HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on 23 February 2005.

PRESENT: Councillor Mrs H Pearson (Vice-Chair) (In the Chair), Councillors Biswas, Lancaster, McIntyre and K Walker.

OFFICIALS: J Bennington, K Jackson and J Ord.

****PRESENT BY INVITATION:** Middlesbrough Primary Care Trust:
Linda Brown, Head of Commissioning
Martin Phillips, Head of Primary Care.

Tees & North East Yorkshire NHS Trust:
Dr A Gash, Consultant Liaison Psychiatrist
J Platt, Director of Mental Health Services
C Williamson.

****AN APOLOGY FOR ABSENCE** was submitted on behalf of the Chair, Councillor Dryden.

**** DECLARATIONS OF INTEREST**

No declarations of interest were made at this point of the meeting.

**** MINUTES**

The minutes of the meeting of the Health Scrutiny Panel held on 12 January 2005 were submitted and approved.

HEALTHY LIVING REVIEW – FINAL REPORT

The Panel considered the draft final report on the Healthy Living Review focussing on the conclusions and recommendations contained therein.

Reference was made to the recent appointment of a Health Improvement Partnership Manager whose key aim would be to develop further joint working arrangements between the Council and Middlesbrough PCT.

Whilst the Panel had received evidence of NRF funding being used for healthy eating initiatives at schools, Members suggested that it could be developed further across the Borough. It was acknowledged that the availability of mainstream funding following the expiration of certain NRF funding would assist in this regard.

AGREED that the draft final report on the Healthy Living Review be approved subject to an additional recommendation that the development of healthy living initiatives within schools be referred to the Overview and Scrutiny Board regarding the possibility of the topic being included within the work programme of the Children and Learning Scrutiny Panel.

EMERGENCY ADMISSIONS REVIEW – MIDDLESBROUGH PRIMARY CARE TRUST

In an introductory report of the Scrutiny Support Officer reference was made to the Panel's decision to seek the views of Middlesbrough PCT on any perceived pressures on services provided and potential impacts of any such pressures.

The Chair welcomed the representatives from Middlesbrough PCT who addressed the Panel and responded to a number of questions which included the areas identified in the report submitted and the briefing note circulated by the PCT.

The main points arising from the subsequent discussion were in respect of the areas identified below.

Current Performance against Key Areas:

- although good progress had been made in respect of the A & E 4 hour target there had been difficulties following the recent D & V outbreak and closed wards to regain a rolling 4 week achievement of 98%;

- although the emergency admission rate, one of the highest nationally, continued to increase each year and was currently 3.2% it had to be seen in the context of a number of factors such as the local deprivation of population; centre of excellence within the midst of a compact urban area; ageing population; changed service models; and reducing the length of stay;

- in consultation with Social Services good achievement had been made regarding delayed discharges;

- good achievement had been reached in respect of Ambulance response, well above 75% for Category A calls;

Data Analysis on Emergency Admissions:

- top 10 reasons for admissions had remained consistent over 3 years in respect of respiratory, chest pain, abdominal pain, viral infection, DVT;

- although attendance rates at A & E had increased by 14% this was at a lower rate than other PCTs in the locality;

- patients over 65 years of age accounted for 30% of admissions but only 11% under 1 day and 45% over 1 day length of stay (LOS);

- there had been significant growth in recent years (12-14%) in admissions under 1 day LOS which in view of greater efficiency in models of care had not had a major effect on bed capacity;

- each 1% growth in emergency admissions equated to an additional 17.7 beds;

- assuming growth of 1% in 2006 for emergencies and 3% in medicine an extra spend of £750k would be required;

- the varying re-admission rates across the specialties was being examined, many with multipathological illnesses and reference made to the case management approach under Chronic Disease Management and Long Term Condition services which assisted in this regard and were seen as proactive systems rather than reactive;

- Capacity Plan showed gaps on beds and theatres to meet planned reductions of waiting times to 18 weeks by 2008;

Recent Progress and Future Plans to improve the services and reduce the pressure on Emergency Admissions:

- Service was now all consultant led with a dedicated medical team, plus good discharge links through FAST team and tracker nurse;

- out of hours (OoH) service was in place ahead of national deadline;

- reduction in A & E waits through introduction of See and Treat, plus efficiency measures and improved access to diagnostics;

- Deliberate Self Harm service, a dedicated Team in Acute Assessment Unit from February 2004 had had a positive impact and the possibility of having dedicated beds for such a service was being examined;

- in terms of Intermediate Care the refurbishment of Parklands had commenced ahead of schedule and would provide expansion from 10 to 21 beds plus 2 flatlets;

- Community Heart Failure Team recruited and introduction of blood test to primary care;

- piloting of Chronic Disease Management approach with 2 Community Matrons across 10 practices;

- recruitment of Respiratory Nurse Specialist for PCT;

- Galvani Practice established for management of care in Nursing Homes;

- Introduction of Emergence Care Practitioners to PCT, to become OoH Services and pilot to start in General Practice on home visits;

- Health & Social Care Team working in 9 practices and piloting single assessment process;

- funding achieved for Community Stroke Service, including pathway redesign, Stroke Co-Ordinator and 10 beds to open in Community Hospital from end of February;

- Falls Strategy and Business Case produced with intention to recruit team from April;

- in terms of the future, reference was made to certain Action Plans which were in 4 key areas of: analysis of data including reasons for growth; improving the pathway; develop services to avoid admission or shorten LOS; and develop services to provide alternatives to A & E or GP;

Impact of OoH on Emergency Admissions:

- new GP contract had increased OoH by 7% (6 pm to 6.30 p.m. Mon-Fri, 3 hours Sat am) otherwise arrangements as before, delivered by Primecare;

- dedicated clinics in Middlesbrough at James Cook University Hospital;

- perception locally that OoH had increased acute activity but no evidence either locally or nationally that emergency admissions/A & E activity had increased;

- local OoH services had managed with difficulties during the two 4 day bank holiday periods in 2004;

- it was acknowledged that there were certain difficulties, which were being examined with a view to making improvements to the service and providing a more consistent approach.

AGREED that the PCT representatives be thanked for the information provided and contribution to the subsequent deliberations which would be incorporated into the overall review.

EMERGENCY ADMISSIONS REVIEW – TEES AND NORTH EAST YORKSHIRE NHS TRUST

In a report of the Scrutiny Support Officer reference was made to the meeting of the Panel held on 21 December 2004 when Members had been advised that the Chair of the South Tees NHS Trust had outlined the issues most pertinent to the review. Although most issues raised had been encompassed within the agreed terms of reference the rate of episodes presented at Emergency Medicine facilities with a psychiatric element to the case, specifically self-harming and especially amongst young men had not been included.

Members had agreed to the inclusion of this aspect in the review and part (b) of the terms of reference had been amended as follows:-

(b) To investigate why the numbers of emergency admissions into James Cook University Hospital are at their current level, with specific attention being paid to those with a psychiatric element to them.'

The Chairman welcomed representatives of the TNEY NHS Trust who addressed the Panel and responded to a number of questions which included the areas identified in the report submitted and the presentation slides circulated at the meeting.

The main points arising from the subsequent discussion were in respect of the areas identified below.

Integrated Care Pathways (ICP) for Self-Harm:

- in a local population of 296,000 there were approximately 2,000 cases of DSH each year with about 700 patients going home from A&E with no psychosocial assessment and no follow up thus increasing the risk of possible illnesses such as suicide;
- an indication was given of recent national guidance and the main aims of ICP:
    - to highlight the milestones of the patient's episode providing a structure for clinical care;
    - to support informed decision making/change;
    - to think carefully about the areas upon which to focus;
- the advantages of ICP were seen as improving quality of care by setting standards; improving patient involvement and information; improving inter-professional communication; reduce variations in treatments; promote cost effectiveness; included best evidence; and auditable outcomes;
- any deviation from the plan or pathway was considered to be a variance and required analysis to provide information for the review of current practice;
- details were provided of some of the factors which were taken into account in assessing mental illness and the use of processes backed be research such as the Beck suicide intent scale; Modified Sad Persons Scale; Edinburgh Repetition Scale; and Epidemiology;
- current statistics reflected a higher incidence of suicide in respect of males but a lower figure than females in relation to self-harm;
- ICP had increased the number of potential patients by 32% and there was evidence that acting on self-harm reduced repetition and suicide;
- Repetition rate continued to reduce from 6/12 before the ICP to 6/12 after (17.4% before to 11.2 % after);
- ICP had resulted in improved communication and better identification of mental illness by A&E staff;
- there were improved links and collaborative working and a better understanding of the purpose of work had developed between A&E, Medicine, PCT and SHA.

AGREED as follows:-

1. That the revised terms of reference as outlined above be approved.
2. That the representatives from the TNEY NHS Trust be thanked for the information provided and contribution to the subsequent deliberations which would be incorporated into the overall review.

**** OVERVIEW AND SCRUTINY BOARD UPDATE**

In a report of the Chair of the Health Scrutiny Panel Members were advised of the key matters considered and action taken in respect of the meetings of the Overview and Scrutiny Board held on 11 January and 8 February 2005.

NOTED

MIDDLESBROUGH PRIMARY CARE TRUST – PATIENT AND PUBLIC INVOLVEMENT STRATEGY

In a report of the Scrutiny Support Officer the views of the Panel were sought on the Middlesbrough PCT's draft Patient and Public Involvement Strategy.

Reference was made to the Government's vision for the National Health Service and in particular the NHS Plan published in 2000 which stated:-

'Patients are the most important people in the health service. It doesn't always appear that way. Too many patients feel talked at rather than listened to. This has to change.'

In this context the Middlesbrough PCT prepared a draft Patient and Public Involvement Strategy which aimed to outline how the PCT would involve and consult with patients, local residents and other key stakeholders in the planning and development of services.

NOTED