**DURHAM COUNTY COUNCIL**

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

**Present:**

**Councillor J Robinson (Chairman)**

**Members of the Committee:**
Councillors J Chaplow, A Bainbridge, R Crute, G Darkes, M Davinson, J Grant, E Huntington, A Patterson, S Quinn, M Simmons, L Taylor and O Temple

**Co-opted Members:**
Mrs R Hassoon

## 1 Apologies for Absence

Apologies for absence were received from Councillors R Bell, P Crathorne, C Kay, K Liddell, L Mavin, A Reed, A Savory, H Smith and Mrs B Carr

## 2 Substitute Members

There were no substitute members.

## 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 County Durham and Darlington NHS Foundation Trust - Review of stroke rehabilitation services

The Committee received a presentation from the Chief Executive, County Durham and Darlington NHS Foundation Trust (CDDFT) that provided an update of the review of stroke rehabilitation (for copy see file of Minutes).

The Chief Executive was accompanied by the Lead Stroke Consultant, Commissioning & Development Manager, and the General Manager of CDDFT together with the Director of Commissioning for DDES CCG.

The Commissioning and Development Manager highlighted the following information from the presentation:-

- Key Facts about Stroke
- Scope of Service Review
- Current Pathway
- Current Discharge Pathways
- Drivers for Change
- Case for Change – Quality of Care
- Case for Change – Workforce
- Next Steps – doing nothing is not an option
- Engagement & our commitment
- Timescales

The Chairman thanked officers for the presentation. He asked for assurances that this was not linked to changes to the regional vascular services and The Chief Executive provided that assurance.

Councillor Crute referred to early supported discharge and asked how the service would know that people received the same level of support at home as they would in hospital. The Lead Consultant advised that early discharge was was not available at present countywide however a small team based in Easington were involved in setting this up.

The Chairman referred to the previous changes to hyper-acute stroke services moving from Darlington to Durham and he expressed concerns about these further changes in respect of the viability of services provided at University Hospital North Durham and Bishop Auckland Hospital. He requested evidence to provide the assurances about the future of these hospitals. The Chief Executive referred to the changes made to hyper-acute services and the recognised significant improvement outcomes as a result. She advised that the key aspect was to have early supported discharge as a commissioned service as this would make a big difference. She referred to opportunities around Bishop Auckland Hospital to enhance the assessment services for frail patients.

The Lead Consultant added that there had been no complaints about patients being in the wrong place following the changes to the hyper-acute services. referring to community services he said that patients did want to be in their own homes and that we needed to make best use of the facilities available. He added that it was important for patients to receive continuity of care and by putting services in place would ensure that happened. Referring to Bishop Auckland Hospital he commented that this was a great facility and was an aspiration to have this as a centre of excellence for elderly care.

The Director of Commissioning explained that there was not a direct link between stroke services and the rest of the services taking place at Bishop Auckland Services. She would share the list of services available at Bishop Auckland Hospital following the meeting with the Committee. She assured the members that Bishop Auckland Hospital was thriving.

Referring to early supported discharge Mrs Hasson expressed concerns about those people leaving hospital where a good service was not available within the community.

The General Manager advised that other services were being developed in relation to discharge to assess. The Director of Integration added that discharge to assess was only carried out when safe to do so.

Councillor Patterson welcomed the advantages of centralisation and was pleased to hear about the aspirations for Bishop Auckland Hospital however she was concerned about transport for patients and their families. She agreed that the best care for patients was to receive that locally however, it had also been noted that in the recent CQC inspection, there were a lot of areas that required improvement. She went on to ask what an acceptable sample size was for public engagement.

The Director of Commissioning assured members that this was not about the centralisation of services, that was the view expressed by the Lead Consultant.
The views of patients would also be sought together with those of clinicians. She added that it would be difficult to say what the sample size would be but said that they would be talking to people who had suffered from a stroke together with their families. They would not receive a 100% response rate but would share who they had talked to and what the response rate was at the end of the engagement exercise.

The Chairman suggested that a special meeting of the committee be arranged whereby evidence could be presented from patients. He believed that this was a significant change to the service and would like to view the evidence to back up the ideas for change. Referring to the slide on the workforce, he asked what had caused the deterioration across the board. The General Manager explained that recruitment to Bishop Auckland Hospital and UHND had been difficult. Retaining therapists had also been problematic due to not delivering the best outcomes. The Chairman asked if this would be improved and was advised that staff would be consolidated in teams and a named clinician would follow the patient into the home or community where teams around the patient would take over.

The Chairman asked a question on behalf of Councillor Smith relating to stroke and mortality figures and was advised by the Lead Consultant that all of the North East Stroke Units have average mortality rates but that it did vary according to postcodes. He assured members that they were not experiencing an increase in mortality rates and added that regular reviews took place whereby clinicians were presented with data.
Councillor Patterson re-iterated her point about travelling and the costs associated with transport and car parking not only for patients but for their families. The Director of Commissioning explained that this was one of the reasons why the service were supportive of discharge to home and this wold also make it easier for families. Their views would be sought.

Councillor Darkes asked if the centralisation reaction was due to staff shortages and he asked for a scheduled plan of where the staff would be recruited from and how they would be recruited. The Director of Commissioning confirmed that they were not preparing to centralise as development plans and options had not yet been proposed. She again referred to the views of the Lead Consultant.

Councillor Darkes commented on the reduction from 9 to 6 units and was advised that this was in relation to the hyper-acute unit and those changes had already taken place.

The Lead Consultant commented that a national directive, led by Professor Tony Rudd on hyper-acute treatments, was about trying to get the size of the units right. He added that in Durham a lot of consultants had been recruited and would hopefully be retained. Referring to the comments made about centralisation he said that it was not only his view but that of his team and something that the therapists would like to see happen.

On answering a question from Councillor Darkes about finding additional staff, the Director of Commissioning advised that they did have a recruitment plan and patients would still have the choice as to whether they wanted to accept the service. The General Manager added that once they had spoken to patients they would have a better understanding of who wanted to be at home receiving treatments.

The Chief Clinical Officer, DDES CCG said that there was evidence to support the restructure in one area. He said that 27 days in hospital was too long and that patients should be in their own homes. He added that investments into the service were much better and he believed that this would help to recruit staff. There had been concerns about the speed of getting patients from home to hospital but with further investments into NEAS from the CCG it was expected that they would deliver.

With reference to the hyper-acute unit Councillor Temple said that the changes had produced a much better service. However, further evidence was needed in relation to early supported discharge as he was not convinced by the arguments put forward. He did agree that to do nothing was not an option but was concerned about what the losses would be as a result of the proposed changes.

Councillor Chaplow was concerned that many patients would say that they wanted to go home and then refuse the help and support when they leave hospital. Her view was that in hospital patients would get the care they required and believed that we had a really good system in place.

Councillor Patterson agreed with Councillor Temple's point that we couldn't do nothing but she added that these changes were due to a shortage of staff as the NHS was heavily under funded.

**Resolved:-**

(i) That the report be noted.

(ii) That the proposed review of stroke support services across County Durham be added to the Committee's 2018/19 work programme.

(iii) That a special meeting be arranged to discuss options for future stroke rehabilitation services across County Durham and for evidence to be presented to that meeting which demonstrated the case for change and also set out the views of patients in respect of the existing stroke rehabilitation services.

**6 County Durham and Darlington NHS Foundation Trust - CQC Re-inspection report and action plan**

The Committee received a report from the Chief Executive, County Durham and Darlington NHS Foundation Trust regarding the CQC inspection report (for copy see file of Minutes).

The Chief Executive, CDDFT reported that the overall rating for this trust was requiring improvement. The CQC had however rated the trust well-led with the leadership team showing a range of skills and expertise, were leaders at every level and were approachable.

The Chief Executive highlighted the summary of findings and the areas for improvement. She advised that maternity services had won the service improvement award in the annual staff awards and had been shortlisted for the Royal College of Midwives annual midwifery awards. She informed the committee that the trust had requested that the CQC carry out an inspection on End of Life Services.

The Chairman congratulated Maternity Services as some areas had been outstanding.

In relation to surgery, Councillor Crute said that there were concerns raised about both sites and that there had been a deterioration in staffing levels, safeguarding and training and said that this indicated a failure at the leadership level. He asked what measures would be put in place to address this. The Chief Executive said that the board shared these concerns about all areas where improvements were required. She advised that a separate review had been undertaken on the overall leadership that gave a confidence. She referred to significant concerns around maternity services at the last inspection that had now improved to outstanding in some areas, and the same concerns were now being expressed in surgery. A number of actions had taken place specifically around self assessment and never events had reported fewer numbers. The trust were keen to see improvements and regular meetings were taking place with the medical director.

Councillor Grant said that it would be good to see comparative data and asked if most trusts required improvement. The Chief Executive confirmed that most trusts that had been assessed required some improvements, and she confirmed that comparative data was available that she could share with the committee.

Councillor Huntington asked what happened inside the trust as she was concerned that areas for improvement were not picked up by the leadership team. The Chief Executive confirmed that any issues were reported via appraisals and were linked to what was going on in the trust. She added that in relation to surgery, there were self assessments carried out in June every year and the deterioration was due to the level of never events that had occurred. An action plan was put in place and managers had picked up on those. She reminded members that the CQC were looking back whilst undertaking the inspection.

Councillor Patterson referred to the number of changes that had taken place recently, including changes to urgent care, removal of A&E at Bishop Auckland and asked how the table on page 17 of the pack compared to the last CQC report. The Chief Executive reported that only urgent and emergency services had been looked at in Durham and Darlington and had been rated slightly better than at the last inspection. She added that more people were seen now within four hours, and this was a comparison to patients waiting to be seen in other areas. There were fewer urgent care attendances coming through A&E but more people were being seen within the four hour target.

With regards to training, Councillor Temple asked for assurances that the culture around this was being addressed. The Chief Executive said that there had been concerns

following the never events and work around the culture had been taking place. The CQC had seen evidence of this work and the comprehensive approach being undertaken.

Councillor Temple asked if there were any signs that the figures were changing and was advised that data could be shared with the committee. She added that with regards to mortality there had been some positive outcomes and again said that this data could be shared with the committee.

The Chairman asked what had been put in place to address the lack of consultants available in A&E. The Chief Executive explained that it was difficult to recruit to A&E but that there was a detailed targeted plan which aimed to make the jobs more attractive. Nurse specialists had been recruited and there was now technology in place to ensure the flow of patients out was facilitated in a better way. The Chairman asked if the trust could come back to committee with a report on how this was going to be addressed.

The Chairman went on to ask about the lack of training for all board members and that staff at UHND had commented that they had not seen an executive director present at the hospital. The Chief Executive explained that executive directors spend half their time in Durham and half in Darlington. The CQC did not challenge this at interview however, the team were now publishing where they would be for team and board meetings. She reminded members that th CQC had described the leadership team as approachable.

Referencing the recently published re-inspection report for North Tees and Hartlepool NHS Foundation Trust which had improved from “requires improvement” to “good”, the Chairman asked if good practice could be learnt and shared from that trust. He reminded the trust that they had said they would be outstanding after the last inspection and asked what actions would be put in place to achieve this result. The Chief Executive said that it was their aspiration to be outstanding in the next two years however as the inspections regimes change there was no guarantee that this would happen. She reported that their own inspections for end of life care were good but they could not force the CQC to carry out on inspection in this area. With regards to North Tees and Hartlepool Trust, the Chief Executive said that they were part of a Learning from Others programme and this had helped them access the move to a good outcome. She advised that CDDFT had also applied to be part of this process.

Councillor Darkes referred to sepsis and was concerned that following a personal loss, nothing appeared to have changed or improved within the last nine years. The Chief Executive confirmed that they did look at all key signs including pathology systems and prompt clinicians. She added that this was an audited system and included a bespoke system whereby the Head of NHS Improvement viewed important steps forward.

The Chairman asked what the Boards opinion was and what action the CCG would take following the outcome. The Chief Clinical Officer, DDES CCG said that they shared the disappointment that there no improvement to the overall score had been shown. He assured members that there was a huge amount of quality work being carried out and meetings and discussions were taking place regularly to discuss the quality. The CCG acted as a critical friend and it had been recognised that a lot of changes were cultural. He believed this was a unique opportunity to allow working together to improve the quality of the services.

**Resolved:-**

(i) That the report be noted.

(ii) That the CQC re-inspection report for County Durham and Darlington NHS Foundation Trust and the associated Improvement Action plan be added to the Committee's 2018/19 programme.

**7 Teams around the practice, Community Services contract and review of Community Hospitals in County Durham**

The Committee received a presentation from the Director of Integration that gave an update on teams around the patient, community services contract and community hospitals in County Durham (for copy see file of Minutes).

The presentation highlighted the following:-

- The Integrated Model
- Teams around patients
- Our ambition
- Progress to date
- Proposed governance structure for the Integrated Care System
- Next steps – including community contract, integrated senior management arrangements, mobilisation work and community hospitals

In relation to Community Hospitals, the Director of Integration advised that this was an important part of the community services offer and the role and function needed to be addressed. A reduced bed base had in Weardale, Sedgefield and Richardson Hospitals had been implemented as the had been a significant drop in occupancy and was inefficient. Activity had now levelled off and the hospitals were seeing 95% occupancy levels.

Sedgefield and Richardson Hospitals had been developed under PFI arrangements and a 14 year lease ran in both hospitals. As the rental costs have to be paid, space would be utilised and it would be recommended to strengthen the use by working with local groups. There were no plans however to increase the number of beds. This was the same for Weardale where occupancy had been around 75% but was now at 95% with the potential to flex the number of beds in winter to accommodate demand.

Referring to Shotley Bridge Hospital, the Director of Integration said that concerns had been raised a number of years ago and the CCGs agreed to undertake a review and work was still ongoing. A reference group had been set up with senior members and officers of the Council that was open and transparent in terms of the planning and proposed changes. The group were now at the stage of receiving recommendations that would be debated at length.

Councillor Temple pointed out that not all community hospitals had been mentioned and asked for an update on Peterlee and Chester-le-Street. The Director of Integration explained that these were outside of the scope that she had been asked to look into. However, she did explain that these hospitals were funded differently.

The Chief Executive CDDFT explained that Chester-le-Street had many additional services available that were all being utilised. The Director of Commissioning said that Peterlee was owned by North Tees and Hartlepool Trust and a large number of services were delivered there including out of hours and community clinics, and there were no issues around void space.

The Director of Integration added that the CCG had plans to utilise some of the space at Sedgefield for office use so would become less of an issue going forward.

The Chairman referenced the recent establishment of the County Durham Integrated Care Partnership and asked where Scrutiny would sit within the governance arrangements. The Director of Integration said that they would illustrate reporting arrangements and she confirmed that they would report to scrutiny with any updates. The Chairman said that this was viewed as a major change and therefore would be added to the work programme to be monitored closely by this committee. Councillor Crute suggested that the structure be revised to show that scrutiny would be involved.

**Resolved:-**

(i) That the report be noted;

(ii) That a more detailed update in respect of the Community Hospitals review be brought to a future meeting of the Committee;

(iii) That the governance arrangements for the County Durham Integrated Care Partnership be amended to show where Scrutiny sits within the process;

(iv) That consideration of the County Durham Integrated Care Partnership be added to the 2018/19 work programme for the Committee.