

HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on 25 July 2016.

PRESENT: Councillors Dryden, (Chair), Cole, McGee, G Purvis and M Walters

ALSO IN ATTENDANCE: K Dover, Service Improvement Lead, South Tees Hospitals NHS Trust
J Hughes, Clinical Nurse Specialist, South Tees Hospitals NHS Trust
T Jasper, Cancer Care Co-ordinator, South Tees Hospitals NHS Trust
C Taylor, Macmillan Programme Manager, South Tees Hospitals NHS Trust
V Touzel, Healthwatch
A Wood, Macmillan Programme Sponsor, Haematologist and Chief of Speciality Medicine, South Tees Hospitals NHS Trust
N Hand, Lead Cancer Nurse, South Tees Hospitals NHS Trust

OFFICERS: E Pout and S Lightwing

APOLOGIES FOR ABSENCE were submitted on behalf of Councillors Biswas, Hellaoui, C Hobson, Hubbard.

DECLARATIONS OF INTERESTS

There were no Declarations of Interest at this point in the meeting.

1 MINUTES - HEALTH SCRUTINY PANEL - 23 FEBRUARY 2016.

The Minutes of the meeting of the Health Scrutiny Panel held on 23 February 2016 were submitted and approved as a correct record.

2 MINUTES - HEALTH SCRUTINY PANEL - 15 MARCH 2016.

The Minutes of the meeting of the Health Scrutiny Panel held on 15 March 2016 were submitted and approved as a correct record.

3 SETTING THE PANEL'S WORK PROGRAMME 2016/2017.

A report was presented to provide Members of the Health Scrutiny Panel with a range of information extracted from various sources to assist in the consideration of suitable topics for inclusion in the Panel's Work Programme 2016/2017.

The submitted report contained a list of potential topics for review, updates arising from previous reviews, suggestions from the Leadership Management Team (LMT), as well as topical issues provided by members of the public, the South Tees Clinical Commissioning Group and Healthwatch.

Members discussed the list of topics and the Officer provided updates and further information as appropriate.

The following topics were proposed for review:

1. Foetal Alcohol Spectrum Disorder (FASD).
2. Better Health Programme.
3. Physical condition of patients on discharge and quality of information contained in the discharge package.
4. Young People's Mental Health.
5. Childhood Obesity.

In addition, updates would be provided on previous topics including:

6. NHS Finances.

7. Transport/Access issues.
8. Urgent Care Review.
9. Healthcare Associated Infections.

AGREED that:

1. The topics listed at 1 to 5 above, would be submitted to the Overview and Scrutiny Board for approval for inclusion in the Panel's Work Programme 2016- 2017.
2. Update reports would be provided in respect of previous reviews listed at 6 to 9 above.

4 **HEALTH INEQUALITIES - CANCER SCREENING AND REDUCING CANCER RELATED DEATHS.**

A report was presented to provide an outline of the meeting. Health professionals who were in attendance to give evidence were introduced and welcomed to the meeting.

In 2015/2016 the Panel began a review into health inequalities in respect of reducing cancer related deaths and improving cancer screening. Members had been informed about the excellent work that was being done through the Macmillan Integration of Cancer Care Programme and were keen to find out more about the work that was being undertaken on cancer pathways.

The Lead Cancer Nurse's role was to support the Cancer Care Co-ordinators and the Clinical Nurse Specialists to ensure there was equality across all pathways. These roles were front-facing with patients to support 31 and 62 day targets to pull and push patients through their pathways more quickly. The Co-ordinators supported the Multi-Disciplinary Teams (MDTs) and worked closely with Consultants, Radiology, Oncology and Secretaries to assist patients. The Co-ordinators were available to answer questions and queries and allay patients' concerns. They also helped patients through chemotherapy sessions, provided support mechanisms and befriending services. An example was given of a patient who was afraid to attend for a chemotherapy session. The Co-ordinator talked to the patient by phone for forty minutes and then arranged to meet the patient at the clinic and sit with that patient.

This role had previously been undertaken by the Clinical Specialist Nurses but as they were now doing more high level conversations and interventions, the Co-ordinators had taken over the lower level 1 and level 2 interventions. It was a really important role for the patients and one that the organisation whole-heartedly supported. The Co-ordinators were new roles and their contracts were fixed term and would be evaluated from both a quantitative and a qualitative point of view. The views of patients and staff would be sought as part of the evaluation. If the role evaluated well, the Trust and the Commissioners would be asked to commission them permanently. Similar roles had been piloted in North Yorkshire and had evaluated well. The Clinical Nurse Specialist role had changed over the years and the Co-ordinator role had been formed by adapting that job description.

One of the Cancer Care Co-ordinators provided a brief insight into her work. The Co-ordinator would initially attend the 2 week clinic and meet patients who were attending to receive the results of their x-rays. The Co-ordinator would ensure a Spirometry (breathing) Test was carried out. The Co-ordinator would attend the clinic appointment with the patient as a form of support and ensure that the patient understood what was being said, what tests would be undertaken and the dates and times of their appointments.

The Co-ordinator would look to see how much time could be saved for a patient moving through the pathway. An example was given of a patient who was due to be referred back to a clinic but no referral had been made. The Co-ordinator chased this up and made the appointment. It was clarified that whilst the process would have happened eventually, the point of the Co-ordinators was to carry out negotiations in the hospital to pull patients through the pathway. Another example was given of patients with a diagnosis who might present at Accident and Emergency when they could have been signposted more appropriately if they had known who to contact for assistance.

The hospital used InfoFlex, an IT system, to record data on all patients that had been taken

through the lung cancer pathway. All discussions with patients were recorded to enable all members of the MDTs to see what that patient had been through. A nursing contact screen had been developed that all Consultants could view. The Co-ordinators also had their own screen. The aim was to improve communications right across the pathway. It was noted that many patients forgot what was said after the word 'cancer' was spoken to them. It was not always necessary for the Specialist Nurse to speak with a patient to reiterate the information they had been given. This was something the Co-ordinator could do because the information was documented on InfoFlex. Anything the Co-ordinator could not answer would be marked on the screen and the Specialist Nurse would then follow it up.

The Clinical Nurse Specialist provided some information on her role and stated that the lung cancer pathway was very busy. One of the issues was the amount of time available to spend with patients. There were currently two, 2 week rule clinics which were supposed to have 8 patients per clinic. However, the clinics were often overbooked and there could be up to 12 patients per clinic. Staffing levels had not increased and therefore nurses were seeing up to 24 patients a week. Whilst only half of those patients attending the clinics might go right through the pathway, there were approximately 440 patients per year with a cancer diagnosis. Patients from the Wards and from Accident and Emergency admissions were also supported.

The Clinical Nurse Specialist would meet every patient at the 2 week rule clinic and again when they received their results. The patient would then receive a Key Worker Card with contact details so that they could get in touch at any time during their pathway. Even when a patient had completed their treatment they could still contact the Nurse Specialist for help, advice and support.

It was clarified that GPs did not have access to InfoFlex but they were faxed the details of the diagnosis within 24 hours of it being made. Whilst it was acknowledged that one IT system would be ideal and would save on administration, it was accepted that since this was not achievable at the current time, other mechanisms were in place.

The Macmillan Programme Manager gave a power-point presentation on The Macmillan Integration of Cancer Care Programme (MacICC). The Programme was developed to review existing services and pathways, consult with all stakeholders to define standardised integrated pathways for patients with cancer from diagnosis to death, support care closer to home and work across traditional boundaries to transform services. This meant providing the right care, in the right place, at the right time, with the right professional.

There were fourteen cancer pathways in the Trust and the review concentrated on lung, lymphoma and brain and CNS (Central Nervous System). The rationale for the choices was explained. Lung cancer was chosen because the prognosis was poor and staffing was very concentrated in that particular pathway. Lymphoma affected a greater age range of people. Younger people were affected by lymphoma usually from the age of 30 and there was a greater possibility of survivorships. This gave the project team the ability to look at people who lived with and beyond cancer and all of the issues associated with having had cancer treatment and coming through it. Brain and CNS were chosen that because it was a much rarer cancer than the other two with a very poor prognosis. Whilst there was not a very big patient cohort, it created a greater dependency on other services because it led to very debilitating illness. A tumour in the brain or spine affected the way people thought and moved.

The review also considered cross cutting issues of palliative care, workforce and community. This included how the workforce and community could be used to better effect and what services were available. Patients had a life outside of the hospital with family and friends and it was important to assess what support was available when a patient was not in active treatment.

The methodology for developing the programme to assess what was happening in the pathways and how this impacted on patients included: process mapping to record the pathway from pre-diagnosis to the end of life, triangulation of data to ensure that everyone was saying the same, a thematic analysis to identify the main areas of concern and patient stories to support issues identified.

Separate process maps were developed for the three areas reviewed and even though each disease was different in its own right, the maps were quite similar. The three pathways all had complex models but highlighted the same issues that were barriers to patients from getting the diagnosis through to treatment. Six main areas of concern were identified which were: Referral, Communication, Learning and Development, Diagnostic waits, Information Technology and Staffing issues.

Whilst some issues were cultural, ie things that had always been done in a certain way, many of them were about limited resources and needing to do things differently. For some patients, whilst they had a diagnosis and had had treatment, there were still gaps in the care provided.

One of the biggest issues identified was diagnostic testing and capacity issues. For example, whilst the Government was pushing for more people to be screened for cancer, there were difficulties recruiting qualified radiologists. The key thing was trying to make best use of testing and move away from sequential testing. If it was clear that a patient had a tumour for example, rather than wait for each test result, it might be better to carry out all the tests at the same time. Although this might cost more, it was often quicker.

Following all the research, the stated aim of the MacICC was to integrate cancer care by promoting patient choice and streamlining working practice across the South Tees and Hambleton, Richmondshire and Whitby health economy. A proposed Programme Structure was developed to promote system-wide improvement from referral, through diagnosis, treatment and living with and beyond cancer. The challenges to each step of the workstream had been clearly identified.

In order to improve outcomes for cancer, consideration had to be given to how screening was carried out, how patients were seen earlier and how GPs could better diagnose. Many patients presented at Accident and Emergency with other symptoms, for example, breathlessness. One of the big issues when promotional campaigns were carried out for lung cancer was that it did not necessarily lead to more diagnoses. In partnership with Public Health Shared Services the Open Access Chest X-Ray initiative had been funded by the Clinical Commissioning Group (CCG). This initiative had been specifically developed for patients who did not traditionally attend GP practices to assist in earlier diagnosis of lung cancer. The initiative was based in two accessible locations in Middlesbrough and targeted at communities in TS1 and TS3 to enable self-referral for a chest x-ray.

Other innovations included the pilot of the new posts of the Cancer Care Co-ordinators and Community Sister/Charge Nurse roles in partnership with Macmillan Cancer Support. One of the key things identified by staff working in the community was that whilst there was excellent acute care provision in hospital, there was no-one based in the community to provide patient support when leaving the acute treatment. Other professionals had been able to participate in the Induction Programme for the Community Sister/Charge Nurses and the Care Co-ordinators to increase their knowledge. The Community Sister/Charge Nurse roles, like the Care Co-ordinator roles, had fixed term funding. If the posts evaluated successfully it was hoped they would be commissioned on a permanent basis.

Some of the challenges going forward for the MacICC were also highlighted.

Members discussed potential areas where the panel could make meaningful recommendations. The representatives outlined how a continued commitment from the South Tees CCG to be involved in this work would be useful. It was recognised that working together was the best way of influencing the whole of the patient's journey and make the best use of resources. The representatives were keen to see this programme being adopted as a strategy.

Members were also keen to see support for increased levels of research in this area.

AGREED that recommendations based on the following be added to the panel's final report into Cancer Screening and Reducing Cancer Related Deaths:

1. That the panel endorse the work of the Macmillan Integration of Cancer Care

Programme and that they would like to see the South Tees CCG provide continued support for Cancer Care Co-ordinators and include continued funding for the posts in the CCG's next commissioning round.

2. Whilst recognising that further research is needed on the benefits of the programme, the panel would like to see continued support for increased levels of research in this area.

5 **OVERVIEW AND SCRUTINY BOARD UPDATE.**

The Chair requested that the Panel note the contents of the submitted report which provided an update on business concluded at the Overview and Scrutiny Board meeting on 14 June 2016, as follows:

- Second Capital Monitoring Review - 2015/2016.
- Final Report of Ad-Hoc Scrutiny Panel - Council Use of Consultants.
- Executive Forward Work Programme.

NOTED

6 **ANY OTHER BUSINESS.**

There was no other business.

NOTED