Better Health Programme – Minutes
7 July 2016

1) Present

Councillors:

Darlington Borough Council – Councillors Newall, Taylor and Tostevin
Durham County Council – Councillors Robinson and Blakey
Hartlepool Borough Council – Councillors Martin-Wells, Cook and Belcher
Middlesbrough Borough Council – Councillors Dryden and Brady
North Yorkshire County Council – Councillors Clark, Blackie and Dickinson
Redcar and Cleveland Borough Council – Councillors Goddard, Ovens, Cooney and Sedgwick
Stockton Borough Council – Councillors Bailey and Hall
Officers:
Stephen Gwillym (Durham County Council), Elise Pout (Middlesbrough Borough Council), Sharon Jones (Stockton Borough Council), Joan Stevens and Laura Stones (Hartlepool Borough Council), Alyson Pearson (Redcar and Cleveland Borough Council), Peter Mennear (Stockton Borough Council)
Better Health Programme:
Amanda Hume, Dr Boleslaw Posmyk, Rebecca Hassack, Dr Neil O'Brien, Ann Farrer, Mary Bewley, Derek Cruikshanks and Andrew Robinson

2) Appointment of Chair

Councillor John Robinson (Durham County Council) was appointed as Chair of the Better Health Programme Joint Health Scrutiny Committee.

3) Appointment of Vice-Chair

Councillor Ray Martin-Wells (Hartlepool Borough Council) was appointed as Vice-Chair of the Committee.

4) Apologies for Absence

Apologies for absence were received from the following:-

Councillor Walker – Middlesbrough Council
Councillor Stelling – Durham County Council
Councillor Scott – Darlington Borough Council (Cllr Tostevin as substitute)
Councillor Akers-Belcher – Hartlepool Borough Council (Cllr Belcher as substitute)

5) To receive any Declarations of Interest by Members

No Declarations of Interest were received.

6) Better Health Programme Joint Health Scrutiny Committee – Proposed Protocol, Terms of Reference and Project Plan

The Principal Overview and Scrutiny Officer presented a report setting out the proposed Protocol, Terms of Reference and Project Plan for the establishment of a Joint Health Scrutiny Committee under the provisions of the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013. The Committee had been established to examine the Better Health Programme (BHP) and any associated service review proposals.

The membership of the Committee reflects the footprint for the Better Health Programme (BHP) and has been extended to include North Yorkshire County Council in view of the patient follows from North Yorkshire into the Better Health Programme area.

The Principal Overview and Scrutiny Officer highlighted to Members that the Committee was the formal statutory body to comment on the proposals but the Committee will not have the power to refer any decision to the Secretary of State, this power being retained by each individual Local Authority.

Future meeting dates have been set but if additional meetings are required, this would be an option.

The Principal Overview and Scrutiny Officer notified Members that representatives of the Better Health programme were in attendance at the meeting to outline the background to the BHP and the pre-engagement activity undertaken and the outcomes.

The Chair confirmed that the Local Authorities adjacent to the Better Health programme area had been informed of the meeting and received copies of the agenda papers to keep them informed.

7) Better Health Programme

A representative from the BHP thanked the Committee for the opportunity to attend the meeting and for the establishment of the Joint Committee. Members were given an outline of what was going to be covered at the meeting, which included the background to the programme, how it had developed overtime, how feedback had helped shape the programme. Members were informed that formal consultation would take place in the Autumn 2016.

The Committee was informed that the BHP had developed over time and now incorporated out of hospital care and was looking at improving standards both in and out of hospital. A BHP representative welcomed early dialogue with the Committee and feedback from the Committee.

The Committee requested details of the specialist services that are being examined as part of the Better Health Programme and also how these services are currently provided at each of the BHP Acute hospital sites i.e. Hours of

operation and how staffing levels are arranged and monitored to deliver the services.

The importance of statistical evidence was highlighted by the Committee and specific information was requested in respect of current performance at acute hospital sites regarding:-

- Current performance in respect of average waiting times in A&E.
- Current performance regarding handover times from NEAS and Yorkshire Ambulance service to Acute Hospital staff.
- Current performance in respect of Elective surgery across the BHP sites including the numbers of elective surgery cancellations and the reasons for these cancellations.
- NEAS Response times across the BHP area.
- Mortality levels across the BHP footprint and beyond.
- What benchmarking statistics are available?

The Chair was also aware that the potential Phase 4 long list of options had been shared at a stakeholder event and requested that this be shared with the Committee along with the key principles to be used during the options appraisal process to ascertain short list options.

The BHP representative confirmed that this information would be available for the next meeting on 21 July 2016.

A member questioned how this ties in with North Yorkshire CCG and it was confirmed that the BHP team were working closely with North Yorkshire CCG. The Committee identified that public engagement needed to take place in the North Yorkshire area.

A presentation was delivered to the Committee by representatives from the BHP, covering the following key points:-

- The BHP programme had evolved from the Acute Services Legacy Project and Securing Quality in Hospital Services (SEQHIS).
- The vision for the BHP is “meeting patient needs now and future proofing for the coming generation with consistently better health and social care delivered in the best place and within available resources.
- Both the Acute Legacy Project and the SEQHIS project looked at best practice and as a result 700 clinical standards were developed and it is now a commissioner led process working closely with partners.
- The project has transformed to include out of hospital care, as the vast majority of contacts people have are with GPs and community health services.
- Some of the reasons why the BHP has developed include an increasing elderly population, recognised shortage of specialist skill and specialist teams provide better outcomes.
- Care delivered through a network of hospitals and community services.

- More seamless care close to or in the patient's home where safe and effective, access to urgent and community care 24/7.
- Patients only admitted to hospital where it is no longer safe or effective for them to be cared for in the community.
- Access to specialist opinion 24/7 where this improves outcome, e.g. heart attack, stroke, trauma, or internal bleeding.
- Planned care organised so there is no unnecessary waiting, no cancellations and patients not exposed to risk of infections.
- Highly responsive, effective and personalised services outside of hospital for people with urgent but non-life threatening needs.
- People with more serious or life threatening emergency needs treated in centres with the very best expertise and facilities in order to reduce risk and maximise their chances of survival and a good recovery.
- Planned care in an environment separate from emergency care which avoids unnecessary delays and cancellations.
- Quality, workforce, access, resources all need to be taken into account when making a decision.

Following the presentation, a Councillor questioned the distance that you have to travel for specialist care, as this is a major concern for patients, families and carers as not everyone drives. For example, it is not only the travelling as part of the specialist care, but the follow up appointments are often at the same hospital, requiring people to travel. For people who cannot drive, trying to get to an appointment at 8.30am is very difficult. A representative from the BHP informed the Committee that there is a whole range of issues relating to access to services and it is one of the areas that the BHP team are looking at and where the services can be delivered locally and safely then they can look at this. Specialist services will need to be balanced with Access. For example, some care that used to be provided at hospital accident and emergency units is now provided by North East Ambulance Service paramedics in ambulances to prevent hospital admissions. Members were informed that whatever can be brought local will be. It is about organisations working together and providing a network of services. A Councillor highlighted that the joining up of services was very flawed, with a lack of connection between services. A BHP representative stated that this was a common theme that had been voiced throughout the consultation events. For example, when people attend Accident and Emergency (A&E), they assume that the department has access to their GP records, and many do not.

A Councillor was of the view that there seems to be a lot of talking around the issues but not necessarily any action. A BHP representative confirmed that action had been taken on some areas, for example, the sharing of GP records. GPs are signing up to the North Care Record in order to be able to share data. It was confirmed by a BHP representative that at the next meeting a list of 'early wins' would be provided to the Committee.

A Councillor questioned whether the BHP will ever come to an end, as it seems to have been developing over many years, moving from one project to the next. In response, a BHP representative recognised that the programme had started out as hospital services and through engagement has broadened out, and

developed and improved as it has moved along. In terms of new technologies being developed, there will always be improvements and transformation of services but it will be carried out in a structured way. For example, the development of trauma centres has demonstrated a 30% reduction in mortality and there are always continual improvements with the NHS trying to keep up. It is similar with stroke, the outcome for stroke patients is improved but the technologies are expensive with specialist doctors providing the services in fewer centres. Feedback received from the public has shaped the programme and changes are a direct result of the feedback. For example, cancelled operations were introduced into the programme as a result of feedback.

A Councillor was interested to hear what penalties were in place for Trusts who cancelled planned operations/procedures.

Regarding the comments contained in the report on public feedback received to date, a member commented that it seemed as though the public comments had been scripted.

A Councillor was of the view that the BHP was another way of the NHS removing local services from local people. Everyone wants better health and the best services but people still like emergency care to be close.

A Councillor questioned what the objective of the meeting was and raised a concern that it had been said that any changes would be met from existing resources. He asked if this would this result in people being left in the community very ill? The Councillor asked whether the Committee would be inviting different people to future meetings. The Principal Overview and Scrutiny Officer informed Members that this meeting was to start the process in order for Members to be satisfied that the options/proposals developed have been done so correctly, that the public engagement is robust and wide ranging. It was confirmed that the meeting was not about endorsing any proposals but ‘taking stock’ and looking at what evidence the Committee may wish to see at future meetings before moving forward into the formal consultation phase.

A Councillor questioned the sharing of X-Rays between hospitals and whether this happened. It was confirmed that this would be reported to a future meeting. A concern was also raised that primary care practitioners had not received training in line with specialist services.

A Councillor raised concern that the BHP was a ‘done deal’ and felt as though we had been here before with a reduction in access for local people at local hospitals. The Councillor was of the view that local hospitals were deliberately and carefully being run down. Distance travelled to access services remained a real concern. The Chair reiterated that the Committee will challenge all elements of the BHP process. The BHP representative confirmed that the team will listen and in particular they welcome he views of the Committee. Members were informed that the programme will be consulting on genuine options and the team will listen.

A Councillor questioned whether ambulance services had been involved in discussion as there are already ambulance delays outside hospitals. It was confirmed that the North East and Yorkshire ambulance services had been involved and will be a significant part as the programme moves forward.

A Councillor raised a concern about the workforce and that due to the cost of medical training not as many people were training. The Councillor questioned whether this would be considered? A BHP representative confirmed that workforce was the main driver and the ability to recruit and retain was essential. Centralising expertise helps to recruit and retain, and this is a significant area of the programme. In relation to recruitment a Councillor highlighted that a shortage of staff was often used to close services on the basis of clinical safety and this has resulted in the public losing confidence in consultations. A BHP representative recognised and understood where the concerns were coming from regarding lack of confidence but welcomed the support and challenge from the Committee. It was confirmed that independent views had also been used, in addition to those of the programme board. The Chair reiterated that the Committee will take evidence from elsewhere such as highways and transport and Child and Adult Services to challenge.

A concern was raised about the knock on effect of the programme on child and adult social care. It was confirmed that Local Authorities were structured into the programme and very much engaged. It was questioned whether community services costs would increase due to the programme. It was confirmed that people are discharged from hospital when medically fit and all areas would be looked at so the system was not destabilised, for example, physiotherapists may be able to treat people at home rather than in hospital.

A discussion ensued on trauma centres and a Councillor asked what would happen if James Cook hospital lost its designated status. It was confirmed by a BHP representative that the BHP is not changing its status and did not expect that its status would change. A Councillor questioned the 'givens' within the programme as it was suggested that James Cook as the Regions Specialist Emergency Centre was a given.

The designation of Trauma Centres was a national decision by Bruce Keogh and it was agreed that 40 to 70 centres should be designated. A Councillor commented that this was a vast difference in number and if some haven't been allocated can the North East increase their number of centres. The Committee requested information around the Keogh review and the recommendations in respect of the number of Major Trauma Centres which should exist in England, including why there is only two designated in the North East.

A Councillor commented that this was a huge programme and how would timescales fit. A BHP representative commented that this will be an ongoing evolving process but a timescale will have to be given.

A Councillor questioned whether the BHP was part of the Sustainability and Transformation Plans (STPs). Reference was made to what the relationship is between the STP for Durham, Darlington, Tees, Hambleton, Richmondshire

and Whitby and the BHP and the Committee would like to know where the synergy exists between them. The Committee agreed to invite lead representatives including clinicians to a future meeting to discuss any links.

A representative from the BHP briefed members on the engagement timeline for the programme and how people can get involved. A Councillor suggested using a texting service, which representatives said they would implement.

Decision

(1) That the contents of the presentation and comments of Members be noted.

(2) That details of the specialist services that are being examined as part of the BHP and also how these services are currently provided at each of the BHP Acute hospital sites i.e. Hours of operation and how staffing levels are arranged and monitored to deliver the services be provided at a future meeting.

(3) That the following information, in respect of current performance at acute hospital sites be provided at a future meeting:-

- Current performance in respect of average waiting times in A&E.
- Current performance regarding handover times from NEAS and Yorkshire Ambulance service to Acute Hospital staff.
- Current performance in respect of Elective surgery across the BHP sites including the numbers of elective surgery cancellations and the reasons for these cancellations.
- NEAS Response times across the BHP area.
- Mortality levels across the BHP footprint and beyond.
- What benchmarking statistics are available?
- Patient data flows between hospitals and specialisms.

(4) That details of the potential Phase 4 long list options that have been identified alongside the key principles to be used during the options appraisal process to ascertain short list options be provided at a future meeting.

(5) That information is provided to a future meeting of the Committee detailing what input Local Authority Social Care specialists have had so far.

(6) That details of 'quick wins' that have been identified regarding advances and improvements in services and care be provided at a future meeting.

(7) That details of Workforce modelling, including how is this being undertaken and where is the programme in establishing an "optimum workforce level" to deliver future services under the Programme be provided at a future meeting.

(8) That information be provided to the Committee around the Keogh review in respect of the number of Major Trauma Centres which should exist in England including what are the ‘givens’ in the programme.

(9) That lead representatives on the STPs be invited to attend a future meeting to provide information on the relationship between the STP for Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby and the BHP.

(10) Details of performance in respect of Hospital discharges, reasons for delays and the undertaking of healthcare assessments pre/post discharge be presented to a future meeting of the Committee.