DURHAM COUNTY COUNCIL

ADULTS, WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

At a Meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in **Committee Room 2 - County Hall, Durham** on **Friday 1 June 2018** at **9.30 am**

Present:

Councillor J Robinson (Chairman)

Members of the Committee:
Councillors P Crathorne, G Darkes, A Hopgood, E Huntington, A Patterson, S Quinn, M Simmons and H Smith

Co-opted Members:
Mrs R Hassoon and Mr D J Taylor Gooby

Also Present:
Councillors L Hovvels and L Maddison

1 Apologies

Apologies for absence were received from Councillors J Chaplow, R Bell, R Crute, J Grant, A Reed, A Savory, L Taylor and O Temple.

2 Substitute Members

No notification of Substitute Members had been received.

3 Declarations of Interest

There were no Declarations of Interest.

4 Any Items from Co-opted Members or Interested Parties

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

5 NHS England Review of Specialised Vascular Services

The Chairman thanked the officers and colleagues from the Council and the various branches of the National Health Service (NHS) for their attendance.

The Chairman noted there would be a presentation from NHS colleagues (for copy see file of minutes) and asked the Principal Overview and Scrutiny Officer, Stephen Gwillym to explain the background in relation to the Special Meeting.

The Principal Overview and Scrutiny Officer noted that at a meeting of the North East Joint Health Scrutiny Committee held on 15 February 2018, representatives of NHS England's North East Region Specialised Commissioning Team presented a report and gave a presentation in respect of proposals to review specialised and some non-vascular services across the North East. Members were referred to the "North East Vascular Services Case for Change" as set out in the agenda papers. The Committee were reminded that it considered a briefing paper at its meeting on 13 April 2018 on the proposed delivery of vascular services in the North East from 3 locations, reduced from 4. It was noted current delivery from: South Tees Hospital NHS Foundation Trust (James Cook University Hospital); County Durham and Darlington NHS Foundation Trust (University Hospital of North Durham - UHND); City Hospitals Sunderland NHS Foundation Trust (Sunderland Royal Hospital - CHS); and Newcastle Hospitals NHS Foundation Trust (Freeman Hospital).

The Principal Overview and Scrutiny Officer noted that Members had raised concerns in terms of Durham being chosen as the location to cease providing specialised vascular services, in terms of reference to Sunderland as being at the "centre of the region" and also in terms of clinical evidence of selecting Sunderland over Durham. It was added that accordingly, the Committee had requested a Special Meeting to consider the proposals in more detail.

The Principal Overview and Scrutiny Officer asked the Assistant Director - Specialised Commissioning, NHS England, Penny Gray to give an introduction.

P Gray noted that purpose of the review was to support the delivery of the patient benefits and outcomes for vascular service in the North East in general and Durham/Darlington specifically. She added that support was sought for the recommendation of the review, for a "three centre service" configuration and noted it was recognised that the choice between CHS and UHND was marginal. P Gray noted that agreement was also sought in terms of the rationale for the choice of CHS rather than UHND, and for support of the implementation of the review as set out in the presentation, including the plans that the commissioners have for communicating with patients and public to explain the changes.

P Gray asked the Consultant Vascular Surgeons for both UHND and CHS, Phil Davey and Paul Dunlop respectively, to explain the case for change and the recommendation for services to be delivered from CHS rather than UHND.

P Davey explained that while he was the lead for Durham, he cared very much for Sunderland, and explained that he and his colleagues giving the presentation were all local people and cared greatly about the delivery of vascular services in our area.
P Davey noted that it had been recognised around 20 years ago as regards the need to centralise delivery of specialised services, though more recently the pace of change had gathered such momentum that historic delivery methods had not kept up.

He noted that use of x-ray technology, with 60% of procedures involving minimally invasive techniques required highly specialised staff and it was not possible to deliver at all district hospitals nationally. He added that Vascular Surgeons were not General Surgeons, it was a separate and very specialised/niche area.

P Davey explained that also over the last 10 years, there had been concern nationally as regards vascular procedures and the UK versus Europe versus the rest of the world in terms of inferior outcomes for the UK and how to address this. He added that both Darlington and Gateshead had previous ceased to provide specialised vascular services, leaving the 4 delivery centres as previously noted. However, P Davey explained that all clinicians agreed that there was a need to rationalise further to three vascular centres and this was set out within the "North East Vascular Services Case for Change 2014".

The Committee were informed that key clinical drivers for change included the strong evidence of a link between surgical volumes and improved patient outcomes from complex arterial surgery, especially abdominal aortic aneurysms (AAA). P Davey reiterated that advances in technology and the shift towards non-invasive treatments methods for vascular patients (endovascular) had an associated increased reliance upon specialised interventional radiology support. Members were informed that the advances in treatment that had greatly improved patient outcomes require 24/7 availability of endovascular practitioners, interventional radiologists or dual-trained surgeons, who have highly expert and specialised skills.

P Davey explained that an ageing population presented a general increasing pressure on services and there was also the AAA screening programme which in order to give low mortality rate required a high volume. He added that a centralised service would also improve overall sustainability and aid recruitment. It was noted that it would also fit with the national service specification in terms of a hub and spoke network model.

Members were informed that benefits to a centralised service included: improved infrastructure, for example imaging services; enable compliant vascular surgical / interventional radiology on-call rotas; appropriate vascular anaesthesia / nursing and allied professional support / expertise; provide adequate critical care support; facilitate essential interactions with other services; and improved post-graduate training and research opportunities.

P Davey explained that the Freeman and James Cook were major vascular trauma centres and therefore the two models that had been considered were a "two centre model", with only those two hospitals, or a "three centre model" that would include either CHS or UHND. He explained that an independent clinical review was accepted to consider the clinical requirements of a third centre. It was explained that The Vascular Society were asked to recommend the most effective and safe configuration of Specialised Vascular Surgery Services within the North East of England and to consider the clinical requirements of a third centre. It was added that the review was supported by the Clinical Advisory Group, both Trusts and endorsed by NHS England.

P Davey explained that both UHND and CHS had made very strong cases to become the third arterial centre with both having: strong clinical relationships and excellent management support.

He noted the final recommendation had been based upon: ability to meet capacity requirements; geography and population density; and existing allied service site profiles.

The Vascular Society Recommendations were to “reconfigure services onto three Arterial Centres with networked Non-Arterial sites:
1. Newcastle, networking with Gateshead
2. Sunderland, networking with South Tyneside and Durham
3. Middlesbrough, networking with Darlington in addition to current networked sites”.

P Davey noted that the decision of CHS over UHND had been a marginal decision, non-critical of either service, and had been based upon: capacity/infrastructure; staffing; theatres/imaging/ICCU; geography and population; travel times (<1 hr); current networking arrangements; co-located services; renal services; and interventional cardiology.

It was explained that the proposed service model would be patient centred with access preserved and enhanced across Durham. It was noted that Durham would continue to provide: out-patient clinics; diagnostics and day case surgery, with Sunderland providing all vascular in-patient activity.

P Davey explained that in terms of patient impact, there would be no change in the number of out-patient clinics, approximately 3,600 episodes per annum. He added that there would also be no change in terms of non-invasive imaging and that day case surgery would to remain in Durham, approximately 200 cases per annum. Members noted that all primary in-patient vascular care delivered exclusively at CHS or James Cook University Hospital (JCUH) and this would affect approximately 650 patients per annum, with 12 cases per week transferring to CHS and 2 cases per week to JCUH. P Davey added that other speciality in-patient vascular support would not change and be provided at UHND and Bishop Auckland General Hospital (BAGH). It was noted that there would be an expected reduction at the tertiary centre, the Freeman Hospital, referrals needing to be centralised.

P Davey noted in conclusion that clinical consensus had now been reached, with a single clinical option to provide a sustainable local vascular service at CHS as the arterial hub with UHND/BAGH/JCUH as spoke sites. He added the proposals were: endorsed by NHS England; supported by the CCG; reinforced by the Clinical Advisory Group; and both Trusts were fully supportive and engaged.

The Head of Communications and Engagement, NHS North of England Commissioning Support Unit, Caroline Latta explained that consultation and engagement would include: and external project partnership board being established; an equality impact assessment; a travel impact assessment; a detailed communications and engagement plan developed in partnership with NHSE, CCGs and Trusts. It was added that this plan would include: patient engagement events facilitated by Health Watch; focus groups; patient reference groups; stakeholder communications and engagement; variety of ways patients and stakeholders can feedback; internal communications; engagement with NEAS.

P Gray noted summarised that there was a need for centralisation, a three centre model; the clinical outcomes and patient benefits had been set out.

She explained that the next steps would be for the Committee to be asked to support the presented plans to enable commissioners and providers to move ahead with the recommended reconfiguration. Members noted that Officers would continue to develop the full business case and there would be a Stage 2 assurance process within NHS England. P Gray concluded by noting the implement communications and engagement activity, continued engagement with Joint Overview and Scrutiny Committees and the ongoing internal communications and to begin the staff consultation process.

The Chairman thanked the speakers and noted a number of questions had been raised, including: had the case been made in terms of CHS; engagement, why was there no formal consultation under the Act; why NHS England was not managing the process; why 2014/15 figures were used why not newer data; what the opinions of CCGs were; viability of UHND going forward; why the sustainability and transformation partnership (STP) was being ignored; all options should be within 60 minutes, only UHND meeting this; there were travel risk regarding the A19, with the local MP, Grahame Morris looking at this issue; it was noted that the consultation stated to serve a 600,000 population, with Durham having 685,000 and Sunderland having 480,000; the case for change noting 33 referrals, with UHND having approximately 60; and as regards whether people from Stanhope and Weardale would look to "migrate" if they found travelling to Cumbria / Carlisle easier.

R Hassoon noted increased waiting times to have surgery and lack of vascular intensive care beds, only general intensive care beds and a lack of skills. P Dunlop noted that the proposals were that if more concentrated to 3 centres, there would be an associated concentration of expertise that should lead to better services. P Davey noted this would help to address and shortfall in services.

Councillor A Hopgood noted as regards proposed communication and engagement and asked if there was a possibility of the proposals being changed on the basis of any feedback. C Latta noted there would be stakeholder events and genuine alternatives and ideas would be considered, with formal consultation if required. Councillor A Hopgood noted that if there was a feeling that the case was fixed, then there would not be meaningful engagement. She added she was not anti-Sunderland, the issues was the large geographical area to the west of County Durham. Councillor A Hopgood noted that the travel times as stated in the document seemed incorrect, with it not realistic and the proposals catered more towards the south and built up areas, not the rural west of the County. The Chairman added that residents of areas such as Stanhope may vote with their feet, and choose Carlisle for example.

C Latta noted she was from a rural community and understood the concerns and that it would be through the engagement process that issues would be rooted out, and that the evidence and issues such as rurality and travel times could be tested. She added that a number of patients that had experienced the service had been contacted directly as regards their experience, with this to be then reported back.

Councillor P Crathorne noted that in the past there had been consultations as regards services at Bishop Auckland and she felt that this had not changed the proposed model in that case, and asked whether in this case it had been decided.

Councillor H Smith noted that the clinical case had been well made in terms of CHS over UHND, for example issues relating to theatre time / experience, numbers of radiologists and specific intensive care beds. She added that however the geography of County Durham was huge and her Division was in rural Teesdale and that there was a long travel time to Durham, with the time to Sunderland being even longer.

Councillor G Darkes noted that Sunderland had 40% less population than Durham and also asked as regards any discussions that had taken place with the North East Ambulance Service (NEAS) in respect of the proposals, noting the current ambulance times.

Councillor S Quinn noted that it seemed that the older centres seemed to be favoured over the newer centres and asked if there was any rationale as regards this.

Councillor L Maddison thanked the Chairman and noted that one of her concerns related to staffing, with the proposals noting they were sufficient at Sunderland and that this suggested they may be overstaffed in the future. She asked if this was not the case and the extra staff was building extra capacity, what was the lead-in time in terms of providing training to enable them to provided services. P Dunlop noted that Consultant Surgeons would transfer via TUPE, some nursing staff would TUPE and there would be more recruitment in terms of intensive care unit staff and theatre staff, adding it was not extra training.

The Chairman asked why the new hospital at Sunderland was not being used, with Members having been told renal patients would have services delivered at Durham. The Associate Director of Operations for the County Durham and Darlington Foundation Trust, Shane Longden explained that Durham was state of the art, however, did not have in-patient / overnight facility. He added there was dialysis services and intensive treatment units at UHND. Mr D Taylor-Gooby observed that the impression had been given that if UHND had been chosen it would require significant investment and therefore the decision appeared to be made. P Dunlop noted that more renal services would have to move to Durham if required.

The Chairman asked whether formal consultation under the Act would be carried out and highlight options regarding CHS or UHND. C Latta noted that stakeholder events would lead to information for critical partners to take away and consider, it was added there was a duty to be honest as regards options that would be achievable and that there would be engagement with previous vascular patients and there was a genuine opportunity to influence mobility plans, helping commissioners regarding services, looking at quality of care and clinical outcomes too.

Councillor A Hopgood noted that in terms of consultation, she felt it was a little disingenuous to use “communication”, as this was a two-way street and engagement was not the correct word as there was no doubt in terms of the clinical case, however, there was an issue in terms of the geography of the County, with those living at Stanhope not being able to get to Sunderland within an hour. The Chairman noted NHS England had not responded to the question of the west of the County.

P Gray reiterated that the Consultant Vascular Surgeons were local people and passionate and would not leave out the west of County Durham, the recommendation from the review was a marginal decision, however, the clinical outcomes for patients were the main factors in proposing the Sunderland centre. P Dunlop added that the proposals were the best in terms of reducing deaths, stokes and amputations. Councillor H Smith noted that that was correct, once you got to Sunderland, however, it was a very long time from the Durham Dales to Sunderland. The Chairman noted as a former nurse he agreed with the clinical case, however he felt the proposal was wrong geographically.

Councillor A Patterson felt that the report was flawed in that it focused on a region, and that it was more of an issue between Durham and Sunderland, and there should be a formal consultation. She added that in terms of canvassing vascular patients, she asked how you would predict those that may become such patients, and suggested it would be better to consult with all residents. Councillor A Patterson added that Durham was not at the geographic centre of the county, however, if Durham was felt to be the best location, would it not be best to relocate services accordingly. She added that from her Division, Crook, to Durham would require two buses and that in terms of the East Durham Corridor, there was easy access along the A19 and to the Metro. Councillor A Patterson noted she felt location was key and that the staff and equipment should be transferred to that location. She continued noting that there should be consultation with residents and the report should include information regarding location. Councillor A Patterson asked as regards other consultation and engagement events and who advertised them, where there were advertised and how to get involved.

The Chairman asked whether Clinical Commissioning Groups (CCGs) and STPs had been circumnavigated in terms of this issue. The Chief Clinical Officer, Durham Dales Easington and Sedgefield CCG, Stewart Findlay noted that both Durham CCGs tried to protect services in County Durham, Darlington and Bishop Auckland, noting the securing of a 3 year contract in terms of acute services, and 5-10 years in terms of community services. He added that in reference to this issue specifically he could not argue in terms of the clinical reasons for colocation of other services. He added that travel time from Stanhope to Sunderland was approximately 1 hour 30 minutes, and was similar to Carlisle, those areas being equidistant from those centres. S Findlay added that tackling transport issues in rural areas was hard, and there had been work with NEAS, though it was noted that despite investment, times had not improved. He asked what discussions had taken place with NEAS in terms of investment and added that it was known that if patients were to get to specialist units then outcome were better. S Findlay asked what the time limit was in terms of reaching a unit where outcomes would be better. P Dunlop noted it was within 1 hour, however there was evidence that even within 2 hours to main specialised centre had better outcomes.

Councillor A Patterson agreed with specialist units, providing better outcomes, even with longer travel times, however, she suggested that if Durham could be used as the location for services then this could serve more people and people and equipment should be moved to the location that was best.

The Chairman noted there had been some argument in the past regarding stroke services, having been provided in Durham, with Darlington losing out and asked why the arguments were different this time. P Gray noted that previous arguments related to strokes services specifically.

P Davey noted stroke services ran alongside vascular services, just they were supported from different locations, with assessment, imaging and stroke care being available at Durham. The Chairman noted that 3 years ago Members were told Durham was the best location for stoke services, why not the best location now. P Davey noted that what made good stroke services was not necessarily the same for vascular services and that the discussions as regards vascular services did not impact upon the previous decisions on stroke services. P Davey reiterated that he had fought for UHND, and added that if Durham had the theatre capacity, equipment, intensive care capacity / staff, and physical space, then it would solely be a geography issue.

He added that it was not possible to deliver world class service at both sites and that he accepted the clinical case for CHS.

Councillor A Hopgood asked what services would be left at UHND and the Chairman asked how this would impact upon the viability of UHND. Councillor G Darkes referred to page 46 of agenda pack, with the Vascular Society noting the decision was difficult and all travel times between units being less than 1 hour, he suggested that this was not correct.

The Executive Director of Operations, County Durham and Darlington NHS Foundation Trust, Carol Langrick noted that in terms of the future viability of UHND, it was a very busy hospital, with very busy services and in some respect for that reason alone it had a vibrant future. She added that in terms of general district hospital services, vascular services was not a typical service and that an absence of such service was not a sign of a hospital without a future. She continued noting that when the proposal had come forward, UHND was disappointed and challenged the proposals, raising questions. C Langrick explained that in the end UHND had been assured in terms of the clinical case for the proposals for CHS to deliver vascular services. She reiterated UHND had a number of services and was committed to the site in Durham, noting the improvement to the Emergency Department and front of house improvements.

Councillor J Robinson noted Councillors were representatives of the people of County Durham and this was why they fought passionately for services for County Durham. S Findlay noted that the geography of the Wear Valley was different to Weardale and added that it was not practical to move resources to UHND in order to make vascular services at this location viable. He noted that this did not mean UHND was not viable without vascular services, as outlined by C Langrick.

A Patterson noted the report set out that UHND was very good at delivering vascular services and felt that perhaps the proposals could put lives at risk in the west. The Chairman noted that all Members could support the move from 4 centres to 3, the concern was whether the location proposed was correct.

P Gray noted that as C Latta had explained, stakeholder events would explore those issues in more detail, including resources and travel. Councillor A Patterson reiterated that such events should be open to all County Durham residents. C Latta noted the events would involve interested parties, including Councillors, charities, Health Watch and patients that had directly experienced vascular services in the last 3 years would be invited to share their experiences. She added this pre-engagement would take place and then there would be an opportunity to take stock before taking the next steps.

Councillor P Crathorne noted it did not seem like proper consultation, and that most people's opinions would not be taken on board. The Chairman noted that he felt the Committee agreed with the clinical case for 3 centres, reduced from 4, however, they were not convinced as regards the geographical argument for CHS over UHND. He added that the Committee had powers of referral to the Secretary of State for Health and Social Care and that Members would fight for their local areas.

The Principal Overview and Scrutiny Officer noted that the North East Regional Joint Health Overview and Scrutiny Committee would consider the proposals at its meeting 21 June 2018. He added that the recommendations of the Committee today would be fed into that body. The Principal Overview and Scrutiny Officer noted that the Committee accepted the clinical rationale as regards the reduction from 4 centre to 3 centres. He added that the Committee was not convinced in terms of the proposal for CHS to deliver vascular services rather than UHND, geographically it had not been fully justified. The Principal Overview and Scrutiny Officer noted that Members had debated the type of engagement proposed against statutory consultation, with the Committee suggesting that the proposals constituted a significant development/substantial variation in specialised vascular health services and therefore require formal consultation particularly in respect of the location of the third regional centre being either Sunderland Royal Hospital or UHND, Durham. He added that in terms of pre-engagement across the County, Members had wanted to see the information gathered from these sessions brought back to this Committee and at the regional level, and to have the consultation widened out to include all County Durham residents.

Resolved:

(i) the Committee receive the report and note the content of the presentation in respect of the proposals to reconfigure specialised and some non-specialised vascular services in the North East and the associated communications and engagement plans;

(ii) the Committee agree to recommend to the North East Regional Joint Health Overview and Scrutiny Committee that:

1. The clinical case for the reduction from 4 to 3 specialised vascular services centres in the North East is accepted by Durham County Council's Adults Wellbeing and Health Overview and Scrutiny Committee;

2. The rationale for the selection of Sunderland Royal Hospital as the third regional specialised vascular services centre is disputed from a geographical perspective as this would leave almost half of County Durham more than an hour's travel away from specialised vascular services;

3. The County Council's Adults Wellbeing and Health OSC believes that the proposals constitute a substantial development and significant variation in health services and that statutory consultation is required under Section 244 of the NHS Act 2006, particularly in respect of the decision of the location of the third regional centre for specialised vascular services between University Hospital North Durham and Sunderland Royal Hospital;

4. The proposed communication and engagement activity in respect of the proposed review needs to be widened to ensure that the whole population of County Durham have the opportunity to provide their views on the proposals given the significant impact upon Durham of the preferred option.