Time commenced – 18.00
Time finished – 20:35

ADULTS AND HEALTH SCRUTINY REVIEW BOARD

8 November 2021

Present: Councillor Martin, (Chair)
Councillors Cooper, Froggatt, Hussain, Lonsdale (Vice Chair), and Grimadell

In Attendance: Zara Jones, Executive Director of Commissioning Operations, Derby and Derbyshire CCG
Jo Keogh, Divisional Director, Chesterfield Royal Hospital NHS Foundation Trust
Louise Swain, Assistant Director, Integrated Community Commissioning, Derby and Derbyshire CCG
Clive Newman, Director of GP Development Derby and Derbyshire CCG

11/21 Apologies for Absence

Apologies were received from Councillor Pegg

12/21 Late Items

There were no late items

13/21 Declarations of Interest

There were no declarations of interest

14/21 Minutes of the Meeting on 15 June 2021

The Minutes from the meeting of 15 June 2021 were agreed as a correct record.

The Chair requested an update for the recommendations at 5/21 and 6/21 for the next meeting.

15/21 COVID 19 Update Report

The Board received a presentation from the Assistant Director of Public Health which gave an update on COVID 19 in Derby. The officer informed the Board that in the 7 days to 30/10 there were 887 cases. The Rate was 345/100,000. The National rate (up to 07/11) was 402/100,000.

Regarding PCR Testing there was a reduction in testing over the half-term week but in the early part of last week, with the return to school, the figures rose. Cases continue to be broadly distributed across the City. The highest rates are in the school age population with an indication of household spread through to older family members. There was an increase in the cases for over 60's to 200 per 100,000, similar to levels seen in January 2021. Some people continue to be hospitalised with COVID although notably fewer than previous waves. There is an interactive map of cases and vaccination uptake down to Middle Super Output Area (MSOA) available, a link could be circulated to councillors.

Regarding Vaccinations there has been an increased update. Communications have taken place on timing and access to vaccination, including community languages and letter drop targeted to areas of lower uptake. Home based vaccinations have been offered to people with severe mental health issues and an outreach or pop-up offer was being developed for homeless and asylum seeker populations. There was an engagement/ conversation programme underway to explore attitudes to vaccination in Derby's black communities, as part of Black History month, and winter health promotion messages and access to support services was being made available at vaccination sites.

Cases in the community continue to be stubbornly high and COVID continues to be a risk; it was recommended that people continue to follow stay safe guidance. There was some concern over the continued high case rate, particularly moving into winter, as well as the potential impact of flu and other circulating viruses. Vaccination uptake continues to be promoted.

A councillor was concerned about the failing efficiency of the vaccination. The officer explained there was a vaccination push for the booster vaccination, and they were looking at an overall rate of about 200 per 100,000. A councillor asked which part of the community was not taking up the vaccine. The officer confirmed the lowest uptake was in the inner City and the more deprived areas of the City, explaining that it was a mixed and complex picture; however, the service was making the vaccine available and accessible to as many people as they could. A councillor asked what the take up of vaccination was by ward, and for school aged children. The officer said she would contact a colleague who had more detail about issues in the community. She explained that the data about take up for school aged children was not reported through the national system now, but she thought it was approximately 40%; she would try and get more detailed figures for the Board. A councillor asked what was the take up of the vaccine across the City and the officer confirmed that it was 77% for the first vaccine dose across the City and 71% for the second vaccine dose. Councillors were concerned that work was still ongoing to reach all communities across the City. The office confirmed that agency work was ongoing to reach out to people across the City and in the last week the percentages of people has risen slightly. There had been several outbreaks in schools and pupils who caught COVID would have to wait for 28 days before being able to have a vaccination. A Councillor asked how long Midland House would be in operation as a vaccination centre, and the officer said she would find out and let the Board know.

Another councillor asked about the pressures the hospitals are facing, how long are people admitted to hospital staying. The officer confirmed the rate of admission was much lower than previously. The number of people that have COVID, who come to hospital was significantly less. The health system was under pressure, but there was less impact than before. The wider pressure was the significant concern about the continued high rates in the community as well as the threat of other winter viruses such as flu. The councillor asked for the current rate of deaths from COVID. The officer confirmed she would look this up and send the information to the Board.

The Board resolved to note the report

16/21 Hyper Acute Element of the Stroke Service

The Board received a report which provided an update on the Hyper Acute Element of the Stroke Service. The report was presented by the Executive Director of Commissioning Operations, Derby and Derbyshire CCG alongside their colleague from Chesterfield Royal Hospital who was a Divisional Director and lead for the programme of work

The officer explained that the NHS Long Term Plan (2019) had identified stroke as a clinical priority for the next 10 years. Chesterfield Royal Hospital (CRH), along with many other stroke service providers, face significant challenges in delivering these ambitions. One of the greatest challenges that stroke service providers face was ensuring the availability of the appropriate workforce, in particular the consultant workforce.

The Improvement Plan was highlighted, and it was explained that an independent review of the stroke service had been undertaken, including scrutiny of how the service operates. A Stroke Improvement Plan had been developed to respond to the immediate challenges of: Staffing and workload; Improving clinical leadership and presence; Governance mechanisms. However, whilst the Trust had made significant progress against the plan, performance remained challenging and was aggravated by a lack of Consultant Stroke Physicians.

The officer drew attention to the medical workforce risk. The Trust had successfully recruited a long-term locum Consultant Stroke Physician; but this did not lessen the risk to the sustainability of the Hyper Acute Stroke Unit (HASU) because of medical workforce availability. A Contingency plan had been implemented to mitigate short-term service risks and all the surrounding trusts have signed up to the plan.

The Derbyshire Stroke Delivery Group recommended a task and finish group should be established to lead a service review and options appraisal of the HASU service. To manage the potential conflict of interest between members, Dr Deborah Lowe (NHSE/I National Clinical Director for Stroke) was appointed as the Independent Chair. The work began in May 2021, the task and finish group meet monthly to agree key actions and drive the programme forward; they report directly to the Derbyshire Stroke Delivery Group. Five initial delivery model options are being discussed for their viability:

- The Chesterfield Royal Hospital's Hyper Acute Stroke Unit provision continues as it is.
- The current Hyper Acute Stroke Unit service at Chesterfield Royal Hospital is strengthened by redesign
- Chesterfield Royal Hospital introduces a review and convey model; a model where patients are assessed and treated within the Accident and Emergency Department followed by immediate transfer to a Hyper Acute Stroke Unit
- Decommission the Chesterfield Royal Hospital Hyper Acute Stroke Unit element of the Stroke Service pathway
- Review of the Chesterfield Royal Hospital Hyper Acute Stroke Unit service as part of a wider East Midlands review to rationalise sites

The Board were informed of the UHDB position "Consolidation of HASU on the RDH site was the right clinical and strategic option. However, the combination of greater than anticipated patient numbers and operational issues has stressed the service to a degree that was not envisaged in the original modelling"

The officer highlighted that the RDH HASU was the 6th busiest in the country; treating around1340 confirmed strokes per annum. Based on the population 11 Medical Consultants were needed, currently there were 7 in post. There was a Consultant, Clinical Nurse Specialist and Therapist expansion plan in development. If CRH HASU Service were to be decommissioned RDH would expect an additional 83 patients per annum including mimics (people with signs/symptoms of stroke but who have not had a stroke).

The officer explained the next steps, as an Options Appraisal Workshop planned for 25 November. Following this, an Independent Panel was planned, possibly on 13.12.21. The Independent Panel would be asked to make a recommendation to Derbyshire Stroke Delivery Group of the preferred option(s).

A councillor asked if the CRH was a centre of excellence now for stroke care and asked where Derby Royal fitted in with Stroke treatment; talking about 35% patients from the Royal go to Chesterfield Royal what was the criteria for patients from Derby going to Chesterfield. In terms of the data this was more about patient flows than about centres of excellence. Chesterfield was a district general hospital and was a much smaller organisation than UHDB. The data shows that circa 35% of Derbyshire patients go to Chesterfield Royal. This proportion was not due to the outcomes or clinical excellence of the service; it is more operationally about where those patients live or where they are based at the time of stroke symptoms and where they get taken to by ambulance; just over a third of Derbyshire patients are impacted by the challenges we are presenting. The patient flows are such that if Chesterfield could not receive patients at that time, a vast majority would go north to Sheffield with a smaller number going to Nottinghamshire, with a smaller number still going to Derby.

A councillor asked if Derby being 6th busiest in the country was a concern. However, before people come to acute services, do you work to prevent people accessing the service; is a similar amount of resource put in to stop people coming through the doors, such as quitting smoking etc? What are the

resources to stop people and how much interaction do you have with those services? The officer highlighted there was a need to do more and that was recognised; we are looking at how we can put more funding into more upstream preventative services, self-care services. There was a range of factors that can come together to cause an individual to have a stroke, there are several preventative services already being invested in. There was a constant increase in healthcare demand and need it was a balancing act between treatment and care. If the service does more preventative work, we will see less strokes in future, but this would be a long-term investment.

The Chair felt it was important to have staff that can treat people. If your nearest and dearest has had a stroke you want them to have the best treatment. There was also the ability of the connection with hospital and relatives being able to visit. The Royal Derby was an extremely busy site and was expressing the pressures on their service already, Chesterfield Royal was a distinct centre geographically and in terms of people's social and mental mapping of where they live. You are seeing as units, a county, and a flow of patients. However, these are human beings who have connections. Most people north of Chesterfield relate more to Sheffield and go there more frequently. Chesterfield is a deprived town, the villages surrounding are also deprived, people don't always have cars, there was an ageing population in this area. The people of Chesterfield are more likely to travel to Sheffield rather than Derby. The Chair asked for the officer's reaction to these comments and also to the viability of the importance of Chesterfield as a Hospital if services are reduced over time?

The Officer confirmed that the service was talking about numbers and data but there are people behind those and we are taking a patient centred approach in our proposed process, looking at a range of criteria, and furthermore it was not just about the patient, it was about family connections, caring responsibilities', travel and accessibility. The Board were given reassurance that the service will be looking at all those factors, the broad stakeholder workshop would make sure that views were heard from every perspective. The service has a duty of care also to the population in terms of clinical outcomes and ensuring safe services. However, the medical workforce challenges are very stark and real; we have contingency planning in place to make sure that we know what we would do if issues arise, but this does not address long term sustainability. The service is looking at all the different criteria, all the points you have raised are part of the process, the independent panel have the job of weighing up all those issues and saying from that what are our recommended options.

The Chair thanked the officer for attending this meeting and hoped that they would take away the points raised from the discussion. The Board looked forward to receiving an update on progress at a future meeting.

The Board resolved to note the report.

17/21 London Road Community Hospital Transformation Project – Wards 4, 5 and 6

The Board received a report regarding the London Road Community Hospital Transformation Project, Wards 4, 5 and 6, which was presented by the Assistant Director Integrated Commissioning at Derby and Derbyshire CCG (DDCCG).

The officer explained the background of this report. Wards 4, 5 & 6 at Florence Nightingale Community Hospital (FNCH) provided 76 short term rehabilitation nursing beds. As a response to covid-19, and in line with national guidance ("COVID-19 Hospital Discharge Service Requirements"), RDH discharged patients from Wards 4, 5 & 6 to enable these wards to be repurposed for supporting the Covid19 response. This provided a system wide opportunity for the partial reallocation of the FNCH monies to fund development of pilots/alternative services which support patients to be discharged home first where possible. There was due to be an Engagement process around October, but this did not take place and has been postponed to the New Year.

The officer highlighted the workstreams/pathways that would allow for improved patient outcomes and explained that all the pilots will be evaluated, and a Business Case will be developed to inform long term decision making/investment.

1. Dementia Palliative Care
2. Additional P2A/P2B Capacity*
3. Derby City enhanced P1 Service delirium pathway*
4. Discharge Assessment Unit
5. Frailty Admission Avoidance
6. DCHS P1/P2 additional capacity

**P1 rehabilitation services people discharged home, care in home with occupational therapy P2 linked to residential rehabilitation beds in Perth House*

The Chair queried whether it was proposed not to have rehabilitation beds and for all patients to go to the Home First System. The officer confirmed that there would be no additional beds in the City, but they are exploring whether ten beds could be provided. They intended to block purchase ten beds in the City.

The officer then highlighted the governance arrangements which included the Derby City and Derbyshire County Councils Overview and Scrutiny Boards, The Joined-Up Care Board (JUCD). The Clinical Commissioning Group (CCG) Governing Body the London Road Community Hospital (LRCH) Programme Board, The Derby City Place Alliance, and the Strategic Discharge Group. Pathways 1, 2 and 3 had been discussed and overseen by the Strategic Discharge Group.

The officer then described the Communications and Engagement Plan. The proposal was to deliver a comprehensive engagement programme which would run for at least twelve weeks. Before starting the engagement, it would

be necessary to collect relevant data on patients from service providers and in discussion with Healthwatch Derby. The engagement would begin once the Quality Equality Impact Assessment process had been completed.

The officer explained the Evaluation Framework which had four main aims:

- To improve outcomes in population health and healthcare
- To tackle inequalities in outcomes, experience and access
- To enhance productivity and value for money
- To help the NHS support broader social and economic development.

A slide highlighting the data and evidence was presented, tracking the percentage of people discharged to match their needs. The pattern showed that the service was improving at discharging people into the right places at the right time. More patients were being discharged to their homes. The Chair felt that the data provided evidence of what was being done but not its effectiveness.

The Chair thanked the officer for providing the report which would have been better appreciated if they had been able to read it before the meeting. The officer had understood that the information had been submitted in advance of the meeting, however apologised if it had not been circulated. The Chair understood that essentially the system was in a healthcare crisis, health, and social care was at level 4. One reason for this was the lack of staff to deliver care, people were not being discharged from beds as quickly as they should be by the Royal Derby Hospital which was causing a whole series of problems. More people discharged from care homes which was not ideal. Patients are not achieving the best in their own home, and it also increases costs on the council as they may stay in their own homes for longer. The Chair was concerned that the process was not working.

The officer explained that the service was in a very difficult position going into November and winter in terms of the recruitment of staff across the board. Clearly the services available are not meeting demand across the board. We are trying to mitigate and to look for alternative ways of finding provision for patients to be discharged. One is looking at commissioning/purchasing further interim block purchase beds so that we can support flow across discharge to assess pathways. However, the system was under intense pressure right across the board.

There was discussion about the compulsory vaccination of Care Home staff and the effect this would have on the staff leaving employment and further recruitment. Councillors felt that Care Home staff were not suitably remunerated for the work they undertake. The officer confirmed the difficulties and explained that the service was doing their best to ensure there was enough capacity, by block purchasing beds from the private sector; it was a very pressured situation but one they were trying to resolve.

A councillor supported the work being done and felt it was a better option than patients being in a Care Home and then going home, but the problem was the lack of staff being available. The councillor asked how many people would be able to manage in their own homes without intensive support, and what was the plan for handover as many people still have ongoing needs for care after

discharge home. The officer was unable to provide this information but would include some data in future briefings. The model would look at demand over a period to see what numbers of staff would be needed and who took over the care of patients. She explained that there were varying levels of need for types of patient for example stroke patients. Another councillor asked if the 10 beds available were at Perth House and if there was a cost analysis between the cost for Care Home beds and for similar beds in Wards 4,5 and 6. The officer explained that a cost analysis would be provided in a report when information was put together. The councillor queried where the beds would come from and how much would they cost. The officer explained the beds would be block purchased from a facility in the City. A councillor asked if the report could come back as a pink paper as they would like to see the detail in advance of the meeting.

The Chair thanked the officer for attending this evening and stated that it was a brilliant report and hoped that the Board would hear from you again as she understood that the Board need to hear further evidence. However, the scenario was a system in crisis that was not working, there are no Home First staff to deliver care. The care packages are for some but not all people, would cost so much that it was questionable whether this would be good value for money. It could be cheaper to have people in a hospital bed where other support was available. The Chair noted that it was now acknowledged by the CCG that nursing beds were needed, but instead of providing them within the NHS, care homes and private providers were being asked to provide them. Whilst not being against this totally she felt that closing all rehabilitation beds at London Road or Florence Nightingale was premature as there would always be a need for 20% to 50% of people who need help and support that involved nursing care. The Chair appreciated that a further report would be brought back to the Board, but would like to ask the Board to support a feedback comment to you at this stage:

The Board supported the report but commented that the decision to permanently close all rehabilitation beds at Florence Nightingale Community Hospital was premature and should be reviewed to provide beds within the NHS for those patients who do need them. The Board was not convinced that some beds were not needed at Florence Nightingale Community Hospital. The Board agreed the comment.

Another councillor asked if the officer and her team could investigate what a mixed offer would be like, not just closing Wards 4,5 and 6 but also providing a cost-based analysis of using Care Homes and retaining beds in Florence Nightingale. The Board asked the officer to investigate the mixed offer and provide feedback on what a mixed model would look like.

The Board noted the report and provided the following feedback comment to the officer:

The Board supported the report but commented that the decision to permanently close all rehabilitation beds at Florence Nightingale Community Hospital was premature and should be reviewed to provide beds within the NHS for those patients who do need them. The Board was not convinced that some beds were not needed at Florence Nightingale Community Hospital.

18/21 GP Appointments (Face to Face and Online)

The Board received a presentation from the Director of GP Development Derby & Derbyshire CCG. The presentation gave an overview of GP Appointments face to face, telephone and online.

The officer gave details of activity in General Practice in Derby and Derbyshire, approximately half a million appointments are offered every month they were at similar levels, or more, than before the pandemic. The number of face-to-face appointments has fallen to 60% from 85% before the Pandemic. However, overall Derby and Derbyshire's appointments are in line with, or more than, other counties in the Midlands. The demand for appointments was currently surging and was approximately 12% higher than normal at this time of year.

In Derby and Derbyshire and across England, COVID has brought changes to the mix of face to face and telephone appointments. The move to more telephone and online appointments was happening before COVID. It has been national policy for a long time. National best practice was to have a mix of ways to treat patients: face to face, online, telephone and a mix of people seeing patients, not everyone needs to see a GP and more options give better outcomes and quicker treatment. GPs should and will offer face to face where appropriate, but there is no agreed and evidence based national standard for the percentage of face-to-face appointments that should be offered – it depends on the clinical condition and what the GP and the patient think is the best option.

Access for patients, and demand on practices, was the main concern for many patients and practices in Derby. The service has not had regular information about access to General Practice but has started to receive this at a practice level. There had been an annual national patient satisfaction survey for a sample of patients from each practice. In Derby the survey showed mixed levels of patient satisfaction, some practices had outstanding levels, and others fell below the national average. The key concern of patients in the survey was their ability to get through to the practice, and about the waiting time for a GP appointment.

The officer explained that Derby practices are offering more appointments now than before the pandemic, also more on the same day. The practices follow COVID rules for infection prevention and control and manage increased staff sickness and absence. They are undertaking COVID vaccinations and catching up on the backlog of patients. GP services are part of an overall programme of health and social care, long hospital waits, cuts to drug, alcohol and smoking services and cuts in social care; all directly increase the demand on General Practice.

There are a lot of national and local initiatives to try and improve GP access, increasing the workforce, providing additional appointments, recruiting, and retaining staff, developing nurses and other staff, reducing unnecessary administration, improving digital access. The officer explained the position in Derby and highlighted that no services have been decommissioned or

paused. There was a backlog on checks on some patients with long term conditions and GPs are prioritising those most at risk.

The access to GPs in Derby was a priority for practices, but they are working hard under great pressure. The demand and pressure on staff would probably be high over the winter, and there were concerns for staff wellbeing as there has been an increase in aggressive and violent behaviour towards GP staff. Practices are reporting high levels of staff stress and burnout.

A councillor asked why on-line services were now not accessible. The officer explained that during the pandemic the standard operating procedure had moved away from on-line, and practices were encouraged to use the phone, some focusing on phone triage over on-line. However, this had since been updated so practices should be returning to a mix of options including online booking.

Another Councillor was concerned that the situation had become worse since the Pandemic and explained that a lot of his constituents were in despair over getting GP appointments. Most of them saying “when we need to contact our doctor it is impossible to get through” and asked if appointments could be booked for the following day or a week in advance or if a link could be sent so people can make appointments by internet. The officer explained that practices try to balance demand against capacity. To ensure they have capacity for urgent same-day appointments, they block chunks of same day appointments for urgent work, limiting their ability to book appointments ahead. The balance between urgent and non-urgent appointments with limited capacity puts patients the loop of being forced to go on the same day. The officer stated that originally the position arose from set national targets so people can book and see a GP in 48 hours (since withdrawn). Some practices are entrenched and cannot make changes to the process. It varied from practice to practice in Derby. However, he recognised that this made things very difficult for patients and needed to be changed, and that the CCG needed to continue its work with practices to help them review and improve their process.

The Chair felt problems getting GP appointments were “dangerous” as some people needing medical help had mental illnesses. Another councillor stated that it was it was difficult or not convenient for some people to get non-urgent appointments and asked if practices could release appointments later in the day. The officer explained that practices are businesses, rules cannot be put in place to make them release appointments, the practices are trying to manage capacity of staff and demand for appointments.

The Board had concerns about staff mental health and asked what had been put in place to help. The officer explained there was a GP Task Force and a National Pilot supporting Health and wellbeing of staff; measures included consultations with patients to try and tone down their behaviour and working independently with practices to support them.

The Chair felt that all health services are under pressure for a lot of reasons but noted that the level of independence of GP Practices makes it difficult to intervene. It was good to have flexibility, but it does make it difficult to bring rigour to the appointment process. There was sympathy for the service, which

was underfunded, and had a shortage of GPs, but there was a need to stress the sense of desperation that people feel at the difficulty of access to GPs. It was important to have a mix of appointments, but actually getting to the bottom of people's problems involved empathy with the patient and in the long run face-to-face appointments save time. The officer felt this was a view shared by most GPs who are also keen to see people face to face where possible and appropriate.

The Board resolved:

1. **to note the presentation.**

2. **The Board recognised that most GP Practices were working to improve access and they urged the CCG to work systematically to urgently improve GP access and in accordance with its plan improve access to face to face appointments**

19/21 Work Programme and Topic Review

The Board considered a report of the Strategic Director of Corporate Resources presenting the proposed work programme of the Board for the remainder of the 2021/22 municipal year.

The Board discussed and suggested items to be included on the Work Programme for 2021/22 and agreed an additional item to be added to the Work Programme

Adult Special Needs – how quickly are people being diagnosed with ADHD

The Chair updated the Board on the progress of the Topic Review. The Board heard that a working group meeting had taken place on 27.09.21. Dates were being finalised for further meetings at the end of November. A letter to be circulated to Care Homes was being finalised.

The Board resolved to note the contents of the report.

MINUTES END