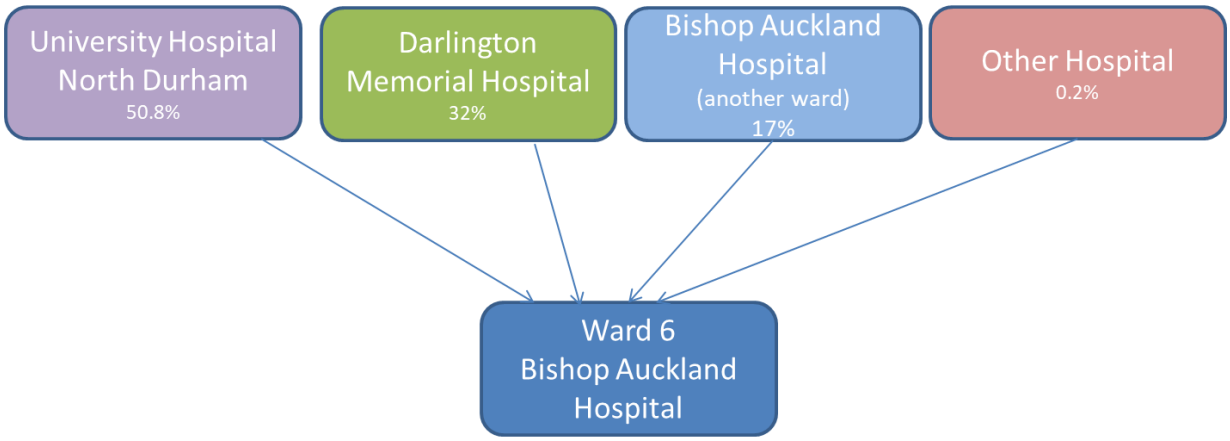


Figure 9

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

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

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

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

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

Figure 10

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

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

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

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

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

Figure 11

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

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

Figure 12

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

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

Eligibility:

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

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

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

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

Figure 13

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

[1] March Admission figures for Eastbourne were not provided and are not included.
[2] Excludes March 2019 as Eastbourne LOS information was not provided.

8.0 Case for Change

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

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

Ward 6 currently accepts patients who are;

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

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

- An increase of Non weight bearing patients being supported at home with temporary home modifications and the utilisation of therapy support The patient's rehabilitation is expedited in their own home. If the patient does require inpatient care then they are supported at a facility close to their home.
- Implementing the SAFER[9] bundle, has enabled earlier discharge planning which has reduced the number of medically fit and stable patients being transferred to Ward 6. Now they are supported by the local authorities and partner agencies to return to their home by implementing enhanced care packages, where required.
- Using the Discharge to Assess methodology and "home first" philosophy more in-patients waiting for a Decision Support Tool (DST) are supported with involvement of Trusted Assessors to return home while these discussions take place.
- The use of The Homelessness Reduction Act, 2017- Duty to Refer Guidance 2018 is helping to ensure that services are working together effectively to prevent homelessness by ensuring that peoples' housing needs are considered when they come into contact with public authorities.[10]
- A Non-Weight Bearing four month pilot was commissioned from February 2019 – June 2019 by County Durham Local Authority, 10 beds were commissioned from two residential care homes on a "Time to Heal" basis to avoid potential lengthy hospital stays. The pilot proved to be a useful exercise with valuable learning. Although activity was lower than expected. It was thought this was due to CDDFT becoming more adept to move non-weight bearing patients into community settings with appropriate support from partner agencies. There is a plan to explore whether this model could be rolled out further.

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

Appropriate rehabilitation services:

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

[9] Emergency Care Improvement Programme
The SAFER Patient Flow Bundle
NHS Improvement
https://improvement.nhs.uk/documents/633/the-safer-patient-flow-bundle.pdf
[10] Homelessness: duty to refer
www.gov.uk
[11] Functional Impact of 10 Days of Bed Rest in Healthy Older Adults
The Gerontological Society of America 2008
www.bgs.org.uk/blog/

8.1 Workforce challenges

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

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

8.2 Financial challenges

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

9.0 Options Criteria and Process

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

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

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

Figure 14 options appraisal criteria

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

9.1 Options Appraisal

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

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

Figure 15 Options for future service delivery

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

Option one – do nothing

Criteria	Score (out of 10)	Narrative
Clinical quality	5	• Ward is currently utilised by those deemed medically fit • There are more appropriate uses for the inpatient provision • The quality of nursing care provided is extremely good
Sustainability/flexibility	5	• The ward currently manages people who could be managed in the community • There is a need to flex the beds to ensure they meet the needs of the local population • The ward does provide additional capacity at times of high demand
Equity of access	5	• People from across County Durham and Darlington as well as out of area utilise the ward • BAH is closer for those who live in the South of County Durham and Darlington

Criteria	Score (out of 10)	Narrative
Efficiency	4	• The inpatient facility is not efficient in terms of managing patients to a point of discharge due to the model of care available, mainly due to lack of therapies • Increased length of stay, which could be improved by more effective discharge processes and community provision
Workforce	6	• Seen as stand-alone unit in terms of pathways and interfaces
Functional suitability	7	• BAH provides a suitable environment to deliver care • Unable to access therapy input in current location due to limited resource
Acceptability	8	• The level of care experienced by patients and their families is good overall • People in the south of the county and in Darlington benefit from the location
Cost effectiveness	3	• Current model is not cost effective • Resource could be better utilised to provide rehabilitation offer
Total	**43**	

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

Criteria	Score (out of 10)	Narrative
Clinical quality	7	• Criteria for these beds would need to be developed • Rehab service with therapy input to promote rehabilitation • The quality of nursing care provided would be retained
Sustainability/flexibility	7	• The ward could provide additional capacity at times of high demand • Model with fit with new ways of working re: bed optimisation and community services
Equity of access	9	• Support in the community • LoS will be reduced so access issues will be limited • Use of all inpatient rehabilitation beds can be utilised to deliver care closer to home
Efficiency	8	• Opportunity to use optimum number of beds to ensure rehab input is provided for those who need it • Co-location of ward 17 to make best use of therapy provision
Workforce	8	• Using economies of scale of existing therapy provision to deliver • Therapy input required at this stage would be based upon ○ Physiotherapy – 5 days a week ○ Occupational Therapy – 5 days a week ○ SALT and dietetics according to need
Functional suitability	7	• There are appropriate number of beds and facilities available on ward 17
Acceptability	7	• Resources will be re-purposed to ensure a more sustainable model is in place • The level of care experienced by patients and their families is good overall • A slight reduction in beds may create concern, however the PCBC demonstrates better use of resource
Cost effectiveness	8	• Better use of resources to manage the demand • Changes to bed configuration will result in therapy input to inpatients
Total	**61**	

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

Criteria	Score (out of 10)	Narrative
Clinical quality	3	• Criteria for patients accessing this would need to be developed in line with service model • Ratio of nursing staff per patient will be reduced
Sustainability/flexibility	3	• Flexibility to use when system in high demand • Sustainability risk re workforce retainment
Equity of access	3	• The model could be offered to all in the CDD area • Travel implications for those out of the Bishop Auckland vicinity i.e. family
Efficiency	4	• Efficient in terms of staff costs • Low efficiency in relation to cost of facilities

Workforce	4	• Working on a care home based staffing model
		• Potential ratio of:
		  ○ 1 qualified nurse (band 5/6) per 24 beds
		  ○ 1 HCA per eight beds
		  ○ Local GPs would be aligned to ward (used as and when required)
		  ○ Potential to require band 7/8a Monday-Friday to manage
		  ○ Existing community infrastructure i.e. district nursing would be utilised
		• NHS staff would not want to work within this model
		• Risk of de-skilling

Functional suitability	4	• Retaining all 26 beds on ward 6 • Hospital facilities are used to deliver services which don't require that level of estate
Acceptability	4	• Retaining all 24 beds on ward 6 • Unacceptable use of NHS estate and workforce
Cost effectiveness	7	• The model would be more financially viable • The ongoing cost of NHS estate and equipment would be costly for the level of service provided
Total	**32**	

Option four - Close all ward 6 beds

Criteria	Score (out of 10)	Narrative
Clinical quality	3	• Criteria for patients accessing this would need to be developed in line with service model • Ratio of nursing staff per patient will be reduced
Sustainability/flexibility	3	• Flexibility to use when system in high demand • Sustainability risk re workforce retainment
Equity of access	3	• The model could be offered to all in the CDD area • Travel implications for those out of the Bishop Auckland vicinity i.e. family
Efficiency	4	• Efficient in terms of staff costs • Low efficiency in relation to cost of facilities
Workforce	4	• Working on a care home based staffing model • Potential ratio of: ○ 1 qualified nurse (band 5/6) per 24 beds ○ 1 HCA per eight beds ○ Local GPs would be aligned to ward (used as and when required) ○ Potential to require band 7/8a Monday-Friday to manage ○ Existing community infrastructure i.e. district nursing would be utilised • NHS staff would not want to work within this model • Risk of de-skilling
Functional suitability	4	• Retaining all 26 beds on ward 6 • Hospital facilities are used to deliver services which don't require that level of estate
Acceptability	4	• Retaining all 24 beds on ward 6 • Unacceptable use of NHS estate and workforce
Cost effectiveness	7	• The model would be more financially viable • The ongoing cost of NHS estate and equipment would be costly for the level of service provided
Total	**32**	

9.2 Preferred Option

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

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

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

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

- Demonstrate that sufficient alternative provision, such as increased GP or community services is being put in place alongside or ahead of bed closures and that new workforce will be there to deliver it.
- Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions.
- Where a hospital has been using beds less efficiently than the national average, it has a credible plan to improve performance without affecting patient care for example Getting it Right First Time Programme (GIRFT)

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

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

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

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

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

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

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

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

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

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

10.0 Benefits Realisation

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

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

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

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

Better use of resources

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

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

11.0 Risks

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

Figure 16

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

12.0 Testing out the Preferred Option

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

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

What this means for patients

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

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

Figure 17 – usage of ward 6 by locality

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

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

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

Figure 18 – usage of ward 6 by area

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

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

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

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

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

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

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

13.0 Proposed Future State

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

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

13.1 Service Model

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

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

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

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

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

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

13.2 Specific Measurable Outcomes

Focusing on outcomes is one way of enabling the transformational change required in the healthcare system. Outcomes need to be meaningful to people who use rehabilitation services and enable them to maximise their potential, manage their healthcare themselves and promote independence. The Government's Mandate to NHS England for 2016-17[14] has an expectation that improvements will be demonstrated against the NHS Outcomes Framework[15] so as to provide evidence of progress and enable comparison of services locally.

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

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

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

The following key areas will be covered:

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

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

13.3 Performance Management

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

The following key areas will be covered:

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

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

[14] The Government's Mandate to NHS England for 2016-17
www.gov.uk/government/publications/nhs-mandate-2016-to-2017
[15] NHS Outcomes Framework
Department of Health (2014) The NHS outcomes framework 2015/16
www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015

14.0 Project Plan

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

High Level Milestones:

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

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

Report Author:
Full Name: Rachel Rooney
Job Title: Commissioning Manager

Report Sponsor:
Full Name: Sarah Burns
Job Title: Director of Commissioning Strategy and Delivery for Durham Dales, Easington and Sedgefield and North Durham CCGs

Date of Report: 07/08/2019

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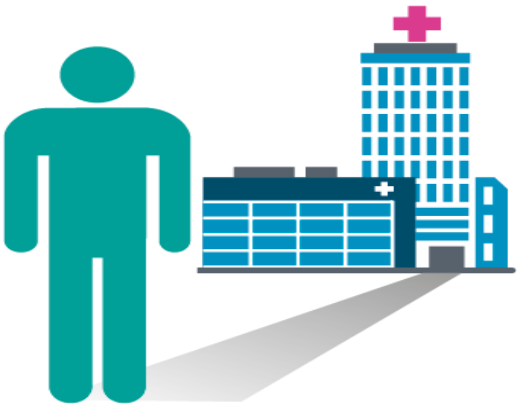
Bishop Auckland Hospital - Ward 6

Capturing the views of patients about the care they have received



Bishop Auckland Hospital
Ward 6 Report

Contents

Healthwatch County Durham

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

We listen

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

We advise

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

We speak up

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

Executive Summary

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

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

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

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

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

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

Observations

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

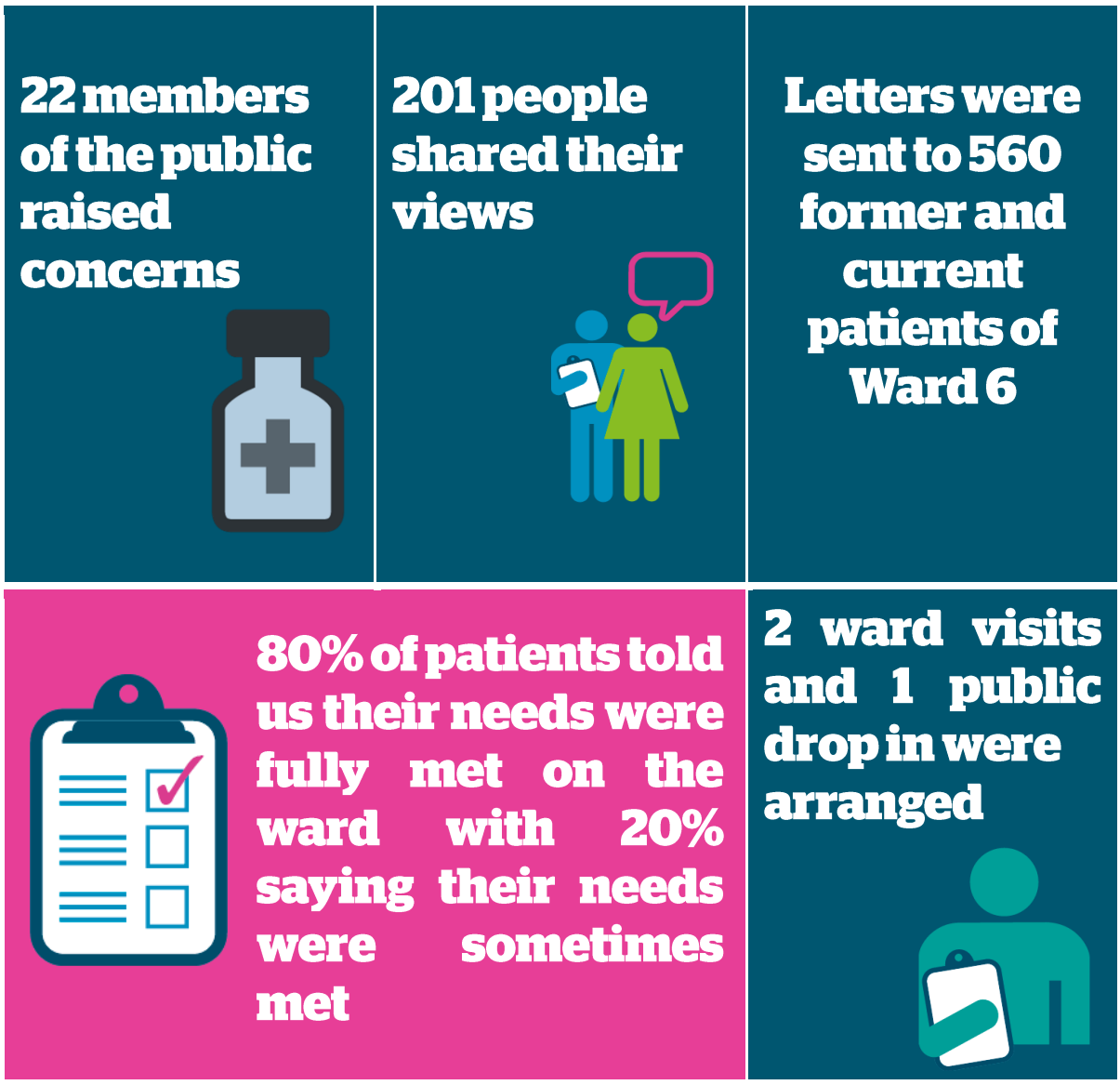
In total 180 questionnaires were completed and Healthwatch spoke to 18 patients and public on ward 6 at BAH and to three members of the public in the hospital café.

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

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

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

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



Recommendations

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

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

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

Background to this work

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

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

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

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

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

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

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

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

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

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

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

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

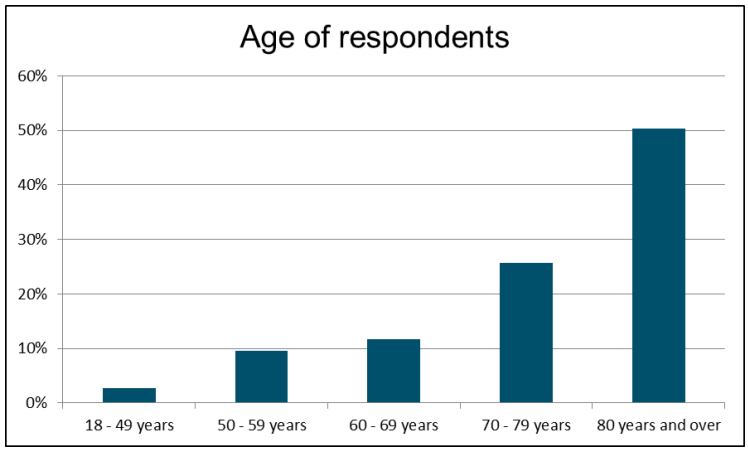
As a result of the ongoing communication by letter and meetings between Healthwatch, the Trust and CCGs over the period from November 2018-March 2019 and also taking into account the views of the public, the local MP and OSC, the CCGs and Trust did submit a workplan request to the Healthwatch board.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

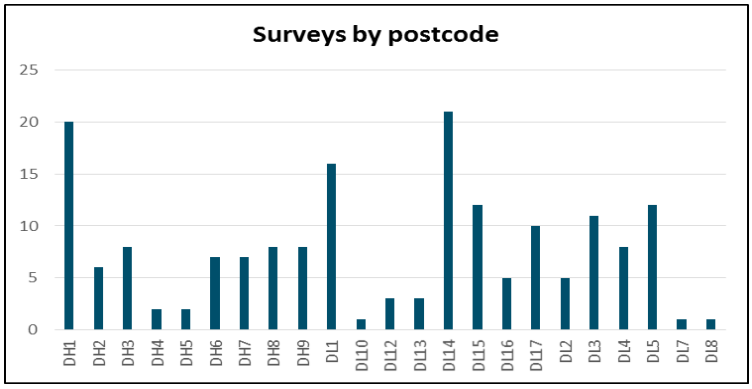
In March 2019 it was agreed that Healthwatch would work with patients during May/June 2019 to determine what was important to them about the care they had received and if there were other support mechanisms that might have helped them with their recuperation. Healthwatch would produce a report outlining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

What we did and what we found

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

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



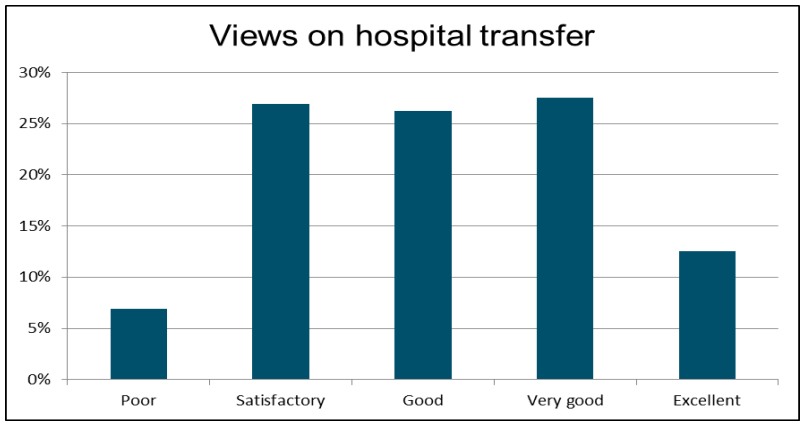


Based on the survey responses and the individual conversations we had at BAH, we have the following observations about what is important to patients about their recovery and where they are cared for.

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

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

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

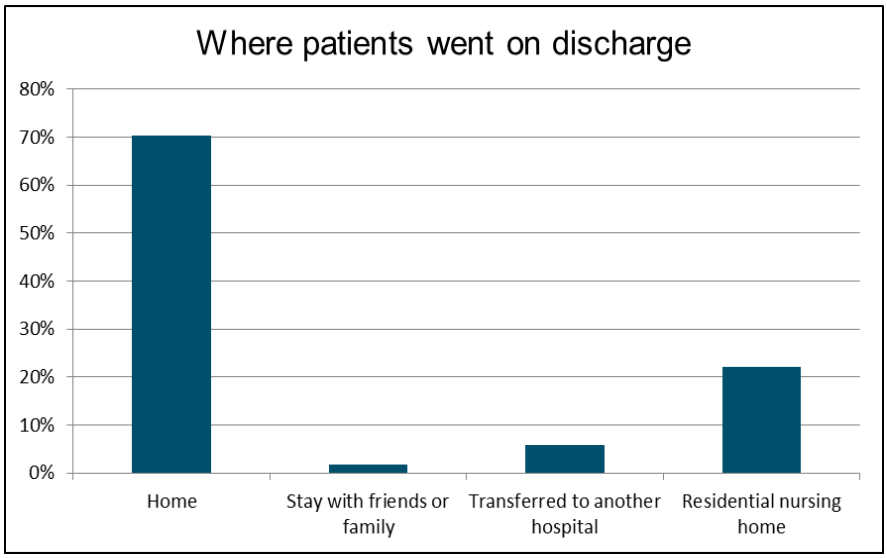


The time patients spend on the ward varies, 27% stayed on the ward up to 1 week, 28% stayed up to 2 weeks and 45% stayed over 2 weeks. The majority of patients (57%) did not receive any therapy services whilst on the ward. Of those that did receive therapy, this rated from 5% poor to 13% excellent. Of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

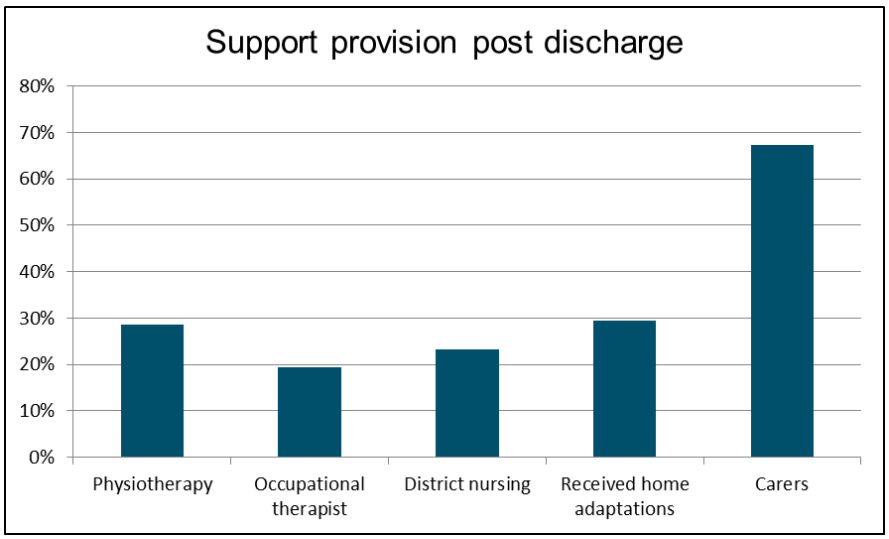
We asked patients to rate the care they had received and the graph below shows their responses. It was reassuring to see that 83% of patients thought their care had been good to excellent, with only 5% of patients telling us their care had been poor. The majority of patients (80%) told us their needs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

"All members of staff were excellent, so kind and caring"

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



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



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

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

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

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

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

Recommendations

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

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

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

Thank You

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

Appendices

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

Appendix 1: NHS briefing paper

NHS County Durham and Darlington NHS Foundation Trust

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

Introduction

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

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

Background

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

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

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

Ward 6

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

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

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

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

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

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

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

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

- In 2017, we identified that ward 6 had a length of stay longer than 35 days. The ward staff, Lead Nurse for Discharge and Matrons commenced Plan Do Study Act (PDSA) cycles to promote a reduction in the average length of stay.

- Changing the culture and practice around discharges. By implementing SAFER (NHS Improvement, published 2017) a practical tool to help reduce delays for patients in adult inpatient wards. When followed it reduces length of stay and improves patient flow and safety. The SAFER bundle blends five elements of best practice:
    - S – Senior review
    - A – All patients
    - F – Flow
    - E – Early discharge
    - R – Review

- In 2017, the local health system implemented 'Discharge to Assess' by utilising the multi-agency and multi-disciplinary Trusted Assessors in TAPs. This facilitates joint decision making in the patient's best interest; to avoid delays in returning to their home or normal place of residence rather than being transferred to Ward 6 inappropriately.

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

- An increase of Non weight bearing patients being supported at home with temporary home modifications and the utilisation of therapy support which is now coordinated through the Teams Around Patients (TAPs). The patient's rehabilitation is expedited in their own home. If the patient does require inpatient care then they are supported at a facility close to their home.

- Implementing the SAFER bundle has enabled earlier discharge planning which has reduced the number of medically fit and stable patients being transferred to ward 6. Now they are supported by the local authorities and partner agencies to return to their home by implementing enhanced care packages, where required.

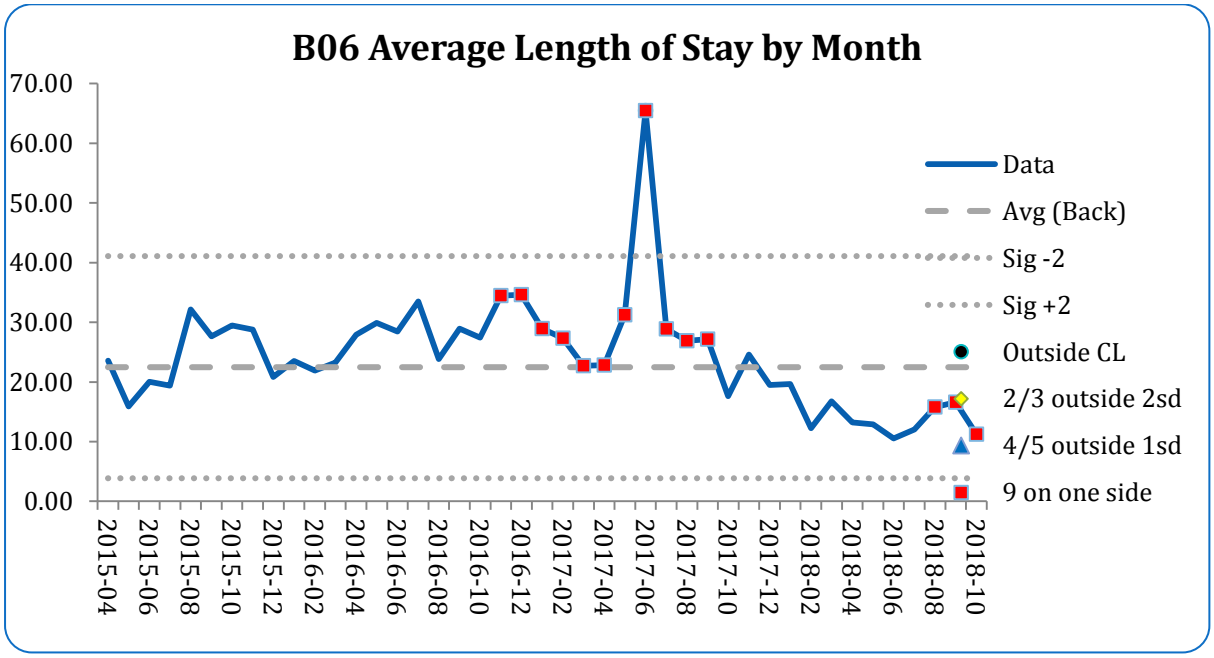
- Using the Discharge to Assess methodology and Home First philosophy more inpatients waiting for a DST are supported with involvement of Trusted Assessors to return home while these discussions take place.

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

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

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

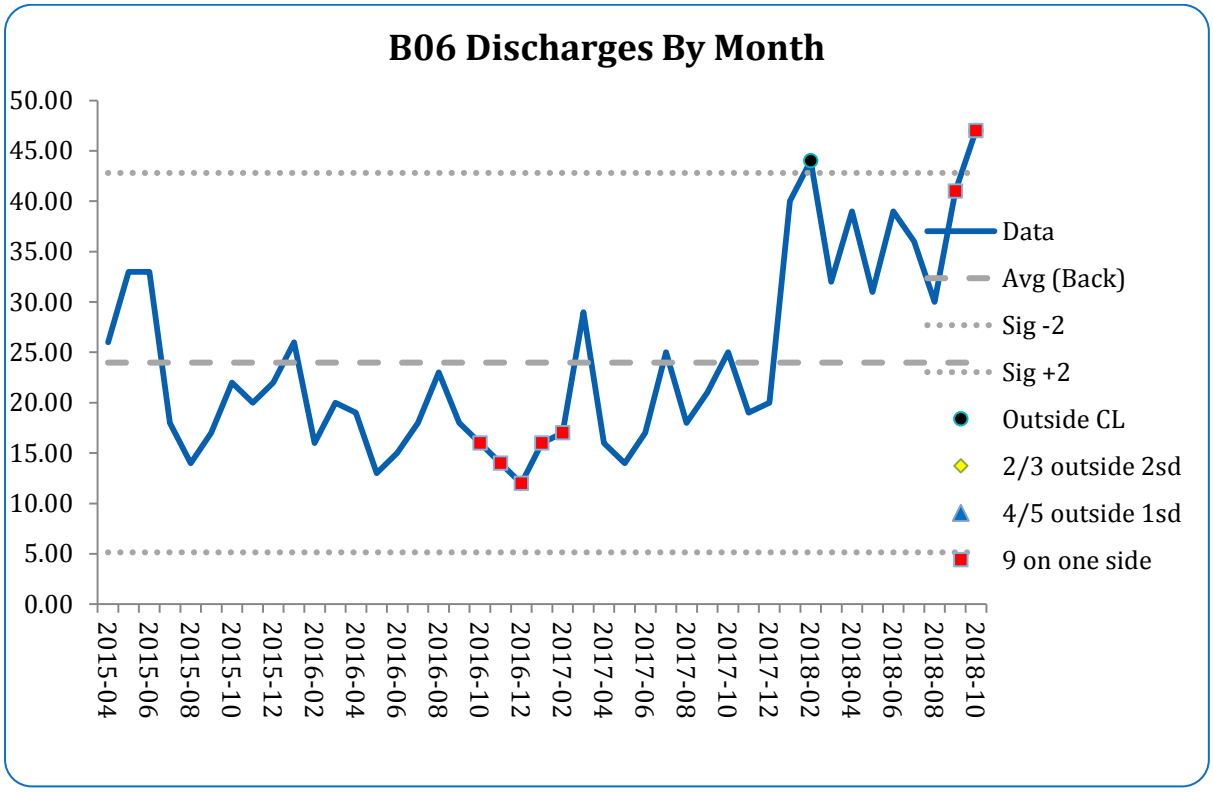
  This is a 54% reduction in 2 years.



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

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

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



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

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

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

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

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

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

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

Recommendation

Overview and Scrutiny Members are asked to:

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

Appendix 2: HWCD survey

Bishop Auckland Hospital Ward 6 Survey

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

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

   ☐ University Hospital North Durham

   ☐ Darlington Memorial Hospital

   ☐ Another ward at Bishop Auckland Hospital

   ☐ Other, please specify .....

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

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

3. Did you receive therapy in hospital?

   ☐ no ☐ yes

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

4. How would you rate your therapy?

   ☐ poor ☐ satisfactory ☐ good ☐ very good ☐ excellent

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

   ☐ yes ☐ no

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

   ☐ poor ☐ satisfactory ☐ good ☐ very good ☐ excellent

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

☐ yes definitely ☐ yes to some extent ☐ no

☐ I did not want to be involved ☐ not applicable at this stage

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

☐ home ☐ stay with friends or family

☐ transferred to another hospital ☐ residential nursing home

☐ somewhere else, please specify…..……

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

☐ Physiotherapy ☐ Occupational therapist

☐ District nursing ☐ Received home adaptations ☐ Carers

☐ Other support, please specify.……

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

☐ yes ☐ no ☐ to some extent

☐ I did/do not expect any further care or support after I am discharged

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

☐ yes always ☐ yes, sometimes

☐ no, please explain why……

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

☐ poor ☐ satisfactory ☐ good ☐ very good ☐ excellent

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

13. Are you?

☐ male ☐ female

14. What is your age?

☐ 18 - 49 years ☐ 50 - 59 years ☐ 60 - 69 years

☐ 70 - 79 years ☐ 80 years and over

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

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

Thank you for taking the time to complete this survey.

Appendix 3: comments and feedback

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

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

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

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

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

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

might change Ward 6 and I do not want you to close it. I am nearly unable to cope so sometime if I had to anywhere I would choose Ward 6.
I was perfectly happy with the care I got while on ward 6
The treatment I received during my stay was excellent
I have completed this on behalf of my sister in law as she is unable to do this herself following a stroke. The discharge experience was appalling. Discharge was discussed by hospital with family and social worker, and care home visited to make assessment; at this point no firm date was set. On 16/01/2019 we were out when hospital phoned to say that discharge was to be that day. We were only out for two hours but by the time we got the message, patient had been discharged and was on her way to care home. We immediately went to the care home who were unaware that she was on her way, they were unprepared for her. No paperwork or care plan was in place. The social worker was also unaware of the situation. The patient arrived by patient transport shortly after us. Her wheelchair and zimmer frame were not sent with her. Family contacted Ward 6 and these were later sent by taxi. The whole experience was a nightmare, more to the family than the patient herself as family & care staff protected her as much as possible as she was and still is very vulnerable following a stroke at the end of October 2018. Follow up support has also been poor and has taken several weeks of phone calls by family to put it in place. Despite us being told by hospital this had been done.
The carer came for six weeks to wash me and she is a great person. Now my husband is my full time carer. The meeting of nurses and carers took place when I was there to close ward 6 someone took that meeting, and those who worked there were crying and really upset. So after that day when patients went home no one else came into the ward. I feel really sorry for who didn't know what was going to happen to them. I hope God has blessed them - then, now, and always.
No complaints at all. Nurses were lovely.

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

Ward 6

Bishop Auckland Hospital

Consultation and communications plan

Final Version

Updated 08.08.19

Contents

Introduction

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

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

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

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

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

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

Context

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

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

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

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

Policy and Legislation

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

- Section 242, of the Health Act 2006
    - *Places a duty on the NHS to make arrangements to involve patients and the public in planning services, developing and considering proposals for changes in the way services are provided and decisions to be made that affect how those services operate.*
- Section 244, of the Health Act 2006
    - *Requires NHS bodies to consult relevant OSCs on any proposals for substantial variations or substantial developments of health services. This duty is additional to the duty of involvement under section 242 (which applies to patients and the public rather than to OSCs).*
- Section 14Z2 of The Health and Social Care Act 2012,

  Places a duty on CCGs to make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways):

    - *in the planning of the commissioning arrangements by the group,*
    - *in the development and consideration or proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them,*

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

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

Other specific considerations have related to:

The 'four tests':

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

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

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

I. Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
II. Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
III. Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).

The Gunning Principles

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

The Equality Act 2010

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

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

The NHS Constitution

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

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

Aims and Objectives

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

To achieve our aim, we will:

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

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

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

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

Scope of the consultation

A focus on rehabilitation

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

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

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

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

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

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

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

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

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

Pre-Engagement

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

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

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

Stakeholders

A stakeholder is anyone who is effected by or can affect, the project. The CCG needs the right information to inform decisions for its community. It continually strives to maintain and strengthen its strong working relationships with its stakeholders.

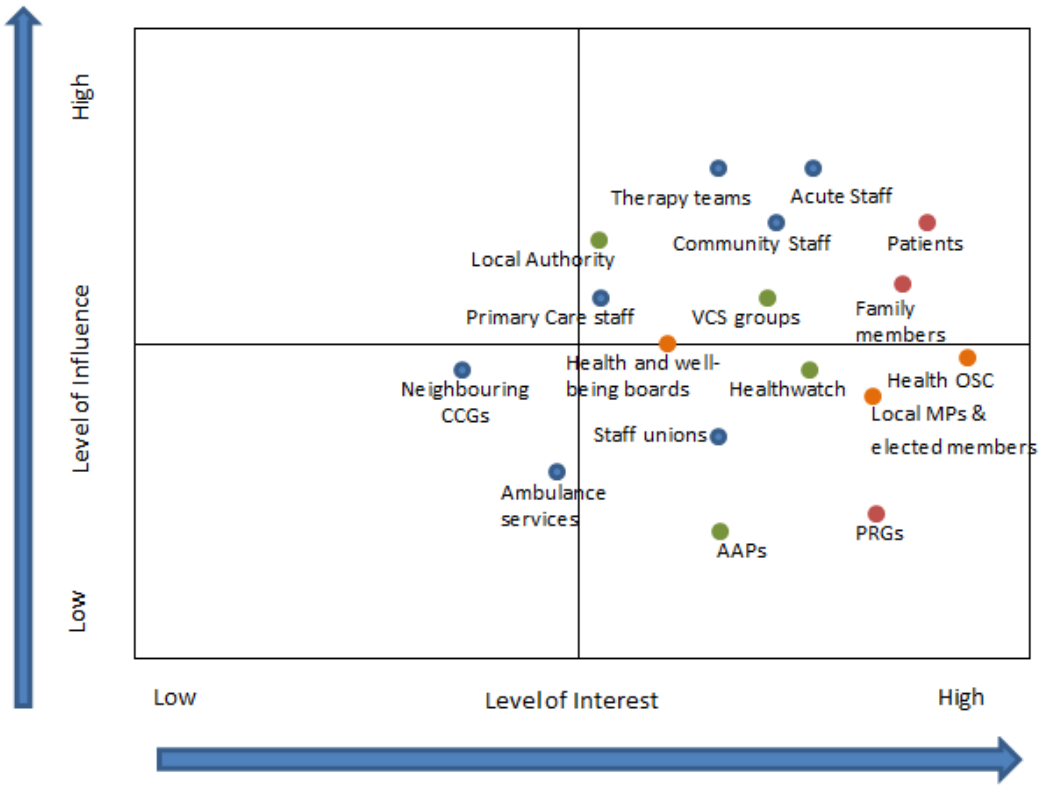
Patients and the public	Healthcare professionals / providers	Partner organisations and Voluntary and Community Groups	Political / Governance
Patients who access these services	CDDFT staff teams at Bishop Auckland Hospital	Local Authority directors of Social Care / Adults services	Local MPs
Family members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

The consultation and communications processes will also 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 County Durham and Darlington areas due to high levels

of deprivation and health inequalities, as well as the diverse make-up of the local population. The engagement team will work to establish links with these groups.

Healtwatch and Patient Reference Groups (PRGs) will be key partners in supporting the CCG with the communications and consultation work to ensure that we simplify messages and don't use jargon and to act as critical friends throughout the process.

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



Methodology - Outline

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

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

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

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

Pre-Consultation activity

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

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

Consultation activity

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

	Continued promotion of ways to respond and contribute	

Post Consultations activity

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

Standard formats of information

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

These include;

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

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

Key messages for consultation

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

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

Questions for Consultation

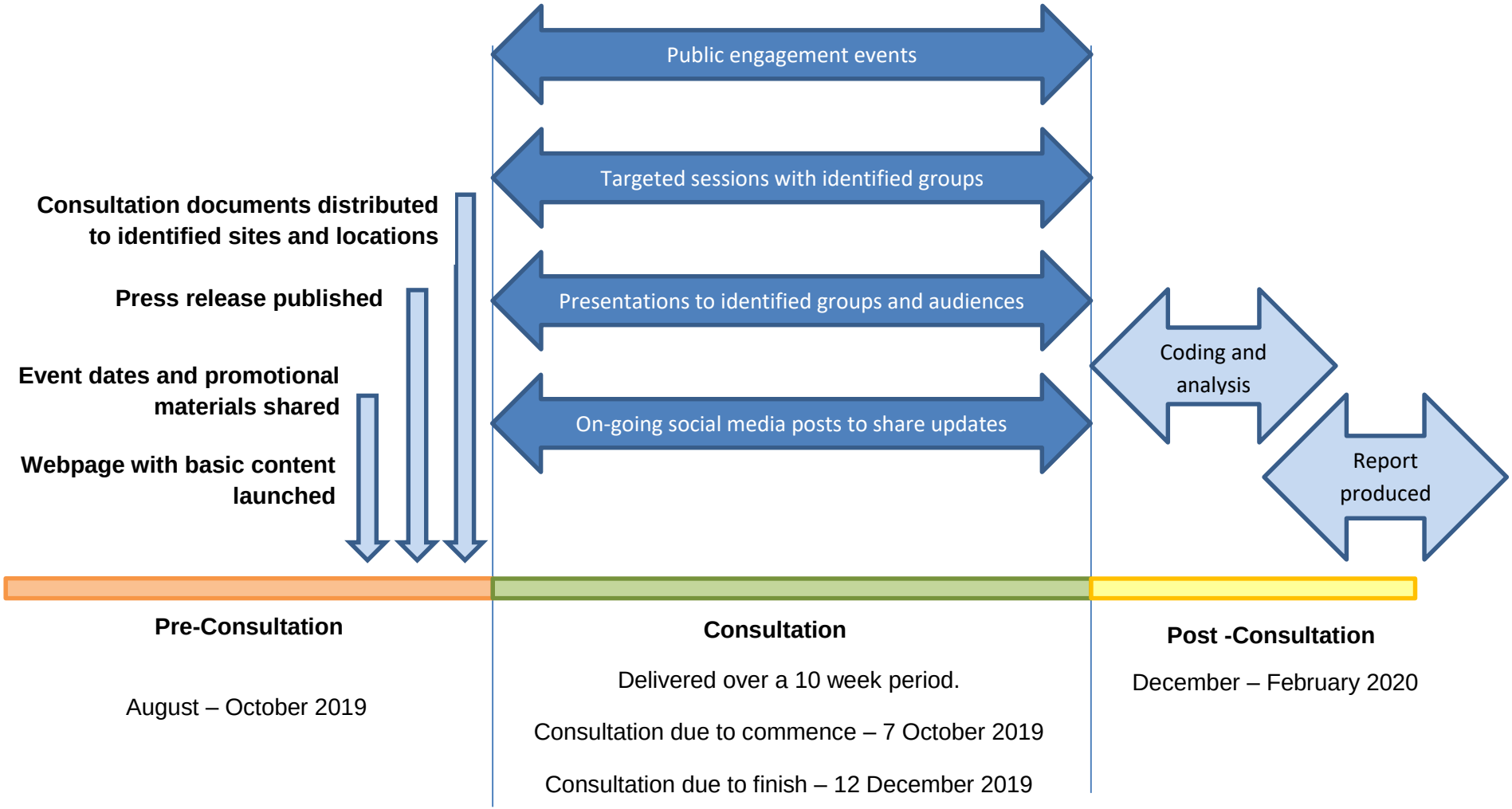
As a structure for the conversations that will take place, the following questions will be included as part of all of the conversations undertaken during the consultation process. To enable appropriate analysis of the feedback from the information provided, these are a mixture of closed and open-ended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

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

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

Timeline

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



Equality Impact Assessment

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

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

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