TEES VALLEY HEALTH SCRUTINY JOINT COMMITTEE

A meeting of the Tees Valley Health Scrutiny Joint Committee was held on 17 December 2009.

PRESENT:

Representing Darlington Borough Council:
Councillors Mrs Scott and Swift

Representing Hartlepool Borough Council:
Councillor G Lilley

Representing Middlesbrough Council:
Councillors Carter and Dryden

Representing Redcar & Cleveland Council:
Councillors Higgins and Mrs Wall.

Representing Stockton-on-Tees Borough Council:
Councillor Mrs Cains (Chair).

OFFICERS: A Metcalfe (Darlington Borough Council), J Walsh (Hartlepool Borough Council), J Bennington and J Ord (Middlesbrough Council), S Zahur (Redcar & Cleveland Council) and G Birtle (Stockton-on-Tees Borough Council).

**** PRESENT BY INVITATION:** Councillor Mrs Skilbeck (Hambleton District Council)

Prof. Peter Kelly, Executive Director of Public Health, Tees Area PCT
Madeleine Johnson, Acting Public Health Specialist for Tees Area PCT
Sarah Marsay, Communication and Engagement Manager NHS Tees
Peter Smith, Personalisation Manager, Stockton-on-Tees Borough Council
Emma Whitworth, Commissioning Support Manager, NHS Hartlepool
Paul Whittingham, PaCE Manager, NHS Middlesbrough and NHS Redcar and Cleveland.

**** APOLOGIES FOR ABSENCE** were submitted on behalf of Councillor Newall (Darlington Borough Council), Councillors Brash and Plant (Hartlepool Borough Council), Councillor Cole (Middlesbrough Council), Councillor Carling (Redcar and Cleveland Council), and Councillors Sherris and Mrs Walmsley (Stockton-on-Tees Borough Council).

**** DECLARATIONS OF INTEREST**

Name of Member	Type of Interest	Item / Nature of Interest
Councillor Mrs Wall	Personal/Non Prejudicial	Any matters arising relating to North East Ambulance Service NHS Trust - related to a number of employees.

**** MINUTES**

The minutes of the meeting of the Tees Valley Health Scrutiny Joint Committee held on 16 November 2009 were submitted and approved as a correct record.

CANCER SCREENING SERVICES AND NEXT STEPS

The Scrutiny Support Officer submitted a report the purpose of which was to introduce senior representation from the local NHS to take part in discussions around the Joint Committee's work in relation to Cancer Screening Services and the next steps that local services need to take in relation to the take up of Cancer Screening Services.

The evidence received so far by the Joint Committee was outlined in the report at Appendix 1 and for Members' information the introduction section of a recent report published by the Department of Health Cancer Reform Strategy – 2nd Annual Report was given at Appendix 2 of the report submitted. Specific reference was made to a number of statements within the document with particular regard to the early stage of diagnosis of cancer, which remained a significant challenge to England in comparison with other countries. Raising awareness and promoting early diagnosis were highlighted as priorities for 2010. The report indicated that it was essential to bring cancer survival rates up to the level of the best in Europe.

It was acknowledged that whilst good progress had been made there was extensive ongoing work and new evidence continued to emerge such as that recently announced relating to genetic links.

In his opening remarks Prof. Peter Kelly supported the Joint Committee's interest in undertaking a scrutiny investigation into such an important subject and referred to the Final Report which was considered to be a good quality scrutiny report and helpful in supporting work currently being developed.

In introducing an update on statistical information and developments on current and future work since the compilation of the Final Report it was acknowledged that unlike the screening in relation to such areas as cardiovascular the impact of cancer screening would take much longer to emerge. The two main issues were identified as ensuring mechanisms were in place to improve early detection and continue to make advances in terms of treatment to support the improved cancer screening programmes.

Madeleine Johnson, Acting Public Health Specialist for Tees Area PCT gave a presentation which provided the Joint Committee with an update on changes and activities since the compilation of the Joint Committee's Final Report.

In terms of clarity and accurate information in the Final Report reference was made to the following:-

a) in respect of paragraph 8.2 of the Final Report it was confirmed that all GP practices offered a cervical cancer screening plus the additional 30 clinics across the Tees PCTs area referred to;

b) in respect of paragraph 9.4 the boundaries of the system referred to covered the whole of the North East, Yorkshire and Humber.

More recent information was provided on the uptake figures recently published on the percentage of eligible women screened for breast, cervical and bowel cancer (women and men) as follows:-

	Breast Cancer Q1 09 5 year uptake	Cervical Cancer 08/09	Bowel Cancer Feb 09
Darlington	80.3	81.3	55.3
Hartlepool	74.3	76.8	48.7
Middlesbrough	75.4	75.0	48.0
Redcar & Cleveland	78.7	80.1	54.5
Stockton	77.8	79.5	54.1

In commenting on the different percentage rates it was confirmed that the programmes aimed to provide consistency in delivering the services and adopt the same approach across the Tees area and the whole of the North East.

It was acknowledged that the reasons for varying degrees of take –up were very complex but quite often involved how individuals perceived their health and the screening programmes and how they dealt with illnesses once diagnosed.

An indication was given of the some of the developments in raising awareness and promoting the screening programmes. Reference was made to a roadshow at Race for Life and work between Tees PCTs and TFM. It was confirmed that efforts were being made for the DVD which had been produced in relation to the Race for Life to be made available to the Joint Committee. A survey had been conducted as part of the TFM event from which 965 responses had been received, which were currently being analysed.

Information was provided on future plans in relation to breast, cervical and bowel screening. In terms of breast cancer screening it was proposed to implement digital mammography and to extend the programme to include women aged between 47 to 50 and 70 to 73. Further emphasis would be placed on family history surveillance and where appropriate women would be invited to have a screening every 12 months as part of the national programme. It was recognised however that there was much to be undertaken in this regard reference being made to the work being carried out by the Cancer Locality Group.

The Joint Committee was also advised of the intention to extend working hours from 8.00 a.m. to 6.30 p.m. weekdays although it was pointed out that much work had to be carried before the full implementation could be achieved. Reference was also made to a new Saturday session, which was to be introduced from a mobile unit at the University Hospital of Hartlepool with effect from 16 January 2010. Members were advised of some of the difficulties including a lack of mammography radiologists and introducing changes to working practices and flexible working arrangements.

In terms of cervical screening programmes the Joint Committee was advised of the implementation of a new target date of a maximum of 14 days from the test to the result but still ensuring an effective and accurate service.

Reference was made to lessons learnt from what was described as the ‘Jade effect’ in giving careful consideration to ensuring that publicity and raising awareness campaigns were reaching the target area of population. Responses to the target campaign had been good and the numbers of women screened for cervical cancer had increased.

An indication was given of the implementation of the Improvement Foundation work, which currently involved six GP practices in Middlesbrough and would cascade eventually to all practices across the Tees. It was noted that there were variances within the GP practices and work was progressing on various means to raise awareness and improve the service.

In terms of the bowel screening programme it was intended to extend the programme to include persons aged between 70 and 75 years of age an area which would be promoted as part of a major regional event which was to be held in March 2010 incorporating a high media profile.

An important area of ongoing work involved the analysis of available data to identify those who take up the offer of screening and to examine the possible reasons for those who choose not to. Such data would assist in finding ways of making it easier and encouraging people to take part in the screening programme. The use of social marketing techniques to target low take up would be pursued.

It was confirmed that statistical information was available within the PCTs Annual Reports, part of the Joint Assessment and on the respective websites.

Members commented on the difference in the take-up of the screening programme with specific regard to Hartlepool and Middlesbrough in comparison with Darlington. Whilst there were complex reasons for this it was acknowledged that often socio-economic factors played a part and the attitude of parts of the population towards health issues. Members suggested that the focus of

attention should be on the areas of lowest take up where careful consideration should be given as to how to deliver the message to achieve the greatest impact. It was acknowledged however that this would be a very difficult task especially in the most deprived areas where preventative health issues were often regarded as a low priority whilst coping with many other problems.

The main areas of current and future plans for all of the screening programmes focussed on the following: -

a) targeted work with GP practices;
b) links to health promotion activities into existing community groups and to seek assistance using expertise from local authorities and other organisations with particular regard to hard to reach groups;
c) exploring innovative options for service delivery;
d) use of social marketing techniques to improve uptake in all screening programmes;
e) continue with the significant work being undertaken to improve on the early detection of cancer;
f) continue work with Cancer Network and Cancer Locality Group.

Members agreed that the work around early detection of cancer was of crucial importance as people with symptoms often went to the GP when the cancer had already reached an advanced stage. It was also noted that women were more likely than men to take up the offer of screening programmes. In discussing cultural issues and the need to change the attitude of certain people towards health issues specific reference was made to the need to progress awareness for the early detection of prostate cancer.

In response to clarification sought regarding community development and the different types of approaches to be pursued it was confirmed that there were six new community development workers in Middlesbrough. Whilst significant work had been achieved there remained a need to ensure that such work was aligned with those providing the service and there were specific areas which required more intense and focussed working. Although ways of targeting specific groups to raise awareness were being pursued sometimes in a less formal manner where appropriate the local NHS representatives indicated that it was a fine balance and it was important to reassure people that a NHS service was being provided in a clinical setting.

In commenting on family history links Members were advised that it was a very complex formula in trying to identify a persons' risk and currently involved different ways of calculation. As part of the ongoing work it was intended to use a standard way of highlighting the risks.

Following an indication of a Members' personal experience of advice given when visiting a GP practice the local NHS representatives confirmed that it was important for such incidences to be reported to enable them to be investigated accordingly.

Confirmation was provided that in terms of the cervical screening programme the results would be sent by letter to the individual concerned and not the GP practice. Monitoring procedures were in place in respect of follow up cases where a person has not kept or arranged a subsequent appointment.

In terms of uptake amongst the BME community the local NHS representatives confirmed that they were aware of the problems and of the need to pursue a service that was culturally acceptable. Such an area formed part of the work being undertaken under the Improvement Foundation work. An indication was given of efforts to recruit staff from the BME community and of current links to assist and advise on what steps could be pursued.

In relation to the ongoing work and the areas for further development as identified it was recognised that given the lack of appropriate resources in some cases the rate of progress would be hindered. Community Development was identified as a key area where local authorities could use their expertise and assist in with the problem areas as highlighted.

AGREED as follows: -

1. That the report outlining the evidence received so far be noted.

2. That the local NHS representatives be thanked for the presentation and information provided which would be incorporated into the Joint Committee's Final Report.

3. That the in addition to the submission of the Final Report to the Tees and Darlington's PCTs for consideration the report be also submitted to the constituent authorities' individual health scrutiny committees.

SWINE FLU BRIEFING

The Scrutiny Support Officer submitted a report the purpose of which was to introduce representatives of the local NHS to present a briefing around Swine Flu and particularly the steps taken to prepare for the challenges it would present.

Prof. Peter Kelly confirmed that whilst the incidence of swine flu had peaked as expected recent figures had shown a continuing reduction in the number of new cases. Reference was made to the current antiviral collection point based at Thornaby in comparison with the four centres made available at the peak period. Since mid August when daily numbers had been 680 as of yesterday the numbers had reduced to 51.

In view of the significant reduction in numbers the Strategic Health Authority had approved a reduction in opening times from 10.00 a.m. to 12 noon. It was confirmed however that a delivery service would still be provided for the elderly and those persons who did not have a flu friend.

Across the North East it was reported that there were five patients with swine flu in adult intensive care and no child was in paediatric intensive care. It was also reported that across the North East there were 35 patients with swine flu who had been admitted to hospital but initially with other conditions.

Reference was made to the immunisation programme which had been set nationally by means of the GP service involving persons in priority groups and healthcare workers including staff in care and residential care homes. Out of the 204 such homes 104 had so far been completed. A team had been set up to undertake the rolling programme which should be completed by the end of January 2010.

The Joint Committee was advised of proposals for the immunisation programme to extend in January 2010 to children up to five years of age. Should the number of people with swine flu significantly increase the most vulnerable such as children and the elderly would be immunised. All four PCTs in the area were in the highest group for take-up for staff being immunised with North Tees Hospital the second highest uptake and James Cook University Hospital the third highest uptake.

In response to clarification sought from Members, Prof. Peter Kelly confirmed that the service was being provided in accordance with current directives from the Department of Health and within the staffing resources available.

AGREED as follows: -

1. That Prof. Peter Kelly be thanked for the information provided.

2. That such information be disseminated to the constituent local authorities.

PERSONAL HEALTH BUDGETS

The Scrutiny Support Officer submitted a report the purpose of which was to introduce representatives of NHS Tees to present a report pertaining to a Personal Health Budgets Pilot to run from September 2009 to August 2012 with a minimum level of funding of £10,000 to successful sites to assist with the project management.

The Chair welcomed Peter Smith, Personalisation Manager, Stockton-on-Tees Borough Council

who
highlighted the key issues of Personal Health Budgets as outlined in a detailed briefing paper together supporting documentation, which had previously been circulated to Members.

The aim of the Personal Health Budget (PHB) pilot was to explore how the success of personalisation and individual budgets in social care could now be expanded and applied to a healthcare environment, to achieve better health and well-being outcomes for individuals whilst also evaluating what impact it may have on the traditional methods of healthcare service delivery.

The key objectives for the pilot were reported as: -

- To allow individuals to have more choice and control over their health and well-being needs.
- To facilitate a cultural change in both individuals and professionals towards how outcomes could be achieved.
- To stimulate flexibility and creativity towards the personalisation of service.
- To use the experiences of personal health budgets users to better inform and shape future commissioning intentions.
- To assist with World Class Commissioning by stimulating the market to ensure the demand for services was met.
- To seize the opportunity as one of the leading organisations nationally to be at the forefront of innovation and transformation.

The report outlined the process to be followed for the pilot programme and the detailed proposals for NHS Hartlepool and Stockton-on-Tees and NHS Middlesbrough and Redcar and Cleveland.

In terms of Hartlepool and Stockton-on-Tees pilot it was proposed to concentrate on Long Term Conditions (LTC) with a specific focus on adults with Continuing Health Care (CHC) needs. Obstructive Pulmonary Disease (COPD), Multiple Sclerosis (MS), Motor Neurone Disease (MND) and pain management issues.

Such condition areas had been selected for the following reasons: -

a) CHC was an area in which health and social care could be integrated to try and resolve the issues of inequity/loss of control that individuals may face when their health needs become more complex, causing social care direct payments to cease. It was reported that there were currently over 450 individuals receiving CHC over the two areas.

b) in terms of pain management both Practice Based Commissioning (PBC) groups in Hartlepool and Stockton were working to address such issues as part of the PBC Incentive Scheme. Hartlepool had one of the highest rates for pain procedures and evidence had shown that these resulted in poor outcomes.

c) In relation to COPD Hartlepool and Stockton both had prevalence rates above the national average and death rates from bronchitis, emphysema and COPD were at almost twice the England rate.

d) In terms of MS and MND there were approximately 400 individuals across Hartlepool and Stockton with MS and MND and there was current work being undertaken with the North East Neurological Society with which this pilot could complement.

It was intended for the pilot to focus on an initial cohort of 80 individuals in the first year (starting April 2010) with an additional 80 in each of years two (2011) and three (2012). As part of the 'in-depth' evaluation, a control group of individuals would also be needed of similar numbers.

It was proposed that the Middlesbrough and Redcar and Cleveland pilot would concentrate on Long Term Conditions (LTC) with a focus on Chronic Obstructive Pulmonary Disease (COPD) which had been selected for the following reasons: -

a) Both areas had prevalence rates above the national average and death rates from bronchitis, emphysema and COPD were at almost twice the England rate.

b) Patients with COPD were high users of acute hospital services including A & E.

c) Links to other COPD initiatives such as the use of telemedicine to promote/support self management to maintain people within their own homes.

d) PHB offered the opportunity to explore options that may support individuals with COPD to better manager their condition through more proactive and creative self-directed support.

The pilot would consist of a cohort of 20 individuals in the first year (2010) with a view to expanding the number of individuals within years two (2011) and three (2012).

Owing to current legislation the personal health budgets would be offered to individuals by means of a notional budget held by the commissioner (PCT) or through a third party brokerage option. Subject to a change in legislation direct payments may be used in future.

The report set out the principles of the PHB pilot. Although work on the pilot planning was still ongoing it was envisaged that the required thresholds for self-assessment would be achieved within the planned timescale of November 2009.

A Tees PHB Programme Board had been established to set the strategic direction for the pilots and to ensure consistencies were achieved across the Tees in relation to areas such as governance, workforce development and communication and engagement. Alongside the Board, North and South of Tees PHB Project groups had been developed to co-ordinate the necessary actions required for the local pilots. It was proposed to start the pilot by 1 April 2010.

A Communication and Engagement Plan had been developed for the project as outlined at Appendix 1 of the report submitted along with an outline communication and engagement action plan as shown at Appendix 2 of the report submitted. It was acknowledged that, as the main aim of the pilots were to provide the individual with more choice and control over their health and wellbeing, communication and engagement was crucial throughout every stage of the pilot planning.

As part of the planning activity, Equality Impact Assessments had been undertaken to identify how the pilot may impact differently on people within the diverse communities on Teesside.

The information and views gathered from engagement activity would be used to further shape the project plan and would inform the national pilot programme feedback.

It was noted that the Action Plan attached to the Community and Engagement Plan was a working document and would continue to be revised to take into account local circumstances.

Clarification was sought from Members as to what steps would be taken to stimulate the market suggesting that lessons could be learnt from local authorities social care in terms of the direct payments scheme. It was acknowledged that this was a key issue to be tackled and it was considered that a statutory service such as health is likely to be more difficult to implement than direct payments. Support would be required to assist in achieving a cultural change for both individuals and health professionals towards how outcomes could be achieved.

Given the complexities of the system and often ever changing circumstances of an individuals health condition Members questioned the extent of which the proposed overall scheme could be implemented. In response the Joint Committee was advised that the pilot scheme would evaluate how personal health budgets could be applied to a healthcare environment and the impact on well-being outcomes for individuals and on service delivery. Nevertheless the proposal for the pilot in respect of the NHS Hartlepool and NHS\Stockton to involve 80 individuals in the first year was seen as a challenge.

In terms of the financial arrangements it was explained that in view of the charging system social care direct payments were mean tested in comparison to health services which are free. It was

noted that legislation was awaited in relation to the financial arrangements which may enable direct payments to be used in the future. In response to Members' concerns of ensuring that the finance was directed to the needs of an individual as appropriate and specific to that person an assurance was given that suitable monitoring arrangements would be in place. In terms of determining the health costings and the notional budget to meet individual's needs it was acknowledged that this would be difficult and one of the main challenges across the UK.

In relation to the Communication and Engagement Plan with particular regard to the various LINk's groups it was noted that they had been forwarded a briefing paper and advised that of their future involvement once the pilot scheme had been formally approved.

AGREED as follows: -

1. That the representatives be thanked for the information provided which was noted.

2. That should the pilot scheme receive formal approval with an intended start of implementation in April 2010 an update report is provided to the Joint Committee after six months in October or November 2010.

3. That in the meantime the Joint Committee be advised as appropriate on the significant stages of the process.

MIDDLESBROUGH HEALTH SCRUTINY PANEL FINAL REPORT

In a report of the Scrutiny Support Officer details were provided of a Final Report of the Middlesbrough Health Scrutiny Panel in relation to Stroke Services in Middlesbrough.

It was noted that the subject had been included within the scrutiny work programme of the Panel following a suggestion from the South Tees Hospitals Foundation Trust.

NOTED

DATE OF NEXT MEETING

It was confirmed that the next scheduled meeting of the Tees Valley Health Scrutiny Joint Committee would be held on Monday 11 January 2010 at 10.00 a.m. in the Mandela Room, Town Hall, Middlesbrough.

NOTED AND APPROVED

ANY OTHER BUSINESS – CARE QUALITY COMMISSION

Reference was made to the Care Quality Commission, which had been set up in April 2009. It was suggested that it would be useful if a representative could be invited to attend a future meeting of the Joint Committee and brief Members on their role and objectives.

NOTED AND APPROVED