NORTH EAST JOINT HEALTH SCRUTINY COMMITTEE

MINUTES

28 JUNE 2017

The meeting commenced at 10.00 am in the Civic Centre, Hartlepool.

Present:

Chair: Councillor Ray Martin-Wells, Hartlepool Borough Council

Durham County Council: Councillor Robinson
Northumberland County Council: Councillors Watson
Redcar and Cleveland Borough Council: Councillor Watts
Stockton Borough Council: Councillor Bailey

Also Present: Dr David Hambleton, Chief Officer, South Tyneside CCG
Kate Brundle, Head of Commissioning for Mental Health and Learning Disabilities, Northumberland CCG
David Chandler, Chief Finance Officer, Sunderland CCG
Donna Owens, Joint Commissioning Manager, North of England Commissioning Support

Officers: Stephen Gwillym, Durham County Council
Peter Mennear, Stockton Borough Council
Mike Bird, Northumberland County Council
Joan Stevens, Statutory Scrutiny Officer (HBC)
David Cosgrove, Principal Democratic Services (HBC)

41. Apologies for Absence

Gateshead Borough Council: Councillor Green,
North Tyneside Council: Councillor Bell,
Redcar and Cleveland Borough Council: Councillor Kay.

42. Declarations of Interest

None.

43. Minutes of the meeting held on 2 March, 2017

Confirmed.

44. Terms of Reference for the North East Joint Health Scrutiny Committee

The Statutory Scrutiny Officer (HBC) submitted a copy of the terms of reference for the North East Joint Health Scrutiny Committee for Members information.

DECISION

That the Terms of Reference be noted.

45. Better Health Programme – Verbal Update

The Durham County Council representatives gave an update on the Better Health Programme Joint Health Scrutiny Committee meeting held on 9 March, 2017 at Darlington, established to cover the Tees Valley, Durham Dales, Easington and Sedgefield and Hambleton, Richmondshire and Whitby STP. The update provided details of the presentations, reports and discussions at the meeting for the Joint Committee's information.

In relation to the Northumberland, Tyne and Wear and North Durham STP clarification was sought as to the scrutiny process in place and progress to date in relation to this STP footprint. It was suggested that information in relation to these queries be presented to the next meeting of the North East Regional Committee.

DECISION

That the report be noted.

46. Work Plan for the 2017/18 Municipal Year

The Statutory Scrutiny Officer (HBC) reported on the proposed work programme for the Committee for the year. The Officer highlighted that no additional items were proposed for the work programme over and above those already scheduled; the Committee's work would be focussed on those issues that were already programmed to come forward. The programme would be, therefore;

September 2017 meeting:
Regular performance update from NEAS North East Ambulance Service)
Congenital Heart Disease – update
NHS England – update

November 2017 meeting:
Community Pharmacies / use of Pharmacies for minor ailments and other services
Big Conversation (Mortality)
Refugee project

February 2018 meeting:

NEAS Quality Accounts.

The Chair supported the proposed schedule commenting that it would allow the Committee an opportunity to deal with the scheduled matters fully while retaining some flexibility.

DECISION

That the work plan for the 2017/18 Municipal Year, as reported, be approved.

47. North East and Cumbria Learning Disabilities Fast Track Transformation Plan: Update and Further Information

Dr David Hambleton, Chief Officer of South Tyneside CCG introduced his colleagues to the Committee who were involved in the North East and Cumbria Learning Disabilities Transformation Project Dr Hambleton and colleagues gave a presentation to the Committee which outlined the following key points and issues –

- The aim of the project was to "bring an end to the model of institutionalisation as a model of care for people with learning disabilities" as there is still a group of people in hospital who we think could be living in the community and many people are admitted to hospitals for years, sometimes very far from home.
- There were high levels of inpatient bed usage and the length of stay was frequently long and not consistent with their description of assessment and treatment
- People with LD (Learning Disabilities) should have more choice and control.
- There was too much 'wrong care in the wrong place' and the plan was to move towards the 'right care in the right place'.
- Hospital is not a home but too many had been there so long, it felt like that.
- Individuals, and their families, struggled to get adequate care in the community and may spend years fighting for it.
- There is a cost issue - £177,000 a year for average inpatient placements and £140,000 a year for fully staffed average living costs in the community for those with higher needs.
- The pace of change is too slow and to some extent we have been here before but there was now a national drive following the Bubb Report and Public Accounts Committee on Care for People with Learning Disabilities, together with a personal interest from NHS England Chief Executive, which had led to the National Reconfiguration Taskforce which also had LGA and ADASS support.
- The actual numbers of people were low. As at 16 May this year there were 216 individuals in long stay hospital beds; 110 Non Secure, 106 Secure. The planned discharges for 2017/18 totalled 93, with 50 of those becoming the responsibility of their local CCG and 43 going into

specialised community care models.

- The new service models were being developed for People of all ages - adults and children - who have a range of complex needs including learning disability, autism spectrum conditions including Asperger's syndrome, plus people with additional mental health conditions, sensory impairments and physical disabilities.
- The new community models would be built around –
  – Getting it right in childhood
  – Supporting Parents and Carers
  – Supporting the transition to adulthood
  – Supporting the transition from adulthood to old age
  – Support wherever someone lives
  – Agreeing key principles for local models and, where it works, economies of scale
  – Avoid 14 different models – consistency across all the CCG areas.
- There were many wider roles in supporting people with learning disabilities and/or autism; health, social care, education, housing (including future planning), occupational training and employment, commissioning, investment in training and support, leisure, self advocacy and advocacy in general, and also simply keeping these individuals safe when they were eventually discharged from a very safe hospital environment.
- Rate of admissions is variable, the rate has increased and it remains a significant issue impacting on inpatient numbers.
  – April 17 – there were 13 admissions in total of which at least 80% remain in an inpatient bed currently. The step down into CCG non-secure beds (care pathway) is an area undergoing examination.
  – A Resolution Panel was now established and a Task and Finish Group was in train to consider a positive collective risk taking interim scheme. Step down discussions with CCGs and specialised commissioning was ongoing.
- In relation to delayed discharges, there are a number of delayed discharges in specialised commissioning, the total identified being 12 (May 17). A number have community as the designated destination, but there are also a significant number that require Step down into CCG non secure beds (care pathway) which is an area funder examination.
- All delayed discharges in specialised commissioning continue to be reviewed and their designated care pathway/designation re-examined. A strategic approach is to be agreed between specialised commissioning and CCGs, with local authorities to progress all discharges in a timely manner underpinned/informed by the 12 point discharge planning tool. Close monitoring of impact and outcomes. The regional local target was100% of all currently identified and agreed specialised commissioning delayed discharges to be discharged within the next 12 months.
- As of May 17 a local data snap shot had 84 in-patients with a length of stay of 5 years or more. 33 CCG and 51 specialised commissioning patients. Data suggests that the length of stay regarding new admissions are reducing but there remains a significant number of inpatients approaching 5 years, and the number of 5 year plus inpatients

is not reducing significantly per quarter.

- Cumbria and the North East is sighted on its regional/national trajectory. All CCGs have been set a trajectory in 17/18 (CCG and specialised commissioning inpatients) based on planned discharges inclusive of 5 year plus. Cumbria and the North East have identified 33 in-patients with planned discharges.
- Cumbria and the North East expects to exceed its Q1 trajectory overall (83). This reflects the inclusion of 3 additional inpatients who remain in hospital which will be added to the 5 year plus cohort and discharges planned and those that had already taken place.
- Finance for implementing the plan was complex involving NHS, CCGs and local authorities. Around £500m was pent across all the agencies. The forecast for bed expenditure was expected to decrease by around £25m though community care costs would increase by £16m and there would be some community service infrastructure costs that were costed at £12m. There would initially be some 'double' costs; money would not be saved immediately and it was anticipated that some transitional funding would be required.
- It was proposed that current inpatients would have a 'dowry' that would follow those discharged from long term hospital care into their new community setting. There were 70 such inpatients and it was proposed that around 40 of them to be 'released' from hospital care. Further work on the dowries and how they would be implemented. Work was ongoing with the local authorities on how this would be implemented.
- It was considered that Cumbria and the North East was in a much better place on this issue than other regions. A lot of work had been undertaken with partners so far and this work could only be progressed with their continued cooperation.

The Chair commented that there did seem to be a lot of groups involved holding lots of meetings for what was a relatively small group of patients. Members had hoped there would be detailed plans available by this stage as to how the discharges would take place and how these patients would be reintegrated into the community. There also appeared to be a gap in the funding. The Chair commented that an inpatient bed was costed at £150,000 with care in the community costed at £140,000 but the 'dowry' that followed the patient was only £32,000; how was the gap in funding to be met.

Mr Chandler commented that the dowry payment wouldn't always meet the 'top-up' costs. The initial guidance issued suggested that the first part of the funding should be used for new community infrastructure. The Finance Group considered this slightly unfair and asked for something in the interim and there would be some additional funding in place for a year but in the longer term funding would be as government guidance. £60,000 would come for community infrastructure with each patient, with £64,000 for care which was likely split 50/50 between local authorities and CCGs. The key was that the funding transferred wasn't going from one pot into another but was being split across a wider range of partner, including CCGs and local authorities.

Members were concerned that this would leave them with a financial liability in relation to the long term continuing care of the people transferred. The Chair added that this also involved people who had been in hospital for five years or more when that was totally unnecessary which had to be considered wrong whichever way it was viewed.

The Vice-Chair raised a series of questions to the NHS representatives –

- What response was coming out of the NHS to the recent BBC investigation which had looked at this area of NHS care.
- The question of support for families was also a major issue. What support would they receive in assuring their relatives received the right care when they were discharged from hospital.
- The Joint Committee had been promised two seats on the group leadng this process; why had this not happened.
- There was concern in local authorities that this process was being rushed without due consideration to what local authorities would be expected to pick up after the discharges had taken place. The recent additional social care precept would go nowhere near meeting these additional costs.
- There appeared to be no additionality around children and young people's care.

Dr Hambleton did not feel it was being rushed and that most certainly would not be the view of the patients, and their families, who had been in hospital for over five years. Money would move as NHS beds closed to the local authorities and CCGs. While this was a relatively small number of people, their needs were high, often complex and they were not and would not be cheap to address. The infrastructure building was around ensuring that they could be discharged to somewhere that could provide the care they needed. It was a sad reflection on our country that other European countries had no such problem; the Dutch had no long term hospital care beds. To get to that point here would take a considerable mindset change with proper personalised packages of care available from the outset.

Dr Hambleton also commented that the quality of the discharge procedure and the ease into which the patients went into their new care arrangements was hugely important. The focus had to be on the individual and their care needs. No one is advocating a reduction in the quality of care simple a change in venue.

In relation to the BBC investigation, Dr Hambleton stated he was not aware of this.

The Vice-Chair welcomed the comments particularly in relation to funding following the patient. Mr Chandler added that it wasn't intended that costs would be shared. The NHS wouldn't be saving money simply to put up local authority spending but the process was trying to ensure that money didn't get in the way of providing the right care.

A member questioned if anything was being done to address the issue of the numbers waiting to go through autism assessments. Ms Brundle commented that there was work looking at how mainstream diagnosis services could be sued to improve the process rather than simply placing all the pressure on the specialised service.

The Chair asked if the breakdown of the seventy long term patients that were to be discharged over the next year had been shared with partners. Mr Chandler indicated that details had been shared with the CCGs and could be shared with the Joint Committee. The Chair assured that the confidentiality of any such information would be protected.

Mr Chandler welcomed the involvement of Elected members in the process and was advised that nominations had been made act as observers on the Programme Board. Mr Chandler was unaware of these nominations and none of those members who had volunteered to participate had received and papers or been invited to participate in the meetings.

In concluding the debate the Chair thanked the four representatives for their attendance and input into the meeting.

DECISION

1. That the presentation and the update be noted and the presentation slides be shared with Committee members.

2. That the position in relation to the member nominations made to the Programme Board be explored and rectified to ensure that they are invited to participate in future meetings.

48. Chairman's urgent items

None.

49. Any other business

None.

The Chair highlighted the proposed future meeting dates for the Committee's information: -

27 September, 2017 at 11.00 am, Hartlepool Civic Centre
23 November 2017 at 10.00 am, Hartlepool Civic Centre
15 February, 2018 at 10.00 am, Hartlepool Civic Centre.

The meeting closed at 11.20 am.

CHAIR