HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on 19 March 2013.

PRESENT: Councillors Dryden (Chair), Biswas, Harvey, S Khan and J Sharrocks (as substitute for Councillor Junier)

ALSO IN ATTENDANCE:

Durham, Darlington and Tees Local Area Team:
B Reilly, Director of Nursing

North East Ambulance Service NHS Foundation Trust:
P Liversidge, Chief Operating Officer
M Cotton, Assistant Director of Communications

North of England Commissioning Support:
A Greenley, Head of Clinical Quality

South Tees Hospitals NHS Foundation Trust:
A Clements, Clinical Director Accident and Emergency
B McCarron, Chief of Service
J Moulton, Director of Planning
S Watson, Operational Services Director

South Tees Clinical Commissioning Group:
C Blair, Commissioning Delivery Manager
M Milner, Urgent Care Lead
Dr N Rowell, Board Member
Dr H Waters, Chair

OFFICERS: J Bennington, E Kunonga, J Ord and E Scollay.

APOLOGIES FOR ABSENCE were submitted on behalf of Councillors Cole, Junier, Mawston, Mrs H Pearson and P Purvis.

DECLARATIONS OF INTERESTS

There were no declarations of interests made at this point of the meeting.

MINUTES - HEALTH SCRUTINY PANEL 26 FEBRUARY 2013

The minutes of the Health Scrutiny Panel held on 26 February 2013 were submitted.

Confirmation was given of the additional information which was being sought as identified at (i) to (vi) in respect of childhood immunisation which included immunisation programmes in place with regard to children looked after and how successful were such measures.

AGREED that the minutes of the meeting of the Health Scrutiny Panel held on 26 February 2013 be approved as a correct record.

WINTER PRESSURES AND THE LOCAL HEALTH AND SOCIAL CARE ECONOMY

The Scrutiny Support Officer submitted a report the purpose of which was to introduce senior representatives from a number of organisations to discuss winter pressures and wider demands being placed on the local health and social care economy.

Winter pressures coupled with a rising demand for healthcare from an ageing population had been an issue of significant political and academic interest in recent years. Such issues were seen as being exacerbated given the current economic climate and unlikelihood of significant additional funding becoming available.

Reference was made to a number of recent items in the local media about demand pressures at Accident and Emergency (A & E) at James Cook University Hospital (JCUH) as well as delays in ambulances being able to 'hand-over' patients to hospital based services.

In order to assist deliberations a series of questions had previously been forwarded to the organisations as outlined in the report submitted.

From the outset representatives concurred with the Operational Services Director at JCUH of the need to create a whole health and social care system in order to cope better with significant pressures as recently experienced over the winter period. The need to examine how all agencies interacted to ensure that patients were discharged from acute hospital beds in a more timely manner was stressed.

Statistical information was provided which demonstrated the significant increase in the number of ambulance arrivals at JCUH and noting that such arrivals were also from elsewhere, York Ambulance Services and helicopter deliveries. Over the period from April 2010 to date there had been a rise from approximately 300 ambulance arrivals per week in 2010 to around 500 per week in winter 2012/2013, a 66% rise. It was pointed out that this peaked at 577 in the week commencing 30 December 2012 and 555 last week.

The Panel was advised that the A & E Department had been planned some 15 years ago to serve approximately 60,000 to 70,000 patients a year. Since that time the growth had been significantly greater than anticipated currently seeing over 100,000 patients a year. The current focus of attention was on making best use of the space available and managing people better to avoid unnecessary hospital admissions thus creating more capacity.

It was recognised that there could be a number of ambulances at any one time and a surge of approximately six to eight resulting in a queue could currently cause problems arriving at JCUH. It was acknowledged that such circumstances were a challenge and that overall bed capacity was one of the main challenges. An example was given of a specific week in January 2013 when more than 100 patients had been in acute beds which from a clinical perspective they didn't need to be. Discussions were ongoing to address such an issue specifically how the health and social care economy can absorb patients back from acute hospital beds. A rapid response service had been introduced over the winter to better support people in their own homes and help to prevent unnecessary hospital admissions. Reference was also made to the launch of a virtual ward which allowed patients with medical needs to have a high level of care in the community.

In cases when there had been a queue of ambulances arriving at JCUH an assurance was given that whilst not an acceptable situation patients had been assessed and prioritised. Whilst JCUH had been in state of alert to mobilise available beds the vast number of patients that had been presented had been overwhelming and often involved the frail and elderly with complex conditions.

The Panel's attention was drawn to a significant build up of patients who could have been discharged to alternative accommodation over the Christmas period when a number of agencies were running at reduced services. From a Social Care perspective winter pressures funding had been made available to local authorities to respond to such pressures but the point was made that additional social workers for a few months would not solely resolve the problem but required a range of measures and much work from respective organisations. The Panel was advised that although three agency social workers had been appointed an indication was given of a number of complex issues which had impacted on the overall situation. Such factors had included sickness necessitating in further recruitment of social workers. The Panel was advised of the complex situation regarding the pressures which had occurred around Christmas 2012 involving all social workers including those at JCUH, community based social workers from Redcar and Cleveland and North Yorkshire. It was acknowledged that the issues were a challenge for 2013/2014 and involved not just health and social care issues. The average length of stay in hospital was reported as four days which was a relatively short of period of time for a social worker assessment to be undertaken and identifying alternative provision or home with support. Much work needed to be undertaken to ensure that the services in place were patient centred and suitable care plans established

ensuring that if necessary hospital admission occurred at the appropriate time.

Reference was also made to the accreditation of JCUH as a major trauma centre and increasing number of occasions when the demand for resuscitation cubicles had exceeded capacity. Such a situation was currently being examined including the possibility of providing additional resuscitation cubicles.

As previously indicated the profile of patients being admitted to hospital were often elderly and patients with increasing complex conditions. It was considered that such a pattern was likely to increase as a result of continuing advances in the medical field and an ageing population. Often the elderly became more frail after a period in hospital and their previous assistance within their own home or a residential home was insufficient to cope with their higher level of support required to meet the patient's needs. At this point identifying appropriate alternative accommodation often resulted in a delay. From a GP's perspective the Panel was advised that in some cases usually involving inexperienced workers in residential homes mindful of recent headline articles in the UK media would see contacting the out of hours provider or direct to A & E as an easier option often resulting in a hospital admission. Difficulties were more likely to occur OOH especially with regard to patients with very complex needs who were unknown to a GP coupled with difficulties in accessing a patient's records. Ensuring that robust contract monitoring arrangements were in place in respect of the Out of Hours provision was part of the overall examination. An indication was given that the new system had improved and that they were working closely with the Clinical Commissioning Group as part of the whole system approach. A view was expressed that further resources were required to enable the provider to have more GPs to visit and undertake patients' assessments.

A view was expressed that the application of penalties as part of contract arrangements was not always regarded as a positive step when endeavouring to pursue a whole system approach and working together rather than encouraging a blame culture.

The Director of Nursing (DDT) drew the Panel's attention to one of the key areas for consideration in ensuring that appropriate information is provided to patients as evidence showed that there was much confusion as to the points of contact and referral. It was considered important that the right messages were given to the public and for them to feel confident as to where to go for the required services.

Information provided on the overall situation was not just indicative of the position in Middlesbrough but reflected similar trends in the North East and across the UK. It was confirmed that the next summit meeting would be held in May 2013 to ensure that plans were progressed and in place for the 2013/2014 winter period. There was considered to be a better understanding of the problems to be addressed and an important element of ongoing work was prevention and early intervention to cope with specific problems such as alcohol, obesity and smoking related issues.

Until such time as a whole health and social care system was fully in place immediate action being taken by STHFT included:-

- plans to open as many beds on the JCUH site throughout the year as possible;
- developing plans to increase support to non-elective programmes over seven days;
- review of lessons learnt in other health economies where the pressures were not so significant;
- review opportunities for using voluntary agencies;
- review opportunities to use tele-innnovation;
- review admission criteria to community hospitals;
- review medical model for supporting community hospitals.

Other representatives referred to the need to examine improved management of long term conditions, better care plans and better measures to ensure immunisation.

From the perspective of the North East Ambulance Service inevitably delays in hospital admissions impacted on the Ambulance Service capacity. Workforce plans were in place to

increase the knowledge and skills of paramedics and seeking assessments on alternatives. Reference was made to the 111 service for non life threatening emergencies whereby fully trained advisers can make an assessment and make appropriate referrals. Key to the current problems was collective working across the North East.

As part of the overall discussions for a whole health and social care system approach the Clinical Commissioning Group gave an indication of issues being examined in addition to those outlined above. Reference was made to making best use of alternative facilities to hospital such as community hospitals, intermediate care, care homes and residential homes.

AGREED as follows:-

1. That all representatives be thanked for their attendance and information provided.

2. That a further update be provided in summer 2013.