SOUTH TEES HEALTH SCRUTINY JOINT COMMITTEE

A meeting of the South Tees Health Scrutiny Joint Committee was held on 18 December 2015.

PRESENT: Councillors S Turner (Chair), E Dryden, T Lawton, N O'Brien, D Rooney and A Watts.

ALSO IN ATTENDANCE:
B Norton - substitute for Councillor R Goddard.
J Bailey - Partnership and Innovations Manager, Commissioning, South Tees Clinical Commissioning Group.
C Blair - Associate Director, Commissioning, South Tees Clinical Commissioning Group.
M Brown - Head of Primary Care, NHS England.
S Clayton - Senior Communications and Engagement Development Officer, NHS North of England Commissioning Support.
A Dewar - Commissioning Manager, South Tees Clinical Commissioning Group.
D James - Primary Care Commissioning Manager, NHS England.
J Kelly - South Tees Clinical Commissioning Group.
A Robinson - NHS North of England Commissioning Support.
A Sinclair - Head of Programmes and Delivery, South Tees Clinical Commissioning Group.
J Stevens - Commissioning and Delivery Manager, South Tees Clinical Commissioning Group.
J Walker - Chair, South Tees Clinical Commissioning Group.

OFFICERS: E Pout and C Lunn.

APOLOGIES FOR ABSENCE Councillor S Biswas, Councillor R Goddard, Councillor S Holyoake, Councillor J A Walker.

DECLARATIONS OF INTERESTS

There were no declarations of interest.

15/16 ****DUE TO THE SUBSTANTIVE CHAIR OF THE COMMITTEE BEING UNABLE TO REMAIN FOR THE DURATION OF THE MEETING, IT WAS PROPOSED, SECONDED AND AGREED THAT COUNCILLOR S TURNER BE APPOINTED AS CHAIR OF THIS MEETING ONLY**.**

15/17 **MINUTES - SOUTH TEES HEALTH SCRUTINY JOINT COMMITTEE - 17 NOVEMBER 2015.**

The Minutes of the meeting of the South Tees Health Scrutiny Joint Committee held on 17 November 2015 were submitted and approved as a correct record.

NOTED

15/18 **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.

It was explained that at the Committee's last meeting on 17 November 2015, Members agreed to view the proposals as a substantial variation, and therefore they were subject to formal consultation. Representatives of the South Tees Clinical Commissioning Group (CCG) were present at this meeting to outline the final options and the formal consultation and engagement plan.

Representatives delivered a presentation entitled 'Making Health Simple - Right Place, First Time' to the Committee, which reflected the confirmed 'Making Health Simple' title for the programme of work.

A short recap of the discussions undertaken at the last meeting of the Committee was provided, which included reference to the potential scenarios being taken forward to the option appraisal stages.

It was explained that three scenarios would be presented to the Committee. The scenarios were the ones most favoured in the recent stakeholder event. All three were considered viable, though had been costed at high level at this stage as it was difficult to determine exactly how the activities would work in the future. Further work would be needed as progress moved through to consultation and towards a final decision being made.

Scenario 1 was based on having GP centres. It was explained that although the concept of having 7-day working for all 46 GP practices right across South Tees was an attractive one, it would not be deliverable due to workforce resources. An additional complication surrounded GP contracts; information as to how 7-day working would operate and be funded had not yet been made available. Therefore, if this model was to be pursued now and established to coincide with impending contract renewals, the financial envelope needed to be available for that. It was explained that the urgent care budget was currently £8.4m and the provision of 7-day working would need to align with that. Although voluntary at the moment, the national edict was that 7-day working was to be in place by 2020.

The potential of establishing six extended opening hours' hubs across South Tees had been explored. These would operate on an extension from the normal GP opening hours to 18:00-20:00 Monday to Friday, and 08:00-20:00 on weekends. By implementing this, the requirement for walk-in centres would be negated. At present, there was one walk-in centre in Middlesbrough and one in Eston, which were four miles apart. It was felt that the increase in the number of hubs would replace this walk-in service.

Scenario 1 involved a GP working front of house in the A&E department. It was felt that there was pressure on the A&E service to deliver targets when patients often attended A&E with primary care needs. It was hoped that by diverting these patients to a GP, the pressures on A&E would be eased. The patient would have the option of remaining on site and being seen by a GP, either by waiting or making an appointment. Alternatively, the patient could be given an appointment to see their own GP, or, if out of hours, could be seen by one of the extended out of hours GPs. The intention was to educate patients as to when they should be attending A&E.

It was highlighted that, if increasing GP opening hours, this would mean that the out of hours period would reduce. This was currently 18:00-08:00, but would change to 20:00-08:00. Reference was made to the activity level during the out of hours period, which currently reduced after 20:00/21:00.

With regards to a GP led minor injury unit with x-ray, James Cook University Hospital would be open 24/7. It was intended that this unit would be separated out from the rest of the hospital.

Regarding scenario 2, this was similar to scenario 1; difference occurred in respect of the potential further extension of the GP centre opening hours. Owing to available resources, there would be less of these - four across South Tees instead of six. However, these would open until 21:30 on both weekdays and weekends; again reducing the out of hours period.

In terms of the Redcar site, the hours of the minor injury unit would be reduced - this was applicable to both scenario 1 and scenario 2. This was currently open 24/7, but the activity levels fell dramatically after 20:00/21:00, with approximately 1-2 patients attending after this time. It was considered that if the Redcar centre was open until 21:30, any patients with a minor injury after that would attend James Cook University Hospital. For all other medical complaints after 21:30, patients would telephone 111 and they would be directed to the most appropriate service. This again would negate the need for the walk-in centres; it was intended

that patients would use 111 as much as possible in the future. 111 would have access to all appointments and services, and would therefore be able to assist patients as required.

In response to a query, it was explained that the x-ray service at Redcar currently operated until 20:00. If a minor injury unit was established at Redcar, it could open until 21:30, with x-ray coverage from 08:00 until 21:30. It was clarified, however, that the centre would close at 21:30, due to the number of patients attending.

The final scenario befitting the financial envelope was scenario 6. Within this model, there would be eight extended GP hubs across South Tees operating on a 08:00-20:00 basis. However, owing to resources, it would not be possible to place a GP at front of house to alleviate the pressures and educate patients presenting themselves.

Out of the three scenarios presented, it was felt that the best option, from the perspective of the CCG, would come from scenario 2. To have a GP present in A&E would assist because patients would continue to arrive at A&E; improved management of this was required.

It was felt that there was currently a lot of pressure being put on GPs, and they were being stretched. Consideration was given to the presence of a GP at the front of A&E, and the opportunity for education that this would present. It was indicated that, as part of the chosen model, it must be made evident that GPs were running the service and not James Cook University Hospital's A&E unit.

Reference was made to walk-in centres and the purposes that they were being used for. It was felt that they were sometimes being used as GP surgeries. Concerns were raised that having a GP at front of house may continue this practice. In addition, it was also felt that this may result in an appointment system being created at A&E, which was not the intention. In response, these points were acknowledged; however, it was explained that this was the reason why the three scenarios were being consulted upon. Questions would be asked and feedback reviewed.

The point was made that one of the reasons why people did attend A&E was because of GP access, preference, etc. It was explained that the new model would facilitate access in terms of opening hours, particularly for people working full-time. Reference was made to the BME and travelling communities who may have accessed walk-in centres more often, or who may not have been registered with a GP. It was indicated that the consultation process would take the varying views of the community into account.

A query was raised as to whether there was currently a GP service at A&E. It was explained that this was currently being piloted to determine the impact that this had. However, the issue at present was that the extended GP hours were not in place as of yet, and therefore it was not possible to determine the impact of this. The pilot was due to finish on 31 March 2016. It was indicated that the availability of a GP in A&E was the kind of service that every health care in the region was exploring; every Trust was looking into this and it was felt that learning could be gained from elsewhere.

Regarding the other 'missing' scenarios between 1-6, it was explained that once the criterion had been applied, further consideration was undertaken in respect of activity and affordable finances; these scenarios did not score as high. Full explanation would be covered in the business case, and every scenario that was considered would be included in the consultation document to enable the public to see which scenarios were discharged and the reasons for this.

It was explained that the aim of the model was to encourage patients to seek advice and to signpost them to the most appropriate service, utilising 111 to achieve this. National changes were being made so that appointments and improved access to professionals could be offered through 111. Extensive promotion of the service would also be undertaken.

Consultation with the public and the message that would be promoted through leaflets and information was that more support for people to self-care would be offered. This was being pursued regionally as well as nationally. Reference was made to the Vanguard Programme,

which would be looking at pharmacies and minor ailment schemes on a region-wide basis. In addition, some online tools to help people support themselves better, together with a marketing campaign aimed particularly at parents with children under 5, who regularly attended centres, would be undertaken regionally.

It was commented that an increasing number of Pharmacists were available on a 24 hour basis, which again would take the pressure off GPs and heavily facilitate matters. It was felt that promoting this to patients presenting themselves at A&E would also help to alleviate the situation.
It was indicated that the consultation documents would describe what the services actually did for people so that the public could better understand what was being consulted upon.

The Committee was provided with details regarding the questions that would be asked during the consultation exercise. It was explained that the final questions had not yet been fully devised. The intention was to commence the consultation on 11 January 2016. The Committee's opinions on the questions to be proposed were sought.

A discussion ensued with regards to the locations of the hubs and the ability to meet patients' needs. The locations of the hubs had not yet been determined and the intention was for members of the public to have their say regarding this. It was felt that issues such as travel distance, parking, noise and safety implications would all play a considerable role, and it was felt that suitable and workable locations needed to be identified in order to avoid disappointment for respondents, as well as to facilitate the consultation exercise. Reference was made to the existing services available in areas across South Tees and the potential of operating multi-disciplines from one locality.

It was explained that the questions would be worded in such a way that consideration would need to be given to the population in general, and would therefore be slightly more objective. This was to ensure that patients across the entire South Tees area could be considered equally.

Attendance at the consultation programme events arranged by the CCG was discussed by the Committee. Members were urged to attend and deliver their views accordingly.

A document detailing statistics of patients not registered with a GP was tabled for Members' information, as requested at the previous meeting. A query was raised as to what work was being undertaken in ensuring that those patients presenting at A&E, approximately 1500 people, who were not registered with a GP, could be registered. In response, it was explained that although patients could not be forced to register, patients were being provided with information as to how to go about this. Further information pertaining to the statistics was requested, i.e. whether the patients were in or out of the local area and whether these were repeat patients or not, i.e. if these were the same people revisiting A&E on a number of occasions. This information would be provided to the Committee at a future meeting.

With regards to the consultation plan, further comments or suggestions were sought from the Committee.
The role of Scrutiny was reiterated to the Committee, and it was indicated that the process of engagement was to be determined by the Clinical Commissioning Group.

It was felt that more information pertaining to the scenarios and exactly what each entailed would need to be provided as part of the consultation exercise, including providing examples of potential geographical areas covered by each scenario.

With regards to the 111 service and ensuring effective promotion of it, it was explained that a national campaign would provide a solid foundation for this. In terms of regional promotion, additional funding had been provided to the North East to advance the national strategy. It was felt that a robust education programme was needed in order to communicate the message to the public. Reiteration around the use of 111 every time a patient made contact with health services would also need to be undertaken. Reference was made to a recent advertisement that had been shown at prime time on BBC in respect of the 111 service.

The Chair sought suggestions regarding arrangements for the next meeting. It was felt that, in light of the statutory consultation commencing on 11 January 2016, the Scrutiny Officers could perhaps work in collaboration in order to determine the Committee's responsibilities and work programme, which could run parallel with the consultation timeframe. This would provide sufficient time for views to be sought and recommendations to be made, prior to the next meeting taking place with health representatives. Members supported this view.

From the perspective of the CCG, it was queried whether the Committee would prefer that the next meeting take place after the views of the public had been compiled, or whether an interim update would be more preferable. It was felt that an interim update would be useful, as this would allow the Committee opportunity to plan its own work programme, before nearing the end of the consultation programme. It was clarified that the consultation would last for a period of 13 weeks.

The Chair thanked the representatives for their attendance and contributions.

AGREED:

1. **That further information pertaining to the GP registration statistics, as detailed in the preamble, be provided to the Committee.**
2. **That arrangements for the next meeting, as detailed in the preamble, be undertaken.**
3. **That the information, as presented, be noted.**

15/19 **REVIEW OF THE LIFE STORE.**

Two documents were circulated for Members' information: an overview of the services provided by the Life Store, together with a phase two engagement timeline.

It was explained that following the review of the previous engagement activity regarding the Life Store, which had been detailed to the Committee previously, in conjunction with a review of the store's operation, which had included costs of the service, types of services being utilised, and access figures, the CCG's Governing Body had recommended that the Life Store close on 31 March 2016.

One of the key factors for the decision-making was the difference in access levels between Redcar and Middlesbrough; the facility was used far less by Redcar and Cleveland residents. In addition to this, it was considered that financial expenditure in terms of investment in the building versus the provision of services out in the community did not reflect value for money. One of the key challenges was that there was no equivalent of this service in the Redcar and Cleveland area.

Despite the closure of the building, it was highlighted that a commitment had been made to the reinvestment of the resource within the two communities. The intention was for the CCG to work closely with public health colleagues in order to create two appropriate models, one for Middlesbrough residents and one for Redcar and Cleveland residents, in order to improve access for both populations.

The next step was to undertake a four-week engagement exercise with the public regarding the impending changes. It was explained that matters such as effective communication of the changes, identification of the potential barriers and challenges for residents accessing the services in different locations, and the importance of signposting residents to other available services that they could continue to use would all be considered.

Reference was made to phase one of the engagement process, where 700 people had been consulted with. It was explained that 70% of the respondents had never used the Life Store previously, and 72% said that they would use another service, or visit their GP or Pharmacist.

Reference was made to the phase two timeline and the activities that would be undertaken.

With regards to the new ways of working, these were currently in development with both the local authorities and public health. It was felt that this was an opportune time to be involved in developing the future models of care in both localities. There would be separate models of care in Redcar and Cleveland and Middlesbrough, which would recognise both the different communities and populations, as well as create better access for people.

The representatives indicated that, once the second phase of engagement had been completed, a further progress report would be provided to the Committee.

Concern was expressed from Members that a lot of information had just been tabled at the meeting and not provided in advance. In addition, it was felt that the stated intentions had not been confirmed in writing. Although it was acknowledged that research had been undertaken, nothing had been evidenced for the Committee to scrutinise. In response, these comments were taken on board. It was explained that following completion of phase one of the engagement programme, feedback from the public and service providers had been presented to the Committee. It had been agreed that an update on the services currently provided, a decision on future operation plans, and details of mitigation planning would be provided to the Committee. It was explained that the purpose of the timeline was to illustrate the further engagement work that would be carried out, and to identify that people would be made aware of what other services would be available to them, with any arising concerns being mitigated through appropriate action.

With regards to future models of working within Middlesbrough and Redcar and Cleveland, there were no further details available on these as of yet. Both local authorities were currently designing very separate models and had not yet clarified what these were, however, collaborative work would continue to be undertaken in order that additional benefits and outcomes could be added to them.

A query was raised with regards to cost and a future model of working. It was explained that it cost approximately £330,000 to operate the Life Store. The vast majority of this sum was spent on the building, whereas the cost to run the services was in the region of £89,000. Consequently, the £330,000 would be freed up to invest across the two localities. It was not envisaged that two buildings would be established, as not everyone would attend. Instead, it was possible that services would be delivered in community settings by way of a pop-up box, but further exploration and final decisions still needed to be made on this.

Regarding sexual health services, concern was expressed as to where these would be relocated to. It was felt that many young people in the town were aware that they could visit the Life Store in confidence, and that it was not connected to other services or organisations that they may be involved with. In response, it was explained that links would be made with colleges and universities, who were currently providing sexual health outreach to young people. Existing venues such as clinics would also continue to be utilised.

With regards to the Life Store access figures, the feedback obtained identified that the majority of visits were for BMI and weight management-related services. As the time critical Christmas and New Year period was on the horizon, it was explained that alternative services and courses had been programmed to commence in January 2016.

It was felt that closure of the Life Store offered opportunity to deliver a better service to more people, but it would be important not to lose the things that made the Life Store unique. The Life Store had been in operation for ten years and it was felt that lessons learned over the course of that period would help drive it forward.

Reference was made to the handout that detailed an overview of the services provided by the Life Store. These services were divided into two parts: the first were services that had been commissioned for the Life Store to provide, which may have been commissioned by Middlesbrough Council, South Tees Hospitals NHS Foundation Trust, or the CCG themselves. The second part referred to services that were not commissioned, but instead were offered by wider groups and organisations - support groups for example. It was highlighted that all of the services listed would continue, just not in the Life Store building.

A point was made regarding an overlap in consultation activity between this topic and in respect of the development of the South Tees Urgent Care Strategy. In response, it was acknowledged that this was not ideal; however, due to the timescales involved, this was the situation being faced. It was felt that the consultation activity pertaining to the Life Store may be more visitor focused, however, communication across projects would continue and be used as appropriate.

It was suggested that, in light of the closure of the Life Store in March, it would be useful to review the impacts that this had had. This would be placed as an agenda item in twelve months' time. The Committee agreed that this would be a good idea.

The Chair thanked Members and the representatives for their attendance.

AGREED:

1. **That the Committee would re-visit this topic in twelve months' time to determine the impacts of the closure of the Life Store.**
2. **That the information, as presented, be noted.**