TEES VALLEY HEALTH SCRUTINY JOINT COMMITTEE

A meeting of the Tees Valley Health Scrutiny Joint Committee was held on 17 January 2011.

PRESENT: Representing Darlington Borough Council:
Councillor Newall,

Representing Hartlepool Borough Council:
Councillor Cook

Representing Middlesbrough Council:
Councillor Cole

Representing Redcar & Cleveland Council:
Councillors Carling, Higgins and Mrs Wall (Chair)

Representing Stockton-on-Tees Borough Council:
Councillors Mrs Cains and Cockerill (as substitute for Councillor Sherris).

OFFICERS: A Metcalfe (Darlington Borough Council), J Walsh (Hartlepool Borough Council), J Bennington and J Ord (Middlesbrough Council), M. Ameen (Redcar & Cleveland Council) and P Mennear (Stockton-on-Tees Borough Council).

**** APOLOGIES FOR ABSENCE** were submitted on behalf of Councillors Mrs Scott and Mrs Swift (Darlington Borough Council), Councillor S Akers-Belcher (Hartlepool Borough Council) and Councillors Sherris and Mrs Walmsley (Stockton-on-Tees Borough Council).

**** PRESENT BY INVITATION:** North East Ambulance Service:
Mark Cotton, Assistant Director of Communications and Engagement
Ann Fox, Director of Clinical Care and Patient Safety
Kyee Han, Medical Director

Tees Esk & Wear Valleys NHS Foundation Trust:
Marian Michie, Associate Clinical Director
Levi Buckley, General Manager Adult Mental Health South Tees.

**** DECLARATIONS OF INTEREST**

Name of Member	Type of Interest	Item / Nature of Interest
Councillor Mrs Wall	Personal/Non-Prejudicial	Agenda Item 4: The Capacity of Community Mental Health Services – Redcar & Cleveland MIND –Board Member.
Councillor Mrs Wall	Personal/Non-Prejudicial	Agenda Item 5: Changes to Ambulance National Targets - North East Ambulance Service NHS Trust – relative of a number of employees.

**** MINUTES**

The minutes of the meeting of the Tees Valley Health Scrutiny Joint Committee held on 13 December 2010 were submitted.

AGREED as follows: -

1. That the minutes of the meeting of the Tees Valley Health Scrutiny Joint Committee held on 13 December 2010 be approved as a correct record.

2. That as part of the background papers to the agenda item for 17 January 2011 relating to the Capacity of Community Mental Health Services with particular regard to the minutes of the Joint Committee dated 11 October 2010 under apologies for absence on the first page it be noted that it should read Councillor Mrs Walmsley on the last line.

CAPACITY OF COMMUNITY MENTAL HEALTH SERVICES

The Scrutiny Support Officer submitted a report the purpose of which was to introduce representation from the Tees, Esk & Wear Valleys NHS Foundation Trust to provide further information in relation to the capacity of Community Mental Health services.

In order to assist deliberations the representatives had been provided with a series of questions prior to the meeting based on a number of issues previously raised by the Joint Committee.

From the outset the representatives confirmed that additional statistical information would be provided relating to the number of community treatment orders. It was acknowledged that whilst community treatment orders had resulted in an increased workload for community teams it was important to recognise that improvements had been achieved including reduced lengths of hospital stays.

In overall terms it was pointed out that the number of community treatment orders was higher than originally expected nationally which was currently being investigated.

It was noted that one consequence of community treatment orders was the complexities around the recall of patients to hospital. In response to a Members' enquiry it was confirmed that a consultant could make a decision for a person to cease being the subject of a community treatment order. An indication was given of the number of re-admissions into Roseberry Park for the period April to December 2010 and for different lengths of stay further details of which could be provided. Such information would be used for comparative purposes and assist in securing further improvements.

Members sought clarification on current monitoring procedures and assurances that appropriate measures would be in place in the future. In response it was confirmed that the Trust regularly met with Commissioners at a local and strategic level to discuss service provision and monitor performance and quality outcomes. In terms of future commissioning arrangements the pace at which such changes were being made had caused some concerns. Reference was made to the Pathfinder programme with particular regard to Redcar and Cleveland, which had been selected as one group of GPs in the North East to take on commissioning responsibilities as part of the Government's plans. Such groups would be working together on areas such as commissioning services for patients direct with NHS organisations and local authorities. Bearing in mind the complexities of the service it was hoped that a consistent approach could be adopted given the likelihood of there being several GP Consortia across the Tees Valley with possible variations around commissioning in different localities.

The new model of care and approach with subsequent reduced lengths of stay in Roseberry Park had resulted in improved processes including the interface between patients and how their cases were reviewed.

Members questioned whether or not there had been any significant increase in pressure on Crisis Teams. Improvements and developments had been made to the Crisis Team provision,

which was provided 24 hours and would continue to be reviewed. It was confirmed that whilst there was currently no major increase in pressure on the Crisis Resolution Teams they were involved in all appropriate meetings taking into account all circumstances and carers being involved as much as possible. All options were examined with admission to hospital being a last resort.

In response to a Members' enquiry involving a constituent's specific alcohol related problems and likely associated mental health behaviour an indication was given of the complexities around such an issue and different affects of alcoholism on mental health behaviour. The various specialist services and joint working arrangements in this regard were also referred to.

In commenting on early prevention services and hard to reach groups with specific regard to young persons reference was made to the responsibilities of the Children and Young People's Service which included the early intervention psychosis teams.

The Joint Committee's attention was drawn to the management structure a copy of which was circulated at the meeting which was now based on a function model rather than on a locality basis as previously operated. It was acknowledged that given the overall financial constraints the need to make efficiency savings was an important consideration. It was pointed out that management costs currently represented 2.8% of the overall budget.

AGREED that the local NHS representatives be thanked for the information provided.

AMBULANCE NATIONAL TARGETS CHANGES

The Scrutiny Support Officer submitted a report the purpose of which was to introduce representation from the North East Ambulance Service (NEAS) to provide a briefing relating to the changes to performance targets for Ambulance Trusts.

With effect from April 2011 a set of national clinical performance indicators would be introduced. The current four hour waiting time standard for A and E would be replaced with a set of eight new clinical quality indicators across five clinical areas that promoted quality and patient safety. It was noted that time would still be measured as part of the new clinical quality indicators as it was a significant risk factor for treating patients but would no longer be the only factor. It was also indicated that such indicators would assist in comparing quality of care delivered across Trusts and shared good practice.

The Joint Committee was advised that the new indicators would include: -

- 'time to full initial assessment'– providing an incentive to assess patients quickly so that clinicians can prioritise the patients that require rapid treatment instead of simply who has been waiting the longest; and

- ''unplanned re-attendance' – encouraging the NHS to look at whether patients receive the best care first time round so that repeat visits to A and E are avoided.'

The Category B, 19 minute response time target for ambulances (serious but not life-threatening) would be replaced with a set of 11 new clinical quality indicators which was intended to improve quality and safety of care by focussing on those groups of patients with the greatest clinical need rather than according to the categorisation of call alone.

Ambulance services would still be required to respond to 75% of all category A (immediately life-threatening) patients within eight minutes and, where needed, to provide transport to such calls within 19 minutes.

The clinical quality indicators had been designed to examine the whole patient care pathway and to encourage discussion in the local NHS about how care could be improved.

Details were provided of the indicators across the five clinical areas of STEMI (ST elevated Myocardial Infarction (Heart Attack)); cardiac arrest; stroke; hypoglycaemia (diabetes)); and asthma.

Information was given of the eleven clinical quality indicators to be measured from April 2011 in respect of the following: -

(i) Service Experience;
(ii) Outcome from acute ST – elevation myocardial infarction (STEMI);
(iii) Outcome from cardiac arrest: return of spontaneous circulation;
(iv) Outcome from cardiac arrest to discharge;
(v) Outcome following stroke for ambulance patients;
(vi) Proportion of calls closed with telephone advice or managed without transport to A & E;
(vii) Re-contact rate following discharge of care;
(viii) Call abandonment rate;
(ix) Time to answer calls;
(x) Time to treatment by an ambulance-dispatched health professional;
(xi) Category A, 8-minute response time.

In commenting on the detail of the indicators Members referred to the various categories under the heading of exceptions with particular regard to circumstances where it is noted that a 'patient refused'. In response an assurance was given that much work had and was being undertaken around such issues in accordance with the Mental Capacity Act.

Members sought clarification as to whether or not there were adequate follow-up measures in place in respect of those cases where a patient had not attended an appointment with a GP. It was confirmed that at such a stage the duty of care would be handed back to GPs and it would be a matter for Primary Care Trusts to examine.

In discussing the proposed quality indicators it was acknowledged that one of the challenges would be the indicator in respect of Service Experience with particular regard to how and at what stage such information was sought. Reference was made to work being undertaken with regard to patient experience questionnaires although it was recognised that in emergency and complex medical circumstances this would be very difficult.

AGREED that the local NHS representatives be thanked for the information provided.

OUT OF HOURS SERVICE

Further to a meeting of the Joint Committee held on 8 November 2010 and in a report of the Scrutiny Support Officer the Joint Committee was advised of additional information provided by NHS Tees about certain aspects of the Out of Hours Service. Members had been keen to seek an assurance that people unable to communicate articulately, for whatever reason would not be disadvantaged or exposed to 'an inferior service' when going through the telephone triage system.

The attention of the Joint Committee was drawn to the response received from NHS Tees a copy of which had previously been circulated.

NHS Tees had recently procured a new integrated Out of Hours service for Tees, which aimed for everyone in Teesside to have access to comprehensive Out of Hours care that would be safe, accessible and delivered through a fully integrated approach using the range of health and social care services available on the community setting. Northern Doctors Urgent Care (NDUC) had been awarded the contract. The service commenced in Hartlepool from 1 November 2010 and would be mobilised across the remainder of the Tees from 1 February 2011.

Taking into account the requirements of the Disability Discrimination Act 1995 NDUC had confirmed that they wished to promote equal access to its service and would ensure that the telephone services provided for all users were as effective as those provided for people who made voice calls.

A capacity and access management system was operated which included a continuous audit of patient demand patterns. Such information was used to deploy a flexible available pool of health care professional resources to ensure all service access requirements were met.

NHS Tees were fully supportive of the Commissioner's ambitions to establish a fully integrated service accessible via one telephone call the number of which was a 0300 number. Wherever possible patients/carers would be 'hot transferred' directly to a clinician thus avoiding the unnecessary wait, possible distress and inconvenience of a call back.

NDUC Out of Hours service currently had typetalk compatible phones and a text phone to enable deaf patients to access the services. It was also noted that language lines could be used to facilitate a three-way discussion with the patient and relevant interpreter.

All front line staff undertook a full induction programme, which incorporated 13 key modules details of which were outlined in the report. Staff were trained to manage the full range of complex calls in to the service and to ask for support and guidance where they felt they were uncertain. The staff training included knowledge of and sensitivity to disabilities such as Special Patients procedure and effective management of patients with communication difficulties and learning disabilities.

In commenting on the information provided Members specifically referred to and welcomed one of the developments in the service as outlined in Appendix 1 of the report which stated that all patient facing documentation and publicity would be written in clear English in black and on white paper for ease of understanding. It was acknowledged that in considering many of the previous NHS documentation the Joint Committee had indicated the importance for such material to be in clear English and for it to be visually easy to read.

AGREED as follows: -

1. That the information provided be noted.

2. That the Joint Committee's comments and congratulations in respect of the statement given in Appendix 1 of the report submitted about layout and design of future documentation be forwarded to NHS Tees.

DEPARTMENT OF HEALTH POLICY PUBLICATIONS

In a report of the Scrutiny Support Officer the Joint Committee was advised of a number of policy documents recently published by the Department of Health covering Public Health and the implementation of the Equity & Excellence White Paper.

Reference was made to Healthy Lives, Healthy People a Public Health White Paper released by the Department of Health on 30 November 2010.

One of the main proposals involved the transfer of public health duties from Primary Care Trusts to local authorities and the creation of a Director of Public Health post within the local authority. In partnership with the new Public Health Service it was estimated that there would be ring-fenced funding of around £4billion for public health.

It was noted that local government would have a much greater role to play in the assessing of local public health need, developing strategies to meet those needs and commissioning appropriate services. A copy of the White Paper's Executive Summary was provided at Appendix 1 of the report submitted.

It was reported that on 14 December 2010 the Government published its response to the Consultation process and outlined its reform intentions in a document entitled Liberating the NHS: Legislative Framework and Next Steps. The Next Steps document outlined the Government's reform intentions across a wide range of NHS and health service related fields. The document outlined how the consultation process had developed Government plans and gave an indication of the most substantial changes to the proposals.

The Joint Committee acknowledged that health overview and scrutiny would be given a strengthened role with increased powers to hold to account any agency in receipt of NHS funds for the provision of NHS services.

It was also pointed out that Health and Wellbeing Boards would become statutory features of local governance. It was intended that the impending health and social care bill 'will provide flexibility for health and wellbeing boards both between and within local authority areas.'

There would be a duty on GP Consortia to participate in the work of local health and wellbeing boards by requiring them to be members. A key aspect of the work of such Boards would be the creation and publication of the Joint Strategic Needs Assessment which would 'provide an objective analysis of local current and future needs for adults and children assembling a wide range of quantitative and qualitative data including user views. In the future it would be a joint responsibility between health and wellbeing boards and GP Consortia and not PCTs and local authorities as currently arranged.

Members' attention was drawn to the section in Next Steps document specifically related to health scrutiny entitled Referral and Enhanced Scrutiny. The Government had stated that it proposed to give local authorities a new freedom and flexibility to discharge their health scrutiny powers in the way they deemed to be the most suitable, whether through a specific health overview and scrutiny committee or through an alternative arrangement. To enable such flexibility, the Bill would confer the health and overview and scrutiny functions directly on the local authority itself.

Although it was noted that individual local authorities had indicated their intention to submit a formal response to the Public Health White Paper, Healthy Lives, Healthy People it was confirmed that the same opportunity was available to the Joint Committee.

AGREED as follows:-

1. That the report outlining policy documents recently published by the Department of Health be noted.

2. That a formal response on behalf of the Joint Committee be not submitted in respect of the Public Health White Paper, Healthy Lives, Healthy People.

DATE OF NEXT MEETING

It was confirmed that the next meeting of the Tees Valley Health Scrutiny Joint Committee was scheduled for Monday 7 February 2011 at 10.00 a.m. in the Mandela Room, Town Hall, Middlesbrough.

NOTED AND APPROVED

ANY OTHER BUSINESS – FLU VACCINATIONS

With the approval of the Chair and Joint Committee and given the current urgency of the matter reference was made to a request for information to be provided at the next meeting of the Joint Committee with regard to the current position in respect of the flu vaccination programme.

Concerns had been expressed regarding recent incidences as reported in the media and in view of this a request had been made for clarification of local circumstances and how the current scenario would help future winter planning.

AGREED that Prof. Peter Kelly, Executive Director of Public Health, NHS Tees be invited to attend the meeting of the Joint Committee to be held on 7 February 2011 to outline the current position with regard to the flu vaccination programme.