NE Regional Member / Officer Meeting

12 February 2016

DRAFT Minutes

Present	
Cllr Derrick Brown	Chair, Stockton-on-Tees Borough Council
Cllr Denise Jones	Vice-Chair, Newcastle City Council
Cllr Marjory Knowles, ,Cllr Sue Richmond	Darlington Council
Angela Frisby	Gateshead Council
Cllr Bill Corbett, Cllr Doreen Huddart, Karen Christon	Newcastle City Council
Cllr John O'Shea	North Tyneside Council
Cllr Ian Lindley	Northumberland CC
Cllr Steve Kay, Alison Pearson	Redcar and Cleveland Council
Cllr Sonia Bailey, Cllr Gillian Corr, Cllr Lynn Hall, Graham Birtle, Peter Mennear	Stockton-on-Tees Borough Council
Cllr Michael Dixon, Cllr Jill Fletcher, Cllr Julia Jackson, Cllr David Snowdon, Cllr Dianne Snowdon, Cllr B Walker, Cllr Norma Wright, Karen Brown	Sunderland City Council
Apologies	
Cllr Norah Cooney, Cllr Mick Stoker, Bev Parker, Louise Scrimshaw	Cleveland FRA
Cllr Joe Armstrong, Jenny Haworth	Durham CC
Cllr Malcolm Brain, Cllr Stuart Green	Gateshead Council
Cllr Marion Talbot	Newcastle Council
Cllr Sandra Graham	North Tyneside Council
Cllr Alan Sambrook, Cllr Brian Gallacher, Cllr Lynne Grimshaw, Cllr Alyson Wallace, Cllr Kate Cairns	Northumberland CC
Cllr Phillip Thompson	Redcar and Cleveland Council
Cllr Tracy Stott,	Stockton-on-Tees Borough Council
Cllr Ronny Davison	Sunderland City Council
In Attendance	
David Corcoran	Local Government Policy Manager, Department of Health
Tim Gilling	Deputy Executive Director and Head of Programmes, Health & Social Care, CfPS
Colin Potter	Senior Regional Public Engagement & Involvement Officer – North Region, Care Quality Commission
Steve Sienkiewicz	CFPS Regional Advocate (North)
Sandra Sutton	Inspection Manager, Care Quality Commission

Welcome

Cllr Brown welcomed everyone to the meeting.

1. **Apologies for Absence**

No further apologies were received.

2. **Minutes of meeting held on 9 October 2015**

The minutes of the last meeting were agreed as a correct record.

3. **Care Quality Commission - Scrutiny and regulation working together**

Sandra Sutton, CQC Inspection Manager, presented the Network with information about how the CQC works. It was highlighted that the CQC make sure health and social care services provide people with safe, effective, compassionate, high-quality care and encourages care services to improve. This is carried out by monitoring, inspecting and regulating services to make sure they meet fundamental standards of quality and safety before publishing findings, including performance ratings to help people choose care.

The CQC aims to provide better information for the public including ratings through improved assessments of services and Chief Inspectors. Stronger national and local partnerships are being developed e.g. health and wellbeing boards, Healthwatch, and Overview and Scrutiny Committees.

The Network learned that a more rigorous test for organisations applying for registration with CQC had been introduced along with a changed approach to NHS acute trusts and mental health with new fundamental standards.

The services the CQC regulate are:

- Treatment, care and support provided by hospitals, community services, GPs, dentists, ambulances, mental health and substance misuse services.
- Treatment, care and support services for adults in care homes, hospices and in people's own homes (both personal and nursing care) and healthcare for children in children's services
- Treatment, care and support services for adults and young people in the criminal justice system including prisons and youth offending institutions
- Services for people whose rights are restricted under the Mental Health Act.

The Network was informed of a new approach to inspecting services whereby the CQC ask five key questions on all inspections, are services safe, effective, caring, responsive to people's needs, and are they well-led?

Based on the response to the key questions the CQC rate an organisation and its main services as either outstanding, good, requires improvement, or inadequate and then publish reports after every inspection setting out what was found. This includes examples of good practice as well as areas for improvement.

The CQC continue to:

- Inspect at any time in response to concerns
- Inspect and review for particular areas of care. For example, special reviews this year on end of life care, care for the over 75s and people's involvement in their care

- Regulate and enforce action
- Maintain ongoing relationships with service providers
- Develop other local relationships – with commissioners, Healthwatch, voluntary and community groups

New regulations and responsibilities were introduced in April 2013 which brought significant changes to how the CQC regulate the 49,500 health and adult social care providers and services across the country. This includes new fundamental standards of equality and safety, a special measures regime (where services found to be providing particularly poor care are closely monitored and offered extra support to help them improve within set timescales), new enforcement powers, and a requirement for providers to display CQC ratings.

Members raised a concern if there was a delay in publishing ratings about making patients aware and enquired if there was there a maximum amount of time before ratings were published. The CQC has a timeline but it is not fixed because of the complexity of different trusts. If there was a trust with significant risk then this would be raised at the inspection and revisited shortly afterward to ensure rectification.

Are trusts put into special measures because they are so bad or due to strict criteria? Only one trust in the north east is in special measures. More concern is shown by CQC at trusts deemed inadequate as it is not showing capability of improvement unlike trusts rated as requiring improvement.

Did trusts welcome or fear CQC inspections? The CQC found that well organised, confident trusts welcomed an inspection and could learn further from the findings. Colin Potter, CQC Senior Regional Public Engagement & Involvement Officer – North Region added that an inspection wouldn't be the first time a trust had been contacted by the CQC as there is already an established relationship in place.

Members asked if they had adequate staffing to ensure quality assurance of the inspections undertaken. Every inspection report is quality assured and is reviewed by a colleague and a manager before being considered by a national panel. In June 2016 all Acute Services will have been inspected including mental health.

Colin then went on to explain the way in which the CQC is working with the Centre for Public Scrutiny to develop closer working relationships with scrutiny committees and elected members. This is to help improve the consistency and quality of local relationships, increase levels of evidence gathered and used to inform CQC regulatory activity, increase the use of CQC information in local scrutiny, and develop information sharing between scrutiny, Healthwatch and Health and Well Being Boards.

The local CQC Hospital inspection manager will be a scrutiny committee's main contact with CQC providing a connection to the primary care inspection team if needed. Scrutiny committees will also have a contact in the local adult social care inspection team to discuss social care inspections. Health scrutiny committees will be contacted before any announced NHS trust inspections in order to share any relevant information. The most local committee to the trust will also be invited to the Quality Summit held after an NHS trust inspection.

Colin was keen to emphasise that scrutiny committees meet with CQC as a partner not as a 'witness'. Developing a dialogue between the CQC and local authority scrutiny enables use of CQC findings of its inspection activity for registered services in an area. Scrutiny committees in return could inform the CQC of committees' plans and progress of work and also share information about people's experiences of the local health and care system and

of individual services. Information from scrutiny reviews, public meetings, and issues from councillors can be useful to CQC.

The Network enquired as to who scrutinises the CQC if that did not come within the remit of health scrutiny. Colin informed Members that although the CQC was an independent body it was directly accountable to the Department of Health (DoH).

The CQC will continue to write to all scrutiny committees as it announces new inspections and alert committees to public listening events. Local press releases and updates on national reports including announcements about special measures should be received and requests for information about CQC reports can be made. A regular ebulletin for all OSCs setting out CQC latest news and ways scrutiny committees can get involved in its work will also continue to be distributed.

4. Local Health Scrutiny of Delayed Transfers of Care

David Corcoran, Local Government Policy Manager, Department of Health, provided the Network with national and regional information regarding the winter pressures on NHS hospitals that were missing their A&E target during the winter which required that 95 per cent of patients should be seen and treated, admitted or discharged within four hours

Delayed transfers of care continued to rise whilst the proportion of delays attributable to social care also continued to increase. There was a rising number of black alerts at NHS hospitals all of which was a repeating pattern in 2015/16 and not only happening at winter.

David was able to provide the national position based on November 2015 data which showed:

A&E 4 hour target

- A&E 4 hour target not being met and lower than a year ago 91.3% as compared to 93.5% a year ago.

Delayed transfers of care

- 5,600 patients delayed, up from 5,100 a year ago (9.8% increase)
- 153,200 total days delayed, up from 140,900 a year ago (8.7% increase)
- Proportion of delays attributable to social care is 31.1%, compared to 26.7% a year ago (14% increase) – 34.2% of delays were for patients awaiting a care package in their own home.

David stressed that the information is not about hitting targets but to highlight poor outcomes for individuals.

Although there is still room for improvement to reach the 95 per cent target the Network learned that in the North East the figures for admissions to A&E shows that it is performing well for the number of patients spending more than four hours from the decision to admit to admission, and is probably the best region in the country.

The North East is doing fairly well for the number of people delayed by reason and the number of days people can be delayed. The main reasons were waiting for further NHS non-acute care but local authorities could impact on delays while patients wait for assessment by social care, admissions to nursing homes, and care packages in a patient's home.

There is a range of support available to local systems which could be scrutinised as part of the delay of transfer of care or winter pressures and questions can be put to social care teams and NHS Trusts whether they are utilising support systems that include:

- System Resilience Groups leading winter planning
- Increased sector led support (LGA – TEASC programme)
- NHS Emergency Care Improvement Programme (ECIP) (this includes improvements to A&E, admissions, and transfer process out of hospital)
- NHS England Quick Guides
- Revised guidance on recording delayed transfers of care (published in October 2015)
- Independent and voluntary sectors
- CfPS published a guide to scrutiny of winter in November 2015

David presented the high impact changes for hospital discharge. Early discharge planning was considered an easy solution to enact with plans in place especially for elected surgery and for emergencies planning should begin within 48 hours. Other changes highlighted included:

- Systems to monitor patient flow
- Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector
- Home first/discharge to assess
- Seven-day services
- Trusted assessors take a holistic approach to care needs
- Focus on patient choice – this needs preparation and the voluntary sector is able to provide additional support
- Enhancing health in care homes

The Network enquired about the monitoring of Clinical Commissioning Groups and their plans. David informed Members of the role that Health and Wellbeing Boards and Scrutiny Committees have a vital role in holding the plans to account and ensuring their delivery.

With the constant failure to hit the targets that have been set Members wondered whether support mechanisms could be put in place. They were informed that NHS England have an Emergency Care and Improvement Plan which has been introduced in the 28 most challenged areas in the hope that this will produce improvement and other areas can learn from that. Towards Excellence in Adult Social Care involves the LG, Association of Directors of Adult Social Services (ADASS), and Public Health England provides a similar approach for local government.

5. Centre for Public Scrutiny Update

Steve Sienkiewicz, CfPS Regional Advocate (North) provided the Network with an update of information from the CfPS.

A project will begin this year in conjunction with NICE who will be attending the CfPS Health Accountability Forum in June. Input is being requested for issues currently facing health scrutiny committees that NICE could provide support. It is then possible to have NICE attend regional scrutiny network meetings throughout the country. Members were requested to provide any information / suggestions via Graham Birtle (Scrutiny Officer Network – Chair).

Newcastle City Council has applied for CfPS input for the offer of Enquiry Days linking in with Citizen Advice Bureau to strengthen relationships with the organisation and the general public.

The Devolution Agenda is very active and is likely to be ongoing for some time so the CfPS is working with five areas (Cambridgeshire, Cornwall, Hampshire and the Isle of White, Sheffield, and Norfolk and Suffolk) for the development of robust and proportionate governance arrangements for combined authorities. A report will be published in Spring 2016.

Other events are currently being offered in London. The Change Game is being repeated on 14 March 2016. A Corporate Parenting training event and training to deal with safeguarding issues has been developed and is being promoted. There is a possibility of the events being delivered in the region but would require sufficient interest and attendance for events to be viable. There will be cost for attending the events in the region (£175 + VAT) and a minimum of 15 delegates would be required. The Network supported the delivery of events in the region.

The next meeting of the Health Accountability Forum was in London on 7 March 2016. It would be useful to get representation from the north east region. A draft agenda has been published and circulated. Tim Gilling added that a key part of the meeting would be to make recommendations about future support for health scrutiny from DoH, NHS England, and Public Health England who currently fund the support programme. Four key themes (Public Health and Tackling Inequalities; Commissioning; Integration of Health and Social Care Services; and Service Redesign) feature in the ongoing discussions with the health partners. Comments were required by 29 February.

The CfPS has recently published documents which are available on the web site (Social Return on Investment, Shared Principles for Redesigning the Local Health and Care Landscape, Winter pressures).

The Chair thanked all the organisations for their attendance and information and also thanked the Members for the questions and quality of debate.

6. Any Other Business

Sunderland City Council thanked the CQC representatives for reports they received about Sunderland Hospitals which alerted the health scrutiny committee to issues it might not have been aware of.

7. Date and Time of Next Meeting – (to be confirmed)

The Network will next convene in June or July 2016.