SOUTH TEES HEALTH SCRUTINY JOINT COMMITTEE

A meeting of the South Tees Health Scrutiny Joint Committee was held on 12 August 2013.

PRESENT: Middlesbrough Council:
Councillors Biswas, Cole, Dryden, Junier and Mrs H Pearson.

Redcar and Cleveland Council:
Councillors J P Hannon, Thomson, Mrs Wall and Wilson.

ALSO IN ATTENDANCE: Councillor B Forster, Redcar and Cleveland Council
A Hume, Chief Officer, South Tees Clinical Commissioning Group
J Stevens, Commissioning Manager, Service Planning and Reform, North of England Commissioning Support
S Harrison, Senior Communications Manager, NHS North of Tyneside.

OFFICERS: M Ameen (Redcar and Cleveland Council), J Bennington and E Pout (Middlesbrough Council).

APOLOGIES FOR ABSENCE There were no apologies for absence.

DECLARATIONS OF INTERESTS

Name of Member	Type of Interest	Item/Nature of Interest
Councillor Mrs Wall	Non-Pecuniary	Any matters arising in relation to North East Ambulance Service NHS Foundation Trust- relative of a number of employees.

APPOINTMENT OF CHAIR AND VICE CHAIR

Reference was made to the proposed protocol for the operation of the South Tees Health Scrutiny Joint Committee which suggested that the Chair of the Joint Committee rotates between Middlesbrough Council, and Redcar and Cleveland Council on a yearly basis. The appointment of two Vice-Chairs, one from each local authority was also proposed.

The suggested procedure for the appointment of Chair and Vice Chairs was agreed and nominations were sought accordingly.

AGREED as follows: -

1. That following nominations Councillor Dryden (Middlesbrough Council) be appointed as Chair of the South Tees Health Scrutiny Joint Committee for the Municipal Year 2013/2014.

N.B. Councillor Dryden took the Chair at this point of the meeting.

2. That following nominations Councillor Mrs Wall (Redcar and Cleveland Council) and Councillor Junier (Middlesbrough Council) be appointed as Vice-Chairs of the South Tees Health Scrutiny Joint Committee for the Municipal Year 2013/2014.

WELCOME - INTRODUCTIONS - SCRUTINY SUPPORT OFFICER

Following introductions the Chair welcomed all present to the first meeting of the South Tees Health Scrutiny Joint Committee for the current Municipal Year.

On behalf of the Joint Committee the Chair expressed gratitude for the excellent work and support provided by Jon Ord during his employment with Middlesbrough Council as Health Scrutiny Support Officer.

The Chair introduced and welcomed Elise Pout as the Health Scrutiny Support Officer.
NOTED

DRAFT PROTOCOL - SOUTH TEES HEALTH SCRUTINY JOINT COMMITTEE

The Scrutiny Support Officer submitted a report the purpose of which was to outline a draft protocol to govern the operation of the South Tees Health Scrutiny Joint Committee for 2013/2014 as outlined in Appendix 1 of the report submitted.

The protocol provided a framework for assisting the joint committee arrangements and had been revised in the light of the Health and Social Care Act 2012.

AGREED that the draft protocol for the operation of the South Tees Health Scrutiny Joint Committee as submitted be approved for the 2013/2014 Municipal Year.

INTEGRATED MANAGEMENT AND PROACTIVE CARE OF THE VULNERABLE AND ELDERLY PROGRAMME

The Scrutiny Support Officer submitted a report the purpose of which was to introduce a number of senior representatives from the South Tees Clinical Commissioning Group (CCG) to provide a briefing on Integrated Management and Proactive Care for the Vulnerable and Elderly (IMProVE) and to seek the views of the Joint Committee on the proposed Communications Plan.

By way of introduction a briefing paper from the South Tees CCG was provided at Appendix 1 of the report submitted which outlined the IMProVE project for which a Communications Plan had been developed which included hosting a series of public events throughout the South Tees area. Reference was also made to a questionnaire which had been designed which would be distributed to various organisations.

It was confirmed that the South Tees CCG made up of 49 general practices served a population of around 280,000 people and was responsible for commissioning a range of healthcare services on behalf of local people, The aim of the CCG was to improve the healthcare of the increasing number of elderly, vulnerable and living with long term conditions whilst ensuring that health services remained safe and sustainable now and into the future. In order to achieve this it was considered there needed to be a change of culture away from a reactive care model to one which was proactive and designed to prevent a deterioration into ill health and hospital admission when not appropriate.

To realise such a vision it was recognised that there was a need to develop integrated services that identified patients who might be at risk at an earlier stage, and work with them and their carers or family, to maintain and support independence for as long as possible.

Following engagement with many health and social care partners to consider the challenges the CCG felt that they were now at a stage to involve stakeholders, patients, carers and the general public in a wider discussion about the type of services they need and the way in which they should be organised in the future.

The briefing paper outlined the main reasons for change to develop more integrated services to enable appropriate support to be delivered in a more timely and co-ordinated way. In order for this to be achieved details were provided of areas to be examined and developed which included:-

(a) opportunities to enhance services in the community, for example, developing better provision for those suffering from respiratory diseases, improving rehabilitation support for stroke patients, providing services in the community and in patient's own homes;

(b) placing GPs at the centre of an integrated service, undertaking more proactive management of patients to identify those at most risk and co-ordinating support across health and social care;

(c) making better use of a 'step up' (GP led direct admissions) model of care which would reduce the number of patients admitted to acute hospital beds;

(d) improving quality care by providing seven day multidisciplinary team ward rounds and reducing the length of stay of those who are admitted;

(e) delivering some out-patient clinics closer to home, where appropriate and reviewing the use of community hospitals to provide better access for patients;

(f) better information sharing across health and social care teams;

(g) providing healthy living advice and encourage self-management and self-care to prevent escalation of health conditions;

(h) increased involvement of the voluntary and third sector in providing community - based services;

(i) incorporating best practice, national strategy and Department of Health guidelines into our approach.

It was noted in particular, the opportunities being pursued for providing care outside of hospital in the community, GP practice or home which was likely to result in changes to the way community hospital beds were used. It was reaffirmed that it was clinically recognised that delays in discharging patients from hospital was often detrimental to the long term wellbeing of elderly people.

The next stage of the overall process was to engage with patients, carers, stakeholder and local people to obtain their views about the vision for improving services and ensuring that more elderly and vulnerable patients with long-term conditions were able to remain independent for longer. It was recognised that this would be a long term plan and involved improving and enhancing existing services in the community. In particular, the CCG was keen to seek views on:-

- Co-ordinated, integrated and seamless care - health and social care staff working together with patients to plan care and manage conditions.
- Encouraging people to have more control over their care- providing information, support and guidance to help people make decisions about their care and wellbeing and manage their health conditions more effectively.
- Care when and where you need it - increasing the range of support provided outside hospital and reducing the reliance on acute and community beds. Ensuring that people get the right service in the right setting with the right support.

The local health representatives gave a presentation emphasising the main aspects of the project and the Communications Plan and reiterated that they were keen to obtain views on the Plan prior to the public engagement.

The proposals formed part of the Transforming Community Services Programme with the aim of pursuing a more integrated cost effective approach between primary, community, hospital and social care services to ensure the 'Right Care, in the Right Place and at the Right Time.' It was recognised that there was a shift from a reactive care model to one which was more proactive which attempted to identify patients who were at risk before their condition deteriorated.

The three main priorities of the plan were confirmed as follows;-

(i) setting clear, ambitious and measurable goals to improve the experience of patients and service users;
(ii) offer guarantees to patients with complex needs involving individual packages of care;
(iii) implement change at scale and pace to cope with such factors as an ageing population.

As previously indicated there was a very high demand in the region for emergency hospital services and the number of patients with long term conditions was predicted to significantly increase over the next ten years. Such factors together with current delays in obtaining

appointments, in receiving responses from partner organisations, in receiving treatments, discharge from hospital and risk of re-admission and the need for improved clinical outcomes and improved communication between health and social care necessitated change to improve the present situation and cope with future demands.

The Plan aimed to:-

- improve patient knowledge;
- influence better clinical outcomes;
- improve self-care;
- ensure that the most appropriate treatment is given;
- reduce waiting times for diagnosis and treatment;
- better discharge procedures, all patients to have a care plan;
- improve access to support services.

The next steps of the overall process involved engagement with the public, obtain feedback and collate responses and develop options for consultation. As part of the Communications Plan a number of public events had been arranged during September and October at Eston, Brotton, Redcar, Middlesbrough and Guisborough where local people, patients, carers and other stakeholders would be able to give their views to help identify options for the future which would be presented to the public as part of a formal consultation process in late 2013 or early 2014.

It was proposed to disseminate information to groups such as voluntary agencies, patient reference groups, Healthwatch, PALS, GP practices, MPs, Local Medical Committees and LA's scrutiny committees. It was also pointed out that there would be focussed work with patients and carers with those who might have or were likely to access services.

The Panel acknowledged the importance of ensuring that the Communications Plan was robust and of having the opportunity of identifying any potential gaps within the overall plan. Members emphasised the importance of engaging with the elderly and indicated that it would be beneficial to consult with the respective Older Persons Partnerships.

An indication was given of recent developments which included Community Matrons in Community Services, Rapid Response service, examining UK's best practice in terms of support which could be provided to stroke patients within their own home and appropriate use of health centres.

In general terms and from initial consideration of the Communications Plan Members indicated that there was currently a lack of understanding by many of the role of such organisations as Healthwatch and that of Community Nurses/Matrons in the community and questioned if there were sufficient resources to deliver such services. The Communications Plan was seen as following a similar pattern to others and Members felt that in order to achieve the best results there was a need to pursue more innovative ways of accessing and communicating with a broad spectrum of people and should be extended to include other social services network, BME organisations, pharmacists and Community Councils.

Members suggested that a seminar be held and an invitation be extended to all Members of both local authorities and relevant organisations.

AGREED as follows:-

1. That the local health representatives be thanked for their attendance and information provided.

2. That a copy of the PowerPoint presentation and a full list of organisations included in the Communications Plan be forwarded to Members of the Joint Committee.

3. That the views of individual Members of the Joint Committee be sought on the specific questions outlined in the presentation and forwarded to the South Tees Clinical Commissioning Group.