SOUTH TEES HEALTH SCRUTINY JOINT COMMITTEE

A meeting of the South Tees Health Scrutiny Joint Committee was held on 7 April 2014.

PRESENT: Councillors Dryden (Chair) Biswas and Mrs H Pearson (Middlesbrough Borough Council)

Redcar and Cleveland Council
Councillors Ayre andGoddard and Thomson.

ALSO IN ATTENDANCE: Amanda Hume, Chief Officer, South Tees Clinical Commissioning Group
Julie Stevens, Commissioning and Delivery Manager, South Tees Clinical Commissioning Group
Siobhan Jones, Senior Communications and Engagement Locality Manager, North of England Commissioning Support Unit.

OFFICERS: J Bennington and E Pout (Middlesbrough Council) and H Armstrong (Redcar and Cleveland Borough Council).

APOLOGIES FOR ABSENCE were submitted on behalf of Councillor Cole (Middlesbrough Council) and Councillor Mrs Wall (Redcar and Cleveland Borough Council). .

DECLARATIONS OF INTERESTS

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

13/9 **MINUTES - SOUTH TEES HEALTH SCRUTINY JOINT COMMITTEE**

The minutes of the meeting of the South Tees Health Scrutiny Joint Committee held on 27 February 2014 were submitted and approved as a correct record.

13/10 **INTEGRATED MANAGEMENT AND PROACTIVE CARE FOR THE VULNERABLE AND ELDERLY**

The Scrutiny Support Officer submitted a report the purpose of which was to introduce a number of representatives from the South Tees Clinical Commissioning Group (CCG) who gave an update on the IMProVE programme for Members' information.

As part of the background information the CCG had provided the following information to the report submitted:-

Appendix 1 - CCG Briefing
Appendix 2 - Engagement Log
Appendix 3 - Communication and Engagement Implementation Plan 2014
Appendix 4 - Draft Case for Change.

Reference was made to information presented at the last meeting of the Joint Committee with specific regard to the number of patients using community beds that could have been supported by other services and those in acute settings for which there could have been more appropriate alternative support. The CCG had confirmed that the aim of the IMProVE programme was to ensure that community services were in place.

The CCG representatives confirmed that they were currently in the process of considering options for change with GP practice members, partners and key stakeholders. Proposals for service change would be put forward as part of a formal consultation process which was due to commence on 30 April 2014. Such a process would include a number of public meetings as well as opportunities for local people to have their say through a range of other channels.

The main components of the document for the Case for Change were reported as follows:-

- • Introduction
- • What We Would Like To Achieve
- • The Drivers for Change
- • New Model of Care
- • The Key Enablers
- • Conclusion.

The key points providers were expected to consider in developing the new service model included the following:-

(a) Avoid transfers of patients from one hospital to another, unless dictated by clinical need or to benefit from different types of service provision on a pathway of care.

(b) Introduce a step up (GP led direct admissions) model - reducing the number of patients admitted to an acute bed. The criteria for set up would need to be developed, and would utilise community hospital /teams, rapid response and a fully integrated approach to care.

(c) Rationalise the stroke pathway so that the rehabilitation element is delivered on a dedicated site in line with national guidance.

(d) Significantly reduce the length of stay for those patients in community hospitals and improve quality of care. Provide seven day multi-disciplinary team ward rounds.

(e) Provide more urgent assessments for the elderly with appropriate diagnostics to aid diagnostics and manage.

(f) Provision of appropriate medical day care treatments in the community.

(g) Deliver appropriate out-patient clinics closer to home, improving the use of community hospital estate and providing better access for patients.

The Joint Committee's attention was drawn to the process for developing options to improve community services the criteria for which had been created and discussed at several engagement events involving clinicians, community staff and representatives of 20 organisations including local healthcare providers and community and voluntary sector organisations. An indication was given of the consultation timeline for gaining the views at several events and/or meetings on the proposed option culminating with the CCG Clinical Council of Members on 10 April 2014. Following Members' questions it was confirmed that the overall engagement had included consultation with staff in residential and nursing homes.

As part of the option development the key elements of the new service model had been assessed as to what was considered essential or desirable.

Reference was made to work undertaken with regard to bed modelling. Despite predicted increases in the elderly population it had been estimated that the introduction of a new model of care, supporting more people to remain independent and improving community support the need for community beds was likely to reduce.

The next stage of developing the option involved applying the agreed criteria individually to the community hospitals to assess quality (ability to deliver services now and provide a quality service); sustainability (ability to deliver future developments and accommodate expansion of community services); and efficiency (cost effectiveness and ability to deliver model currently and into the future). An indication was given of other aspects to be taken into consideration in respect of each of the community hospitals.

Members sought clarification on possible improvements with regard to access and timescales involved with a number of current processes including blood tests and x-ray facilities.

The Joint Committee was advised of the proposed community development and re-investment between April 2014 and March 2016 which would include recruitment of additional staff and ongoing appropriate training of current staff.

Whilst it was acknowledged that many vulnerable patients were eligible for patient transport Members reiterated current difficulties concerning local transport services with particular regard to Redcar and East Cleveland. Members referred to increasing problems of isolation and loneliness being experienced by an increasing number of the elderly population. It was acknowledged that there would be a further opportunity to highlight such issues as part of the formal consultation on the proposals which would include other aspects such as early intervention and more proactive care. Confirmation was given of how the Joint Strategic Needs Assessment and other related research informed the development of the proposals.

In discussing the overall engagement plan and range of groups involved specific reference was made to the steps taken to consult with hard to reach groups. It was agreed that a Members' reference to an increasing number of other ethnic minority groups such as Eastern European groups would be examined.

AGREED that the representatives be thanked for the information which was noted at this stage of the process.