SOUTH TEES HEALTH SCRUTINY JOINT COMMITTEE

A meeting of the South Tees Health Scrutiny Joint Committee was held on 7 March 2016.

PRESENT: Councillors E Dryden, R Goddard, S Holyoake, T Lawton, N O'Brien, S Turner, J A Walker and A Watts

ALSO IN ATTENDANCE:
C Blair, Associate Director, Commissioning, South Tees Clinical Commissioning Group
M Brown, Head of Primary Care, NHS North of England
S Clayton, Senior Communications and Engagement Development Officer, NHS North of England Commissioning Support
A Clements, Medical Director for Urgent and Emergency Care
M Cotton, Assistant Director of Communications and Engagement, North East Ambulance Service
J Evans, Redcar & Cleveland Council
D McDougall, Head of Emergency Care (South), North East Ambulance Service
M McGuire, Chair, Durham, Darlington, Tees Local Professional Network (Pharmacy)
T McHale, Assistant Manager, Healthwatch Tees
Dr R McMahon, Vice Chair, Cleveland Local Medical Committee
L Nelson, Assistant Dean (Business Engagement and Collaborative Provision), University of Teesside
J O'Connell, Operations Director, South Tees Hospital NHS Foundation Trust
A Robinson, NHS North of England Commissioning Support
J Stevens, Commissioning and Delivery Manager, South Tees Clinical Commissioning Group
Dr A Tanasabi, South Tees Clinical Commissioning Group

OFFICERS: E Pout and C Lunn.

APOLOGIES FOR ABSENCE: Councillors D Rooney and S Biswas.

DECLARATIONS OF INTERESTS

The Chair advised Members that if they had any personal interest in this review, if they were a patient at a practice affected by the proposals, for example, it would facilitate matters if declarations were made so that these could be noted and any potential undermining of the process avoided.

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

1 **MINUTES - SOUTH TEES HEALTH SCRUTINY JOINT COMMITTEE - 11 DECEMBER 2015.**

The minutes of the meeting held on 11 December 2015 were submitted and approved as a correct record.

NOTED.

2 **MINUTES - SOUTH TEES HEALTH SCRUTINY JOINT COMMITTEE - 18 DECEMBER 2015.**

The minutes of the meeting held on 18 December 2015 were submitted and approved as a correct record.

NOTED.

3 **DEVELOPING LOCAL URGENT CARE SERVICES - MAKING HEALTH SIMPLE.**

The Scrutiny Support Officer presented a report, the purpose of which was to provide the Committee with an outline of the meeting and to introduce a number of representatives that were in attendance. Background information pertaining to the initiation and progress of the review was also provided.

The Scrutiny Support Officer explained that the South Tees Clinical Commissioning Group's consultation on the development of urgent care services had commenced on 11 January 2016, and would continue until 1 April 2016. The Committee had received details of the proposals and a report summarising that information was attached at Appendix 1 of the submitted report.

In order to enable Members to make an informed opinion on the proposals, it was explained that this meeting had been convened in order to provide opportunity for the Committee to discuss the proposals with a range of local stakeholders. The meeting would take the form of a formal 'round table' discussion, with the focus of the debate being to receive input from each representative on the potential impact of the urgent care review on their service/area, and to hear any views that they had. It was highlighted that the information conveyed would assist the Committee in the evidence gathering process, and would enable subsequent production of a report based upon their contextualised expertise.

It was explained that once the discussion had taken place, Members would subsequently have the opportunity to receive information from the South Tees Clinical Commissioning Group (CCG) on the progress with the consultation to date.

The Committee was advised that once the consultation had closed, the CCG would be invited to a further meeting to present the outcome of the public consultation, which would allow for an informed response to be prepared.

The Chair invited the representatives to proceed with their comments.

Representatives of the CCG commenced the discussion with a re-cap of what was being consulted on.

It was explained that nationally, introduction of a 7-day work pattern for GP working was required. In respect of the South Tees locality, it was intended that this would commence at an earlier stage. Further information was currently awaited from NHS England as to how GP contracts would appear going forward.

A second national stance revolved around the utilisation of the 111 service, which included increased usage of 111; having access to a Clinical Hub within 111; and the ability to book appointments for GP surgeries via 111.

It was highlighted that the development of the Clinical Hub within South Tees was currently well underway.

The consultation consisted of three options; people were being asked about the number of GP extended centres that should be offered, together with their opening times. It was summarised to the Committee that fewer centres with longer opening hours could be provided, or alternatively an increased number of centres with shorter opening hours.

A further element of the consultation concerned the proposal of having GP presence at the front of A&E, the purpose of which would be to divert those patients presenting more minor ailments towards a more appropriate treatment route.

A representative of the North East Ambulance Service advised the Committee that, in relation to the 111 service, the Clinical Hub was currently being developed to support the integration with both GP surgeries and out-of-hours surgeries. Reference was made to the system entitled NHS Pathway, which incorporated a triage of questions that those contacting 111 were asked. It was indicated that the Clinical Hub would offer support for 111 as the pathway

progressed.

A Member commented that, in relation to the 111 service, there had been some controversy around other call centres and user dissatisfaction with them. It was queried whether these proposals would replace doctors with a call centre service. In response, the CCG representatives explained the intention of undertaking this initiative on a regional basis in order to avoid removal of too many GPs from the system, but it was indicated that GP presence within the Hub was required in order to support the 111 service.

A Member made reference to the closure of the walk-in centres - Eston Grange and The Resolution. The CCG representative advised that the GP extended hours would replace the existing walk-in centres. It was clarified that although a walk-in facility would no longer be available, patients would be able to attend on an appointment-basis. An alternative option would be to contact the 111 service; if the outcome of that call was the need for a GP appointment, then the service could facilitate that.

In response to a Member query regarding the necessary closure of well-utilised walk-in centres, the CCG representatives explained that it was known currently, through attendance audit exercises, that surplus amounts of patients were attending walk-in centres unnecessarily, or that there were more appropriate treatment options available to them. It was highlighted that 7/10 people attending the walk-in centres were referred back to their own GPs for management of their condition. It was also known that a number of other attendees could have been more appropriately managed via self-care or pharmacy attendance. It was indicated that the two walk-in centres were situated in very close proximity to one another, a set-up that the CCG had inherited, and did not offer sufficient support across the South Tees locality. This was because patients residing in those areas attended the walk-in centres, whereas patients not residing in those areas did not. It was explained that the new Hubs would be sited across South Tees, which would hopefully improve access for all.

Invited representatives discussed the reasons for the review into urgent care and what it was hoped would be achieved from it.

It was felt that the current system was seen as quite complex. This did not only refer to walk-in centre cases; reference was made to emergency admissions in respect of elderly and housebound patients who required care and support after surgeries had closed, which therefore often resulted in hospital admission. The proposal, in response to this, was to operate on a 7-day basis.

The Committee was informed that a number of surgeries had implemented 'GP First', which revolved around an initial telephone based assessment by a doctor in order to determine how quickly the patient needed to be seen. It was hoped that 111 would be able to undertake this process and then direct patients as appropriate. It was felt that walk-in centres were not being replaced with 111, but instead, patients would be offered extended opening hours and continued access to medical notes, which walk-in centres did not currently offer. It was felt that improved access for patients would be available through four or six Hubs across South Tees, depending upon which of the proposals was favoured.

Representatives from Healthwatch Tees advised the Committee that the organisation had been involved in a significant amount of public consultation across both Middlesbrough and the Redcar and Cleveland areas. The feedback received had shown that patients found the old system to be confusing and suggested that it should be streamlined. A suggestion was also made to have medical staff involved in the 111 service. It was felt that these issues had been incorporated into the proposals offered.

Members commented on the feedback that had been observed in respect of the proposals, with reference being made to local press articles and message boards, as well as wider social media. In response, representatives from NHS North of England Commissioning Support explained that in the initial stages of the consultation, there had been some negative feedback received. However, as the consultation had progressed and further explanation was made as to what the various options represented, people generally appeared more in favour of the proposals than against. In addition, work had been undertaken within the walk-in centres

themselves, where direct conversation with patients had been achieved. It was explained that this activity not only highlighted that the majority of those in attendance were there because they could not get an appointment to see their own GP, but when details of the proposals were explained to them, patients appeared in favour of those proposals. In respect of those patients not in favour, reasoning for this had been collated; further details pertaining to this would be provided to Members via a presentation later in the meeting.

In respect of the initial negative feedback received, the CCG representative explained that the focus initially was upon what potentially the system was taking away, however, once it had been explained to people that the intention was to introduce either four, six or eight extended centres or GP Hubs, peoples' understanding had changed significantly. Subsequent feedback from the public had been very different once the details of and reasons for the proposals had been conveyed.

A Member commented on the potential impact upon A&E departments following closure of the walk-in centres, particularly as departments were currently overwhelmed. In response, the CCG representative explained that there were examples across the country of where similar systems had been established - not exactly the same as often this concerned CCGs working with their providers to close walk-in centres or minor injury units and not put anything in their place, whereas here, the proposal was to provide GP centres. Modelling work to determine the potential impact upon A&E had been undertaken. This showed that the impact would be fairly minimal in terms of the number of people attending The Resolution and Eston Grange walk-in centres at the moment, and also considered what could potentially move across to A&E. Discussions between the CCG and James Cook University Hospital had taken place in order to determine how some of those risks could be mitigated; how those patients could be managed if some did move across to A&E; and how the appropriate course of treatment or intervention for patients could be provided, whether that be in a primary care setting or at the A&E department at James Cook University Hospital.

A Member commented upon patient habit and the challenges associated with adapting their behaviour. However, it was felt that if a suitable filtering system was instilled to ensure that respective A&E and GP cases were referred appropriately, then behaviour adaptation would be heavily facilitated.

A Member raised concerns in respect of the current and potential pressures facing both A&E departments and GPs. It was felt that to have a GP located front of house in A&E would pose a significant burden upon resources, particularly when GPs would be covering 7-day working. It was felt that this gatekeeping function could potentially be completed by less qualified personnel, similar to the 111 service. Of the options presented, it was indicated this would only be possible under option three, but it was felt that eight centres would be too many. It was indicated that perhaps a fourth option, for six centres with the omission of a GP at the hospital, could have been offered.

A Member made a comment regarding doctor-patient relationships and people experiencing difficulties in making appointments to see their GP. It was queried why not all surgeries followed the same system for appointment-making. In response, the representative of the CCG explained that across the South Tees area, there were 44 practices; it was clarified that although some of the documentation referenced 46 GP practices, there had been some merges and there were now 44. All 44 practices were Members of the South Tees CCG, however, each were operated independently, and therefore it was their own decision as to how they structured their appointment system and run their practices to fulfil contracts. A Member commented that, for consistency on this issue, it may have been useful for the CCG to offer guidelines to all of the practices operating within the South Tees area.

The representative of the Cleveland Local Medical Committee felt that an apparent shift in focus had occurred over the duration of this work. It was felt that when it first commenced, the focus of the review was upon urgent care, whereas now, it appeared to be upon 7-day GP services. It was indicated to Members that the majority of what GPs provided was not urgent care, but routine care, and the two things were subtly different, but had been combined together. It was felt important that this be borne in mind.

In extension to this point, a Member queried how this distinction could be made between the two for the lay person. In response, it was felt that this distinction would depend on what work was to be comprised within the extended hours, whether it would purely be urgent care provided by GPs, or whether all GP surgeries would only provide routine care. This level of detail had not been included within the consultation, where it perhaps should have been.

It was suggested that differing personal opinion may make it difficult to divide the two areas, as what patients may perceive to be urgent, doctors may view as routine, and vice-versa.

The representative of the Tees Local Professional Network felt that the lay person understanding the subtle difference between urgent and emergency care and 7-day GP opening was a critical point, and agreed that further consideration may have needed to be given.

The point was made that, in effect, the two walk-in centres would not be replaced with NHS 111, and instead they would be replaced with four, six or eight urgent care centres through extended GP opening, which was a positive step. However, due to workforce demographics and the various types of minor ailments being presented to GPs, which could have been treated via alternative channels, it was suggested that a more appropriate emergency medication supplier was required.

The process of contacting 111 and subsequent attendance at A&E was reiterated to Members. It was felt that work could have been undertaken to improve this. Reference was made to a pilot study that had been carried out in the region, whereby patients had been referred from NHS 111 into their pharmacy for urgent medication. This had subsequently been promoted by the Department of Health as Gold Standard, though there had not been any further information released regarding this.

In response to these comments, the CCG representative indicated that a regional strategy was in place that considered such matters as pharmacy, self-care, etc. Reference was made to the Vanguard Programme whereby additional funding had been made available to bring these matters forward. Therefore, where this consultation was focused more on 7-day working and the urgent care area, it was not being undertaken in isolation. It was explained that the CCG was also working regionally through the Vanguard Programme to look at areas such as the NHS 111 service and pharmacists.

A short discussion ensued in respect of minor ailments. Reference was made to the Health and Wellbeing Board and the pharmaceutical needs assessment, which showed a gap in terms of a minor ailment scheme so that pharmacies could see lower conditions such as head lice, hay fever, etc.; GPs were seeing such cases unnecessarily. Supplementary to this, representatives highlighted the issue of deprivation in the area and the associated impact that this had on GP-Pharmacy visits. It was explained to the Committee that, in some cases, patients would wait for an appointment to see their GP in order to receive a free prescription, whereas if they attended a Pharmacy directly, they would be required to pay.

Members discussed patient-pharmacy relationships. Reference was made to the independent nature of pharmacies, how they were operated, and how relationship formation differed to that of patient and GP.

The Committee considered the 111 service and the integration of appointment booking services with GP surgeries. A comment was made that further consideration needed to be given as to how this would work, and the appropriateness of the triage process that had been established.

In terms of the notion of patients seeing their own GP, representatives indicated that walk-in centres were currently a GP service, but patients could not see their own GP. Further, access to patients' medical records was not possible at current walk-in centres. Although the new Hubs would not be operated by patients' own GPs, access would be available to medical records, which was felt to be an improvement on the current system.

The representative of the South Tees Hospitals NHS Foundation Trust explained to the

Committee that, from their perspective, there was interest in this piece of work for two reasons. The first concerned the possible impacts upon A&E departments, and the second revolved around the organisation's current operation of The Resolution walk-in centre.

In terms of alternative provision for patients currently utilising the two walk-in centres, Members heard that work was currently being undertaken between the hospital and the CCG to consider this. The extension of GP opening hours at evenings and weekends was welcomed, as it was felt that this would impact positively upon the system and in respect of A&E, but did not offer an alternative solution as to where patients currently accessing the walk-in centres would attend. Consequently, modelling work to determine this in respect of the four, six or eight proposed Hubs was being completed.

A Member queried the work being carried out in respect of the location of the Hubs. In response, the representative explained that the hospital was in positive engagement with the CCG to map the locations to each of the proposed options.

A discussion ensued with regards to the option of having GP presence in A&E.

A Member commented that the inclusion of GPs within the proposals seemed unnecessary, as it would put them under an increased amount of what is already a high level of pressure.

Consideration was given to integration that had been undertaken in other areas of the country, including Manchester and Northumberland, and the varying outcomes of this. It was indicated that although a mixture of success had occurred in other areas, there was nothing to suggest that that this would not work in South Tees, but the importance of having a clear indication of the GP's role from the outset was acknowledged.

It was indicated that the Royal College would have examples of where both positive and negative instances of this integration had occurred across the country, but it was important to consider that, in terms of statistics, primary care load differed according to locality. Members heard that when recent data was modelled for South Tees, for example, approximately 15-18% of primary care attendances at A&E could perhaps have been dealt with by a GP. Each emergency department across the country experienced a different caseload, which depended upon what resources were available in the local community.

In terms of the potential impact of the proposals on GP practices, it was suggested that GP capacity may be increased by the extended opening hours, as day appointment slots would be made available. In conjunction with this, the CCG representatives made reference to the STAR scheme, indicating that patients who had been managed by this service had been less likely to visit their GP, which therefore also increased capacity.

A discussion ensued regarding co-location and the availability of support services.

It was explained to the Committee that the Royal College of Emergency Medicine believed that primary care facilities should have been provided adjacent to emergency departments, and that if a robust streaming mechanism was in place to deal with patients as they arrived, i.e. patients with a more primary care need were directed to the primary care facility, and patients with an emergency care need were directed to the emergency care facility, this would facilitate matters.

Members heard that there were plans to potentially co-locate facilities at the James Cook University Hospital site. However, there were concerns that this did not exist currently, and therefore the estate would need to be altered in order to manage both the process and the associated demand. If the modelling was not accurate, it was important that the demand could be managed appropriately. Consideration was given to the concerns of the patient and it needed to be borne in mind as to what was best for them. It was felt that primary care presentations did need to be managed at the emergency department and a facility for this was required. Discussions were currently taking place to determine how best to achieve this provision, and how the timing of this would accommodate the timing of the overall changes being planned.

Consideration was given to patient management in respect of co-location. Reference was made to the branding of A&E and the automatic process of patients attending for treatment. It was felt that presentations in South Tees had been managed effectively, with the primary care load on the emergency department being lower in comparison to other areas of the country.

A discussion ensued in respect of extended hours and urgent care. A representative of Healthwatch indicated that from involvement in the consultation process, there had appeared to be some confusion around this.

The CCG representatives indicated that things were changing and a response needed to be provided in reflection of national requirements. Reference was made to the Prime Minister's Challenge Fund and associated pilot data in terms of extended hours and urgent care. It was clarified that, initially, Challenge Fund work had referred to urgent appointments, whereas now, it was about GP access in general and having that spread across seven days.

A Member commented on the services being delivered and the potential consequences if these were not fit for purpose. In response, the CCG representatives explained that evidence from the Royal College for Emergency Medicine had been utilised in this regard. Mention was also made of patient attendance figures at walk-in centres on evenings and weekends, which had also suggested that patients sought improved access to GPs.

A discussion ensued in respect of frail and elderly patients, and those with multiple medical conditions in relation to the emergency and urgent care system.

Representatives indicated that, currently, the only option for frail and elderly patients that required treatment in the out-of-hours period was to call 111, which would result in attendance at A&E. It was explained to the Committee that in such circumstances, it was very difficult for safe decisions to be made, particularly in respect of cases of dementia and multiple conditions, and therefore hospital admittance would most likely follow. Reference was made to discharge procedures and the impact of such admittance on hospital services. Mention was made of the options available to the ambulance service, and the impact that the STAR scheme had had on assisting this. Consideration was given to the availability of GPs in ensuring that these patients could remain at home in the first instance. It was felt that the proposals did offer a foundation by freeing up some GPs into the late evening to be able to manage this, and assist in the avoidance of unnecessary hospital admittance. It was suggested that freeing up hospital appointments during the day so that more of the GPs could visit these patients in their own homes.

In response to an enquiry regarding the reduction in hospital attendances since the introduction of the STAR scheme, it was explained that this specific information was currently awaited. In extension to this point, however, the representative of the CCG informed the Committee that there had been 5000 fewer attendances at the walk-in centre at The Resolution, some of which could be attributable to the various changes that had been initiated, including the STAR scheme. It was highlighted that James Cook University Hospital had not seen the level of growth in A&E that the rest of the country had seen. It was felt that a collective approach with various partners in implementing a number of changes had assisted with this.

Reference was made to NEEPS as a potential statistical evidence base for illustrating the number of people being transported to A&E, in the time since the implementation of the STAR scheme. In response, the CCG representative indicated that this evidence would not necessarily be reflected through NEEPS, as this measured different pressures within the system. However, it was indicated that in respect of the frail and elderly, those patients, once presented at A&E or delivered via an ambulance, were admitted into hospital.

The CCG representative indicated that there was evidence available to quantify a 7% reduction in admissions over the last year. Members requested that this be presented at the next meeting of the Committee, which was agreed.

A query was raised as to whether, as part of the proposals, ambulances could take people to the Hubs rather than to A&E. The CCG representatives confirmed this to be the case.

The representative of the South Tees CCG highlighted to Members that over the last five years, where two walk-in centres had been in operation, there had been no reduction in A&E attendances. Similarly, there has been no reduction in GP workload for increased demand, and there had been no reduction in emergency admissions. The only reductions that had occurred, within the last couple of years, were as a result of community services being enhanced - for example: community nursing, Rapid Response and the improvement programme. Operation of the walk-in centres had not reduced the number of A&E attendances.

A short discussion ensued concerning Trust targets and frail and elderly patients experiencing lengthy hospital stays. It was commented that the current system had perhaps concealed this. In response, the CCG representative indicated that the Group had helped with the achievement of various targets and standards; from the CCG's perspective it was not acceptable that any patient had had to wait more than four hours to be seen in A&E. Therefore, regardless of whether the Trust was achieving the standard or not, anything that supported identification of where the blockages or delays were within the wider system was considered positive, as focus upon removing those could then be made. It was indicated that the Trust standard was 95%, but if every patient could be seen within four hours then that should have happened.

A short discussion ensued regarding the capacity for GPs to assess frail and elderly patients. A comment was made in respect of GP contracts and the various schemes currently in operation that could make progression difficult in this area, for example: GPs were paid by population size; out-of-hours providers were paid by contractors, etc. Representatives agreed that different contracts did make some matters difficult to change. In response to this, the CCG representative indicated that the Group had endeavoured to form positive relationships with partners in order to progress work forward. Reference was made to the Vanguard Programme in facilitating work progress.

A Member commented on the potential benefits associated with having GP presence in A&E, but raised concerns as to where those GPs would be derived from, given that there was a national shortage. Reference was also made to the support available to patients from Social Work teams in hospitals, and a query made as to how well this had been working.

In response, the CCG representative advised that there were two issues here: one concerning the workforce and one concerning the location of the Hubs.

In terms of the location of the Hubs, nothing had been decided as of yet. It was explained that once the number of Hubs had been determined, the estates deemed most appropriate in each of those locations would then be looked at. There would be set criteria around what each estate would need to provide, how accessible it was, the space that needed to be available, etc., and it would need to reflect the population being served. As an illustration, it was explained that the population served by four Hubs would be very different to the population being served by eight. As the consultation drew to a close, that was something that would need to be worked through.

In terms of the workforce, it was explained that this was a big issue. It was a national pressure; prior to commencing on the consultation, the CCG had contacted many of the providers in order to understand what their view of the workforce was, and how they could deliver some of the models being looked at. A request was sent out to the market and different providers had advised what they could and could not offer.

In response to a Member enquiry, the Committee was informed that the market comprised of those currently providing healthcare services, both at local and national level. It was explained that an advert was placed in OJEU Tenders and Public Procurement, and interested parties had been invited to discuss different models of urgent care, or different ways of providing primary care.

It was highlighted that there was a significant amount of interest from a variety of different groups, including: Local GPs; The Foundation Trust; North East Ambulance Service; Private

contractors; and Northern Doctors. It was expressed that there were many different services currently providing responses to the same group of patients, which was felt to be confusing. As a consequence of this exercise, it was felt that stakeholders had achieved a better understanding of what patients' needs were in order to enable contact with the right service first time.

A discussion ensued in respect of Redcar hospital.

With regard to the reduction in A&E visits, a Member commented that residents in Redcar were starting to use the primary care significantly more than they had done so previously. Consequently, a request was made to view the statistics for both facilities, as Members did not wish to see A&E figures being reduced, whilst figures for other services, such as the minor injury unit, increased. In response to this, the CCG representatives indicated that a breakdown of what activity had been occurring over the last 24 months would be provided. As a supplementary point, the representatives indicated that although there had been initial concerns that patients from Guisborough would solely attend James Cook University Hospital and avoid using Redcar, this had not been the case.

Representatives indicated that the extension of the x-ray opening hours at Redcar hospital had made a significant difference to the workings of the facility. In addition, the volume and variety of x-rays that the nursing practitioners could take were limited, and therefore work was currently being undertaken to broaden this so that patients did not need to be re-directed to James Cook University Hospital. It was intended that the services offered would be developed as much as possible in order to enable full support for the service.

A Member provided anecdotal evidence pertaining to a resident's poor experience of Redcar hospital, and questioned whether the needs of the local population were being met.

In response, representatives explained that Redcar hospital was operated by two different organisations - one whose responsibility it was to manage the building, and another who was responsible for the x-ray equipment. It was indicated that there had been problems with the x-ray equipment for an extended period of time, however, this had now been remedied. It was acknowledged that confusion and frustration may have been caused by dual management of the facility, but there was no single owner accountable for all operations.

The Chair requested that representatives provide some evidence regarding the current situation at Redcar hospital to facilitate discussion at future meetings. Representatives from Healthwatch indicated that a lot of information was shared between the organisation and the CCG, therefore any evidence provided would assist with monitoring action.

A discussion ensued regarding the process for admitting patients into hospital.

In response to a comment made regarding the work of the admitting team and the level of experience in terms of the doctors involved, the CCG representative indicated that this pathway had been looked at. Work had been undertaken with the Trust to ensure that a senior decision maker was available at key times to ensure that appropriate decisions could be made.

It was highlighted to the Committee that, when a consultant was present in the emergency department, more appropriate and safer decisions were made. Reference was made to the work of junior doctors and the training process.

Members heard that consultant appointments in emergency medicine had been made in September 2015, and that there was now 24/7 consultant presence in the emergency department over Fridays, Saturdays and Sundays. It was explained that these appointments were made for two reasons: firstly, of the major trauma workload that occurred at James Cook University Hospital, over 70% of this was on Fridays, Saturdays and Sundays, and therefore a consultant would be there upon arrival of a major trauma case. Secondly, the intention was to reduce the number of unnecessary admissions; there was national evidence that if a consultant was on the emergency department floor, the number of unnecessary admissions was reduced.

In response to a Member enquiry regarding the process of deeming an admission as unnecessary, representatives explained that this was a judgement call that would be supported through vast experience and training. Unnecessary admissions were those that did not require clinical intervention by the hospital. It was explained that if nursing care or medical care could be delivered at the patient's home or care home, then that admission could be deemed as unnecessary. In light of this, it was considered vital that work be undertaken with the CCG to ensure that some of those social support services were available out-of-hours, as at the moment they were not as robust as they were during the working week.

The Committee briefly discussed access to services on Sundays. Following reference to potential evidence sources to demonstrate the number of admissions being made, the Scrutiny Support Officer indicated that this would be followed up.

The representative from Adult Social Care informed Members that both Local Authorities had actively engaged with the CCG in order to improve the current systems.

Consideration had been given to the urgent care consultation and how that aligned to the wider issues facing the service.

With regards to out-of-hours services, it was explained to the Committee that Social Workers were available 24/7 via the Emergency Duty Team, though pressures were faced when matters did occur out-of-hours. Work was currently taking place to further align the activities of the Rapid Response teams with the Health Rapid Response teams in order to provide increased support to patients' needs.

It was felt that furthering opportunity for patients to be seen by their own GP out-of-hours would support the Emergency Duty and Rapid Response teams.

Regarding care homes, this was felt to be a pertinent issue for Adult Social Care in ensuring that the care home sector was properly supported. It was explained that one of the methods being undertaken was to ensure that care homes were better supported by primary care and community health services.

Members conveyed that it would useful if evidence from the Social Care departments could be provided for the next meeting - what interventions had been started and what impact they had actually had, for example.

It was highlighted to Members that, in addition to out-of-hours hospital admittance, elderly and frail patients may have alternatively been allocated a residential care placement, which was not felt to be in their best interests either. It was highlighted that the service wanted to enhance the support that patients received in their own homes.

In response to an enquiry regarding the proposals being beneficial to the work undertaken by the Social Care teams, it was felt that the additional access and extended hours would be of benefit to both the Social Care teams and to the care homes, particularly in terms of enhancing primary care and community care support. Reference was made to the STAR scheme in achieving this, which could potentially be extended through this model.

In terms of a favoured proposal out of the three presented, the Adult Social Care representative explained to Members that it was important to balance the extended opening with the number of Hubs, and the operation of the Hubs until 21:30 felt most appropriate in this regard. Consideration was given to the number of Hubs versus the population being served. In addition, mention was made of the importance of having out-of-hours support and advice available to Social Care professionals, in helping to resolve some of the issues around both hospital admissions and long-term care admissions.

It was highlighted that there were a number of Social Care services in operation that were available seven days per week, but work was being undertaken with the CCG as to how this could be advanced. It was pointed out that the department was currently looking to extend Social Work within the hospital, but this would need to align with the discharge pathway work

being undertaken at the hospital; untimely activity to either would prove detrimental going forward.

Reference was made to the voluntary sector and the key input that it had in respect of supporting patients being discharged from hospital. It was imperative that this be considered when determining suitable ways forward for public sector services.

Overall, it was felt that, from the perspective of Social Care, the proposals offered would help to support the whole system, though it was acknowledged that further detail was required as to how all services would be managed and interact. Options were available, for example in respect of the STAR scheme, though further work was required.

In response to an enquiry regarding the hours worked by hospital Social Work teams, it was explained that this was hosted by Middlesbrough's Social Services, and operated between 8:00/8:30-17:00. Weekend working had been pilot previously, but was not found to be being used as effectively. It was highlighted, however, that this was ready to be re-implemented when needed. It was indicated that, in terms of out-of-hours, there was an Emergency Duty Team that covered the entire Tees area, which would pick up referrals for the community.

A Member queried what additional support was available to older people that had been admitted to hospital. In response, representatives explained that a frailty unit had been established in order to bring an increased number of professionals together with the aim of discharging patients more quickly. Matters such as the size and personnel involved in the unit were currently being assessed.

It was highlighted to Members that the Acute Trust had significantly been restructured, which would become evident from 1 April 2016. It was acknowledged that partnership work was required with the CCG in terms of improving pathways, which hospital representatives were optimistic about.

The Healthwatch representative indicated that the organisation had recently completed a report in respect of hospital discharge, which was currently being reviewed by the Trust. It was explained that one of the issues arising from that report concerned in-patient transport and a suggestion that it could be operated more efficiently. A further element concerned bed blocking around prescriptions; patients waiting for medication in order to be discharged. It had been suggested that patients be discharged with a prescription in order to alleviate some of the pressures around this.

Hospital representatives indicated that there was heightened focus within the organisation to discharge against targets. Currently, this was set at a minimum of 25% by midday, with a secondary target of 35% also by midday. The trust was looking at all of its systems to achieve those targets. It was acknowledged that patients needed to be discharged as soon as possible in order to create capacity within the system, and to prevent any unnecessary cancellations within it. Work would include looking at a range of internal processes around this, including bed management.

A Member queried multiple partnership working and whether there were any constraints as to what information could be shared between agencies. In response, it was explained that information sharing protocols were in put in place in order reduce any constraints, particularly around Multi-Disciplinary Team (MDT) working. It was indicated, however, that there were constraints in getting those in place, as patients were required to consent to their data being shared.

Mention was made of the timely sharing of data; the success of this, particularly in respect of patients being discharged from hospital, relied upon effective communication between professionals, as information was stored within different systems and not all in one place.

A short discussion ensued in respect of local transport links for patients. The CCG representative indicated that once it had been determined how many Hubs would be established, accessibility options would be reviewed. The Chair indicated that this would be looked at in greater detail at a future Committee meeting.

The Chair advised the Committee that a presentation would be given after a short break. The Chair thanked all of the representatives and clinicians for their attendance and valuable contributions to the meeting up to this point, which would help shape the Committee's final report. Those representatives and specialists required elsewhere were invited to retire from the meeting at this stage.

Representatives from NHS North of England Commissioning Support provided the Committee with a short presentation regarding the progress of the consultation exercise to date.

In summary, it was felt that the consultation was progressing especially well. A tremendous amount of good publicity had been achieved across a variety of different mediums; the profile and awareness of the consultation had been raised significantly and there had been a variety of opportunities for people to participate within it. Working with a voluntary sector partner, Groundwork North East, a specific piece of work to focus on minority, marginalised and disadvantaged groups within communities had been undertaken, with 80 discussion group sessions being facilitated. It was indicated to Members that the work completed so far had provided excellent opportunity for discussion and response to some of the concerns that the public had raised.

As part of the consultation, it was explained to the Committee that a mid-term review had been completed; the consultation had been independently validated by the Consultation Institute, who had undertaken the review with the Commissioning Support Team.

Members heard that nine public events would be taking place during the consultation exercise. Initially this was eight, however, feedback had been received in relation to some of the first events and, in response, and the decision had been taken to schedule an additional event in Guisborough, in order to provide those residents with increased notification of the consultation. For the same reason, work was undertaken before both the first event in North Ormesby and the Guisborough event, whereby information leaflets and posters were distributed in order to help raise the profile of the consultation.

Work had been carried out with GP patient participation groups, and a Councillor drop-in session had been scheduled for Councillors of both Middlesbrough Council and Redcar and Cleveland Council. This session would be taking place on Wednesday, 9 March 2016.

Two engagement sessions with patients had already been undertaken at the walk-in centres, with a further two sessions planned to take place before the end of the consultation.

Images from the public consultation events were shown to the Committee.

Regarding the communications and publicity aspect of the consultation, it was explained to the Committee that awareness had been raised through mainstream media channels including BBC Tees and Look North, which had been very positive. Other localised channels, of equal importance, including Zetland FM, Talk of the Town and Coastal News, had also been utilised.

Members were informed that hard copy documentation pertaining to the consultation had been forwarded to a range of contacts in order to raise awareness. These included: GP practices, pharmacies, dentists, voluntary sector partners, and public places including libraries, leisure centres and supermarkets.

It was highlighted to the Committee that, from 7 March 2016, Royal Mail would be distributing information to every property within the South Tees area, which consisted of circa. 130,000 properties. It was explained that previous distribution issues with a local firm had resulted in Royal Mail being appointed to deliver leaflets. As there were just over three weeks of the consultation remaining, the intention was to encourage as many people as possible to participate. The aim was to avoid reaching the end of the consultation and for those people who wished to respond failing to do so.

In addition to the Royal Mail drop being undertaken, it was explained to Members that four public events would be taking place in Eston, Middlesbrough, Guisborough and Redcar.

Facilitators would utilise these sessions to pose 'challenging questions' to attendees; the intention here was to undertake further detailed discussion in order to enrich the data obtained through the consultation.

Members were informed that digital work had been undertaken with the Evening Gazette to create site skins. It was explained that these were advertisements that appeared around the sides of the homepage of a website. These were produced to encourage people to participate in the consultation process, and to remind of its timescale.

In response to an enquiry, it was explained to Members that the chargeable elements of the publicity of the campaign comprised the Royal Mail delivery work, the Evening Gazette digital work and some social media work. It was explained that work above and beyond that routinely undertaken, and which required additional resource to complete activities, was chargeable.

Members queried what activity was charged for in respect of social media. In response, the Commissioning Support representatives explained that Facebook had provided a targeted advertisement service to those users that resided in the South Tees area. Sponsored content advertisements for the consultation would have appeared on users' pages; taking them directly to the questionnaire upon clicking the hyperlink. A short discussion ensued regarding the effectiveness of this strategy.

During discussion, both Members and invited representatives provided details of their experiences with social media, and the work that they had carried out in assisting with the promotion of the consultation.

In terms of engagement and opportunities for people to participate, various methods were utilised in order to ensure that residents were able to become involved. It was indicated to the Committee that these included:

- Circulation of hard copies of documentation;
- Use of social media;
- E-mail contact with stakeholders;
- Nine public engagement events;
- Facilitated group discussion events;
- GP practice group sessions;
- Sessions at walk-in centres;
- A day at Teesside University where discussion with 250 students had taken place;
- Engagement with both Local Authorities; and
- Dealing with individual requests for information to be consigned.

In light of this, it was felt that the opportunities for participation and engagement were both wide and varied, and of a very good standard.

Regarding activity carried out at the walk-in centres, Members heard that discussion had been undertaken with managers to determine more information about the patients accessing those facilities. It was explained that this had highlighted that a number of people using those services did not speak English as their first language. In response to this, work had been undertaken to have posters and flyers translated into the top five supplementary languages spoken in the South Tees area: Albanian, Arabic, Farsi, Slovak and Tigrinya, which would be displayed at the centres. In addition, walk-in centre managers were informed that if volunteer discussion group could be formed, translation services to facilitate those sessions would be provided. It was highlighted, however, that all residents regardless of their language were still welcome to attend the main public events, if they wished to.

It was highlighted that, to date, 174 surveys had been completed and processed. The representatives were not concerned about this at the moment, as it was explained that approximately 80% of surveys were usually returned within the final two weeks of the consultation process. Also, it was considered that the number of returned questionnaires was not the only factor - it was also about the quality of the feedback obtained via other engagement methods and activities.

In terms of the minority, marginalised and disadvantaged groups within communities, a number of organisations had been approached. These included:

- 'Recovering Together' in Middlesbrough;
- 'Lifeline' in Redcar and Cleveland;
- 'Carer's Together';
- 'Alzheimers Association';
- Food banks;
- 'North Ormesby Ladies' Craft Group';
- 'South Asian Taxi Drivers' Group';
- African refugee community groups;
- BME young peoples' groups; and
- Afghan community groups.

It was explained that a significant amount of work had been undertaken with BME groups, and Groundwork had undertaken work with one of the BME networks to ensure good access to those groups and communities.

A query was raised as to whether any work had been undertaken with women's refuge groups - 'My Sister's Place' or 'Eva Women's Aid' for example. The representative for the NHS North of England Commissioning Support would check on this and advise accordingly.

With regards to some of the concerns that people had expressed in respect of the proposals, the Committee was advised that, in response to these, a question and answer sheet examining the issues would be produced in order to assist in alleviating those concerns. This sheet would be uploaded to the consultation website and circulated via appropriate means, which would include both social media and direct mailing avenues.

In respect of the mid-term review, it was indicated to the Committee that this had gone very well. The Consultation Institute had indicated that the consultation in its methodology and process was excellent. There were some matters fed back that would be reviewed, a suggestion for more items/information to be added to the website for example, but their review was that it was one of the top 3% of consultations that they had worked with so far. The Commissioning Support representatives indicated that, overall, they were pleased with the progress of the consultation and its current position. It was reiterated that some very good feedback had been received, and a wide reach for people to participate had been achieved. It was highlighted that as much work as possible would be undertaken during the final weeks of the consultation in order to encourage as many people as possible to participate.

Members thanked the representatives for their update and work undertaken to date.

Representatives congratulated the Commissioning Support Team for the work undertaken in order to ensure that everyone had the opportunity to participate. It was queried whether any work similar to the walk-in centres had been undertaken in A&E departments. In response, it was indicated that this would be considered, but the intensity of patients' experiences within A&E would need to be borne in mind. Members felt that there was potential that leaflets and/or questionnaires could be handed out to those accompanying patients to A&E.

A short discussion ensued with regards to the next steps for the review. The Chair indicated that further evidence from the representatives, as discussed during the course of the meeting, would be useful for the Committee in terms of generating its final report.

The CCG representatives indicated that following the conclusion of the consultation on 1 April 2016, the formal public consultation report comprising the analysed feedback from all of the questionnaires, discussion groups, public events, etc. that had been completed, would be produced week commencing 16 May 2016. The next Committee meeting to discuss this report, and any other matters, would be arranged to take place in June 2016.

The Chair thanked all in attendance for their time and contributions.

AGREED that:

1. **The CCG representatives would provide evidence/information in relation to A&E attendances and admissions over the last year.**
2. **The Scrutiny Support Officer would research potential evidence sources regarding examples of GPs located within A&E departments.**
3. **The representative(s) from NHS North of England Commissioning Support would ascertain the involvement of women's refuge organisations in the consultation process.**
4. **The information, as presented, be noted.**

4 **ANY OTHER BUSINESS.**

No further business was discussed.