HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on 26 February 2009.

PRESENT: Councillor Dryden (Chair); Councillors Carter, Clark (as substitute for Councillor Purvis), Cole, Dunne, Lancaster and P Rogers.

OFFICERS: J Bennington and J Ord.

**** PRESENT BY INVITATION:** Councillor Brunton, Chair of Overview and Scrutiny Board

Middlesbrough Primary Care Trust:
Michelle Martin, Governance Manager
Neil Stevenson (Senior Commercial Manager (Acute) Tees-wide Commissioning Directorate)
Grace Rosbotham, Practice Based Commissioning Manager

North East Ambulance NHS Trust:
Stephanie Basra, Assistant Director of Operations
Allan Grieff, Assistant Operational Manager

Dr Nigel Rowell, Chairman, Middlesbrough Practice Based Commissioning Group, Endeavour Practice, Middlesbrough

**** AN APOLOGY FOR ABSENCE** was submitted on behalf of Councillor Purvis.

**** DECLARATIONS OF INTEREST**

Name of Member	Type of Interest	Item / Nature of Interest
Councillor Brunton	Personal Non-Prejudicial	Agenda Item 5 – Practice Based Commissioning – registered at GP practice

**** MINUTES**

The minutes of the meeting of the Health Scrutiny Panel held on 5 February 2009 were submitted.

Reference was made to the update provided in respect of the Panel's Final Report in relation to Audiology Services. Given the significant improvements which the local NHS had achieved with particular regard to progress in reducing waiting times relating to audiology services it was suggested that a report on the matter be submitted to the Overview and Scrutiny Board and to the Executive.

AGREED as follows: -

1. That the minutes of the Health Scrutiny Panel held on 10 February 2009 be approved as a correct record.

2. That a report in relation to the progress achieved by the local NHS with regard to the Panel's Final Report on Audiology Services in Middlesbrough be submitted to the Overview and Scrutiny Board.

PATIENT TRANSPORT TO AND FROM JAMES COOK UNIVERSITY HOSPITAL – PROGRESS REPORT

The Scrutiny Support Officer submitted a report the purpose of which was to introduce representation from the local NHS to provide an update on patient transport services following

the Panel's review. A copy of the Panel's Executive Summary had been circulated at Appendix 1 of the report submitted.
The Panel was reminded that as NEAS had conducted its own review into Patient Transport Service (PTS) it had previously been agreed that an update be provided on the topic in six to eight months time.

The Chair welcomed the local NHS representatives who outlined the current position.

A briefing paper (Appendix 2) had previously been circulated which outlined a response received from the South Tees Hospitals NHS Trust to each of the Panel's recommendations covering the following:-

i) The report stated that Commissioners recognised that transport requirements for patients needed to be more widely considered as part of the package of care. In line with the National Guidance, PCTs were now reviewing the commissioning process.

ii) It was stated that planning on the whole worked well with existing block contracts although many renal patients' journeys were required outside the ambulance contract, resulting in the Trust's use of taxis. It was acknowledged that future development of ambulance services needed to consider patient requirements as transport that was required Out of Hours and Out of Area were sometimes more problematic because of the alternative transport arrangements currently supplied by NEAS.

   South Tees Hospitals NHS Trust had introduced a number of initiatives to improve transport for renal patients including: -

   a. Development of an action plan for the renal unit to review renal services including transport. A number of options had been considered including the trial of community transport services in conjunction with NEAS. The Trust had conducted an initial trial with at first poor results. The scheme was now in its final month and the audit would be repeated and results compared.

   b. Best Practise requirements as described in the Cheshire and Merseyside Renal Action Learning Set Report September 2006 would be: -' to be in a position where our patients are being transported to and from the individual units under a standard scheme and one provider, we need further information from the commissioning team before we can progress any further discussions.'

   c. A DH audit of renal services to include transport of renal patients had been undertaken though the results had yet to be published.

   d. Work with taxi companies and individual renal patients to improve the service patients' received in respect of allocation of transport to use the same drivers for the same patients.

The current service level agreement was with North East Ambulance Service (NEAS) as vehicle provision did not enable all renal patients to be provided for, as many arrived outside normal operating hours.

The Renal unit had undertaken a patient satisfaction audit in December as identified under (ii) above and further opportunities to improve the service would be discussed with NEAS in line with future comments.

iii) South Tees Hospitals NHS trust had identified the need to form close links with transport links in the community and as a result had now: -

   - joined the Tees Valley Community Transport group to identify commissioning opportunities to support patients attending hospital appointments.

   - representation on the Tees Health and Transport partnership to look at common issues in relation to patient transport.

- forged partnerships with other charity organisations to engage with the Links network to establish a transport group.

- worked with the East Durham travel response Scheme to support out of hour area access to hospital appointments.

iv) South Tees Hospitals Trust were looking at all available options in relation to patient transport and had recently attended the Tees Valley Community Transport Group and would attend further meetings with the Tees health transport partnerships.

v) South Tees Hospitals NHS Trust supported the need to provide a single contact number for patients and staff to use when booking transport in Teesside. It was noted that the service needed to be further developed to ensure it was utilised effectively.

vi) South Tees Hospitals Trust supported the delivery of extended ambulance service 0700-1900, which would better fit the current hospital service times.

The Chair welcomed Stephanie Basra, Assistant Director of Operations and Allan Grieff, Assistant Operational Manager, North East Ambulance Service (NEAS), who addressed the Panel and highlighted the key areas of the review of Patient Transport Services (PTS) which had been concluded in September 2008.

A briefing paper from NEAS was provided at Appendix 3 which covered the following areas.

In response to an identified need to inform customers (patients, commissioners, hospitals, taxpayers) of what service they actually received when purchasing PTS from NEAS a stakeholder event for commissioners and hospitals had been arranged for 2 March 2009 to launch such work.

In addition to the annual patient survey other means of compiling patient views were being explored. The appointment of members of the public, including service users to become members and governors of the Foundation Trust should FT status be achieved was seen as an important and valuable step towards ensuring that the views of the communities were embedded in service delivery and strategic planning.

Support for a single booking service for PTS within Teesside was reaffirmed. Confirmation was given that NEAS was keen to work with the Primary Care Trust to secure improvements to the Transport Information Service.

Reference was made to work, which had commenced prior to the conclusion of the review to address the needs of renal dialysis patients in Teesside. Work was progressing with staff to redesign rotas and local community transport providers, Future Regeneration of Grangetown and Wheels of Freedom to pilot a service to improve the service to patients. The aim was to transport patients in a timely manner with a high quality and caring service without additional cost to the taxpayer.

It was pointed out that further work had been completed to extend the times of the services offered to hospitals. Discussions were being held with James Cook University Hospital regarding the provision of a dedicated discharge vehicle to assist timely discharge of patients from hospital.

Following the review it was intended to develop an engagement strategy to strengthen existing communication channels between NEAS, PCT and hospital trusts at an operational and tactical level.

In an attempt to improve the efficiency of the service delivered NEAS had negotiated with hospitals in Teesside and agreement had been reached to introduce a banding time system for transportation of patients. It was suggested that this would allow NEAS to increase the number of patients transported on vehicles, reducing mileage and wasted capacity.

An indication was given of work to be undertaken to address the management knowledge and skill gaps, which had been identified during the review.
NEAS viewed the current patient transport service transforming over the next five years into a fully integrated demand responsive transport service with its roots in the principles of Right Patient, Right Resources, Right Place, Right Time, First Time, ensuring quality and safety at all times.

It was acknowledged by the NEAS representatives that whilst the overall review had identified some strengths there were a number of weaknesses which needed to be addressed. Given an average loss of £3,500,000 on PTS each year the issue of providing a viable business was a key concern. Following the review five work-streams had been established to carry out a 13 month work programme to cover the following areas:-

i) to examine ways of ensuring that a viable business was provided;
ii) to examine efficiency and how the service was provided;
iii) to examine management development in PTS and more widely across the Trust;
iv) to pursue further engagement with service users, LA partners, community transport providers;
v) to develop performance management – establish meaningful targets.

The first stage of the process was to focus on providing a viable business and the second stage to examine what else could be done to achieve further improvements to provide an integrated patient transport service. During the five year programme there was a need to develop measures to cope with the wide range of different and often very complex needs of patients and as part of the ongoing discussions and negotiations NEAS would be working closely with the local authority.

With reference to the stated £3,500,000 annual deficit it was confirmed that there were significant funding issues but that such a figure related to the North East and the amount in respect of the Teesside area was much less in proportion to other areas. It was noted that at present NEAS's A & E income was subsidising the loss on PTS.

In response for further clarification an indication was given of current management training to enable managers to carry out a whole range of different skills which continued to be developed to cope with changing demands and user development needs.

Members reiterated their support for a single contact number for patients or staff to book patient transport and expressed concerns at the continuing confusion and current problems of quality of information regarding the Transport Information Service run by the PCT. It was acknowledged that the high turnover of staff many of whom were on short term contracts had resulted in a lack of consistency of service. Neil Stevenson (PCT) confirmed that in order to assist with staff retention and recruitment it was intended from April 2009, subject to the necessary funding, to provide staff on more permanent contracts.

NEAS representatives emphasised that the need to address the needs of renal dialysis patients had been recognised prior to the conclusion of the review. In order to improve the quality of service to such patients reference was made to work which was being undertaken to redesign staff rotas and work with the Tees Valley Community Transport Group. It was noted that in order to provide an appropriate, consistent form of transport and trained drivers to better understand a patient's needs there had been a change of emphasis from the use of taxis to local community transport providers. Members were advised however that further work was required to improve and refine the service.

In overall terms the NEAS representatives indicated that whilst they were limited by financial constraints and much work was still to be undertaken to improve patient transport services it was considered that steps had been taken to secure improvements and that a significant difference to the service would be achieved in 12 months time.

In commenting on a number of individual patient's experiences associated with transport problems it was confirmed that steps had been taken to identify more easily where service failures had occurred. Reference was also made to the annual patient survey which reflected a very high satisfaction rate but did not include renal patients.

Whilst Members noted the ongoing work including the attempts to stimulate the local third sector it was considered significant improvements were still to be achieved and asked that a further update be provided when new commissioning arrangements would be in place.

AGREED as follows:-

1. That the local NHS representatives be thanked for the information provided.

2. That the local NHS representatives be asked to provide a further update on patient transport services in six months time.

PRACTICE BASED COMMISSIONING

The Scrutiny Support Officer submitted a report the purpose of which was to introduce representation from the Middlesbrough Practice Based Commissioning Cluster.

The Chair welcomed Dr Nigel Rowell who highlighted the key areas identified in a briefing paper, which had previously been circulated.

Practice Based Commissioning (PBC) was seen as providing front-line clinicians with resources and support to become more active in commissioning decisions. The aim of PBC was to provide high quality services for patients in local and convenient settings and that GPs and nurses and other primary care professionals were in a prime position to translate patient need to redesign services that best delivered what local people wanted.

Details were given of what was considered to be a good example of achieving such aims involving the recent transfer of genitourinary medicine ("STD") clinics from a hospital setting to the community. The Panel was advised that the practice based commissioning group had undertaken a detailed survey in 2006/7 of young people to find out where they would wish to receive care in the event of them contracting a sexually transmitted disease. A service had subsequently been designed around their needs. Such a process had involved the identification of interested clinicians, GPs and nurses, training needs, premises, equipment, and infrastructure that would support their clinical role. It was noted that the estimated cost of the same care in hospital was to escalate dramatically to £1.9 million. It had been considered that by PBC that the costs could be reduced and the patient experience improved. Members were advised that after 22 months the service had been ready to go live in February 2008 but they had subsequently been informed by the Professional Executive Committee of the Primary Care Trust that the service would have to be put out to tender to the private sector.

It was felt that there were many lessons to be learnt from such an experience including the very lengthy and time consuming process involved and ever changing government policy and guidelines. It was indicated that doctors and nurses in the area tended to be in the profession for the long term and that the outcome of their efforts in developing a service as identified had dented their confidence in PBC.

In terms of the national position as indicated in DoH documentation in June 2008, only 62% of GP practices supported practice based commissioning and only two thirds of practices had agreed a commissioning plan with only 58% confident that their plan would improve the quality of patient care. It was considered that with ever changing positions it was very difficult for practices to feel involved and very easy for them to feel disenfranchised.

As ultimately the PCT was responsible for meeting financial balance and expenditure it was felt that they were unwilling to release funding to allow practices to take risks on services for patients and therefore inhibited new developments and innovative thinking. To be asked to spend savings, which had to be culminated in the first place, was considered to be extremely difficult.

In terms of the development of community services Middlesbrough was seen to be far more advanced than many others in the UK. Reference was made to community services available in muscular skeletal medicine, dermatology, genitourinary medicine, minor operations and skin surgery, and recently the practice based commissioning group had started to look at Ear, Nose

and Throat and Gynaecology services to identify some elements that could be provided appropriately in the community.

Reference was made to recent developments. In January the PBC group had commissioned a consultation event about care of the elderly. One of its aims had been to examine the feasibility of a consultant led elderly care service in the community. Reference was also made to a screening service to identify patients with heart failure, which was due to start in May 2009 using state-of-the-art echocardiography machines and BNP blood testing. It was pointed out however that it had taken nearly 5 years to implement following PCT mergers, changes in personnel and identifying sources of funding.

It was felt that for the average GP there was little incentive to get involved with practice based commissioning and in particular funding was perceived as being held tightly and centrally controlled. Current financial arrangements allowed little opportunity for resources to become available and to develop innovative services in accordance with the prevailing regulations and in order to provide appropriately trained staff. The internal market between GP practices and hospitals was considered to be a major barrier to working together to provide services across the primary-secondary divide.

Although there were considered to be major problems as a result of current financial arrangements in the NHS both locally and nationally which had hindered joint working it was considered that there had been some marked successes with PBC in Middlesbrough such as the genitourinary clinic as previously mentioned.

Reference was made to the development of educational sessions for GPs and practice nurses across Middlesbrough and Redcar and Cleveland to promote good practice and use of local resources. Such education sessions had been well attended and aimed at GPs to be better informed to ensure appropriate referral decisions and that patients received the same access and same level of service.

It was confirmed that so far there were no formal mechanisms in place to monitor a GP practice that was over or under referring or over and under spending.

In response to Members comments on how to ensure quality of service the local NHS representatives indicated that it was not within the remit of PBC to address such matters but an assurance was given however that it was high on the PCTs agenda to ensure that appropriate performance systems were in place.

It was agreed that there was a place for PBC in the public health strategy approach and preventative agenda. GPs had recognised such a need and were developing a more cohesive approach to tackle the whole issue. One of the main areas of work involved tackling obesity and an indication was given of some of the measures being pursued.

Although there were a number of barriers to overcome including a strong blame culture attached to financial risk and an internal market it was felt by the PBC Group that with appropriate measures PBC will assist in the commissioning of appropriate services in community settings for the benefit of patient outcomes.

AGREED as follows:-

1. That Dr Rowell be thanked for the information provided and participation in the subsequent deliberations.

2. That Dr Rowell be asked to attend a subsequent meeting of the Panel with other local NHS representatives to discuss further the issues raised.

MIDDLESBROUGH PRIMARY CARE TRUST – ANNUAL HEALTHCHECK DECLARATION

The Scrutiny Support Officer submitted a report the purpose of which was to introduce representation from Middlesbrough Primary Care Trust to provide a briefing on the Healthcare Commission's Annual Healthcheck process.

The Chair welcomed Michelle Martin who addressed the Panel and focussed on PCT performance and activity against a few key elements of PCT operation of specific interest to the Panel as detailed in a briefing paper previously circulated.

The report summarised that a rigorous process had been applied and that no significant lapses had been identified and it was anticipated that full compliance would be declared with all the core standards by April 2009.

The Panel acknowledged the current support from the PCT in terms of the Panel's scrutiny investigations and joint working arrangements with the overall aim of securing improvements for patient outcomes.

AGREED that Michelle Martin be thanked for the information provided and that a response be submitted to the Primary Care Trust Healthcheck process.

OVERVIEW AND SCRUTINY UPDATE

In a report of the Chair of the Health Scrutiny Panel, Members were advised of the key matters considered and action taken arising from meetings of the Overview and Scrutiny Board held on 10 February 2009.

NOTED