MINUTES OF HEALTH SCRUTINY COMMITTEE MEETING - WEDNESDAY, 6 JULY 2016

Present:

Councillor Hobson (in the Chair)

Councillors

Callow	I Coleman	Hutton
Mrs Callow JP	Elmes	

In Attendance:

Councillor Graham Cain, Cabinet Secretary for Resilient Communities

Mr Roy Fisher, Chairman, Blackpool Clinical Commissioning Group
Mr David Bonson, Chief Operating Officer, Blackpool Clinical Commissioning Group
Ms Pat Oliver, Director of Operations, Blackpool Teaching Hospitals NHS Foundation Trust
Mr Ian Ellwood, Discharge Manager, Blackpool Teaching Hospitals NHS Foundation Trust
Mr Steven Garner, Service Manager, Healthwatch Blackpool

Mrs Lynn Donkin, Public Health Specialist
Mrs Liz Petch, Public Health Specialist
Mrs Ruth Henshaw, Corporate Development Officer
Mrs Sharon Davis, Scrutiny Manager
Mr Sandip Mahajan, Senior Democratic Governance Adviser

1 DECLARATIONS OF INTEREST

There were no declarations of interest on this occasion.

2 PUBLIC SPEAKING

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

3 EXECUTIVE AND CABINET MEMBER DECISIONS

The Committee noted that there were no Executive or Cabinet Member decisions on this occasion.

4 FORWARD PLAN

The Committee considered the items contained within the Forward Plan, July - October 2016 within the portfolio of the Cabinet Secretary, Councillor Graham Cain relating to health scrutiny functions. The Committee requested an update on the 'Health and Wellbeing Strategy' and was advised by Councillor Cain that public consultation on the draft Strategy had concluded and the final draft would be considered for approval by the Health and Wellbeing Board on 20 July 2016.

5 PUBLIC HEALTH SCRUTINY REVIEW - FINAL REPORT

Mrs Sharon Davis, Scrutiny Manager presented the Public Health Scrutiny report. She explained that the Resilient Communities Scrutiny Committee, who had been previously responsible for health scrutiny, had undertaken a review following issues identified in the Public Health Annual Report 2014. The Annual Report had been a response to the Due North report in 2014 which had looked at regional health equity issues. She added that the scope of the review had been extended to include consideration of the Joint Strategic Needs Assessment which formed the main evidence base for the Health and Wellbeing Strategy. Review meetings had been held and Cabinet Members with relevant health responsibilities had been consulted.

Mrs Davis referred to the six recommendations contained in the report which would be considered by the Executive following the Health Scrutiny Committee meeting. She added that the Cabinet Secretary, Councillor Graham Cain would take into account any scrutiny comments.

The Committee agreed to approve the final report for consideration by the Executive.

6 COUNCIL PLAN PERFORMANCE REPORT 2015-2016

Mrs Ruth Henshaw, Corporate Development Officer advised that Council Plan key performance indicators (KPIs) had been set by the Corporate Leadership Team. The report covered performance for 2015-2016 in relation to health KPIs. These had previously been reported to the Resilient Communities Scrutiny Committee who had been responsible for health scrutiny functions.

Overall performance was good but there were three exceptions where performance was not on target. These were non-opiate drug users completing treatment successfully and sustaining progress; numbers of overweight children aged 10-11 years old and the percentage take-up of NHS Health Checks (adults aged 40-74 years old).

The Chair queried why there was a significant difference in non-opiate and opiate drug users completing treatment successfully and sustaining progress. Councillor Cain explained that a drugs strategy was being developed and suggested that detailed information could be provided for the Committee’s next meeting.

Members referred to tackling the problem of overweight children and raised concerns that vending machines selling unhealthy snacks were located in some health centres, and that with the high levels of tourism a large number of unhealthy snacks were readily available. The Committee also commented on the importance of parental responsibility and queried what work was being done with parents.

Councillor Cain noted the issue of overweight children and unhealthy snacks being sold in health centres and undertook to take the issue forward through the Health and Wellbeing Board. He added that there were various initiatives underway to support young people such as the Better Start Programme and the Head Start Programme supporting teenagers.

Mrs Lynn Donkin, Public Health Specialist explained that developing better health for people was a complex area with a range of work required. She gave the example of a

successful campaign 'Give up Loving Pop' (GULP) which had encouraged young people to give up fizzy drinks for at least a month. There was no direct work with parents although there were initiatives such as Better Start, an Outreach Strategy and healthy choices were promoted through an awards scheme for healthier catering. She added that the Council and partners had signed up to a 'Healthy Weight Initiative' and joint work had been developed through the Healthy Weight Steering Group.

Members queried why the percentage take-up of NHS Health Checks (adults aged 40-74 years old) had decreased. In response, Mrs Liz Petch, Public Health Specialist explained that this was mainly due to more accurate data recording at GP practices rather than a real drop in health checks. Some GPs had been recording health information in the wrong data fields but data quality had improved. She added that Blackpool was one of the top ten areas in the country for levels of health checks.

Members noted that one of the key projects in the 2015-2020 Council Plan period was the 'New Business District' which aimed to attract more professionals to work in Blackpool town centre. Members recognised that previously there had been an increase of professionals with a higher than average disposable income working locally and considered that professionals would have a positive impact on the wider wellbeing of the town.

The Chair queried how much confidence there was that red indicators would have improved for the next performance report in September 2016. In response, Councillor Cain explained that a lot of work needed to be undertaken in partnership and that all partners wanted to tackle areas of concern. He added that continuous improvement was always sought and best use needed to be made of resources including extra resource when viable.

The Committee agreed:

1. To receive detailed information on the significant difference in non-opiate and opiate drug users completing treatment successfully at the next meeting.
2. To receive an update from the Cabinet Secretary concerning progress with tackling overweight children with particular reference to unhealthy snacks being sold in health centres.

7 BLACKPOOL CLINICAL COMMISSIONING GROUP PERFORMANCE REPORT

Mr David Bonson, Chief Operating Officer, Blackpool Clinical Commissioning Group (BCCG) and Mr Roy Fisher, Chairman, BCCG presented the BCCG's performance report for March 2016 and for the full year, 2015-2016. Mr Bonson explained that the BCCG had to follow national reporting requirements and key target measures. The BCCG commissioned a range of services provided by other organisations and so shared performance responsibility. The key measures covered a range of access to service areas.

He highlighted areas where performance was below target and needed improving. The target for accident and emergency waiting times from arrival to being discharged after treatment was for 95% of patient visits to be achieved within four hours. The end of year outcome was under 93% and for March 2016 only around 86%. Mr Bonson explained that accident and emergency waiting times were nationally challenging and that winter

months had a knock-on impact for the rest of the year with ongoing efforts to regain performance. Members enquired about the two measures for types of accident and emergency attendance and requested more detailed information on the 'all types' of attendance measure. Mr Bonson explained that the walk-in health centre in Whitegate Drive, Blackpool offered a Tier 3 GP-led primary care service and this level of accident and emergency service had to be recorded separately and agreed to provide more detailed information following the meeting. Mr Fisher explained that the Tier 3 service at the walk-in centre on Whitegate Drive provided an important part of the care pathway including pointing patients in the right direction of care.

He added that urgent care systems were generally under pressure, e.g. ambulance emergency call-outs had increased. This had resulted in ambulance response times falling short on all targets for March 2016 and the full year 2015-2016 across Lancashire. Pressures were also seasonal with the greatest number of call-outs during the winter period. However, more recently figures were back on track for the Lancashire area.

Mr Bonson explained that although the performance report measures were for Blackpool, the BCCG was responsible for regional commissioning of the North West Ambulance Service (NWAS) and therefore the figures presented were for the wider area. It was noted that more localised performance figures demonstrated that the NWAS met targets within Blackpool and it was agreed that a more detailed discussion on the ambulance response rates in Blackpool would be brought to a future meeting.

Members sought clarification on the difference between two of the Category A red indicators which both required 75% of response times to be within eight minutes but were below target. Mr Bonson explained that the first red indicator was for life-threatening emergencies and the second red indicator for other extremely serious call-outs such as road traffic accidents. Members added that the public wanted reassurance that a good ambulance service was being provided and good work should be publicised.

Members enquired how Accident and Emergency services and ambulance services would cope with increased pressures particularly during the winter period and what planning was taking place. Mr Bonson explained that a multi-agency resilience group of key health and social care operational partners forecast pressures and reviewed resources and plans to manage pressures during winter and all year round. Specific winter planning started around September each year. Ms Pat Oliver, Director of Operations, Blackpool Teaching Hospitals added that summer months were often the busiest period for accident and emergency with the increase in visitors, events and festivals. Delays discharging patients also had a knock-on impact.

Mr Bonson referred to the provision of mental services with particular reference to improving access to psychological therapies (IAPT) and recovery rates for psychological therapies. The Chairman asked for clarification on the meaning of the various terms.

Mr Bonson explained that the therapies focused on counselling and other forms of 'talking' therapies. The first measure, upon which the others were developed, was complex and was a national estimate on the percentage of the local population expected to need to access mental health services and the local access target. The recovery rate was an important and challenging measure. Services were performing poorly at just over 35% recovery, which was well short of the 50% target. He explained that recovery could

only be deemed successful if a patient had made significant progress although this might not mean a full recovery. The Committee requested that full definitions of measures be circulated following the meeting.

Members noted that early intervention with young people could reduce longer-term mental health problems and asked how young people were supported. Mr Bonson explained that mental health provision for young people and adults was provided by different services. He agreed to provide information on the provision of mental health services including progress with recovery rates to a future meeting.

Mr Bonson added that a backlog of IAPT work had arisen but more recently progress had been made and performance was now above target. A new system had been developed whereby patients could self-refer to the right pathway, rather than through their GP, for less complex services such as counselling which meant bottlenecks were reduced by ensuring patients were in the right pathway queue.

The Chairman noted that the report covered a wide range of performance data but nothing on quality. In response, Mr Bonson confirmed that quality of care data was collected including complaints data and use of the 'Friends and Family' test for whether people would recommend a hospital service. Mr Fisher added that GPs had Patient Participation Groups which fed into collated datasets. Quality of care data was considered through the BCCG's Quality and Engagement Committee and quality assurance could be reported back to Members.

The Chairman queried the performance of waiting times for cancer treatment and why the ultimate target was not set at achieving 100% performance success. Mr Bonson explained that monitoring against the target commenced as soon as a GP referral was made for assessment by a hospital consultant. However, the monitoring of performance did not take into account individual delays. There were various reasons for delays including patient choice, assessments identifying unexpected health problems and 14 cancer groups with different pathways. Some forms of cancer could be tested for and identified relatively quickly whilst others were extremely complex. He added that the national targets had been developed based on robust evidence.

Ms Oliver explained that the Hospital Trust considered approximately 1,000 patients each day for cancer related issues and gave assurance that the progress of each patient was carefully tracked.

Members queried the impact of financial penalties referred to in the performance report. In response, Mr Bonson explained that there was a national requirement to impose penalties on providers missing performance targets, in particular waiting list targets. However, rather than just imposing punitive penalties on struggling providers the best use of funds for a more patient-focused approach was pursued. Mr Fisher explained that fines imposed on Blackpool service providers were reinvested in those services to promote improvement.

Mr Bonson and Mr Fisher were thanked for their report.

The Committee agreed:

1. To receive detailed information on attendance types of patients at Accident and

Emergency.
2. To receive a full performance report on the ambulance service including response rates from Blackpool Clinical Commissioning Group and the North West Ambulance Service.
3. To receive definitions on the various terms and measures used concerning improving access to psychological therapies (IAPT) following the meeting from BCCG.
4. To receive information from BCCG on the provision of mental health services including progress with recovery rates at a future meeting.
5. To receive a quality of care performance report from BCCG at a future meeting.

8 HEALTHWATCH BLACKPOOL - PROGRESS REPORT AND PRIORITIES

Mr Steven Garner, Service Manager, Healthwatch Blackpool presented Healthwatch's Impact Report 2015-2016 and draft priorities for 2016-2017.

He highlighted that Healthwatch had undertaken a wide range of review and survey work throughout the last year identifying the effectiveness of health and social care provisions mainly based on the views and concerns of local people using services. Subsequent reports had followed with a number of recommendations mainly directed at service providers. Responses had been sought from the providers concerning the recommendations with progress on actions was also sought.

The Chairman noted that some providers had not yet responded to recommendations and queried the reasons for the lack of response. Mr Garner considered that there were no serious issues as providers had generally welcomed review findings. He added that there was no legal duty requiring providers to respond but just to note recommendations.

Mr Garner explained that the annual report outlined the impact of Healthwatch's work and recommendations. He advised that notable recommendations taken on board by providers related to people's wellbeing including increased food rotas and choice and better activities co-ordination at care homes. Other key work had included reviewing urgent care provision and why people were not making the best use of accident and emergency services. The urgent care review had also led to the service provider apologising for a lack of information being provided to patients whilst waiting for services and without refreshments. The provider aimed to ensure improved patient awareness in future.

Mr Garner added that a particularly important finding was that the 'voice' of service users was not currently being taken into account for the strategic development and commissioning of services. This was an important issue that needed addressing given that development and commissioning of services ultimately impacted upon the services available and delivery of services.

Mr Garner explained that consultation had taken place seeking the public's views on health and social care priorities for 2016-2017. The consultation had identified five broad priority areas which would be refined. The priorities were GPs, hospital services, emergency services, adult mental health and care homes.

The Chairman referred to the previous agenda item, Public Health Scrutiny Report which

included a recommendation that Healthwatch should look beyond its approach of surveys for identifying people's concerns and adopt a greater focus on work promoting public health and tackling health inequalities. Mr Garner responded that Healthwatch did work with Public Health partners and closer working would be developed further, in particular taking into account the 'voice' of service users. He gave examples of public health work including being on a steering group to tackle tobacco and alcohol issues. Healthwatch had also been involved in developing the Joint Strategic Needs Assessment for identifying and tackling local priorities to produce the Health and Wellbeing Strategy.

Members noted that adult mental health services had been identified as a priority. Members expressed concern that children's mental health services had not been prioritised citing that issues such as young people's stress and anxiety had been recently prominent in the local press. Members emphasised that early help for young people could alleviate a lot of future health issues. Members commented that they were aware of recent issues with Children and Adolescent Mental Health Services (CAMHS), such as the time taken to access treatment and assessments.

Mr Garner responded that Healthwatch had undertaken a small review of CAMHS alongside a wider review of young people's wellbeing. Issues identified included the need to send reminders for appointments, parents' concerns not being acted upon, the length of waiting time and lack of support between appointments. Healthwatch was aware that changes were being made to CAMHS and would pursue outstanding issues but did not intend to undertake another review. He added that the Health and Wellbeing Strategy had particular sections on young people's wellbeing and other initiatives were ongoing such as Better Start.

The Chairman asked what the Healthwatch working relationship was with the Care Quality Commission (CQC). Mr Garner advised Members that Healthwatch was independent but adopted close working with the CQC, e.g. Healthwatch had awareness of the CQC's inspection reviews and that in return the CQC did consult with Healthwatch when undertaking inspections.

The Committee's comments would be considered by Mr Garner and he was thanked for his report.

9 DELAYED TRANSFERS OF CARE

Ms Pat Oliver, Director of Operations, Blackpool Teaching Hospitals (BTH) and Mr Ian Ellwood, Discharge Manager, BTH presented the Delayed Transfers of Care report. Transfers of care issues concerned delays affecting patients who had finished one stage of their treatment but then had to wait some time before bed facilities became available at the next stage. Transfers of care could be internal or external and could be to another health or social care provider. The next stage of care could be at a facility such as a care home or the patient's own home.

Ms Oliver outlined the wider background context of issues and pressures that could impact on patient discharge services. She referred to the earlier agenda item on the Blackpool Clinical Commissioning Group's performance report and issues concerning accident and emergency waiting times and ambulance response rates. She explained that 'front door' issues impacted upon 'back door' performance and vice-versa, for example a

patient unable to be transferred from a hospital bed impacted upon an accident and emergency patient. She added that there were three wards dealing with a range of patients with complex issues.

Ms Oliver explained that there many patients arrived in winter with respiratory diseases, heart attacks, infections and were generally frail and vulnerable people. There was a lot of pressure on local ambulance services due to much higher than average demand in Blackpool compared to regional neighbours.

Members requested if figures could be provided as to inappropriate use of ambulance services. Ms Oliver agreed to obtain inappropriate use figures from the North West Ambulance Service for a future meeting. She added that a joint piece of work was taking place with GPs concerning out-of-hours services with a view that GPs could direct appropriate cases to hospital in good time rather than people unnecessarily using emergency services.

Mr Ellwood explained that there was a national performance dataset for measuring delayed transfers of care as presented in the report and appendices. Figures were for a five week period (one month) from 13 May 2016 to 13 June 2016. The recent five week period was compared against the parallel five week period in 2015.

Mr Ellwood reported that the number of delays for the five week period in 2015 averaged around 30 per week, which had risen to around 50 for the parallel period in 2016. He explained that the number of corresponding lost bed days, which had also risen, depended on the complexity of individual patients' needs and reasons for delays. There could also be other factors such as seasonal variation due to bank holiday pressures.

Ms Oliver added that delayed transfers of care, with patients still resident in wards unnecessarily, could potentially have an annual financial cost of up to £1million for each ward of 20 beds. There were 25 wards and the delays equated to the loss of two wards amounting to an annual cost of up to £2million. The current pressures creating delays reflected a national trend and Ms Oliver advised that it was important to work towards reducing the number of delays to closer to the previous year's performance of 30 delays per week.

Mr Ellwood referred to whether delayed transfers were due to health or social care services. He explained that delays could be due to issues within NHS healthcare services, social care services such as care homes or both. Delays had risen in all three service groups compared to the last year reflecting the total rise in delays. He added that whilst most delays still stemmed from healthcare services proportionately this had changed. Healthcare service delays had accounted for over half in 2015 but were now less than half with social care and joint service issues rising.

Members noted the significant increase in delays in 2016 compared to 2015 and national trends and queried if the trend was to continue how increased pressures could be managed in 2017. Mr Ellwood agreed that there were lots of pressures resulting in a worsening national trend. He referred to reasons for delayed transfers of care and highlighted that nationally several categories were used for reasons for delayed transfers. These included waiting for professional health or social care assessments, further NHS treatment, funding delays, waiting for care home packages or placements and community

equipment being unavailable. The different causes in delays had all risen over the last year reflecting the total rise in delays, in particular delays in professional assessments, waiting for further NHS treatment and patient choice of care home. He added that proportionately the largest increase in cause of delay had been patient choice.

Mr Ellwood added that traditionally delays had been mainly due to internal hospital reasons such as complex assessments. However, this had shifted more towards external factors across the private social care sector. The two main factors were complexity of patients' needs such as dementia and behavioural issues and being able to find the right environment for them and also demand against limited capacity. Enabling care at people's home was being promoted but capacity was limited locally and nationally. Capacity had increased for issues such as dementia but pressures were constantly growing.

Mr Ellwood referred to work that had taken place over the last 18 to 24 months to tackle the range of challenges. Internal processes had been improved such as identifying robust evidence for funding and reduced bureaucracy but further improvement was still needed. Ms Oliver gave an improvement example of electronic referrals and added that communication was important in order to identify omissions or agree solutions. Mr Ellwood added that more work was taking place with multi-disciplinary teams and that improvements could be made through increasing social worker presence at hospitals in view of the increasing complexity of patients' needs.

He also added that better links had been created with social and community services as well as health and social care commissioners of services. The links had resulted in regular meetings with social care managers and commissioners with all partners collectively looking at individual bottlenecks in care transfers and agreeing appropriate actions to tackle delays. Actions included identifying potential capacity and streamlined ways of working, consideration was also given to whether a patient needed to be in hospital.

Ms Oliver highlighted concerns that wider social funding cuts had a detrimental health impact through increasing social isolation. There was a growing elderly population who were particularly affected. There had been a debate across Lancashire concerning social care needs and funding pressures, in particular the costs of residential care homes. Blackpool Teaching Hospitals Trust was promoting better use of community services through community teams. Members agreed that cuts had had an impact but were always carefully considered.

The Committee's comments would be considered by Ms Oliver and Mr Ellwood and they were thanked for their report.

10 HEALTH SCRUTINY COMMITTEE WORKPLAN 2016-2017

The Chairman referred to the Health Scrutiny Workplan for 2015-2016 and progress with the Implementation of Recommendations. Members were informed that this was an initial outline Workplan which was evolving and aimed to focus on key strategic health issues and future health service plans. There were a range of actions to pursue following the earlier performance agenda item with Blackpool Clinical Commissioning Group (BCCG).

Members were informed that training seminars were being arranged with BCCG, Blackpool Teaching Hospitals and the Council's Public Health Team to learn more about their roles and work. Members were reminded that an additional meeting had been arranged on Wednesday 12 October 2016 to receive a progress update on issues at the Harbour care facility and improvements made.

The Committee agreed:

1. To approve the Scrutiny Workplan subject to the inclusion of the additional items identified for consideration with the Blackpool Clinical Commissioning Group.
2. To note the 'Implementation of Recommendations' table.

11 DATE AND TIME OF NEXT MEETING

The Committee noted the date and time of the next meeting as Wednesday 28 September 2016 commencing at 6pm in Committee Room A, Blackpool Town Hall.

Chairman

(The meeting ended 8.00 pm)

Any queries regarding these minutes, please contact:
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