HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on 3 February 2016.

PRESENT: Councillors: S Biswas (Chair), J G Cole, A Hellaoui, B A Hubbard and T Lawton and J McGee.

ALSO IN ATTENDANCE: E Lovell, Communications and Engagement Lead for the Better Health Programme.

OFFICERS: E Pout and C Lunn.

APOLOGIES FOR ABSENCE: Councillors: S Dean, E Dryden and C Hobson.

1 **MINUTES - HEALTH SCRUTINY PANEL - 12 JANUARY 2016.**

The Minutes of the Health Scrutiny Panel held on 12 January 2016 were submitted and approved as a correct record.

AGREED

2 **BETTER HEALTH PROGRAMME.**

The Scrutiny Support Officer presented a report, the purpose of which was to provide the Panel with an introduction to the Better Health Programme (BHP - formerly known as SeQIHS - Securing Quality in Hospital Services), and to consider the role of the Panel in the programme.

The BHP was an initiative which focused upon the examination of acute hospital care and it aimed to identify changes that may have been required to achieve the desired standards of quality in hospital care across Darlington, Durham and Teesside. The work was being led by the Clinical Commissioning Group (CCG) and the Foundation Trusts, who were working with stakeholders and the Local Authorities.

In addition to hospital care, the programme recognised the importance of well integrated 'NOT in Hospital' care provision, and would also be examining how primary, community and social care were connected in the area, and how this could be improved in the future to meet increased demand.

Edmund Lovell, Communications and Engagement Lead for the BHP was in attendance to provide Members with more detailed information on the programme, to discuss their involvement, and to receive feedback.

A short introduction to the project team and personnel involved in the BHP was provided to Members, prior to a presentation pertaining to the following areas being made:

- The origins of the BHP;
- Why the BHP was needed and the clinical case for change;
- The focus of the BHP;
- Headline Statements;
- Clinical Standards;
- What constituted 'NOT in Hospital' services;
- Examples of 'NOT in Hospital' service standards;
- A summary;
- Timeline 2016 for the BHP;
- Local public engagement events; and
- Social media links.

It was highlighted to the Panel that the BHP was led by clinicians who considered the future of health services in Darlington, Durham and Tees.

Initially, the BHP had looked at hospital services only, but had extended its remit in the autumn of 2015 to include 'NOT in Hospital' care provision.

It was explained that the programme had been established at a time when Primary Care Trusts (PCTs) were in operation; a piece of work entitled the 'Acute Services Legacy Project' had commenced during this time. This work had looked at the standard of services that were provided in hospital from an acute perspective, i.e. from a medical emergency point of view, rather than from a planned or elective care viewpoint.

The programme subsequently became known as SeQIHS, which was concerned with patient care standards in hospital settings. It was acknowledged that there was some variation in the standard of care being provided by different hospitals. It was felt that residents in the Middlesbrough locality were very fortunate in that a regional centre, James Cook University Hospital, offered an excellent service, with more specialist levels of care being provided in comparison to other local hospitals.

In terms of ensuring that everyone had access to the highest level of care, it was explained that at the end of 2015, as part of the BHP, a decision was made to also pursue the 'NOT in Hospital' care perspective.

The BHP was led by a number of CCGs - South Tees, Hartlepool and Stockton, Darlington, Durham Dales Easington and Sedgefield, and north Durham - working with Foundation Trusts, Local Authorities, stakeholders and patient representatives. Reference was made to an event that had been held in late January 2016, where representatives had spoken to both internal and external stakeholders about the programme.

Concerning the reasoning for a BHP and the clinical case for change, a number of issues that had been identified by doctors were provided to the Panel. These were as follows:

- Workforce - insufficient clinical staff (particularly doctors) to maintain current acute hospital services.

  It was explained that an insufficient number of consultants and junior doctors was currently being experienced. In addition, pressures on other clinicians were also evident. With regards to the current pressures facing nursing, it was possible that some of this may improve following changes to the limits being imposed by the Department of Health. In respect of physiotherapy and support for people with musculoskeletal problems, it was explained that one of the consequences of not having enough Physiotherapists was that other clinicians were being relied upon to support doctors. It was acknowledged that there was a pressing need to review workforce and service structures.

  It was highlighted that it would take trainee doctors commencing their studies a minimum of fifteen years to fully qualify as consultants, therefore any issues concerning the number of doctors would not likely be resolved until at least 2030. Consideration was also given to other matters such as changes in work-life balance structures, people opting to work part-time, etc. in relation to this.

- Clinical standards - Members heard that significant variation existed between services, and that there was an inability to achieve desired standards with the current configuration. Around 720 standards had been identified that, if the best possible care was being provided, would be achieved. At the moment, however, approximately two-thirds of these were being attained.

- Health outcomes - growing demands for care exacerbated by inequalities and some poor outcomes when compared nationally.

- Public engagement - in terms of improving access to local services, it was felt that people were potentially being admitted to hospital when not required. Reference was made to the design of outpatient services and a change programme that was taking

place in North West London hospitals to modernise this. Consideration was given to face-to-face consultant appointments and the best use of time for both patients and consultants in terms of this.

- Financial pressures - it was felt that the resources available would not be sufficient enough to continue providing the current number of major service locations. Reference was made to the Nicholson gap; although financial resources for health continued to rise, so too did the demand and costs for services. It was highlighted that although change was required, this clinically-led work was commenced for concern of standards and was not about financials.

- Five Year Forward View - this referred to the national transformation agenda that was about looking at new models of care, although there was opportunity to shape local systems.

Regarding focus on better health, around 100 clinicians had been working in groups to look at future models for a number of different services, which were as follows:

- Accident and Emergency;
- Critical Care - i.e. intensive care;
- Acute Surgery - 'emergency surgery' of different kinds;
- Acute Medicine - people who fell ill and entered hospital; an increasing elderly population may increase the number of admission figures;
- Interventional Radiology - Radiology referred to such matters as x-ray, CT scans, MRI scans, etc. Increasingly, Radiology was used during complex surgery - for example: stent insertion guided by cameras; vascular surgery, etc.
- Acute paediatric, maternity and neonates - Paediatricians were the link between all three who cared for the babies and new mothers.

In respect of headline statements around the aforementioned services, a number of these were outlined to the Panel. These included the following:

- Trauma centres save lives and improve outcomes - patients involved in serious accidents would be admitted to, for example, James Cook University Hospital, whereas in the past they may have been admitted to a local hospital. It was explained that improved patient outcome may have been achieved by by-passing the local hospital and entering a trauma centre.

- There was variation across hospitals and access to support services - e.g. not every hospital had Interventional Radiology. Reference was made to a vascular theatre that had been built in the University Hospital of North Durham so that venous surgery could be carried out; a function that not every hospital could offer.

- Hospitals did not currently offer consistent clinical cover 24/7, particularly in respect of specialist cover, which delayed diagnostics and decision making at weekends - it was explained that there was evidence that patients did do better in instances where a senior clinician consulted them more quickly. It was felt that hospitals at weekends were especially quiet and that such a slowdown in pace may not necessarily have been positive for neither patients nor such a pressurised system, which needed to be kept going.

- Accident and Emergency departments did not necessarily have doctors or consultants on site 24/7. In terms of maternity services, if patients were delivering in a doctor-led unit on a Wednesday afternoon, a different level of cover would be experienced from delivering on a Sunday morning, which was considered unacceptable. Reference was made to the differences between 98 and 168 hour ward cover that were currently being considered by Obstetricians and Gynaecologists. It was highlighted that the requirement at the present time was to have an Obstetrician on site in the labour unit.

- An increase in access to specialist surgery for some conditions was required - reference was made to historical medical practice and the generalist model of a

general surgeon or general physician taking care of patients. An increasing number of surgeries were becoming specialist, and although general surgery remained a speciality, this was reducing. Reference was made to operation waiting times in relation to this.

- There were not enough doctors in paediatric specialities to provide a safe service 24/7 across all units - there were aspects of Paediatrics that were becoming more specialised. The principal view was that parents wanted to get the best level of care for their children and therefore services needed to be robust.

- Sufficient numbers of consultants for all complex labours and midwives for one-to-one support needed to be ensured - regarding the latter, parents sought reassurance that support would be available during labour if required. Members heard that a national debate and subsequent report on maternity services was currently awaited. If Obstetricians were providing 24/7 cover, their focus would be on more complicated matters, though it was felt that patients had a better experience with midwife-led care. The issue concerned the onset of complications and whether women would want to be in midwife-led units on remote sites. Such units had been established, for example in Hartlepool by North Tees and Hartlepool NHS Foundation Trust, and what was being found was that the numbers were not high enough for the service to be sustained because, given the choice, patients wanted the reassurance that they could receive immediate care if there were complications. It was highlighted that around 25% of women whose labours started in a midwife-led unit would need to be transferred to an obstetric consultant-led unit, which in turn would put a large demand on the ambulance service. It was acknowledged that more work needed to be done around this.

- Extremely pre-term and low weight babies did better in specialist hospitals providing neo natal intensive care with high volumes of activity - reference was made to a report that had been prepared around this in respect of James Cook University Hospital and North Tees General Hospital, which would be picked up as part of this review.

With regards to Clinical Standards, a list was provided to the Panel which identified some of the organisations where the standards had derived. These included:

- London Quality Standards - this consisted of a strain of different standards, e.g. maximum time for a patient going into hospital to wait and see a specialist;
- Royal College of Obstetricians and Gynaecologists;
- Royal College of Physicians;
- Royal College of Paediatrics and Child Health;
- Royal College of Emergency Medicine - it was explained that, until relatively recently, this had not been recognised as a specialty, but there was a greater recognition now for specialists to deal with patients in crisis before moving on to another area;
- Royal College of Anaesthetists; and
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD).

Regarding 'NOT in Hospital Services', it was explained to the Panel that this was a piece of work that had entered the programme relatively recently. This consisted of services that were provided to patients outside of the hospital setting, for example:

- Primary Care - e.g. GP Surgeries, Pharmacies, Dentists and Optometry;
- Health Services - e.g. Urgent Care Centres, Nurses and Matrons, Physiotherapy / Occupational Health, and Local Clinics / Units;
- Social Care - e.g. Social Workers, Support Workers, and Reablement Services;
- Community Services - e.g. Sitting Services, Home Help Services, Meal Providers and Discharge Support; and
- Voluntary Groups - e.g. Befriending Groups; Common Interest Groups and Support Groups - it was acknowledged that work with voluntary groups in terms of support provision could be improved.

Examples of 'NOT in Hospital' work stream standards were provided to the Panel, which were

split into two groups - Proactive Care and Prevention and Self Care.

With regards to Proactive Care, this concerned:

- Increasing Emergency Health Care Plans - e.g. if a patient became ill and deteriorated; end of life care, etc.;
- The encouragement of primary care ward-rounds in care homes;
- Provision of virtual support to GPs and Acute Clinicians - this concerned the use of technology in consultations - e.g. potential for applications such as Skype to provide this;
- Improvement of Community Rehabilitation and support to enable earlier discharge; and
- Improved support following discharge from hospital.

With regards to Prevention and Self Care, this revolved around:

- Diabetes Education - to reduce emergency presentations and amputations. Reference was made to the number of patients in Durham and Darlington that had required foot amputations and the work that had been undertaken around reducing this. It also concerned increased support downstream which would help to reduce risks;
- Rescue packs for patients with respiratory conditions which could reduce emergency presentations; and
- Parent awareness and support of childhood illnesses and injuries - reference was made to the Urgent Care consultation and identification of this as a significant issue.

In response to an enquiry, it was explained that Dr O'Brien, a GP in North Durham, was leading on the 'NOT in Hospital' work programme. With regards to Social Care, it was yet to be confirmed as to how this area would interact with the programme. It was possible that individual Council representatives would be invited to partake within this work stream.

Reference was made to the 111 service and potential overlap with the 'NOT in Hospital' programme. It was acknowledged that this work was not being undertaken in isolation: work pertaining to other areas such as Urgent Care was also being completed. Reference was made to regional and national work being undertaken. It was highlighted that this work could not be undertaken in isolation and would tie in with other work streams.

In terms of a summary, Members were advised that this programme sought to improve quality of care. It was about the matching of clinical resources, which were constrained, to the needs of the population, and was about ensuring that the right services were offered in the right place and that people understood what services they needed, and how they could be accessed.

Details pertaining to the 2016 timeline for the BHP were provided to the Panel.

Regarding public consultation, it was explained that a number of consultation events had been organised across the area, which Members would be welcome to attend. It was explained that attendance from patient participation groups was particularly encouraged, although the events were being widely advertised.

The purpose of the events was to ascertain peoples' opinions on what they felt was offered well and what they felt could be improved. There was an opinion that people felt that if they were admitted to hospital, they would receive the same level of care whichever hospital they went to. It was explained to Members that an aim of the consultation exercise was about communicating that not all hospitals provided the same thing. It was intended that ongoing communication with the same groups would be established in order to gather feedback throughout the year, and to provide opportunity to address the standards from an alternative perspective.

In response to an enquiry regarding underperforming services, it was explained that although the closure of hospitals would not be pursued, reconfiguration of some services would be looked at. It was explained that some services were being offered in some hospitals that in the

future would not be, which was driven by the need to secure the best level of resourcing. It was acknowledged that similar reviews had been undertaken previously, with reference being made to work that had been carried out at Bishop Auckland and North Tees Hospitals.

A short discussion ensued regarding staff rotation, networking and the availability of human resources across specialist and generalist facilities. Regarding 24/7 work cover, reference was made to changes in specialisms, such as stroke, and it was highlighted that work rotas must have been both suitable and sustainable to support this, with reflection also being made in terms of the volume of patients entering facilities. Reference was made to workloads and differing working patterns.

A Member queried the impact that deprivation would have on the reconfiguration of services. In response, it was explained that potentially there would be issues, access to transport for example. It was felt that there was a view that, in the North East, too much reliance was being placed on hospital beds because of deprivation; however, this thought could be challenged by undertaking further work in communities to ensure that people could remain in their homes for longer. Reference was made to work carried out in Darlington around the topic of Multi-Disciplinary Teams (MDTs) for elderly care. It was explained that MDTs comprised a number of different professionals that met to discuss the most appropriate package of care for an individual to keep them safe and supported. Reference was made to the work currently being undertaken by the Public Health Team in respect of preventative measures.

A discussion ensued regarding resource use and allocation, demands on services and preventative measures such as screening, with the aim of preventing people from entering acute services.

A query was raised regarding resources in respect of Radiology. In response, reference was made to both high end Radiology utilised during surgery, and to more routine work such as CT/MRI scans. Consideration was given to associated reporting requirements and impacts upon workload, and to a rise in demand for other mechanisms such as blood tests and tissue analysis. Fundamentally, it was felt that increased demand for Radiological testing equated to an increased demand for Radiologists. Consideration was given to the appointment of permanent Radiologists in comparison to Locums. It was commented that if patients could see Senior Clinicians more efficiently, the number of tests and subsequent pressure on Radiologist teams could potentially be reduced.

A discussion ensued with regards to the shortage of specialist doctors across the locality. Reference was made to hospital facilities and reputations, career choices and lifestyle factors that could potentially impact upon this. Reference was made to Locums, different specialisms and the sustainability of different hospital models and services.

It was explained to the Panel that, to a degree, this programme was nationally driven. Simon Stephens, Chief Executive of the NHS, was driving this work forward via a five-year forward review, and that there was a requirement to transform. This work had been clinically led in that doctors had asked how services would be sustained in five years' time, when there would be fewer junior doctors, in order to ensure that local people were receiving a superior service. National backing, such as support via the Vanguard Urgent and Emergency Care for example, provided support to proceed ahead with what clinicians wanted to do. Reference was made to the organisations that had provided the service standards. It was felt that, nationally, doctors had been listened to and work was progressing.

It was acknowledged that there was a will to make changes locally, but this was a large project. It was explained that some of this change would require the amalgamation of services, as had been undertaken previously with stroke care services, and which had allowed for improved service provision to patients, but other elements would concern resources and the utilisation of staff in other areas - use of paramedics in areas such as emergency care for example, but further work was required in order to determine appropriate models.

A Member commented that too much may be being asked of specialist doctors. In response, it was explained that there were some hospitals that were under a significant amount of pressure and in some of those, there were not enough consultants to provide the desired

service. Consequently, an increasing number of professionals were expected to be on call more frequently, which may have resulted in the loss of some expertise.

A short discussion ensued with regards to hospital management and Government targets. Reference was made to the Urgent Care consultation and the role of Primary Care. It was suggested that if more hours were available in Primary Care, the pressure on other departments such as Accident and Emergency could potentially be reduced. It was felt that there was support for a model where senior doctors could spend increased time with patients, but consideration would need to be given to matters such as workload management, the resources available, and service amalgamation.

Regarding the role of Scrutiny in this programme, it was explained that this work was going on across a number of Local Authorities; a Joint Committee may need to be established to support this.

In terms of timescale, a query was raised in respect of the implementation of the programme. It was explained that some matters would be formally consulted upon later in 2016, but others would be rolled out over a longer period of time, for example: 'NOT in Hospital' care models. It was anticipated that it would take approximately four years to complete the identified work.

It was felt that the programme would be very challenging at times, and therefore it was very important that all areas worked together and embraced change.

The Chair thanked Edmund for his attendance and contribution to the meeting. It was intended that Edmund would attend the Panel at a future date in order to update on the programme's progress.

NOTED

3 **ANY OTHER BUSINESS.**

No further business was discussed.

NOTED