MINUTES OF HEALTH SCRUTINY COMMITTEE MEETING –
WEDNESDAY, 28 SEPTEMBER 2016

Present:

Councillor Hobson (in the Chair)

Councillors

Callow	I Coleman	O'Hara
Mrs Callow JP	Elmes	

In Attendance:

Mr Roy Fisher, Chairman, Blackpool Clinical Commissioning Group (BCCG)
Ms Yvonne Rispin, Director of Ambulance Commissioning, BCCG
Ms Jeannie Harrop, Senior Commissioning Manager, BCCG
Mr Mark Newton, Consultant Paramedic and Head of Service, Urgent Care, North West Ambulance Service (NWAS)
Mr David Rigby, Sector Manager, NWAS

Dr Arif Rajpura, Director of Public Health
Ruth Henshaw, Corporate Development Officer
Sandip Mahajan, Senior Democratic Governance Adviser

1 DECLARATIONS OF INTEREST

There were no declarations of interest on this occasion.

2 MINUTES OF THE LAST MEETING HELD ON 6 JULY 2016

The Committee agreed that the minutes of the Scrutiny Committee meeting held on 28 September 2016 be signed by the Chairman as a true and correct record.

3 PUBLIC SPEAKING

The Committee noted that there were no applications to speak by members of the public on this occasion.

4 EXECUTIVE AND CABINET MEMBER DECISIONS

The Committee noted that the Health and Wellbeing Strategy had been approved at the Council meeting on 21 September 2016. At the Executive meeting on 12 September 2016, Healthwatch Blackpool had expressed concern that tackling mental health was not a priority in the Strategy. Healthwatch had been informed that the Strategy sufficiently incorporated mental health. Also in view of an expected Health and Wellbeing Strategy for Lancashire, the performance monitoring framework had not been set but delegated to Dr Arif Rajpura, Director of Public Health to develop so Members could have an interest in the progress with the Lancashire Strategy development and Blackpool monitoring framework. Dr Rajpura confirmed that work was in still progress for the Lancashire Strategy and local monitoring framework.

Progress with implementing the Public Health Scrutiny Review recommendations and Health and Wellbeing Strategy Action Plan plus effectiveness of outcomes of both areas would be monitored through the Committee's Work Programme.

The Chairman referred to PH57/16, tendering of a new Integrated Clinical Recovery, Drug and Alcohol Treatment Service, and asked if the target £200k saving was built into the tender specification. Dr Rajpura confirmed that the tender required a minimum saving of £200k, with a single contract supplier, 'Prime Provider' model. The current provider, Horizon incorporated three sub-providers: Alcohol and Drug Services (ADS), Delphi for clinical health support and Renaissance for recovery support. The creation of one provider would simplify and streamline management structures, communications and performance management.

In response to questions from the Committee in relation to any impact on service delivery and reinvestment potential, Dr Rajpura advised that as the £200k savings related to management and office costs, he anticipated that there would be no service impact, although there would still be a £1.5million budget pressure.

5 FORWARD PLAN

The Committee noted that there were no items on the Forward Plan, October - December 2016 on this occasion within the portfolio of the Cabinet Secretary, Councillor Graham Cain relating to health scrutiny functions.

6 COUNCIL PLAN PERFORMANCE REPORT - QUARTER ONE, 2016-2017

Mrs Ruth Henshaw, Corporate Development Officer reported on key performance indicators (KPIs) April-June 2016 in relation to three groups - opiate drugs users, non-opiate drug users and alcohol users - and the percentages (%) of these substance users successfully completing treatment. She explained that for the drug users the KPIs included not re-presenting within six months. There had been steady progress with all three KPIs.

Mrs Henshaw referred to the 6 July 2016 meeting when the Committee had requested details of why there was significant difference in progress between the opiate and non-opiate users. Explanatory commentary had been added to the performance report.

Dr Rajpura referred to opiate users' success rates which were below the national target and explained that the KPIs for all drug users focused on the clinical health stage but took no account of sustained recovery. He suggested that as people did relapse without further support a better approach would be to focus on providing real recovery, i.e. recovery rates sustained for at least six months after clinical support.

Dr Rajpura went to explain that many opiate users faced deep-rooted complex conditions, and that although some users did successfully recover, the KPI had been easier to achieve previously with more manageable clients.

The Committee queried the life expectancy of drug users and Dr Rajpura explained that

locally and nationally there had been an increase in deaths caused by drugs related use. Around 50% of opiate users did eventually recover. However, there were a high percentage of opiate drug users that never recovered and died usually quite young e.g. before they reached 30 years old. In recent years, the purity of drugs such as heroin had caused a number of early deaths. Around 50% of opiate users died due to the drugs. Older opiate users would also face other health issues and their problems were another reason in the national rise in deaths.

Councillor Maxine Callow enquired how long an opiate user might be prescribed methadone. Dr Rajpura stated that methadone prescriptions might run for two years or more. In reality, many opiate users would still be on methadone when they died. He added that the very low expectancy for drug users, i.e. 30-40 years old, meant a low local life expectancy rate overall of just over 75 years.

In response to a question on drug users with multiple problems Dr Rajpura referred to the integrated service approach which would support many users with complex problems. He added that alcohol treatment had proven challenging and the new integrated approach would use more effective specialist support for each of the alcohol and drug areas.

With regard to integration into society, Dr Rajpura explained that it was important to focus on ensuring that some opiate users did recover and were supported through a range of wider long-term initiatives, e.g. to aim for homes, skills and employment, reducing social isolation and friendship. He highlighted the Camerados Café which had been introduced into Blackpool Library and had proven highly successful in supporting people including not only coming off drugs but finding activities, jobs and even starting businesses.

In relation to awareness raising of the risks of drugs and alcohol, Dr Rajpura confirmed that there were public health campaigns particularly targeted at young people including supporting schools with health education and wider awareness information. There were particular recent projects such as Better Start supporting parents and young children and Head Start to support teenagers build resilience.

The Chairman referred to the five KPIs that were only reported upon annually and enquired whether in-year progress could be reported if there were issues, i.e. an assurance check that there would no significant end-of-year under-performance. Dr Rajpura confirmed that work in all areas was on-going with regular performance management.

The Chairman asked why some KPIs were only measured against the previous year, which might be starting from a low base, but had no specific targets. He also suggested that actual numbers for each KPI would be useful in providing better context. Dr Rajpura agreed that there could be percentage targets for each year with numbers added in.

The Committee agreed that the Health Key Performance Indicators should all have specific targets for monitoring progress and actual performance numbers alongside percentages.

7 NHS BLACKPOOL CLINICAL COMMISSIONING GROUP - NEW MODELS OF CARE UPDATE

**MINUTES OF HEALTH SCRUTINY COMMITTEE MEETING –
WEDNESDAY, 28 SEPTEMBER 2016**

Ms Jeannie Harrop, Senior Commissioning Manager, BCCG presented an update on implementation of New Models of Care (NMC). These concerned new approaches to health (and social) care across Blackpool and also across the Fylde coast and Wyre districts. The Committee noted that update followed a report in March 2016 to the Resilient Communities Scrutiny Committee had previously requested an update on funding ('Value Proposition') and NMC impact including patient stories of their NMC experiences. Ms Harrop explained that communications staff were developing more channels for patients to feed back.

Ms Harrop explained that Blackpool and neighbouring areas were one of fifty 'vanguard' areas nationally leading on NMC pilots following successful funding bids to NHS England. The NMC aimed to achieved integrated approaches to health and social care, more community and neighbourhood based care i.e. healthcare 'hubs', better use of technology and reduced costs.

Members noted that there were two Extensive Care Service (ECS) centres – Moor Park and South Shore – covering six neighbourhoods that provided support to people aged over 60, with a small range of long-term conditions. Teams of health and social care professionals were based at the hubs and aimed to support people better manage their conditions and reduce the need for hospital-based care.

The Chairman noted the successful overall progress including numbers of referrals and asked if there were any specific demonstrable evidence of targets. Mr Fisher stated that progress was in line with expectations including cost savings and keeping patients out of unnecessary hospital trips and that it was a long-term transformational programme.

Ms Harrop explained that funding criteria limited the range of conditions that could be considered. Patient choice was also important although there was still room to reduce the number of people choosing to leave ECS and a number of older people did not wish to join mainly due to misunderstandings that they would be de-registered with their GP or simply preferred to be treated by their GP. She added that more detailed ECS progress along with patient stories were included in the report appendices.

In relation to the IT system challenges of compatibility referred to in the detailed progress appendix, Mr Fisher explained that patient records systems needed to work with community systems and work was in progress to deliver the changes needed. Ms Harrop added that the changes would allow healthcare professionals to work in communities with hand-held devices.

Ms Harrop explained that although substantial funding of £4.32m had been secured recently to continue NMC work, the amount was far less than the £9.6m originally bid for. Therefore it had been necessary to substantially revise elements of the proposed programme although the ECS programme would be mainly unaffected.

The emerging Enhanced Primary Care (EPC) programme had had to be considerably revised. EPC would link in with ECS and would be rolled-out from October 2016 to provide health and wellbeing support for people with challenging long-term conditions aged over 18. A 'hub' based approach would be developed with GP referrals and professionals able

to directly respond to calls or sign-post registered patients.

The reduced funding meant less staff being recruited, instead staff would work more directly across various areas and more closely with operational partners such as NWAS. She added that the Care Home Team would be working more directly with all fifteen care homes fielding all healthcare calls.

In response to a question on whether there were sufficient Care Home Team placements, Ms Harrop explained that six staff were proposed at the current stage of the pilot. Often transfer delays occurred between care homes and hospitals so the proposed approach to directly manage call home calls would reduce the need for hospital transfers.

The Chairman queried the significant funding shortfall on the EPC outcomes sought. Ms Harrop confirmed that ECS had received all funding bid for but EPC had got less than half sought. Therefore a much more integrated approach to EPC would be required which included staff working across both schemes.

In relation to the effectiveness of multi-agency working and sharing information for patients' benefits, Ms Harrop stated that understanding about the schemes was still developing and would involve partners such as the voluntary sector, Fire and Rescue and occupational therapists.

The Committee noted that other integrated approaches were being undertaken including those set out in the Health and Wellbeing Strategy, 'one stop' hubs involving partners such as Blackpool Council and NWAS and work being undertaken with care homes including the use of telecare. Members noted that all ambulance crews had been trained and understood the health and wellbeing options including tackling issues such as social isolation and safeguarding people.

Ms Harrop confirmed that pathways remained open, e.g. if discharged from ECS the patient might then be accessing the EPC hub.

Dr Rajpura explained that episodic care was also community-based with community representatives working with the police, healthcare staff and other local services for example the Fire and Rescue Service used social care visits to look at wider health and wellbeing issues such as trip hazards and smoking. Mr Rigby added that opportunities were made to ensure access to community defibrillators, such as those in new build designs working with Blackpool Coastal Housing (BCH).

8 NORTH WEST AMBULANCE SERVICE PERFORMANCE REPORT FOR BLACKPOOL

Ms Yvonne Rispin, Director of Ambulance Commissioning, BCCG presented details of NWAS's annual performance for 2015-2016 and up to the end of July 2016.

Ms Rispin explained that BCCG was responsible for commissioning ambulance services across the region on behalf of all the thirty-three CCGs. In addition to Paramedic Emergency Services (PES) provided by NWAS, BCCG commissioned the NHS 111 contract (for non-emergency calls) and the five Patient Transport Services (PTS) for non-emergency transport. NWAS jointly delivered the 111 service and provided PTS to three county areas

including Lancashire. She advised that NWAS's annual budget totalled £320m of which £250m was for PES, £40m for PTS and £20m for NHS 111.

Ms Rispin referred to the headline national ambulance targets and NWAS' performance regionally and locally in Blackpool and explained the different call categorisation targets set out in the report.

In response to concern expressed that fast response vehicles were not always being available, Mr Newton stated that targets had to be pursued and vehicles deployed appropriately. He added that sometimes it was assessed that incidents were not critical and were downgraded. Ms Rispin added that there could be double-counting impacting upon targets, i.e. multiple callers for an incident but each having to be recorded separately.

Ms Rispin explained that although Red 1 and Red 2 performance were significantly challenging and that activity had increased by 13%, NWAS had the highest national performance for Red 1 and was second for Red 2. She added that there were various issues to manage such as frequent callers and patients with care plans.

Ms Rispin re-iterated earlier references to initiatives to divert people from unnecessary hospital trips, the pressure to 'turnaround' patients effectively at accident and emergency with 'knock-on' impact. She added that proposed clinical care hubs would prove effective in tackling various issues.

Members noted that during 2015-2016, there were over 1.217m paramedic call-outs requested of which Red 1 incidents accounted for 2.5% of the total, Red 2 for 39% and the remainder for 57.5%. Ms Rispin reported that from April to end July 2016, there had been 405k calls resulting in 402k incidents.

Regionally, NWAS came in at 74% for Red 1, 66% for Red 2 and 91% for Red 'All'. She emphasised that nationally ambulance services were struggling against ever increasing demand. NWAS had experienced a rise of 13% for total Red activity but still had nationally the best performance for Red 1 and second best for Red 2. Performance in Blackpool was even better due to it being a densely populated area within a relatively small terrain.

The Chairman noted that Red 1 performance had been boosted by support from the Fire and Rescue Service but seemed an unreliable approach given that Fire and Rescue would also have their own pressures. Mr Newton explained that often the Fire and Rescue Service would arrive first at incidents so might be in a position to give immediate aid. There were 2,300 such incidents in 2015-2016 which amounted to under 1% of all incidents. Ms Rispin clarified that the support was not usually included in the performance figures. However, Red 1 performance had been at 74% which was just short of the 75% target required to secure 20% of the quality performance funding premium from NHS England. Therefore NHS England accepted that the 75% target had been achieved by including the additional support and £7.5m funding was secured.

The Chairman referred to a recent article in the Lancaster Post which had reported significant staffing issues with ambulance crews experiencing severe degrees of stress and

low morale. Mr Rigby stated that staff turnover was low although it was recognised that ambulance crews undertook a lot of training and were highly specialised roles which were much more complex than in previous years. He added that demand for ambulances had increased significantly in recent years and therefore a range of health and wellbeing support was in place to support staff Furthermore patient treatment options needed to be considered other than hospital trips which might not be necessary.

Ms Rispin explained that a number of initiatives had been developed to tackle the growing demand to identify whether earlier alternative options were ~~better~~ more effective than transporting people to hospital. Members noted that the 'Hear and Treat' service had managed 11% of calls by ascertaining whether a vehicle was needed and offering telephone advice 'See and Treat' required observations at the scene which led to no need for hospital trips and alternative support amounting to 22% of people. The remaining tier was 'See, Treat and Convey' which meant taking people to hospital and was 67% of patients. Mr Newton added that GPs' awareness of care plans and the need to avoid hospital admissions unless required was also helping manage pressures. Mr Rigby referred to other initiatives such as community defibrillators as a valuable resource in saving time, costs and ultimately lives.

Ms Rispin clarified that whilst overall demand and activity had increased, the number of trips required to go to hospital had reduced. However, if demand pressures grew then as well as the current initiatives further consideration would need to be given to use of resources and further options.

Ms Rispin referred to the 'knock-on' demand pressures particularly with demand also rising in accident and emergency hospital wards. There was a handover and turnaround time of 30 minutes for hospital crews to pass on patients to clinical hospital staff. The same time requirement applied to acute hospital trusts to ensure space was made available to take patients. Fines could be imposed on the ambulance and acute trusts for breaches of time. Times were averaging 35 minutes for the North West but concordat agreements were being developed to press the time down.

The Committee noted that the NHS 111 service was for non-emergency calls and incorporated an advice line for patients including sign-posting to the right care service. The current five year contract started in 2015. There were four KPIs relating to prompt call answering and, where appropriate, ensuring callers were directly transferred to clinicians. Most 111 calls resulted in primary care non-emergency services with 14% requiring an emergency vehicle. There were plans to build a 'virtual' call centre hub.

PTS was generally for pre-booked services with 2.2m patients carried annually for routine journeys Monday to Friday. There were five KPIs devised by BCCG for planned trips relating to answering calls in good time, maximising eligible bookings, waiting time for vehicles and travel time. Unplanned bookings could be at short notice and including weekends and bank holidays. Enhanced priority service trips were for renal and oncology treatment with more enhanced KPIs.

NWAS' PES coverage was geographically the largest in the country covering urban and rural areas with the second greatest population of 7.5m people. Patients were delivered to twenty-three acute hospital trusts including mental health sites. There were eighteen

out-of-hours (OOH) services.

Ms Rispin referred to transformational work which also linked to NMC. There had been a national review of urgent and emergency care. A single pathway of service was being created which would be co-ordinated through clinical care hubs.

The Committee queried how the emergency services' Red 1 and other Red targets would be achieved in the event of a major incident and the impact on the wider community. David Rigby explained that all the emergency services and other key partners, including hospital trusts, ambulance services and health centres, had emergency plans, including cross border plans and undertook exercises. He highlighted the Cumbrian floods earlier in 2016 as a good example of major emergency co-ordination. There were various other initiatives such as 'night safe havens' offered by local authorities and open to visitors affected and he added that resources could be freed up such as the NHS 111 service.

With regard to a question of major incidents at local hotels, Mr Rigby replied that the Fire and Rescue Service deployed a lot of resources and sometimes only specific agencies were required.

The Committee referred to charges for PTS and how the system was managed for patients using PTS from outside the area. Ms Rispin explained that patients were not charged, but were directed towards the most appropriate form of transport based on their needs and that cost-effectiveness was considered, for example oxygen support might be needed or a taxi might be the best option. She added that patient choice and GP referrals from outside the area needed to be included in the criteria for use of PTS.

9 HEALTH SCRUTINY COMMITTEE WORKPLAN 2016-2017

The Chairman referred to the Health Scrutiny Workplan for 2016-2017 and progress with the implementation of recommendations. The Chairman informed the Committee that the scheduled winter planning report, agreed at the last meeting, had not been produced. Mr Roy Fisher, Chairman, Blackpool Clinical Commissioning Group (BCCG) stated that national guidance from NHS England had been received recently. The winter planning needed to incorporate guidance requirements so an up-to-date report would be available for the Committee's December 2016 meeting

The Chairman added that the Care Quality Commission (CQC) had undertaken a recent inspection of a local GP health centre, Grange Park, which had resulted in a poor inspection and improvement plans being required, which would involve ongoing support from NHS England and BCCG with contingency plans. Members noted that the CQC were monitoring progress with a re-inspection due in October 2016 and therefore agreed to consider an update at the December 2016 meeting.

The Committee agreed:

1. To approve the Scrutiny Workplan subject to the inclusion of a progress update concerning improvements at the Grange Park Health Centre at the December 2016 meeting.
2. To note the 'Implementation of Recommendations' table.

10 DATE AND TIME OF NEXT MEETING

The Committee noted the date and time of the next meeting as Tuesday 29 November 2016 in Committee Room A, Blackpool Town Hall.

Chairman

(The meeting ended 8.15 pm)

Any queries regarding these minutes, please contact:
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