DURHAM COUNTY COUNCIL

ADULTS, WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

At a Special Meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in **Committee Room 2 - County Hall, Durham** on **Friday 7 September 2018** at **9.30 am**

Present:

Councillor J Robinson (Chairman)

Members of the Committee:
Councillors J Chaplow, R Bell, P Crathorne, R Crute, J Grant, T Henderson, A Hopgood, K Liddell, A Patterson, S Quinn, A Reed, A Savory, H Smith, L Taylor, O Temple and C Wilson

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

Also Present:
Councillor L Hovvels

1 Apologies

Apologies for absence were received from Councillors G Darkes, E Huntington, C Kay and M Simmons.

2 Substitute Members

There were no substitute Members.

3 Declarations of Interest

Councillor A Savory declared an interest in respect of the item in relation to Community Hospitals Update as Chairman of Friends of Weardale Community Hospital.

4 Any Items from Co-opted Members or Interested Parties

The Principal Overview and Scrutiny Officer, Stephen Gwillym noted that Mr David Taylor-Gooby, Co-opted Member of the Committee, had submitted the following:

"As you are aware the community services in Durham are being reorganised following the new contract. I have been informed that this results in some services being relocated as Durham is reorganising the contract. I would like the Overview and Scrutiny Committee to look at this if possible to ascertain the effects on patients".

However, due to the number of important items on the agenda, it was noted that D Taylor-Gooby would wish for the issue to be discussed at a future meeting of the Committee as part of the work programme.

5 Community Hospitals Update

The Chairman introduced the Director of Integrated Community Services, Lesley Jeavons and asked her to present an update report on Community Hospitals (for copy see file of minutes).

The Director of Integrated Community Services reminded Members that she had attended Committee in May this year with a report on Community Hospitals and now had a further update in that respect. She reminded Members that back in April 2017 that Senior Officers from the County Durham and Darlington Foundation Trust (CDDFT) and North Durham and Durham Dales, Easington and Sedgefield (DDES) Clinical Commissioning Groups (CCGs) had met and requested that consideration be given to the role and function of part of the Community Hospitals offer across County Durham, with a view to recommending options for service delivery over a medium to long term.

Members were referred to a table at Paragraph 3 within the report, setting out the complex tenure and mix within the Community Hospital estate in the County. The Committee noted previous reviews and the funding arrangements in terms of those via block contract and those via a payment by admission.

The Director of Integrated Community Services referred Members to Appendix 2 to the report which set out the current position in terms of bed use at the Community Hospitals. It was added that work undertaken had shown that some patients had experienced two discharges prior to returning home, with patients coming from acute sites to intermediate care where it may have been possible for them to return home in the first instance. Members noted that the ethos in Durham was "home first" and that this would be possible more as community services developed.

Members were referred to the types of staffing and medical cover provided at the Community Hospitals across the County and of important service development opportunities as the emphasis shifted away from acute hospital environments and to a service closer to a patient's home.

The Committee learned as regards issues in relation to therapy, day hospital functions, delayed transfers of care and other services delivered from Community Hospitals. Members were reminded of the Teams Around Patients (TAPs) initiative and how this was linked to more services being provided in local communities.

The Director of Integrated Community Services noted that since reducing the bed base in September 2017 across three of the hospitals, the remaining beds were operating at an effective level and there was a flexibility to be able to open additional beds in times of surge and increased activity.

She added there was the link to TAPs and that the recommendation from the previous Director of Integration had been for no change, noting the ongoing work in terms of Shotley Bridge Hospital, which was subject to a separate report for consideration by Members at today's meeting. It was noted that there would be additional work undertaken in terms of looking at internal efficiencies and that there would be continued monitoring in terms of the bed use within Community Hospitals to inform whether the bed base was being utilised effectively.

The Chairman thanked the Director of Integrated Community Services and asked Members for their questions and comments on the report.

Councillor R Bell asked as regards those elements of the estate that were subject to Private Finance Initiatives (PFI) and whether once the period of payments had completed was the building owned by the Foundation Trust. Councillor R Bell noted that the strategic direction seemed to be to look to discharge straight from acute care to the home wherever possible and asked how local communities would "know" as regards those patients and how local people would know that the relevant community services were in place, what safeguards were in place.

Councillor R Crute noted that the table at Paragraph 3 referred to bed compliment, however, the report in the agenda pack in connection to Shotley Bridge Hospital stated that less than 24 beds was "not effective" and asked as regards the differing statements.

The Chief Executive Officer, CDDFT, Sue Jacques noted that in respect of PFI, once the payments had been made the property would transfer to the NHS, with significant savings from that point.

The Director of Integrated Community Services noted in terms of local communities knowing about the role of Community Inpatient Beds and the new "Teams around Patients" model, there was a job to be done in terms of the publicity of services as part of the mobilisation and transformation process, and this had been identified. She added that this was an area the Committee may wish to monitor and noted she would be happy to come back to update Members in relation to progress, uptake and outcomes. She noted that from surveys and interviews it would be possible to add information in terms of peoples' actual experiences of community services. The Chief Clinical Officer, DDES CCG, Dr S Findlay noted that access to the TAPs was not direct, rather there would be referral via GPs and District Nurses and therefore there would be a coordinated flow overseen by the relevant professionals.

The Director of Integrated Community Services noted that in terms of bed compliment that how beds were used in the future would be reviewed at that time. Councillor R Crute noted that Members needed some definitive advice in terms of numbers that were cost effective and that there were concerns that the inpatient beds numbers within Community Hospitals could be linked to their long term sustainability.

Councillor R Bell supported Councillor R Crute in terms of being able to understand what "critical mass" was required and that this was an issue to be watched very carefully. Mr D Taylor-Gooby noted all involved "wanted it to work", however, there was a need for information on how it would work, as there had been an aspiration in terms of this for a long time and there was a need to have the public's confidence.

Resolved:

(i) That the update report be received for information.
(ii) That the work underway to utilise space across the estate be noted.
(iii) That a further report be brought back to the Committee which sets out the performance management framework which was to be established around the Teams around Patients model and how this was delivering improved healthcare outcomes for patients.

The Chairman noted that Item 7 on the agenda, in relation to the Review of Specialised Vascular Services, would be taken as the next item, Item 6, with the Shotley Bridge report to be taken after as Item 7.

6 NHS England Review of Specialised Vascular Services

The Chairman introduced those in attendance for this item and asked Mr Phil Davey, Clinical Lead and Vascular Consultant, CDDFT to give an update presentation in relation to the NHS England Review of Specialised Vascular Services (for copy see file of minutes).

Mr P Davey noted the background in terms of the NHS England Review and previous attendance at the Committee. He reminded Members of similar reviews in Manchester and Yorkshire and that the aim was for good staff and facilities to deliver good outcomes, while still helping locally in terms of repatriation after surgery. Members noted the proposed hub and spoke model as described at a meeting of the Committee on 6 July 2018 with the reduction from 4 to 3 specialised vascular services centres in the North East, those being Middlesbrough, Newcastle and one other. It was reiterated that the review had not been critical of services, however, the case for Sunderland had been made in terms of capacity and infrastructure, including theatres, imaging and its Integrated Critical Care Unit (ICCU). Mr P Davey added that in terms of geography and population travel times from secondary care were shown to be less than one hour, and also it had been noted the networks in place at Sunderland were felt to be superior to those at Durham. He added that the co-location of services at Sunderland, renal and interventional cardiology, also counted in Sunderland's favour.

Members noted: the data in terms of vascular in-patient activity had been refreshed for 2017/18; the outcomes of the work carried out by NHS England regarding travel times; the outcome of the travel impact assessment and modelling carried out by the North East Ambulance Service (NEAS); and the outcome of the rapid self-assessment undertaken by CDDFT and City Hospitals Sunderland (CHS) on how they would be the third arterial centre. Mr P Davey referred Members to slides showing the relevant postcodes within the County, travel times and in-patient activity for 2017/18, including heat maps for elective and non-elective admissions.

Members noted the national standards and service specification “emergency access to vascular interventional radiology must be within 1 hour from initial consultation to intervention”, not 1 hour from a patient’s postcode to a centre. Members were given further information in terms of Abdominal Aortic Aneurysm (AAA) for 2018 by postcode, in-patient length of stay for 2016/17, and travel time differences between the University Hospital of North Durham (UHND) and Sunderland Royal Hospital (SRH) for key postcodes.

Mr P Davey referred Members to modelling carried out by NEAS in terms of impact from the proposed reconfiguring of vascular services, noting that there was effectively no impact in terms of category C1 or C2 patients, those most seriously ill.

The Committee were reminded of the rationale in terms of the interdependencies with renal and interventional cardiology, and their existing co-location at Sunderland. Members were referred to information in terms of the self-assessment and the differences in terms of costs, including capital, with the total for Sunderland being around £4million, and for Durham being around £35 million.

Members noted in summary: infrastructure was already in place at Sunderland to provide key interdependencies; current networking arrangements in place at Sunderland; the majority of care would continue to be delivered in Durham, out-patient, diagnostics and day cases; the service in Sunderland would be fully compliant including travel times for emergencies; work by NEAS showed minimal impact on emergency travel times; and self-assessments had shown a significant impact on moving services to Durham in terms of finance and impact, for example renal services.

Mr P Davey noted that following the additional analysis since the July meeting of the Committee, the view had been confirmed that: clinical consensus had been reached in terms of a 3 centre model to provide the best possible care/outcomes for patients; the only viable clinical option was for the third centre to be located at Sunderland for the reasons stated, this being supported by commissioners, both Trusts and the Vascular Network; the proposals fit with NHS England’s national service specification; and that travel impact assessment demonstrated some additional travel time for patients and carers, but this was mitigated as lengths of stay were relatively short and patients would be repatriated where clinically appropriate to do so.

The Chairman asked the Medical Director, NHS England, Mr Chris Gray to speak in relation to the report and presentation. Mr C Gray noted NHS England were reassured in terms of the service change, with the solution proposed meeting the outcomes now and for the future. He added it was shown that Sunderland had the capacity and services needed and added that importantly there was commitment from both Durham and Sunderland to make the proposals work.

The Chairman thanked the speakers, and also all those involved in the additional work in bringing further information to the Committee. The Chairman noted that it was the role of Overview and Scrutiny and Elected Members to represent the people of County Durham and to ensure the viability of UHND for the future. He asked Members of the Committee for their questions and comments on the presentation.

Councillor R Bell noted the strong clinical case for Sunderland to be the third specialist vascular services centre, and noted the small proportion of emergency cases from those key postcodes as set out. He added that he disputed that the difference between UHND and CHS from those postcodes as being an additional 10 minutes and noted that this was proposed to be mitigated by NEAS by "an adjustment in resources levels". He asked what this adjustment would be, for example faster response time from NEAS. The Director of Commissioning and Development, North Durham CCG, Michael Houghton noted this did not mean an additional resource, rather NEAS would look at how resources were utilised operationally and adjust accordingly.
Councillor R Bell added that he felt that the Committee should formally ask for follow up information from NEAS, with a mind to a formal agreement in terms of this.

Councillor A Patterson noted she felt the proposals represented a significant change with significant impacts. She added she would also challenge the accuracy of some of the travel times quoted, feeling it had been a desktop exercise, not taking into account the actual geography, traffic levels or road infrastructure. She referred to the heat maps relating to elective patients, as set out in the presentation, and noted that many from the west of the County could be considered to be closer in travel time to Newcastle or Middlesbrough and they may elect to go to those hospitals rather than Sunderland or indeed Durham. Mr P Davey highlighted that the heat maps referred to in-patient activity and added that for around every 4,000 patients only one-sixth required to be in-patient. He noted that for the 60 patients that had attended Bishop Auckland for example that this would equate to in terms of the proposed model that only 10 patients would need to be admitted to Sunderland, with the remaining 50 patients being treated in the same way they would be now, via services at Bishop Auckland or UHND. The Regional Director of Specialised Commissioning North, NHS England, Robert Cornall added that the pathway for those needing surgery was proposed to be via Sunderland, and if not requiring surgery they would remain to be treated locally at Durham.

R Hassoon noted concerns, from experience, in terms of proposed repatriation after surgery and asked as regards assessments carried out before this process. Mr P Davey noted that such repatriation would only be once a vascular care episode had been completed, patients would not be moved if further care was required.

Councillor H Smith noted the additional information had been useful and agreed that the clinical case for Sunderland had been made overwhelmingly, as had the financial case. She noted however that from the perspective of the DL12 and DL13 postcodes that the travel times stated were hopelessly optimistic, especially when factoring in car parking issues and the public transport provision in those areas.

Councillor A Hopgood agreed as regards the clinical case, and added that indeed Members had understood this at the July meeting. She noted that she was not convinced in terms of the travel time issues, with an apparent change in definition of where the emergency was considered from. Councillor A Hopgood noted recent closures of the A19 over the summer period, at least one time every week, and asked if these incidents had been taken into account.

Councillor S Quinn noted issues previously discussed in terms of ambulance waiting times when dropping off at Accident and Emergency and whether this would also impact.

The Chairman noted this was an issue being looked at by Chief Executive Officer, CDDFT.

Councillor R Crute asked whether there was a particular reason for the recommendation in terms of endorsement from the Committee prior to engagement. The Chairman noted that the issue was regional and the Regional Director of Specialised Commissioning North added that the programme of engagement would inform on the process to help ameliorate impact. Councillor A Hopgood noted that informing was not the same as engagement. The Regional Director of Specialised Commissioning North noted that through the engagement process if points were raised then where possible some changes could be made.

The Principal Overview and Scrutiny Officer noted that the review was region-wide and that the North East Joint Health Scrutiny Committee had asked that information be provided to Durham County Council's Adults, Wellbeing and Health Overview and Scrutiny Committee. He noted the information in terms of the clinical case, the costs, the impact assessment from NEAS and the options in terms of the Committee. Councillor R Crute noted he felt there was no requirement for Members to endorse the proposals as set out, with the recommendation within the report asking for the Committee to receive the report and note and comment upon the presentation in terms of the proposals and associated communication and engagement plans. He added that he felt the comments from Members had been made clearly and could be added and taken forward. Councillor A Hopgood agreed that there was no recommendation to endorse the proposals, noting she accepted the clinical case, accepted the financial case, however did not accept the case in terms of travel times.

Resolved:

(i) That the Committee receive the report.
(ii) That the comments made on the report are communicated to NHS England's North Region Specialised Commissioning Team 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.

Councillor J Robinson left the meeting at 11.00am

Councillor J Chaplow Vice-Chair in the Chair

7 Shotley Bridge Hospital Update

The Vice-Chair introduced those in attendance for this item and asked the Director of Corporate Programmes, Delivery and Operations, North Durham CCG, Mike Brierley to give an update report in relation to Shotley Bridge Hospital (for copy see file of minutes).

The Director of Corporate Programmes, Delivery and Operations reminded Members of the background of the North Durham CCG working with NHS Property Services to look at what future service delivery options may look like, the right services in the right places.

It was highlighted that the driver for change was the current state of the building and there was an opportunity to align strategy to provide more care closer to home, through review of the actual health needs and future needs in the area.

Members were given information in relation to the economic and financial case for change, together with a clinical case for change, the latter including the changes in GP services, and the relationships between health and social care services, working closer together in delivering care, for example TAPs.
The Director of Corporate Programmes, Delivery and Operations noted a stakeholder event in October 2017 and Reference Group Meetings, with the group including local Members and MPs, with the Portfolio Holder, Councillor L Hovvels chairing the group. It was added that the Healthcare Planner had set out the requirements for a new build based upon current activity with a 10% allowance for population growth. Members noted the options as set out within the report and were informed of the issues in relation to beds, theatre, chemotherapy, urgent care and out-patients.

Councillor J Robinson entered the meeting at 11.10am

Councillor J Robinson in the Chair

The Director of Corporate Programmes, Delivery and Operations referred Members to the next steps as set out in the report, which included: an outline business case to NHS England by the end of 2018; public consultation in early 2019; a full business case Spring/Summer 2019; with construction later in 2019.

The Chairman thanked the Director of Corporate Programmes, Delivery and Operations and asked Members for their questions and comments.

Councillor O Temple noted he had not slept well since reading the report and noted two truths. Firstly that a six-storey high building was not right for modern healthcare, with local Members understanding this, however, there was an expectation that something comparable in terms of services would replace this. He noted secondly that all the statistics that had been fed into the Healthcare Planner had been from current activity at Shotley Bridge Hospital, which he felt had been run-down deliberately over a period of time. Councillor O Temple explained he felt that it should be need that was tested, not the number of people that passed through the door. He added that while paragraph 71 of the report stated “It is important to clarify that no decisions have been made about the future delivery of services within Shotley Bridge…”, paragraph 38 referred to a 24 bed ward, paragraph 41 referred to CDDFT and UHND stating they did not supportive of delivering surgical services at locations other than their main sites. Councillor O Temple added that paragraph 45 noted plans to refurbish and increase capacity at the Durham chemotherapy unit and in relation to urgent care, the report stated that urgent care was only recommended during the hours 8.00 am to 12.00 midnight. He noted that these all seemed to be decisions that have been made. Councillor O Temple asked that the Committee not accept the report, rather note the report and request that a postcode analysis based on need be undertaken and this fed into the Healthcare Planner.

The Director of Corporate Programmes, Delivery and Operations noted that in terms of any run-down of services, this was not the case and patients were not referred away from Shotley Bridge. He added that where an appointment may become available sooner at another location, this would be offered to a patient for them to make a choice. He continued by reiterating that there had not been any decisions made, and that in terms of bed provision there would be a need to provide cost-effective solution, with the recommendation being for 24 beds. The Director of Corporate Programmes, Delivery and Operations noted the refurbishment in terms of the UHND Chemotherapy Unit, however, decisions had not yet been made and work would be undertaken to understand this issue. In relation to urgent care, he added that there were many other strategies and that the options were for discussion, with the recommendation being based upon activity. The Director of Corporate Programmes, Delivery and Operations noted the first draft postcode analysis and added that further analysis work, utilising Public Health systems, may be undertaken, with some work having been done provisionally.

The Chairman asked as regards what would be in the business case. The Director of Corporate Programmes, Delivery and Operations noted it would include: the strategic case; the financial case; options; the consultation process; and engagement prior to moving to a preferred options stage.

Councillor R Crute asked what information had been presented via the Reference Group and what had been presented to Committee. Councillor R Bell noted he seconded the request by Councillor O Temple in relation to analysis by postcode of demand not simply activity. He added that by activity would be acceptable if there was not a sense that some were steered towards other services.

Councillor L Hovvels noted she chaired the Reference Group and noted that the model being developed was good. She added that Members' voices were being heard and that meaningful information was being provided to keep up-to-date on progress and affording an opportunity to shape that progress. Councillor O Temple noted he was grateful for the Reference Group.

Councillor J Chaplow noted the report referred to potential in relation to hospice provision. The Director of Corporate Programmes, Delivery and Operations noted this was one option and discussions were taking place.

Councillor A Hopgood noted paragraph 23 noted sharing of resources and facilities and added that if there was potential impact on UHND then local Members for the Durham area should also be engaged with, for example impacts in terms of infrastructure, car parking and so on.

Councillor A Patterson noted the report recommendation asked to accept the report for information, however, to have a report in terms of the next steps and options back at Committee prior to consultation, inviting the Reference Group Members to attend. Councillor O Temple agreed, with the inclusion of a report by demand and locality. The Director of Corporate Programmes, Delivery and Operations noted that this type of information was being worked on and could be reported back.

Resolved:

(i) That the report for information be noted.
(ii) That a further report be presented to a future meeting of the Adults, Wellbeing and Health Overview and Scrutiny Committee, including analysis of need by locality/postcode, with members of the Reference Group being invited to attend that meeting.

8 Review of Urgent Care Hubs across Durham Dales, Easington and Sedgefield CCG

The Chairman introduced those in attendance for this item and asked the Director of Commissioning, DDES CCG Sarah Burns to give a presentation in relation to the review of Urgent Care Hubs across DDES CCG (for copy see file of minutes).

The Director of Commissioning began by explaining the difference of Extended and Enhanced Primary Care Access (EPCA) and Urgent Care, with changes that had been made in April 2017 in terms of retaining minor injuries units at Bishop Auckland and Peterlee, expanded same day appointments during the day across DDES for illness, and evening and weekend hubs in 9 areas across the geography. It was noted this was to get the right care for individuals, with "right care, right place, right person, right time", and to "talk before you walk", access services via the NHS 111 telephone number.

Members were referred to a comparison in relation to services in DDES with those in North Durham, in terms of minor injuries units, GP out-of-hours services, and extended access hubs. It was explained that there were other services in place, including: additional same day appointments in General Practices; day time "overflow services"; out-of-hours service; Vulnerable Adults Wrap Around Services (VAWAS) extension 8am-8pm weekdays and weekends, with proactive visiting if GP has concerns; day-time visiting services, from October 2018; and seven day palliative care services, from October 2018.

In relation to how the NHS 111 service directs patients, it was noted that a Directory of Service (DoS) sets out the conditions seen by a particular service, and that they did not differ between each EPCA hub. It was added that patients presenting injury would go to a minor injuries unit, either Peterlee or Bishop Auckland, or an out of area service if that was closer. Figures from an audit in the Durham Dales for the period 1 April – 18 August were given, noting one instance where there had been a missed opportunity.

The Director of Commissioning introduced Dr David Robertson, a GP from Barnard Castle to speak in relation to how a General Practice worked.

Dr D Robertson thanked Members for the opportunity to speak and noted one of the main points to note was the burgeoning quantity of patients seen at General Practices, and there was an ageing population combined with a greater complexity with some patients having 3, 4 or 5 issues. He added that in these cases managing multiple medicines and dealing with longer term conditions were becoming more commonplace.

Dr D Robertson noted that it was important to understand that General Practices worked as a team, with a significant percentage of care being given by Nurses, Healthcare Assistants and Receptionists where appropriate, as well as outside of the practice for example via VAWAS or District Nurses. Members noted that while EPCA focused on same day appointments it was noted some chronic and day-to-day issues were being managed via EPCA. Dr D Robertson noted that there was a particular geography and cohort of people in the Dales area, and there was need to ensure that the needs of patients in this area was met.

Members were introduced to Craig Hay, Emergency Care Practitioner (ECP) who was in attendance to speak as regards the role of an ECP or Advanced Nurse Practitioner (ANP) in comparison to a GP. C Hay explained how ECPs and ANPs usually came from another discipline, for example from an A&E background, from the ambulance service or Practice Nurse and this gave them a broad range of experience in many types of patient from acute cases through to issues associated with elderly. Members noted that ECPs and ANPs worked with autonomy and had the ability to spot serious illness, with many also being able to proscribe. It was added that their decision making ability was an excellent asset to the GP provision and out in communities too. It was explained that not all issues could be addressed via ECPs or ANPs for example pregnancy issues or mental health issues, though there were other clinicians within the practice team that could assist with those areas. C Hay explained that NHS 111 were the gatekeepers in terms of service adding that they were very accurate and safe with the appropriate patients being directed to the ECPs and ANPs. He noted that while ECPAs were not A&Es and sometime patients felt they were at the wrong site, they were seeing the correct clinician.

The Director of Commissioning noted the work since attending Committee including: a consultation, communication and engagement strategy having been developed; meeting with the Chair and Vice-Chair of the Committee in terms of an evidence log; Healthwatch having agreed to provide independent advice; a “myth-buster” having been developed with information supporting the review; there has been substantial support from Patient Reference Groups (PRGs); and there had been meetings with key Councillors across DDES; work with NHS England on the “5 tests” and NHS England Assurance have support for our approach; there was further patient engagement undertaken.

The Director of Commissioning asked Angela Seward, Chair of the Durham Dales Patient Reference Group (DDPRG) and Chair of Barnard Castle GP Surgery Group to speak in relation to her experience. A Seward noted that it had been clear that the DDPRG had consulted at every turn and there had been a lot of data presented, including that during the April to July period the Stanhope/Barnard Castle hub saw no patients. She added that there had been some misunderstanding in terms of the Richardson Hospital, noting it was not a “walk-in”, rather appointments were made via NHS 111. A Seward noted that there had been consultation and the information that had been provided was clear, and the DDPRG supported the CCG in the proposed changes to help our rural population. The Director of Commissioning noted there had been similar PRGs within the Peterlee, Easington and Sedgefield areas.

Members were referred to slides highlighting the engagement and publicity undertaken, including on social media, regional publicity and via DDES Health Federations and displays within surgeries and via websites such as NHS Choices.

The Director of Commissioning noted in summary of the review: services are valued, but utilisation is very low in some areas; 111 received very positive feedback; current capacity was double the national recommended requirement; there were concerns as regards retaining staff in hubs where usage was low; value for money of current services was an issue given the health needs of the DDES population; and Practices are supportive of the proposed changes and think we could meet patients' needs in a different way. Members noted how the proposed services could look and were asked as regards what would enhance the proposals, and also noted how consultation would take place and what questions that would be put to patients.

The Chairman thanked the Director of Commissioning and the other speakers and asked Members for their questions and comments.

Councillor J Grant thanked the speakers for the clarity of their presentation and noted she felt there needed to be more publicity of the 111 and the hubs as another option other than a GP appointment, she noted that she had been asked to ring back to the GP surgery rather than the option of 111. Councillor S Quinn noted the opposite experience, with her GP surgery advising of the option to call 111.

Councillor R Bell noted promotion of the Richardson Community Hospital and felt it could be clearer as regards appointment only via 111 and that it did not treat injury, even via 111. The Director of Commissioning noted each hub had received the same publicity, with the regional message, and added that depending upon the clinical issue then each type of service would be appropriate, for example chest pains would perhaps warrant a 999 response. The Chief Clinical Officer, DDES CCG added that the entire region worked similarly, to go to the nearest service, with the DoS setting out where.

The Chairman noted that consultation, communication and engagement plan was set out from page 45 of the report and the Director of Commissioning noted the timescales in terms of consultation. Councillor R Bell noted that where 111 did not direct to a local centre, then the public should be made aware of what was available, to allow the public to challenge. The Chief Clinical Officer, DDES CCG noted that the DoS would set out suitable centres and Dr D Robertson noted his staff would look to see where a patient is directed to Bishop Auckland, whether it would be possible to direct to Barnard Castle.

The Principal Overview and Scrutiny Officer noted that given the concerns in terms of the missed opportunity and the proposed 6-8 week consultation, the Committee could take assurance and have further information over that period to monitor the situation.

R Hassoon asked as regards mental health provision at GP surgeries and noted she believed NHS Choices had been disbanded. Dr D Robertson noted that typically, though not always, ECPs and ANPs did not have mental health training and patients would be directed to a GP, for example if in the Dales area to Bishop Auckland. The Director of Commissioning noted that she would check as regards NHS Choices.

A Seward added that the Barnard Castle GP Surgery Group cared very much as regards the Richardson Community Hospital and wanted to understand the difference in services between EPCA and the Richardson.

Resolved:

(i) That the Committee receive the report and comment of the presentation and information contained therein.
(ii) That during the 6-8 consultation, information in terms of missed opportunities be recorded and monitored, and reported back to Committee at a future meeting.

9 HealthWatch County Durham Annual Report

The Chairman thanked the Project Lead, Healthwatch County Durham, Marianne Patterson and Mr Christopher Cunnington-Shore, Board Member of Healthwatch County Durham to present their annual report (for copy see file of minutes).

The Project Lead referred Members to the annual report as appended to the agenda papers and noted the background as regards the creation of Healthwatch as a consequence of the Health and Social Care Act 2012, to be an independent consumer champion and to push for change and improvements in health and social care. She added that all Local Authority areas had a "Healthwatch", with County Durham having a relatively small complement of 4½ FTE staff, albeit with a huge number of very active volunteers, including the Chairman and Board Members, including Mr C Cunnington-Shore.

Members noted an engagement statement was being worked upon and it was noted that over the first year it was clear the tone was for collaboration, and for Healthwatch to help gather meaningful feedback from service users, whilst still retaining independence, wanting outcomes for patients. Councillors noted work that had been undertaken including in terms of pharmacy services, powers to "enter and view", looking at high performing wards and UHND and seeing what lessons could be learned. It was added that Healthwatch had also provided information and signposting and had been asked by the Council to user-test in respect of data accessibility, with 6 recommendations having been taken on board. The Project Lead noted that Healthwatch County Durham was shortlisted for a Healthwatch England Award and learned as regards work in terms of barriers to Cancer Screening and Stroke Services.

Mr C Cunnington-Shore noted he felt it was important to understand what was meant by the phrases Healthwatch being "on board" and "engaged with". He felt it would be important for Healthwatch to let Overview and Scrutiny know as regards the level that Healthwatch had been involved in any issue and what support was given, and allow Overview and Scrutiny to challenge any assertions as regards engagement, consultation with Healthwatch.

Councillor R Bell asked if it was possible for Overview and Scrutiny to ask Healthwatch in terms of consultations. The Project Lead noted it was possible depending upon the issue and capacity.

The Principal Overview and Scrutiny Officer noted the requirements in terms of the 2012 Act and with the Committee inviting Healthwatch to the meetings in order to have a conduit for the exchange of information, with several examples and regular meetings of the Chair and Vice-Chair with Healthwatch representatives.

He added that it would be useful when the Committee was presented with cases for change that Healthwatch had been involved in the process, and not simply asked for a retrospective opinion.

Resolved:

That the Committee receive and note the presentation by Healthwatch County Durham in respect of their Annual Report 2017-18.