SOUTH TEES HEALTH SCRUTINY JOINT COMMITTEE

A meeting of the South Tees Health Scrutiny Joint Committee was held on 17 November 2015.

PRESENT: Councillors S Biswas, E Dryden, R Goddard, S Holyoake, T Lawton, N O'Brien, J A Walker and A Watts and M Walters (as substitute)

ALSO IN ATTENDANCE: C Blair, Associate Director, Commissioning, South Tees Clinical Commissioning Group
S Clayton, NHS North of England Commissioning Support
J Kelly, South Tees Clinical Commissioning Group
A Robinson, NHS North of England Commissioning Support
J Stevens, Commissioning and Delivery Manager, South Tees Clinical Commissioning Group

OFFICERS: C Lunn and E Pout

APOLOGIES FOR ABSENCE Councillor D Rooney.

15/12 **MINUTES - SOUTH TEES HEALTH SCRUTINY JOINT COMMITTEE - 13 OCTOBER 2015**

The Minutes of the meeting of the South Tees Health Scrutiny Joint Committee held on 13 October 2015 were submitted and approved as a correct record, subject to the following amendment:

Page 6 - engagement update should read "*The aim was to have Models to share with the Joint Committee at its next meeting on 17 November 2015, with the potential to consult commencing in January 2016."*

15/13 **URGENT CARE - DEVELOPING A SOUTH TEES CCG URGENT CARE STRATEGY**

The Scrutiny Support Officer presented a report, the purpose of which was to provide the Committee with an outline of the meeting and introduce a number of professionals who were in attendance to provide evidence.

At the Committee's last meeting on 13 October 2015, the South Tees Clinical Commissioning Group (CCG) reiterated the case for change behind the development of a South Tees CCG Urgent Care Strategy. The North of England Commissioning Support Unit (NECS) also outlined the public engagement activity that had taken place to date.

Representatives from the CCG were in attendance to provide further details, including an outline of the potential options which have been developed as a result of the recent pre-consultation discussions.

Representatives from the South Tees Clinical Commissioning Group delivered a presentation entitled 'Developing an Urgent Care Strategy' to the Committee, which covered the following topics:

- Stage 1 Recap - Gathering Ideas, Feedback and Examining Best Practice;
- National Commissioning Standards for Integrated Urgent Care;
- Proposed 7 Day Working for GPs by April 2017;
- The Prime Minister's Access Fund;
- Urgent Care Networks and Vanguard Programme;
- Stage 2 - Developing Appraisal Criteria;
- Stage 3 - Scenario Appraisal (November 2015);
- Scenarios Which Scored Highly; and
- Stage 4.

The representatives explained that at stage 1, the purpose was to gather ideas, feedback and

examine best practice around urgent care models in order to develop them going forward. It was highlighted that demands on the NHS were increasing and something different in respect of urgent care services was needed. A case for change document, which had been provided to the Committee previously, had been shared with the public and other key stakeholders and partners.

Members were informed that a public engagement exercise, the purpose of which was to gain views on current and future urgent care services, had taken place between July and September 2015. Following an enquiry raised at the 13 October 2015 meeting of the Committee, the representatives confirmed that engagement work with the homeless had now been undertaken via food banks. This had been incorporated into the engagement report, which was available on the CCG's website.

The representatives explained that whilst undertaking this work, national guidance had been released in October 2015 to advise CCGs of the action required to align with the national strategy.

The Committee was reminded at this stage that existing contracts for out of hours and walk-in centres was extended to the end of March 2017, therefore CCGs were aware that an alternative approach was required by 2017.

The presentation slide referring to the National Commissioning Standards for Integrated Urgent Care illustrated the use of 999 and 111. It was explained to Members that this was a national approach, which would emphasise the use of 111. The way that 111 would be utilised in the future would be changing, for example: 111 would have access to the summary care record; the directory of services currently within 111 would be expanded to encompass social care services; and the ability to book GP appointments directly would be implemented.

With regards to a clinical assessment, advice and treatment service, it was explained that 111 would have a hub of clinical experts attached to it, whom would be available to support patients over the telephone. Patients would continue to go through a triage process with the call handler, but they would then be able to speak to a variety of professionals as required - e.g. a GP, a Pharmacist, Mental Health Worker, Paediatric Nurse - there would be various people located within the hub. The representatives highlighted that resources would be offered on a regional scale, as it would be unrealistic to expect a hub to operate in every local area. Regarding face to face treatment services, it was hoped that, locally, there would be opportunity to influence these more.

In response to an enquiry, the representatives explained that a triage system was currently in place through 999, which was a service that ambulance service call handlers currently provided. It was explained that, on occasions, people contacted 999 inappropriately for minor ailments; call handlers were required to work through a protocol in order to determine which service the caller required, before transferring them to that respective service (i.e. ambulance, police or fire). However, 111 was now being promoted as the national alternative to 999, in a way similar to the alternative police telephone number 101. 111 was to be used for more non-life threatening illnesses / problems, which would also offer an online guidance service for self-care. There would again be a triage system; however the support offered by experts would be increased.

A comment was made with regards to local and national working and the boundary issues experienced when dialling 999. It was felt that delays were experienced by callers being put through to the incorrect geographical area. The representatives agreed to look into this matter and report their findings to the Scrutiny Support Officer.

With regards to 7 day working, a new contract would be in place for GPs, which would include an option for 7 day access 8am-8pm. Initially, this would be voluntary, with practices working together to cover populations of at least 30,000.

There was a recognition that it would not be feasible for every GP practice to offer this access, as it was understood nationally that there were not enough GPs available. However, by working jointly for larger populations, it was felt that this service could be delivered. Although

not every practice would open, the scheme would facilitate access to patients' records, meaning that other GPs, aside from the patient's own, would be able to converse with patients as required.

Clarification was sought with regards to access to medical records. The representatives explained that patients would be required to give consent to their medical records being shared, though advice on a more general nature could still be provided if patients did not wish to disclose these.

It was explained that schemes would be introduced on a phased approach and approved by 2016. It was anticipated that the schemes involved would be those that had already been identified as part of the Prime Minister's Access Fund (previously known as the Prime Minister's Challenge) - i.e. the STAR scheme in the South Tees area, and the Vanguard Programme.

With regards to the Vanguard Programme, it was explained that the NHS Spending Review was due out at the end of November 2015. It was expected that further details would be made available when the results of the Spending Review were released.

Members were provided with details pertaining to the Prime Minister's Access Fund. It was explained that funding pilots throughout the country to improve access in general practice, and looking at innovative ways to do this, had been undertaken.

The STAR scheme that South Tees had put in place, which had been commissioned by NHS England through this particular project, provided integrated hubs with extended GP access to the 290,000 population that South Tees currently had. It was explained that out of hours services were currently being offered 6.30pm-9.30pm, however nationally, the stipulation was 8am-8pm. The representatives explained that the STAR scheme had looked at the activity flow, which had identified a big drop in activity after 9.30pm. The decision to pilot opening until 9.30pm was taken and would be reviewed accordingly. Opening had also been extended for weekends and bank holidays.

The STAR scheme was integrated with the current NHS 111 service and provided medical support to out of hours community services, ambulance services and care homes. The possibility of utilising Skype so that care homes could have direct communication with GPs was currently being undertaken.

Patients would access the service via a triage through 111, and directly bookable appointments with GPs would be offered. It was felt that this would be positive for patients in that there would no longer be a requirement for patients to physically attend a centre and wait, instead they would be given an appointment slot within the service. There would be telephone and web-based video consultations offered to patients as alternative ways for them to gain access to their local clinicians.

It was explained that the STAR scheme had recently commenced, and therefore supportive evidence to determine the performance of the scheme would be gathered in due course. However, with regards to phase 1 schemes that had been running for a while, the Committee was advised that there had been press coverage to discuss whether Sunday openings were required, as not many people were accessing services on that day. The representatives advised that these were six-month pilot schemes, and therefore to change behaviour, a longer time spell was required. It was felt that there would be opportunity for GPs to do other things on a Sunday when in the surgeries, for example: cancer screenings, but there had been national reluctance by some GPs to open on a Sunday. Judging by activity in other areas, such as A&E and walk-in centres on Sundays, it was felt that there was a need, but this would be followed closely.

Following an enquiry concerning the publicising of the STAR scheme, it was explained that it had not been publicised to date, as GPs wanted to ensure that the system was up and running properly, that they had complete access to all of the practice systems, and that they had a sufficient number of GPs to support it. The STAR system was now in operation and training in respect of a communication plan would be undertaken at James Cook Hospital from

December 2015. Publicising of the system would be undertaken once all training had been completed.

In response to a query concerning out of hours community services, it was explained that the STAR scheme would support services such as District Nursing and Rapid Response particularly well. At the moment, once a GP surgery had closed, personnel did not have direct access to a patient's records - they would need to contact another out of hours service. Through the STAR scheme, a District Nurse, Community Matron, etc. could make contact and acquire GP advice in instances where they felt that that they did not have sufficient information of the patient's medical history available.

In response to an enquiry, it was explained that various different pilots were taking place across the country to look at different considerations, for example: looking at patients' long term conditions and the necessity for weekend appointments. In the case of South Tees and the STAR scheme, it was focused more upon urgency - i.e. people needing appointments the same day. It was about what could be achieved in 7 day opening going forward - e.g. GPs working together in federation to provide more comprehensive services.

Reference was made to current working patterns / options available to GPs, and how increased flexible working would be offered in the future.

Regarding urgent care networks, it was explained that every region had been required to establish one of these. A network had been established in the North East that included Cumbria and Newcastle. It had links to North Yorkshire but that area was not included. The network met on a bi-monthly basis and the purpose was to provide a North East strategy, but deliver towards the national urgent care strategy requirements. The network was also responsible for overseeing delivery of the Vanguard Programme. It was explained that over the summer of 2015, there was opportunity to obtain additional funding by submitting bids to accelerate delivery of the strategy. The North East had put in a successful joint bid, and therefore consideration now needed to be given to the work required across the region.

In response to an enquiry, it was explained that 12 CCGs had come together to form the network and work collaboratively to manage the fund between them. A Commissioning Support Team had been introduced to assist in the allocation of resources. No monies had been received as of yet. The lead CCG at the moment was Durham and Darlington. Various bids would be put forward and the importance of transparency was highlighted. The network submitted the bids to the Vanguard Programme and then money was allocated against delivering on the various projects. It was felt that there would be opportunity for CCGs to influence spends within their respective areas, and so whatever was put in place had to cover the entire North East and Cumbria.

The Vanguard Programme was funded nationally and supported the implementation of national guidance. With regards to the number of people involved, the programme spanned a population of 2.7 million across the North East, which included 10 Foundation Trusts, 12 CCGs, 9 System Resilience Groups (SRG), 1 Ambulance provider (NEAS) and 1 NHS 111 provider (also NEAS).

It was highlighted that South Tees SRG had been identified almost as an exemplar site for the work undertaken around the community and the improved programme, and so it would be leading on that particular work stream and sharing learning with other CCGs in the North East. Similarly, other CCGs were further ahead in areas such as clinical hubs, and would therefore share their learning and lead on those work streams.

The 111 model would sit within the Vanguard Programme and would be completed regionally. This would feed into the national strategy to make sure that the national criterion was being delivered against.

Regarding face to face appointments / treatment areas, work had been carried-out with stakeholders over the last few months to identify potential ways forward. Stakeholders had been asked to develop criterion for a good model of care going forward. Engagement was initially undertaken with South Tees SRG, and then refined to include other stakeholders

including: South Tees CCG Governing Body; CCG Clinical Council of Members; Public Engagement; and CCG's Patient and Public Advisory Group (PPAG). A number of areas were looked at including: Patient experience; Finance; Access to the right services; and Workforce capacity. Members present at the meeting who attended the stakeholder meetings shared their positive experiences of them.

It was explained to the Committee that information arising from the stakeholder meetings was utilised to identify a consensus of opinion, which would be shared with the business case going forward. Protocols were developed to measure against scenarios, e.g. what was essential in the new model, what was desirable, and what weighting was attached to each. This formed stage 3 - scenario appraisal. The CCG's Urgent Care Operational Group, which met weekly and included NHS England and Local Authority representatives, applied the appraisal criteria to suggest scenarios and agree a score. Healthwatch attended the meeting as a critical friend to ensure that the process was completed fairly. There were no GPs present owing to a conflict of interest.

It was explained that the scenarios which scored highly were:

- In line with national guidance outlined previously, the development / enhancement of the NHS 111 model, which would be worked up through the Vanguard Programme.
- Aligned to proposed new GP contract arrangements; extended GP opening hours 8am-8pm 7 days per week delivered around populations of around 30,000 replacing existing walk-in centres.

It was explained to the Committee that, owing to duplication of the new system, the option to close walk-in centres was being considered. This would need to be carried-out in collaboration with NHS England, as the walk-in centres had a GP list attached to them and therefore NHS England would need to engage in terms of how the list worked.

A short discussion ensued with regards to the utilisation of walk-in centres, the facilities available to patients on site, and the outcome of patient visits. It was clarified during discussion that although all 46 practices had agreed to work together through the STAR scheme to provide 8am-8pm cover, access would be provided via hubs, as opposed to every individual practice opening independently.

Members were advised that the next stage of this process would be to model these scenarios to determine how much they would cost, what the activity flow was, and how these may change for implementation - e.g. increased operational hours for GPs may be commissioned depending upon the activity flow.

- A further scenario scoring highly was alignment of the out of hours period (to include home visits and appointment booking) to the new GP in-hours arrangements with further exploration of where and how many sites appointments could be delivered from.

It was explained that whatever was decided with regards to the GP opening hours, the out of hours service would commence after the GP surgeries had closed. Therefore, further exploration would need to be undertaken to determine suitable locations for the hubs.

In response to an enquiry raised regarding access to services after-hours, it was explained that activity dropped dramatically after 9.30pm, with no bearing upon A&E and other areas - it was the same everywhere.

- A further scenario scoring highly was a GP presence at front of house in A&E, triaging and diverting patients with primary care needs. All life threatening emergencies (999 calls) would be directed straight to emergency room. Additionally, potentially patients attending A&E for primary care needs were given a direct appointment into another service (including GP practices).

It was explained that individuals often attended James Cook University's A&E department that could have been treated by their GP, if they were registered to one. It was felt that there were

educational opportunities available here by way of supporting patients to register with a GP if required, and to also advise of more appropriate action to take in terms of seeking medical assistance in the future. Exploratory work regarding the potential for direct appointments to be booked for A&E visitors, with their own GPs, was currently being undertaken.

In response to an enquiry, it was explained that as part of the process, providers (GPs) were invited to discuss potential models to determine the feasibility for future delivery. The response to this had been very positive. Providers had also indicated that the new models of working would allow for more flexible ways of working; could potentially attract more GPs to the local area; and also allow GPs to increase their experience in other areas through rotational work, which would in-turn benefit the local population.

A query was raised regarding the number and percentage of people attending A&E that were not registered with a GP. It was explained that this information was available, but was not available to hand. The information would be obtained and provided to the Committee accordingly.

A short discussion ensued with regards to patients being referred for x-rays and the processes that should have been followed in respect of this.

- With regards to minor injuries, the scenario appraisal showed potential for:

- Either two minor injury units, one in James Cook and one based in Redcar which had x-ray and GP cover, with opening times that corresponded to demand; or

- One 24/7 minor injury unit at James Cook Hospital.

It was identified through the stakeholder engagement sessions that the public were often confused about which site to attend.

It was felt that there were pros and cons to both potential options, but these would need to be investigated further.

The representatives explained that, to date, the scenarios that scored highly against criteria were progressed to modelling, with various teams looking at aspects such as activity flow, estate position and finances available. Equality impact assessments were currently being undertaken to determine what the changes would mean for the public. Further engagement with patient groups was also being undertaken. If the scenarios were seen to be viable, a business case would be presented to the CCG Governing Body in December 2015, with follow-up consultation being undertaken, if required.

The representatives asked the Committee to confirm whether or not they felt that formal consultation should have been carried-out, based on the information provided. Opinions on a potential timeline for formal consultation and representation on joint scrutiny bodies were also sought.

It was highlighted at this stage that approximately 4,500 of the patients accessing the South Tees walk-in centre were from Stockton, a notion which was part of their initial set-up. However, when introduced, PCT centres were in place and a different way of working had been followed. Now, because there was a walk-in centre in South Tees, the cost for any patients accessing the centre from North Tees would be picked up by South Tees operators.

During discussion, reference was made to the distance that patients needed to travel to visit medical facilities; the appropriate reasons for patients visiting different medical centres and the facilities available; and the options available going forward that would help eliminate confusion for patients.

It was felt that a minor injury unit would never be an A&E unit, owing to the differences in expertise, services and resources, and therefore there would always be a variation in the level of service between facilities.

The Committee discussed the information and proposals provided.

In response to an enquiry, the representatives indicated that there was full confidence that all of the work required at stage 4 would be completed in time for a formal consultation to be undertaken in January 2016.

Clarification regarding the points of consultation was sought. It was explained that this would refer to closure of the walk-in centres, if this was confirmed to be a viable option, together with the models and options available in terms of the James Cook and Redcar minor injury units.

It was felt that it would be beneficial to bring forward the plan of consultation to enable the Committee to advise on it, prior to consultation work being undertaken. It was agreed that this discussion would take place at the 18 December 2015 meeting of the Committee.

Reference was made to the Teesside economy and an enquiry was raised regarding the potential for the administration of these services to be undertaken on Teesside. The representatives indicated that because local GPs were being commissioned under the STAR scheme, it was expected that the service would be delivered and administered locally, and therefore that resource would remain in the Tees economy. With regards to the administration behind the STAR scheme, it was expected that this would be localised as far as possible, but with the 111 service expanding regionally, further investigation would need to be undertaken through the programme boards in order to determine how financial retention could be influenced.

The representatives sought the Committee's view on branding issues and potential ideas for the naming of the service. It was felt that urgent care was too far open to interpretation. A number of options provided by the public were outlined to the Committee. It was agreed that any suggestions by Members would be forwarded to the Scrutiny Support Officer for listing.

The Chair thanked the representatives for their contribution to the meeting.

AGREED:

a) That the issue be viewed as a substantial variation and therefore subject to formal consultation. The consultation plan would be presented to Members at the 18 December 2015 meeting of the Committee.
b) That the Scrutiny Support Officer seek further clarification on the establishment of a new Joint Committee, to potentially include Stockton and Hartlepool, and liaise with colleagues from neighbouring authorities and the Clinical Commissioning Group.
c) That the NHS South Tees Clinical Commissioning Group representatives would look into the issues experienced with 999 boundaries and report their findings to the Scrutiny Support Officer.
d) That the number and percentage of people visiting A&E that were not registered with a GP would be provided to the Committee Members.
e) That any suggestions for the branding of the service would be forwarded to the Scrutiny Support Officer; and
f) That the information be noted.

15/14 **ANY OTHER BUSINESS**

BREAST SURGERY AT JAMES COOK UNIVERSITY HOSPITAL

The Chair advised the Committee that having received indication that breast surgery would not be offered at James Cook University Hospital, a letter had been sent to the Chairman of the Trust to clarify the position on this.

NOTED