North Yorkshire County Council

Agenda

Meeting: Scrutiny of Health Committee

Venue: The Grand Committee Room, County Hall, Northallerton DL7 8AD

Date: Friday 27 January 2017 at 10.00 am

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Business

1. Minutes of the Scrutiny of Health Committee held on 18 November 2016

(Pages 6 to 14)

2. Declarations of Interest

3. Chairman's Announcements - Any correspondence, communication or other business brought forward by the direction of the Chairman of the Committee.

(FOR INFORMATION ONLY)

- Joint Scrutiny of Health
- Mid Cycle Briefing update

4. Public Questions or Statements

Members of the public may ask questions or make statements at this meeting if they have given notice to Daniel Harry, Principal Scrutiny Officer (*contact details below)* no later than midday on Tuesday 24 January 2017. Each speaker should limit himself/herself to 3 minutes on any item. Members of the public who have given notice will be invited to speak:-

- at this point in the meeting if their questions/statements relate to matters which are not otherwise on the Agenda (subject to an overall time limit of 30 minutes);

Enquiries relating to this agenda please contact Daniel Harry on 01609 533531
or e-mail daniel.harry@northyorks.gov.uk
www.northyorks.gov.uk

- when the relevant Agenda item is being considered if they wish to speak on a matter which is on the Agenda for this meeting.

5. Sustainability and Transformation Plans – update - Report of the Scrutiny Team Leader (North Yorkshire County Council)

(Pages 15 to 27)

6. Transforming our Communities – mental health services – Report of Janet Probert (Hambleton, Richmondshire & Whitby CCG) and Richard Dalby (Tees Esk and Wear Valley NHS Trust)

(Pages 28 to 84)

7. Dying Well and End of Life Care - Report of the Scrutiny Team Leader (North Yorkshire County Council)

(Pages 85 to 129)

8. CQC Diabetes Review – overview of diabetes prevalence and responses – Report of Lincoln Sargeant and Clare Beard (North Yorkshire County Council Public Health)

(Pages 130 to 134)

9. Funding of Community Pharmacies – update on discussions at Mid Cycle Briefing on 16 December 2016 - Report of the Scrutiny Team Leader (North Yorkshire County Council)

(Pages 135 to 137)

10. Work Programme – Report of the Scrutiny Team Leader (North Yorkshire County Council)

(Pages 138 to 142)

11. Other business which the Chairman agrees should be considered as a matter of urgency because of special circumstances.

Barry Khan
Assistant Chief Executive (Legal and Democratic Services)

County Hall
Northallerton

January 2017

NOTES:

(a) Members are reminded of the need to consider whether they have any interests to declare on any of the items on this agenda and, if so, of the need to explain the reason(s) why they have any interest when making a declaration.

A Democratic Services Officer or the Monitoring Officer will be pleased to advise on interest issues. Ideally their views should be sought as soon as possible and preferably prior to the day of the meeting, so that time is available to explore adequately any issues that might arise.

(b) **Emergency Procedures For Meetings**

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Scrutiny of Health Committee

1. Membership

County Councillors (13)				
	Councillors Name	*Chairman/Vice Chairman*	*Political Party*	*Electoral Division*
1	ARNOLD, Val		Conservative	
2	BARRETT, Philip		NY Independent	
3	BILLING, David		Labour	
4	CASLING, Elizabeth		Conservative	
5	CLARK, Jim	Chairman	Conservative	
6	CLARK, John		Liberal	
7	DE COURCEY-BAYLEY, Margaret-Ann	Vice-Chairman	Liberal Democrat	
8	ENNIS, John		Conservative	
9	MARSHALL, Shelagh OBE		Conservative	
10	MOORHOUSE, Heather		Conservative	
11	PEARSON, Chris		Conservative	
12	SIMISTER, David		UKIP	
13	TROTTER, Cliff		Conservative	

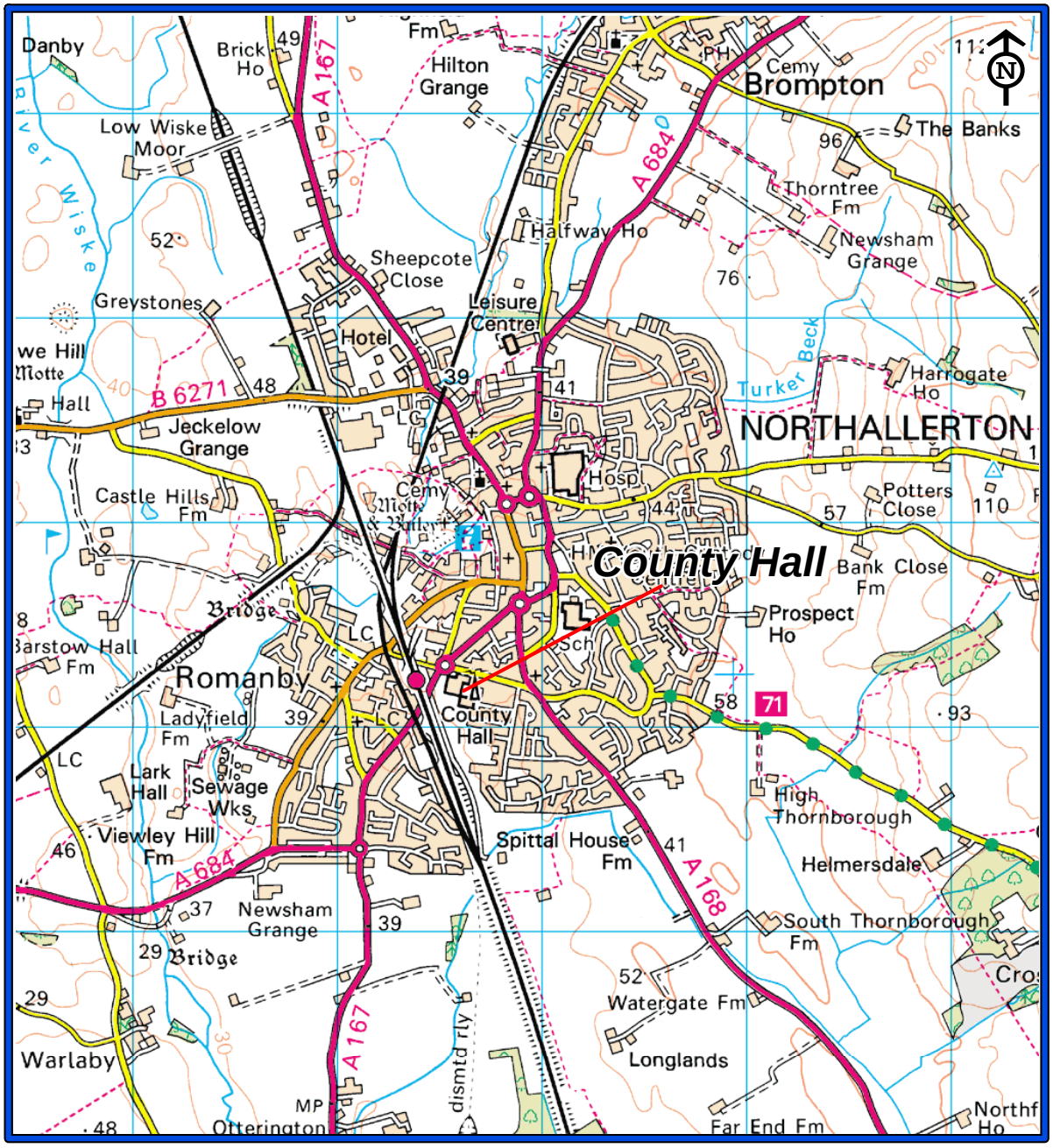
Members other than County Councillors – (7) Voting		
	Name of Member	*Representation*
1	HARDISTY, Kevin	Hambleton DC
2	CHILVERS, Judith	Selby DC
3	GARDINER, Bob	Ryedale DC
4	MORTIMER, Jane E	Scarborough BC
5	BROCKBANK, Linda	Craven DC
6	SEDGWICK, Karin	Richmondshire DC
7	GALLOWAY, Ian	Harrogate BC
Total Membership – (20)		**Quorum – (4)**

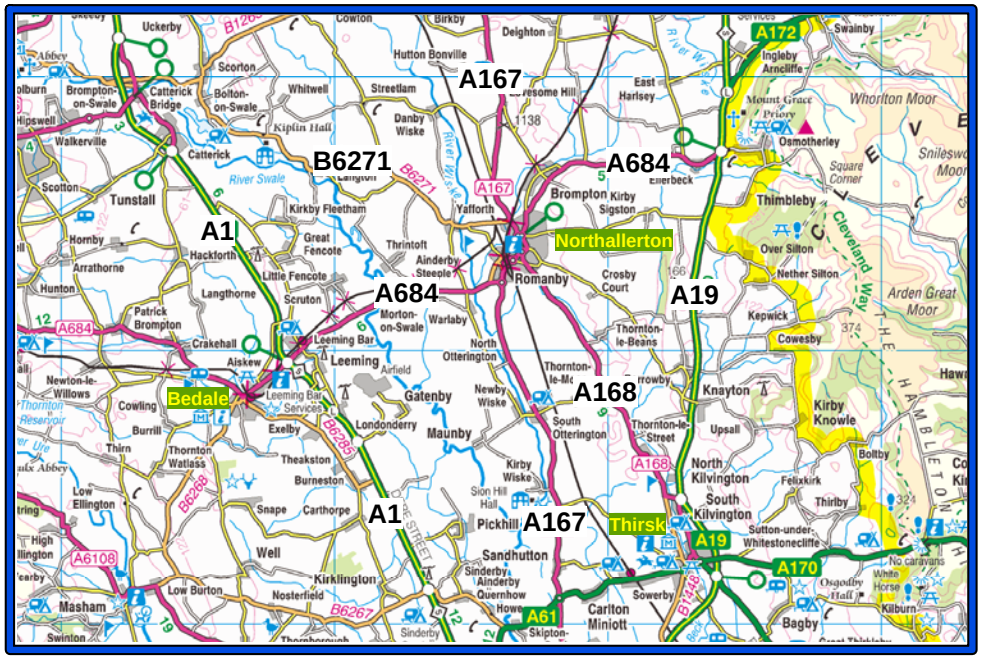
Con	**Lib Dem**	**NY Ind**	**Labour**	**Liberal**	**UKIP**	**Ind**	**Total**
8	**1**	**1**	**1**	**1**	**1**	**0**	

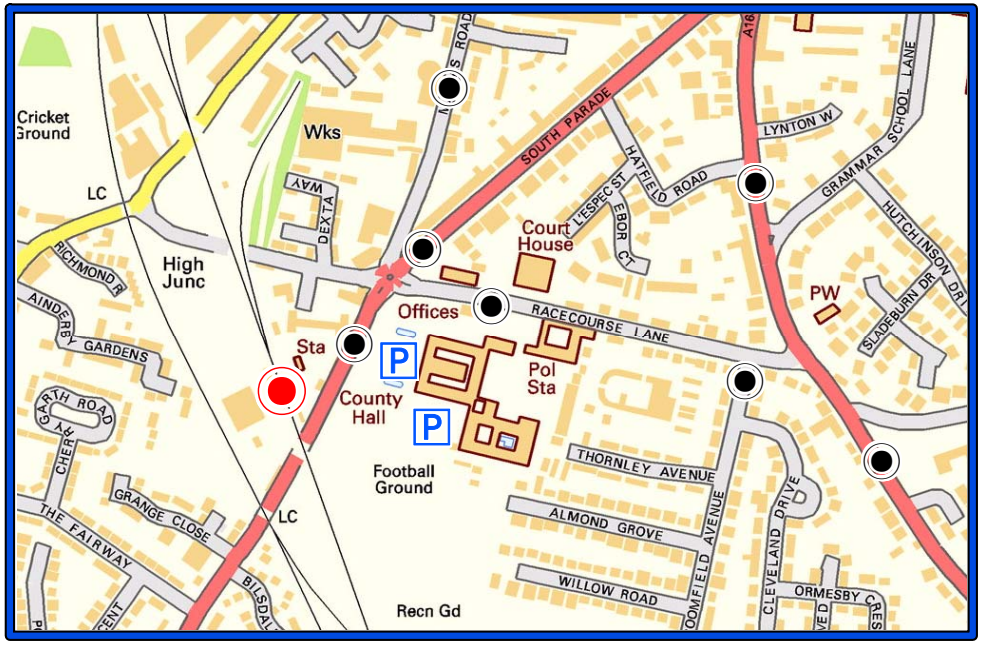
2. Substitute Members

Conservative		**Liberal Democrat**	
	Councillors Names		*Councillors Names*
1	HESELTINE, Michael	**1**	GOSS, Andrew
2	BUTTERFIELD, Jean	**2**	SHIELDS, Elizabeth
3	BASTIMAN, Derek	**3**	
4	SWIERS, Helen	**4**	
NY Independent		**Labour**	
	Councillors Names		*Councillors Names*
1	McCARTNEY, John	**1**	MARSHALL, Brian
2		**2**	
Liberal		**UKIP**	
	Councillors Names		*Councillors Names*
1	SAVAGE, John	**1**	

		Substitute Members other than County Councillors		
		1	VACANCY	(Hambleton DC)
		2	VACANCY	(Selby DC)
		3	SHIELDS, Elizabeth	(Ryedale DC)
		4	JENKINSON, Andrew	(Scarborough BC)
		5	HULL, Wendy	(Craven DC)
		6	CAMERON, Jamie	(Richmondshire DC)
		7	HASLAM, Paul	(Harrogate BC)







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North Yorkshire County Council

North Yorkshire County Council

Scrutiny of Health Committee

Minutes of the meeting held at County Hall, Northallerton on 18 November 2016.

Members:-
County Councillor Jim Clark (in the Chair)
County Councillors: Val Arnold, Philip Barratt, David Billing, John Clark, Margaret-Ann de Courcey-Bayley, Caroline Dickinson, John Ennis, Shelagh Marshall OBE, Heather Moorhouse and Chris Pearson.

Co-opted Members:-
District Council Representatives:- Judith Chilvers (Selby), Jane E Mortimer (Scarborough), Karin Sedgwick (Richmondshire), Ian Galloway (Harrogate) and Cllr Elizabeth Shields (Ryedale).

In attendance:-
South Tees Hospitals NHS FT: Barbara Stoker, Director of Integrated Therapies
Hambleton Richmondshire & Whitby CCG: Janet Probert, Chief Officer and Abigail Barron, Head of Strategy/Community Care
Tees Esk & Wear Valleys NHS Trust: Martin Dale, Strategic Project Manager and Brian Coupe, Head of service for Mental Health Service
Vale of York CCG: Elaine Wyllie
Martin House: Clair Holdsworth, Deputy Director of Clinical Services
County Councillor Gareth Dadd

County Councillor Clare Wood

County Council Officers: Daniel Harry (Scrutiny), Amanda Reynolds (Assistant Director for Integration, HAS)

Apologies for absence were received from: County Cllr David Simister, County Cllr Cliff Trotter, Cllr Bob Gardiner (Ryedale) – substitute Cllr Elizabeth Shields, Cllr Kevin Hardisty (Hambleton) and Wendy Hull (Craven).

Copies of all documents considered are in the Minute Book

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123. Minutes

Resolved

That the Minutes of the meeting held on 2 September 2016 be taken as read and be confirmed and signed by the Chairman as a correct record.

124. Any Declarations of Interest

There were no declarations of interest to note.

125. Chairman's Announcements

The Chairman provided the Committee with an update relating to the following matters:-

- **Vanguard/New Models of Care in Harrogate District** - Over three years ago the 'Healthy Ripon Strategy' was launched by the then North Yorkshire and York PCT to secure the long term future of the hospital. Little progress with the implementation of the strategy appears to have been made since 2014 and there are concerns that the implementation of the 'Healthy Ripon Strategy' has stalled. In light of what has happened to the Lambert at Thirsk, the Chairman noted his concerns about the future of Ripon Community Hospital, calling upon the Foundation Trust to consult upon any future changes to service delivery well in advance.

- **Joint Scrutiny of the Better Health Programme - Meeting 13 October 2016** - At the meeting of the Better Health Programme Joint Health Scrutiny Committee on 13 October 2016, a number of planning scenarios were presented for the delivery of health services through the STP. Two of these scenarios involved changes to services provided by Darlington Memorial Hospital (DMH). This could result in the downgrading of accident and emergency, consultant-led maternity and paediatric services.

  At County Council on 9 November 2016, a motion was passed, calling on the Better Health Programme to review to take into account the needs of residents and communities that rely upon these critical care services remaining at the Darlington Memorial Hospital.

  Similar motions have been passed by other local authorities.

- **National pharmacy findings** - The government is negotiating a new pharmacy contract and consulting about this. The industry body that leads the negotiation is the Pharmaceutical Services Negotiating Committee. Depending on the terms of the new contract some pharmacies may well no longer be viable and have to close. At present, there are 121 Pharmacies in North Yorkshire.

  At County Council on 9 November 2016, the issue was discussed following the proposal of a motion. The matter has been referred back to the Scrutiny of Health Committee. It is on the agenda for discussion at the Mid Cycle Briefing on 16 December 2016.

- **Mid Cycle Briefing discussions - 14 October 2016** – The session was devoted to an informal discussion with representatives from the 5 CCGs that cover the county about their approach to the commissioning and provision of End of Life Care services.

  The outcome of the discussions will be included in the report on in-depth piece of scrutiny that we are doing on End of Life Care.

126. Public Questions or Statements

County Councillor Gareth Dadd raised concerns about the Lambert Hospital and how the closure of the facility had been mis-managed by the South Tees Hospitals NHS Foundation Trust. He also sought reassurance about the following:

- When are the community rehabilitation beds on the Rutson Ward going to be decommissioned?
- Will all necessary contracts be in place to ensure that those people who are affected receive a continuity of the care?
- Where will the palliative care beds be in Thirsk?

- What is planned for the future use of the Lambert site in Thirsk? Are there discussions taking place about the possible use of the site as a community health hub?

County Councillor Gareth Dadd also praised Hambleton, Richmondshire and Whitby CCG for the way in which they had handled the consultation on the future of the Lambert.

The Chairman asked Janet Probert of the Hambleton, Richmondshire and Whitby CCG to respond to the issues raised by County Councillor Gareth Dadd under the next agenda item.

127. Hambleton, Richmondshire and Whitby CCG: Hambleton and Richmondshire - 'Transforming our communities', including developments at the Lambert Hospital

Considered -

The report of Abigail Barron, Head of Strategy, Community Care Hambleton, Richmondshire and Whitby CCG updating on the outcome of the public consultation relating to Transforming our Communities and providing assurance on the engagement and consultation process undertaken.

Abigail Barron provided an overview of the consultation process highlighting that there were: 18 pre-consultation events attended by 493 members of the public; 33 consultation events attended by 392 members of the public; a specific consultation meeting with the Lambert Hospital Action Group; and an online survey with 353 responses.

Barbara Stoker stated that occupational health services would continue to be provided from the Lambert until a suitable clinical space could be found for the physiotherapy equipment.

In response to the questions raised and reassurances sought by County Councillor Gareth Dadd, Abigail Barron stated that:

The commissioning arrangement put in place when the Lambert closed for 6 temporary beds on the Rutson Ward will only cease once a local bed base is operational in Thirsk. The CCG is working with Herriot Gardens towards a 1 December 2016 start date.

The CCG is working with South Tees Hospitals NHS Foundation Trust to decommission the community beds on the Rutson ward and replace these with step up step down beds across Hambleton and Richmondshire. These changes will be phased in between December 2016 and March 2017

The CCG is working with Broadacres to finalise timescales for the step up step down contracts for Stokesley, Northallerton and Leyburn and these will be in place prior to any changes to the Rutson Ward.

The CCG has agreed with Thirteen Group as the housing provider for Herriot Gardens that two units will be leased for the purposes of step up step down care and palliative and end of life care. In addition to this the CCG has also agreed to lease an additional unit exclusively for palliative and end of life care.

The CCG will declare the Lambert Building as surplus to requirements for its commissioned services by 31 December 2016. The building will then be handed

back to NHS Property Services. The CCG has assisted the three GP practices in the Thirsk Locality with the development of a bid to NHS England, if successful, this bid will secure funding to enable to GPs to lead work on a feasibility study to assess options for a primary care facility in Thirsk. As part of this bid development, the CCG has encouraged primary care colleagues to include other stakeholders such as housing providers and the third sector in these developments. The CCG expect the Lambert site to be included in the feasibility work and would be supportive of this.

Janet Probert acknowledged the disappointment about the way that the closure of the Lambert had been managed in the early stages and thanked both District and County Councillors for all the work that they had done to support the consultation process and promote constructive and meaningful dialogue.

Janet Probert confirmed that the site is owned by NHS Property Services and so the future use is not under CCG control. However, there is a duty upon NHS Property Services to look at possible use by public and voluntary sector bodies before there is any consideration of selling a site.

Janet Probert stated that the aim of the CCG was to enable services to be delivered as locally as possible, where it was clinically safe to do so. This was not always possible with some specialist services.

Janet Probert suggested that plans for the future of Whitby Hospital be brought to a future meeting of the Committee. She also invite members of the committee to see the 'Extra Care Beds' that have been out in place.

In summing up, Cllr Jim Clark emphasised that the consultation on the Lambert would have been better to have taken place before it was closed and not after. He also noted that whilst this was not the outcome which was wanted, the CCG had run an inclusive and informative consultation process.

Resolved -

a. To thank Janet Probert, Abigail Barron and Barbara Stoker for attending

b. That the committee be fully briefed on the future use of the Lambert site

c. That the committee be fully briefed on progress with the establishment of the new. Post Lambert, service provision in the area and any issues arising around continuity of care.

128. Sustainability and Transformation Plans - Update

Considered -

The report of the Scrutiny Team Leader providing details of progress with the development and implementation of Sustainability and Transformation Plans both nationally and locally and highlighting some of the challenges faced and areas that Committee Members may wish to look at in greater depth.

Daniel Harry gave an overview of the content of the report and some of the key issues for Committee Members to consider, including:

- the impact of North Yorkshire being covered by three separate STPs
- possible downgrading of services and increased travel times to specialist or emergency services
- a shift in health expenditure away from North Yorkshire to other areas

- a shortage of the capital funding needed to transform and modernise health services
- doubts as to whether the STPs will be able to deliver the financial and performance improvements.

Cllr Jim Clark noted that the development of the STPs was a rushed process that focussed on the NHS and not the broader partnership of agencies that were needed to make improvements to patient care and outcomes.

Cllr Jim Clark raised his concerns that the focus of the 3 STPs upon urban areas and large acute hospitals outside of the county would lead to a steady flow of NHS funding out of North Yorkshire to places such as Middlesbrough, Leeds, Bradford and Hull.

Cllr Jim Clark also stated that the Leader, the Chief Executive and the Director of Health and Adult Services at the Council were calling for 1 STP for North Yorkshire.

Cllr David Billing supported the call for 1 STP for North Yorkshire and drew attention to the financial gap that the three STPs had to bridge by April 2021, which has been estimated to be £1,750 million. He questioned how such massive savings could be made without a radical change to local health services.

Cllr Philip Barrett endorsed the comments of the Chairman and raised his concerns about the future of health services to people living in Craven District and whether their needs would be overshadowed by those of people in Leeds and Bradford.

Cllr Jim Clark stated that the STP process was fundamentally flawed as it was based upon patient flows to large acute hospitals and did not look at patient outcomes and the role of integrated health and social care services in the community.

Cllr Jane Mortimer said that the STP plans to date were too high level and too vague and appeared to have completely omitted any reference to mental health.

Members raised concerns about the future of Darlington Memorial Hospital. Early proposals considered by the STP suggest that Accident and Emergency and consultant-led maternity and paediatric services there could be downgraded. Concerns were also raised about the impact that this would have upon journey times and the accessibility of emergency and specialist health services.

Cllr Ian Galloway highlighted his concerns about the future of Ripon Community Hospital under the STP process.

Cllr Jim Clark stated that the STP is a planning process or tool and that they are not constituted or statutory bodies with clear and robust governance arrangements. Whilst the STP leads report to NHS England, there is a real issue around lack of accountability to and engagement with the agencies, organisations and people in the STP footprint.

Cllr John Clark thanked the Cllr Jim Clark for monitoring the development of the STPs over the past months and keeping it firmly on the agenda of the committee.

Cllr Clare Wood stated that the STPs needed to be scrutinised and reiterated that the County Council was actively pursuing 1 STP for North Yorkshire.

Janet Probert offered a CCG perspective in the development and implementation of STPs, highlighting the need to be part of the conversation and engaged in the planning process so that NHS money for rural populations was made available.

Members debated a resolution proposed by the Chairman.

Resolved -

The North Yorkshire County Council Scrutiny of Health Committee resolves to:

Call an urgent meeting with the 3 lead officers for the Sustainability and Transformation Plans that cover North Yorkshire (1) Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby; 2) Humber, Coast and Vale; and 3) West Yorkshire and Harrogate) to address the committee's concerns that the current plans do not meet the health and wellbeing needs of the population of North Yorkshire.

Specifically, that the implementation of STPs will result in:

- the diversion NHS funding from North Yorkshire to support large urban populations in places such as Middlesbrough, Leeds, Bradford, and Hull
- the downgrading and/or closure of services provided by smaller hospitals in North Yorkshire (the Friarage, Harrogate, Ripon, Scarborough) and those used by people from North Yorkshire (York, Darlington), such as Accident and Emergency and consultant-led maternity and paediatric services.

129. Tees, Esk and Wear Valleys NHS Foundation Trust - One Year On - Mental Health Service in York/Selby area and Bootham Hospital

Considered -

The report of Martin Dale, Strategic Project Manager and Brian Coupe, Head of Service, Tees, Esk and Wear Valleys NHS Foundation Trust updating on the position for mental health and learning disability services since Tees, Esk and Wear Valleys NHS Foundation Trust took on services for the Vale of York from 1 October 2015.

Martin Dale and Brian Coupe gave an overview of the changes that had been made to the mental health services delivered in the Vale of York CCG area since October 2015. It was noted that Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) took on the contract at a time of upheaval, with the sudden closure of Bootham Park Hospital, following an inspection by the CQC.

It was noted that the closure of Bootham Park prompted a wholesale review of mental health services in the area and the estate that is used to deliver them. Many of the properties that have been taken on are not suitable to provide modern mental health services. As such, there will be a significant re-configuration of estates. As NHS Property Services own most of the buildings used by TEWV in York and Selby, there will be no release of capital funding should the buildings be vacated.

Martin Dale stated that the aim is to increase the intensity, capacity and resilience of community mental health services and reduce the dependency upon in-patient beds. The recovery model will be embedded in all approaches to treatment and support.

Brian Coupe outlined the extent to which service users had been involved in the reorganisation of mental health services and in the plans for a new hospital.

Martin Dale informed the committee that the CQC had made an unannounced inspection of all TEWV services last week and that the outcome of that inspection was anticipated in January 2017.

Cllr Heather Moorhouse noted that scale of the challenge faced by TEWV and the large amount of work that had been done over the past 12 months to improve services.

Cllr Jim Clark queried whether TEWV experienced any shortages of skilled staff, as was the case elsewhere in the health and social care system. In response, Martin Dale stated that TEWV tended to be able to recruit and retain the staff they needed. He recognised, however, that there were challenges around the provision of mental health services for people with dementia and the specialist skills required in that role.

Cllr David Billing highlighted concerns about the Child and Adolescent Mental Health Services provision particularly for those children and young people with more severe and enduring mental health problems.

Elaine Wyllie gave an overview of the consultation process that was underway on the new hospital, noting that 30 consultation events would be held across the Vale of York. The proposal is for a 60 bed hospital, 30 beds for adult acute and 30 beds for older people. The potential sites are Bootham Park Hospital site, Clifton Park, Shipton Road, Haxby Road (former Bio-Rad site).

Access to public transport was highlighted as a key factor in determining how the original 11 potential sites were narrowed down to 3.

Elaine Wyllie urged committee members to engage in the consultation process.

Resolved -

a. That the update on the work undertaken to address the transformation of mental health services following the contract charge on 1 October 2015 be noted

b. That the public consultation regarding the development of a new mental health hospital in the Vale of York be noted

c. That Martin Dale, Brian Coupe and Elaine Wyllie come back to the committee in the new year to provide feedback on the outcome of the consultation.

130. Dying Well and End of Life Care - Hospice Care for Children and Young People

Considered -

The presentation by Clair Holdsworth, Deputy Director of Clinical Services, Martin House.

Clair gave an overview of the service provided by Martin House, how palliative and hospice care for children and young people differs from that provided to adults, and some of the issues encountered by children, young people and their families when seriously ill and in need of palliative care. Specifically:

- The need for care and services that is right for their age – from neonates to young adults
- Short breaks, with nursing and medical support when required
- To be able to continue with their education and have the opportunity to participate in social activities and be with their friends
- Specialist support for siblings
- Bereavement support for the family.

At present, Martin House receives approximately 20% of its funding from the public sector with the remaining 80% funded through donations, legacies, fundraising and retail.

Clair Holdsworth stated that a piece of research had been undertaken that suggested that there were 398 children in North Yorkshire that needed specialist palliative and hospice support. It is understood that this is an under-estimate and that the real figure is likely to be around 560.

Clair Holdsworth noted that the main referral routes were via consultants and social care.

Members questioned what key challenges were for Martin House in providing palliative and hospice care for children and young people. In response, Clair Holdsworth highlighted the following:

- Recruitment of qualified/skilled staff – albeit that in-house training schemes are in place to up-skill workers
- Shortages of some specialist staff within the NHS locally, which creates gaps in community-based service provision
- Identifying 'hard to reach' children and young people
- A shortage of counselling services for children in the community.

Resolved -

a. To thank Clair Holdsworth for attending

b. That the Committee note the report, the issues highlighted and consider them as part of the in-depth scrutiny work that is being undertaken.

131. Dying Well and End of Life Care

Considered -

The report of the Scrutiny Team Leader providing an update on the progress that has been made with the in-depth scrutiny that the Scrutiny of Health Committee is undertaking on End of Life Car (EoLC) across North Yorkshire and asking Members to review the progress to date, seek clarifications and make suggestions for further lines of enquiry.

Daniel Harry outlined the progress that had been made to date with the implementation of the project plan. Members were invited to identify any gaps or omissions in the identified lines of inquiry.

Resolved -

That the progress and suggestions for further lines of enquiry be noted.

132. Work Programme

Considered -

The report of the Scrutiny Team Leader highlighting the role of the Scrutiny of Health Committee and reviewing the work programme taking into account current areas of involvement and decisions taken in respect of earlier agenda items.

Resolved -

That the Work Programme be noted.

133. Annual Report - Director of Public Health

A link to the above report was supplied with the agenda for information.

134. NY Healthwatch Annual Report 2015/16

A link to the above report was supplied with the agenda for information.

135. NY Independent Health Complaints and Advocacy Annual Report 2015/16

A link to the above report was supplied with the agenda for information.

136. Other business which the Chairman agrees should be considered as a matter of urgency because of special circumstances

There was no other business.

The meeting concluded at 1pm.

DH

North Yorkshire County Council
Scrutiny of Health Committee
27 January 2017

Sustainability and Transformation Plans - update

Purpose of Report
The purpose of this report is to provide Members with a summary of discussions at the Scrutiny of Health Mid Cycle Briefing, that took place on 16 December 2016, and an overview of the current state of the Sustainability and Transformation Plan (STP) process.

This report also highlights a number of concerns that remain regarding the development of the three STP plans that cover North Yorkshire and suggests some lines of enquiry that the Members may wish to pursue.

Background

1. The North Yorkshire Scrutiny of Health Committee has been scrutinising the development of the NHS England Sustainability and Transformation Plans over the past 9 months. At the last meeting of this committee on 18 November 2016 a 'stock take' report was discussed which provided: an overview of the STP process; the priorities and financial position of the three STPs that cover North Yorkshire; and suggested further lines of enquiry. In response, the committee resolved to:

   Call an urgent meeting with the 3 lead officers for the Sustainability and Transformation Plans that cover North Yorkshire (1) Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby; 2) Humber, Coast and Vale; and 3) West Yorkshire and Harrogate) to address the committee's concerns that the current plans do not meet the health and wellbeing needs of the population of North Yorkshire.

   Specifically, that the implementation of STPs will result in:

   - *the diversion of NHS funding from North Yorkshire to support large urban populations in places such as Middlesbrough, Leeds, Bradford, and Hull*
   - *the downgrading and/or closure of services provided by smaller hospitals in North Yorkshire (the Friarage, Harrogate, Ripon, Scarborough) and those used by people from North Yorkshire (York, Darlington), such as Accident and Emergency and consultant-led maternity and paediatric services.*

   The meeting with the lead officers took place at the Mid Cycle Briefing (MCB) of the committee on 16 December 2016.

Sustainability and Transformation Plans

Overview

2. There are 44 STPs in England and each one covers the period October 2016 to March 2021. The STPs range in scope, with the smallest area covering a population of 300,000 and the largest 2.8 million. They have principally been determined based upon patient flows to key acute hospital trusts.

3. The plans must cover the following:

- Top local issues that will help close the three 'widening gaps' identified in the NHS Five Year Forward View (health and wellbeing, care and quality, finance and efficiency)
- The full range of health services (with expectations that they will also cover local government social care provision)
- Span a range of delivery plans, covering different geographies
- Not duplicate but fill gaps between existing agreements.

4. The plans also need to take into account current workforce shortages within the NHS and promote collaboration between health organisations.

5. The formal consultation on any major service changes will take place in June 2017 to avoid a clash with local government and mayoral elections in May.

North Yorkshire

6. North Yorkshire is covered by three STPs: 1) Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby; 2) Humber, Coast and Vale; and 3) West Yorkshire and Harrogate. In line with the approach taken in the NHS Five Year Forward View, each STP has an estimated 'Do nothing deficit' by 2020/21. These are:

    - Humber Coast and Vale STP - £420 million
    - West Yorkshire and Harrogate STP - £1.075 billion
    - Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby - £253.8 million

    These estimates include figures for social care.

7. The aim is to reduce these estimated deficits down to £0 by 2020/21 by tackling the three 'widening gaps' identified in the NHS Five Year Forward View. These are health and wellbeing, care and quality, finance and efficiency.

Three distinct approaches

8. The three STPs that cover North Yorkshire are being developed in line with NHS England guidelines and share many of the same priorities and objectives. They are, however, differentiated by their local context and perspective, as below:

    - Humber Coast and Vale - from the start there has been a strong focus upon a 'bottom up' approach and meaningful engagement with patients and carers about their health needs and how services could best meet those needs in the future
    - Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby - the development of the STP has benefited from work that was already underway to look at service redesign as part of the 'Better Health Programme'
    - In West Yorkshire and Harrogate - the STP has also benefited from a pre-existing strategic review programme, known as the 'Healthy Futures Programme'. It is built up from six local area place-based plans covering Bradford District and Craven, Calderdale, Harrogate and Rural District, Kirklees, Leeds, and Wakefield.

Scrutiny of Health

9. The North Yorkshire Scrutiny of Health Committee is involved in the three Joint Scrutiny of Health Committees that cover the STP footprints. It is of note that both the Joint Scrutiny of Health Committees for Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby and West Yorkshire and Harrogate pre-date the STP process. The scrutiny of STPs has been included in the pre-existing joint scrutiny arrangement for the 'Better Health Programme' and the 'Healthy Futures Programme', respectively. As such, the scrutiny of these programmes only covers an element of the

STP process, typically major service changes at acute trusts, and not the totality of what is being proposed through STPs.

Mid Cycle Briefing - 16 December 2016

10. A Mid Cycle Briefing is a closed meeting of the committee Chairman and Spokespersons. As such, formal minutes are neither taken nor published and members of the press and public do not attend. Please see Appendix 1 for details of those people who attended the meeting. What follows, therefore, is a brief summary record of the key issues raised by the STP leads, in response to questions from the members of the Mid Cycle Briefing:

Principles

- The STP process is a collaborative planning process. It is not a about the creation of a new NHS-led organisation or corporate body
- The STP must add value to what is already underway
- The aim is to improve care pathways and invest in preventative, community based services to help move inappropriately and inefficiently spent funding out of hospitals and back into the community
- There are large distances to travel and the aim is to keep services as local as possible
- There is a need to do more prevention and early intervention and look at tackling the wider determinants of health and wellbeing
- There is a need to ensure that hospitals are clinically effective and financially sustainable in the long term.

Opportunities

- The coverage of county by three STPs offers a unique opportunity for the County Council to influence the health system across all those health service areas that provide acute services to the people of North Yorkshire. North Yorkshire may have lesser influence if it ends up in one STP
- The STP offers an opportunity to re-direct funding from large hospitals to community-based health and social care services.

Governance and funding

- Local governance, local plans and local delivery continue to have primacy
- Under the STP, funding will continue to be allocated to the Clinical Commissioning Groups (CCG)s as the statutory organisations.

Shared priorities across the STPs

- Prevention
- Primary care development
- Mental health and mental wellbeing across all service areas
- Investment in integrated community provision
- Strategic commissioning
- Acute care collaboration at scale
- Efficiency planning to bring systems into balance.

Implementation

- Accountable Care Systems will emerge in some places, as part of the implementation of the STPs, which will see a changing role for the CCGs
- Further work needs to be done to support an increase in the efficiency and responsiveness of the Yorkshire Ambulance Service

- Existing transformation plans, such as work around Whitby, will not be changed as part of the STP process, as long as there is local support and a robust business case for the work that is already underway
- Development of community hubs will be a key element for the delivery of health and social care services in the more remote and sparsely populated areas of the county, such as Craven.

11. It was noted that it was not possible to provide details of planned changes to services in a given STP area as the plans are still being developed. It was too early in the process.

12. At the end of the meeting the STP lead officers agreed to provide, for this report, answers to some questions that there had not been sufficient time to address in the meeting and also a summary of their current position. The answers that have been provided are included in full in Appendix 2. The response from Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby STP was not available in the time for the publication of this report.

National perspective

National statements

13. There have been a number of statements issued by NHS England senior managers over the past 2 months that give some indication of the next steps for the STP planning process. Some of the issues raised are outlined below:

- There is a recognition that the STP process needs to be refreshed to improve communications with staff and communities
- The majority of the 44 STPs will remain as collective, strategic planning groups but a small number, around 5, will become entities in their own right with a remit to manage the system
- There will be a stronger focus on reducing back office costs within the NHS and a number of pilot STPs will lead on this work, with a view to rolling it out across all STPs
- As of April 2017, STPs will become the single application and approval point for local organisations to access NHS transformation funding.

14. The recent focus upon winter pressures and the sharp increase in A&E attendance and emergency admissions has highlighted shortcomings in the way that health and social care services are commissioned and provided. The winter pressures have also revealed the sheer scale of hospital based treatment costs, the fluctuations in demand for hospital services and an apparent inability to regulate or anticipate that demand. Recent press releases by NHS England indicate that the week ending 1 January 2017 saw a 34 per cent rise in A&E attendances and a 19 per cent rise in emergency admissions, compared with the same period last year.

National debate

15. A number of national commentators, organisations and agencies have identified some shortcomings in the STP process, in publications like the Local Government Chronicle and the Health Service Journal, as summarised below:

- The level of government funding made available to adult social care is insufficient, creating a social care ‘gap’ which makes it unlikely that all of the NHS savings highlighted as part of the NHS Five Year Forward View will be achieved

- It is argued that the prospect of judicial review of any major service changes in inhibiting the STP process
- Additional funding to the NHS that was to support service transformation is being used to reduce budget deficits, reducing the ability of the NHS to redesign community based services and care pathways in a way that will reduce pressure on hospitals
- NHS workforce issues, such as uncompetitive pay and the impact of Brexit, remain and threaten any transformation of services
- Insufficient thought has been given to the digital elements of the STP plans, particularly how the 10 universal capabilities outlined in the local digital roadmap guidance will be achieved
- There has been a lack of engagement with district councils in the STP planning process to date.

16. It is of note that the STP process is still seen as the vehicle for reforming the NHS, driving down costs and improving the quality of care. Concerns remain, however, as to quality and robustness of the plans that are being developed and the processes that are being put in place to deliver them.

Local perspective

North Yorkshire County Council and STPs

17. North Yorkshire County Council continues to request that the Secretary of State and NHS England review the STP boundaries with a view to creating one STP for North Yorkshire. This position is supported locally by the North Yorkshire Local Medical Committee (which represents GPs in the county), City of York Council, East Riding Council and Hull City Council.

18. The Council has also adopted the position to note but not sign off the three STPs at this stage.

19. In the interim, senior officers from the NYCC Health and Adult Services (HAS) department are working across the three STPs to ensure that there is input from social care and public health. There is a challenge, however, in servicing three separate STPs and the various strategic and operational meetings that they hold, particularly when they are geographically dispersed (typically Hull, Leeds and Tees Valley).

North Yorkshire Health and Wellbeing Board

20. The Council continues to work with partners on the North Yorkshire Health and Wellbeing Board (HWB) to find a way in which health and social care commissioning and service provision can be integrated and a joint approach taken across the county. This work pre-dates the emergence of STPs but is now being seen as a way in which the Council can make sense of three STPs and ensure that the voice of North Yorkshire is heard. A paper will be going to the HWB on 18 January 2017 entitled 'Development of future joint/integrated commissioning arrangements in North Yorkshire'.

Conclusions

21. The Mid Cycle Briefing discussions provided a useful opportunity for the STP lead officers and members of the Scrutiny of Health Committee to work through a number of issues that were of concern and gain some measure of reassurance that the voice of North Yorkshire would be heard. Whilst it is accepted that the plans are still under

development and much of the detail around the future of NHS services is yet to be finalised, there are a number of issues which remain of concern:

- The ability of the non-NHS services, particularly those working at a county level, to meaningfully engage with the planning process across three STPs that are physically based in Leeds, Hull and the Tees Valley
- A lack of clarity about the extent to which a broad range of organisations who provide key services to people at risk in the community are being engaged, such as district councils and the community and voluntary sector
- That the increasing demand upon social care services will impact upon NHS services, placing the achievement of identified NHS savings in doubt
- The shortage of necessary capital funding to enable service transformation
- The impact of any NHS-led service re-configuration upon travel distances and times, particularly to emergency and urgent care services, for people in the more rural and sparsely populated areas of the county
- The risk posed to local health and social care, community-based funding and services in the county by the need to support acute care and increase capacity in large, urban population centres elsewhere
- The risk that local priorities will be overridden by system-wide STP priorities
- The risk that proposed major service changes will emerge on a piecemeal basis prior to any formal engagement process undertaken by the STPs and that it is not clear how this will be managed.

22. Whilst there are concerns, it is recognised that the STP process is a catalyst for change that will accelerate the co-ordination and integration of health, social care and community services. It is the logical extension of the work that has been done over the past 5 years through the Better Care Fund and other initiatives and it has the potential to secure the long term future of acute trusts, whilst also re-directing funding to community-based health and social care services.

Recommendations

That the Committee notes the report and pursues the lines of enquiry outlined below.

How is the STP process going to be able to:

1. Deliver integrated health and social care services in a large rural county, split across 3 STP footprints
2. Address the shortages in qualified, skilled and experienced health and social care staff, staff who are urgently needed to enable the transformation of services and to deliver integrated and new forms of care
3. Allocate finances within their STP, in particular capital funding, which is seen as essential in transforming service delivery in North Yorkshire. For example, mental health inpatient facilities at York and Harrogate and community hospitals at Whitby and Ripon
4. Address concerns nationally and locally about governance, scrutiny and accountability issues, in particular in relation to the new organisations that are being developed for service delivery, such as Accountable Care Organisations?

Daniel Harry
Scrutiny Team Leader
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18 January 2017

Appendix 1

North Yorkshire Scrutiny of Health Committee

Mid-Cycle Briefing on 16 December 2016

Discussion on Sustainability and Transformation Plans

Attendance

The meeting was attended by:

County Councillors
Jim Clark (Chair)
Margaret Ann De Courcey-Bayley (Vice-Chair)
Philip Barrett
John Clark
David Simister.

Apologies – Cllr David Billing.

West Yorkshire and Harrogate STP
- Ian Holmes, West Yorkshire STP Program Director
- Amanda Bloor, Chief Officer of Harrogate and Rural District CCG

Humber Coast and Vale STP
- Emma Latimer, Humber Coast and Vale STP lead and Chief Officer Hull CCG
- Chris O'Neil, Humber Coast and Vale STP Programme Director
- Simon Cox, Chief Officer, Scarborough and Ryedale CCG

Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby STP
- Alan Foster, Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby STP lead and Chief Executive, North Tees and Hartlepool NHS Foundation Trust
- Janet Probert, Chief Officer, Hambleton, Richmondshire and Whitby CCG

Rob Webster, the lead officer for the West Yorkshire STP, did not attend.

Appendix 2

North Yorkshire Scrutiny of Health Committee
Answers to Supplementary Questions from the Mid Cycle Briefing on 16 December 2016

West Yorkshire and Harrogate STP

How will the STPs work with local government to stabilise the care market in the county? What will be done to help recruit and train the nursing staff required to run nursing homes?
Please see the attached slide taken from the HaRD published plan which describes the approach to the care market.
More broadly, at STP footprint level a workforce 'enabling' work stream has been established through the West Yorkshire and Harrogate Local Workforce Action Board (LWAB). It's aim is "*To ensure that workforce is a positive enabler and not a constraint to achieving the WY STP plan"* Membership of the group includes colleagues from Local Authorities, commissioners and providers.

Four Workforce work programmes have been agreed, each with specific projects aimed at ensuring the right staff, with the right skills to meet foreseeable needs *for the whole system*.

In seeking to understand the current workforce and the future needs in the light of STP plans, the group is mindful of the needs of the care home sector and other parts of the health and care 'jigsaw' which are part of the whole- for example the independent sector, research. Colleagues in both registered and non-registered roles move between sectors and workforce planning needs to provide for the future workforce needs of all parts of the 'system'.

LWAB is mindful of the workforce needs of the care home sector and the critical part played by care homes in overall system flow. As we start to quantify future workforce numbers (and the resulting training requirements) we will be including estimates of the needs of the care home sector. Help from NYCC in quantifying forecast workforce needs for the sector- and any new roles likely to emerge, would greatly assist this process.

A number of localities in the WYH STP are trying out innovative approaches to supporting the care home sector. For example- in Harrogate there are dedicated GPs for each care home and geriatricians aligned to each locality. The HDFT Infection Prevention and Control team has worked closely with care homes locally to improve quality and the community nursing teams have provided additional support and training in the prevention of pressure ulcers. Airedale has some excellent examples of using tele-health to support care quality in the care home sector and Harrogate is seeking to adopt some of these initiatives.

Have you taken into account the reduced funding for social care and the increased demand upon social care services?
The information has been produced with cooperation and involvement of local government officers. We recognise the challenges facing the health and social care economy and the increased demand on both social care and health services over the STP time period. The Do Nothing and Do Something position reflects the position of social care.

Do your plans enable the STP 'do nothing deficit' to be met? If not, then what is the consequence? What else may NHS England consider?

The STP is a draft plan which demonstrates a way that the "do nothing deficit" can be closed from £1.1bn to less than £0.2bn with the health gap being closed. However it is important to note that the STP Do Something is not a final signed off plan but is a high level plan of how it could close the gap and will be subject to existing commissioning processes and engagement prior to being finalised.

How are you going to access suitable capital funding to transform the way in which services are delivered?
The proposals do assume that significant capital investment to enable the transformation required to deliver. However, this is in the national context of severely restricted access to capital in the NHS over the next few years. Through the STP we are bidding for transformation funding as and when it becomes available nationally. Indeed we have been successful in gaining access to capital and non-recurrent revenue as part of the only Accelerator Zone for Urgent Care in England.

We are currently also in the process of bidding for transformation funds around cancer, mental health, learning disability and diabetes for which we will know the outcome by the end of March. We are also within our local sub STP areas working with local government around alternative access to funds to enable the changes proposed.

How will collective decisions be reached? How will the STP hold partner organisations accountable for their performance?
The STP is based on the principle of subsidiarity. The work is done and decisions are taken as close to the patient as possible – and will be taken through the existing decision making processes.

Where relevant parties agree that work should be done at a WY&H level, governance arrangements are being developed to allow collective decision making. This includes a joint committee of CCGs and a committee in common across the Acute Trusts in West Yorkshire and Harrogate. Similar arrangements are emerging for mental health and community providers.

The STP does not hold partner organisations to account for their performance. We are working closely with NHS England and NHS Improvement to develop closer partnership working and shared objectives so that there is a consistent focus on what needs to be done across the system.

There has been historical under-investment in community health services in North Yorkshire over the past 2 to 3 years. What will the STPs do to correct this?
Harrogate and Rural District CCG has over the last 3 years has uplifted the contract value for community services by a growth that reflects the local demographic assumptions.

In addition through the Vanguard programme community services have received an additional non recurrent investment to allow redesign of services of £2.2m.

In order to invest in any service, funding needs to be diverted from another area of spend. The STP plans focus on prevention of ill health, reducing both demand on and variation in, hospital care use and a focus on local place based integration of health and care services.

Allocations will not change as result of STP but working this way can help drive efficiency through transformation and release resource from one part of the system to invest in another.

All to provide a breakdown of the 'do nothing' deficit for their STPs and the elements that cover North Yorkshire. The breakdown to be provided by service type. For example, by hospital and by CCG. The breakdown also to clarify whether the figures include social care.

For Harrogate and Rural District 'place':

- The overall 'do nothing' position is £38.9m deficit by 2020-2021 – this includes all health and social care spend
- The 'do nothing' position is £35.5m deficit by 2020-2021 for CCG, hospital and specialist services.
- The 'do nothing' position for the CCG is £16.4m deficit by 2020-2021

All to provide details of how much money they intend to try and move from large acute providers to community services over the next 5 years.

This figure is an STP aggregate aspiration and will vary from place to place. It is subject to change as proposals are firmed up and year end positions and contract negotiations are concluded

At this point in time, the STP represents a set of high level proposals rather than specific worked up financial or operational plans. The aspiration underpinning the proposals is to move funding from acute to non-acute services through differential growth in resources to different sectors. At **WY&H level in aggregate**, the described ambition is to achieve around a 3% and 4% growth per annum in community services and mental health services respectively, funded through managing growth in acute expenditure to 1% per annum.

Craven is one of the most remote parts of the country. What are your priorities for services and funding in that area?

Rurality issues has been one of the key priority areas for Airedale Wharfedale Craven Commissioning Group in Craven, not just for 2017 going forward, but from our inception in 2013. We have worked closely with the voluntary sector in Craven, NYCC and Craven District Council and have a very positive relationship in working together on the schemes we have implemented to address rurality and health inequalities.

Our programmes have included

- keeping people well
- those who are ill or have a long term condition(s)
- care home health
- access issues

Operating within a single strategy across the Bradford District and Craven area provides us with great opportunities to share models of care and delivery across different areas whilst ensuring the people we serve remain at the centre of their care offer, which has to be tailored to their environment.

How will you work with the STP for the Morecambe Bay area to address the needs of people in the Bentham and Ingleton areas?

We all work to a set of geographical boundaries and are ever mindful of ensuring there is no adverse impact to the people who live along those boundaries. With regard to Bentham, specifically, we work closely with our CCG colleagues who cover Bentham to ensure that they are included in our discussions on commissioning intentions and service reviews. For example, there has been a meeting recently about AWC accountable care developments and the catchment population of the main provider trust to establish the geographical boundary for accountable care plans.

Ian Holmes, Programme Director, Healthy Futures

Humber Coast and Vale STP

How will the STPs work with local government to stabalise the care market in the county? What will be done to help recruit and train the nursing staff required to run nursing homes?
STP partner organisations, including local authorities, are working together to address the health and wellbeing, healthcare and social care needs of each community. As part of this process partners will agree short and longer term measures to address challenges, including current pressures in social care.

Within our workforce workstream we will develop a framework that enables employers to attract, recruit, develop and retain the health and social care staff that we need across Humber Coast and Vale (HCV) to deliver high quality sustainable care to service users, enable service transformation and introduce new ways of working.

Our Local Workforce Action Board (LWAB) has planned two initiatives to help us to make sure we have the skills we need to deliver our strategy across HCV.

- Support staff at scale - We are investing in bringing through additional support staff and investing in developing their skills. These support staff will work in hospital and in the community to develop skills across primary, secondary and social care. There will be a clear progression structure to help retain staff and the opportunity to work in different parts of the system. We will look to use our current staff differently for example creating multi - disciplinary roles for receptionists, pharmacist and mental health practitioners. This programme will start in 2017 which is when staff will enter the workforce.

- Advanced Practice at scale - We are investing in developing 'advanced practitioners' both in hospital and in the community. This will help to fill gaps in the workforce and will have a clear career path to encourage people to continue working with us. This programme will begin in 2017 and staff will take two years to qualify.

Have you taken into account the reduced funding for social care and the increased demand upon social care services?
Reduced funding and increased demand for social care has been taken into account in the development of our plans. We have targeted investment in both primary care and out of hospital care. We have built this into our overall financial model which anticipates achievement of a balanced position through to 2021.

Do your plans enable the STP 'do nothing deficit' to be met? If not, then what is the consequence? What else may NHS England consider?
Yes, currently we have an estimated £420 million deficit by 2020/21. Through the 10 workstreams listed below, we plan to address the deficit and balance our books.

- Hull
- East Riding
- Vale of York
- Scarborough and Ryedale
- North Lincolnshire
- North East Lincolnshire
- Strategic Commissioning
- In Hospital
- Mental Health
- Enablers.

Of the overall 'do nothing' deficit of £420 million for the Humber Coast and Vale STP, it is estimated that £73 million of this gap, or 17%, will be closed through initiatives described within the STP programme. The remaining amount being closed through organisational level schemes (QUIPP, CIP and organisational level savings). This is broken down by workstream as below.

Workstream	VoY	S&R
Place based care	£14.2 million	-£0.7 million
In hospital	£3.1 million	£3.1 million
Strategic commissioning	£1.7 million	£1.8 million
Mental health	£0.3 million	£0 million
Total	**£19.3 million**	**£4.2 million**

How are you going to access suitable capital funding to transform the way in which services are delivered?
We have submitted a request for additional capital funding to facilitate our proposed service developments. In the event that additional central funding is not made available, we believe that we will be able to fund the required developments through existing capital allocations and alternative, revenue based financing models.

How will collective decisions be reached? How will the STP hold partner organisations accountable for their performance?
The Strategic Partnership Board and the Executive Group set the strategic direction of the programme, and make key decisions and recommendations. Partner organisations will hold each other to account through discussion at SPB meetings.

All members of the HCV STP are currently in the process of signing up to the Memorandum of Understanding (MoU). The MoU states - "Members of the HCV Strategic Partnership Board representing their organisations will need to have sufficient authority to attend on behalf of its organisation and make decisions on its behalf, whilst acting at all times in accordance within the terms of their own organisations governance and the NHS Constitution (where applicable)."

Each workstream will be held to account through its Senior Responsible Officer and Programme Manager. Lead Programme Managers will be asked to submit a monitoring report every 4 weeks to the PMO. The monitoring report will request information on:

- Progress against milestones
- Progress against metrics (financial and non-financial)
- Risks / issues
- Issues they may want to raise to Executive Group.

There has been historical under-investment in community health services in North Yorkshire over the past 2 to 3 years. What will the STPs do to correct this?
The STP plans include a shift in emphasis from secondary care to community and primary care services. The plans aim to reduce the growth into the secondary care sector through prevention and alternative service models in primary care and community services. This will see additional investment and a shift of resources into these areas, and help to both reduce the pressure on secondary care and close the financial gap.

How will you ensure that Scarborough, which is 40 miles away from the nearest alternative hospital, continues to have viable acute services?
The STP plan will be delivered through local, place based approaches. The Scarborough and Ryedale CCG patch will build upon the work undertaken through the Ambition for

Health programme, supported by all major public stakeholders, including North Yorkshire County Council. This commits to providing clinically and financially sustainable services in Scarborough and Ryedale, including using alternative service and care models.

The programme of work is geared towards maintaining local access to urgent and emergency care, paediatrics, and obstetrics for the Scarborough and Ryedale population. The wider scope is to reduce the reliance (and pressure) upon acute hospital care through greater use of self-care, primary care and community services. The STP will look at how hospital services across a wider footprint are configured to make them financially and clinically sustainable, providing the best available care in the most appropriate settings.

How will the STP address the £10m financial gap that is facing the Scarborough system, once the 'acquisition' funding comes to an end?
The STP model includes the loss of the financial support currently being received by York Foundation Trust. This adds to the system financial gap which is then addressed through the STP plans by 2021.

Chris O'Neill
Programme Director
Humber Coast and Vale STP

Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby STP
The response was not available at the time of publication of this report.

Hambleton, Richmondshire and Whitby
Clinical Commissioning Group

Transforming Mental Health Services

Date: **27 January 2017**

Report for: **Assurance**

Author: **Sheila Fletcher, Assistant Commissioning Specialist, Partnership Commissioning Unit**

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1. Introduction and Purpose

This cover report provides the context and background to the appended document: *Transforming Adult and Older Peoples' Mental Health Services in Hambleton and Richmondshire – a case for change.* Members of the Health Overview and Scrutiny Committee are asked to consider and comment on the information contained in this report and appended documents.

The report *Transforming our Communities* that was presented to Health Overview and Scrutiny Committee in November 2016 outlined proposals for the transformation of services in line with the vision of the Clinical Commissioning Group (CCG) for community services across Hambleton Richmondshire. Building on that, this report and appended case for change document provides a briefing on proposals to transform adult and older peoples mental health services, informed by the principles and recommendations agreed in the *Transforming Communities* consultation.

Specifically this report presents;

- the case for change for transforming adult and older peoples mental health services, available at Appendix 1
- proposals to commence a period of pre-engagement with key stakeholders and the wider general public on the development of future models of adult and older peoples mental health services
- a draft engagement and consultation strategy available at Appendix 2.

2. Background

In 2013 HRW CCG published its case for change in *Fit 4 the Future*. This outlined the CCG's vision for the development of community services in the coming years. Public and stakeholder engagement undertaken during this time demonstrated support for the case for change, with a real understanding from the public for the need to change.

In line with *Fit 4 the Future* and the outcomes of the *Transforming our Communities* consultation, it is now the ambition of the CCG to transform adult and older peoples mental health services aimed at developing a modern, recovery-focused model. The Five Year Forward View for Mental Health has made an arguable case for transforming mental health care in England. Meeting the needs of those with mental illness and the promotion of good mental health and wellbeing is key to the Clinical Commissioning Group's (CCG) overarching strategic vision. For people with mental health issues, this means looking at a wide range of services, including those which respond to and rehabilitate patients when they are in crisis, as well as considering a range of more proactive services, both through statutory services and the voluntary sector, which can promote health and independence and hence improve well-being.

This case for change has as its focus the provision of services to people with mental health problems, highlights the level of need in the area, the variable quality of services people often encounter and considers the complexity of current service arrangements.

3. Case for Change

The attached Case for Change outlines the different drivers that support the need to review how current services are provided. These include The Five Year Forward View for Mental Health (2016), Mental Health Crisis Care Concordat (2014), Prime Minister's Challenge on Dementia 2020 (2015), North Yorkshire Mental Health Strategy 2015-2020 (2015) and Building the Right Support (2015).

The latest Joint Strategic Needs Assessment told us that the number of people in Hambleton and Richmondshire with mental health related illness and their outcomes are broadly worse than that of the national picture. In order to respond in a meaningful and effective way service providers must look at how mental health services are organised and how all partners work together. It is clear that with an ever increasing prevalence of people with mental health problems and the health needs associated with them that services cannot remain as they are. The CCG and its partners, with service users and their carers have identified some of the main issues and priorities for the development of mental health services. This is a great opportunity to improve mental health services while following the CCG's general principles of providing care closer to home wherever possible, allowing people to remain at home as long as possible and putting quality of care, patient safety and experience at the heart of what we do.

4. Communication and engagement

The CCG and its partners have developed a comprehensive communications and engagement strategy around a *Transforming Mental Health* vision to engage with patients, carers, stakeholders and partners in Hambleton and Richmondshire. This is available at Appendix 2 and outlines:

- Engagement and consultation principles
- Aims and objectives
- Stakeholder analysis
- A three-phased engagement process and timescales Engagement and consultation methodology
- A communication and engagement plan including key messages and questions
- Communications/engagement management and responsibilities
- Reporting, feedback and evaluation mechanisms

5. Recommendations

In progressing the development of the vision for *Transforming Mental Health*, this report seeks the insight and observations of Health Overview and Scrutiny Committee and invites them to consider and comment on the information contained in this report and the case for change report appended.

Appendix 1

Transforming Adult and Older Peoples' Mental Health Services in Hambleton and Richmondshire - a case for change

Foreword

Welcome to the vision for Transforming Adult and Older Peoples' Mental Health Services across Hambleton and Richmondshire. This outlines – and sets the scene for open debate – the priorities for developing health and social care services in the area over the coming years.

This document sets out the case for changing adult and older peoples' mental health services in Hambleton and Richmondshire and introduces the engagement phase of our transformation programme.

We have identified, thanks to their help, some of the main issues and priorities of our patients, their carers and our partners. It is clear that with an ever increasing prevalence of people with mental health problems and the health needs associated with them that services cannot remain as they are. We have a great opportunity to improve the services that we provide to our population while following our general principles of providing care closer to home wherever possible, allowing people to remain at home as long as possible and putting quality of care, patient safety and experience at the heart of what we do.

By the end of the engagement phase of this work we hope to have identified options that ensure local NHS services are the best they possibly can be to meet future healthcare needs. We are looking forward to meeting as many people as possible and hearing your ideas and opinions.

Acknowledgements

The writing and development of this document has been carried out as a partnership involving representatives from Hambleton, Richmondshire and Whitby Clinical Commissioning Group (HRW CCG), the Partnership Commissioning Unit (PCU), Tees, Esk and Wear Valley NHS Trust (TEWV), North Yorkshire County Council (NYCC) and NHS England.

This case for change is intended as a partnership document led by HRW CCG in partnership with other local organisations. It will evolve and develop before a final version for members of the public is published.

1. Introduction

Hambleton, Richmondshire and Whitby Clinical Commissioning Group (HRW CCG) is responsible for commissioning the majority of the healthcare services received by its population. Ensuring that people receive the best possible care within the resources available is a complex task and HRW CCG is committed to undertaking this in partnership with patients, their carers, partner organisations and local stakeholders.

The focus for this document is the adult and older people mental health services in the localities of Hambleton and Richmondshire. Its purpose is to provide an over-arching document to be used as the basis to start detailed discussions in both localities. As discussions progress further, it is anticipated that locality-specific ideas and issues will be identified which will need to be reflected in locality plans and documents accordingly.

In addition, as part of commissioning mental health services, we need to consider the wider needs of people who experience mental health problems, for example those with long term conditions, learning disabilities and dementia, frailty and social isolation.

2. Background

In 2013, the CCG launched the *Fit 4 the Future* programme to involve local people and service users in the commissioning of services and to prepare the local health (including mental health) and social care system to meet the challenges of its population. Since the publication of *Fit 4 the Future* the CCG has been refining the vision and case for change through extensive public and stakeholder engagement to influence the direction of travel. This involved a formal 14 week consultation process which included 33 public consultation events, two public meetings, numerous other stakeholder meetings and an online survey.

Emerging themes and issues were also raised through the *DISCOVER!* engagement programme. *Discover!* is an innovative engagement tool set up by the Partnership Commissioning Unit to support the commissioning of local mental health services. *DISCOVER!* events were undertaken during Summer 2015 to look at mental health services in rural communities.

Public and stakeholder engagement undertaken during this time demonstrated support for the case for change, with a real understanding from the public for the need to change. This included a rich source of evidence gathered from the consultation undertaken on the development of the North Yorkshire Mental Health Strategy and in addition the North Yorkshire Dementia Strategy.

Feedback from this consultation was broadly similar and can be summarised in the following themes:

- Keep people in their own homes for as long as possible
- Care close to home
- More information for patients and their carers
- Better patient transport
- Facilitating social interaction
- More support for carers
- Utilise new technologies as part of the solution

Following this extensive consultation, in July 2016 the CCG published its *Transforming our Communities* programme which describes proposed new models of community based care which have been developed in partnership with local clinicians and members of the public over the last three years.

In line with *Fit 4 the Future* and the outcomes of the *Transforming our Communities* consultation, it is now the ambition of the CCG to transform adult and older peoples mental health services aimed at developing a modern, recovery-focused model. It is widely recognised that improved mental health and wellbeing is associated with a range of better outcomes for people of all ages and backgrounds. These include improved physical health and life expectancy, better educational achievement, increased skills, reduced health risk behaviours such as smoking and alcohol misuse, reduced risk of mental health problems and suicide, improved employment rates and productivity, reduced anti-social behaviour and criminality, and higher levels of social interaction and participation. This has an impact across all statutory and non-statutory providers and it is important therefore that services work together across the system to shift the focus from illness to wellness.

This document describes the key components of a successful mental health care system and explains why, at this current time, and supported by appropriate evidence, they are not yet optimally established to meet the future need in Hambleton and Richmondshire. This information is intended to form the basis of an informed discussion about the services that should be commissioned for the future.

3. The local challenge

Hambleton is a large mainly rural district, running from York in the south to Darlington in the north.[1] Approximately 10% falls within the North York Moors National Park. There are five market towns, Bedale, Easingwold, Northallerton, Stokesley and Thirsk, and 130 villages. Just over half of the population live outside the market towns and population density is one of the lowest in the country. Richmondshire is one of the largest districts in England, covering an area of just over 500 square miles (1319 square kilometres) two thirds of which is in Yorkshire Dales main centres include Richmond, Catterick Garrison, Leyburn, Hawes and Reeth. Outside of urban centres and market towns, the areas are sparsely populated with 70.6% of the population living in rural areas and 15.3% of the population living in areas which are defined as super sparse (less than 50 persons/km).

Hambleton and Richmondshire has a predominantly rural area with a local population that is increasing and ageing, with significant in-migration from other parts of the UK in the pre-retirement and the recently retired age groups.

Much of the population is healthy and well and makes a major contribution to the health and wellbeing agenda as direct carers, as volunteers in their local voluntary organisations and through silent, often un-noticed work both with families, their neighbours and their faith groups. However, a significant number also have specific mental health needs around accessing and receiving high quality support and information; managing their own support as much as they can; maintaining a family and social life; work and education and contributing to community life.

[1] North Yorkshire H&R JSNA

According to the latest Joint Strategic Needs Assessment (JSNA) however, both Hambleton and Richmondshire mortality from suicide and underdetermined injury is higher than that of the national average; although the numbers are small the impact consequence to people is evident. In addition, the population experiences a worse picture against the national of levels of mental health and illness and the percentage with dementia aged 18 plus (not age standardised) and percentage with depression aged 18 plus (not age standardised).

In respect of the current provision of mental health services, the majority of people with mental health needs receive their care in the community. Adults and older people requiring in-patient services are admitted, in the main into the Friarage Hospital in Northallerton. Other or specialist intensive mental health is provided in Teeside or Darlington.

The essence of mental health care is that there is much we can do to help people to self-manage and prevent deterioration of conditions through better education and awareness and putting plans in place to help people respond in a crisis. We can also provide better support for family and carers to help them understand and be part of the new approaches we are using to support people with mental health conditions, for example earlier recognition of issues, access to support services sooner and using new technologies and caring for more people at home where possible.

In this process therefore, it is vital that we do not just consider the treatment of those already diagnosed with mental health conditions, but also consider what preventative strategies, supported by Public Health, we can employ to keep people mentally healthier for longer and invest in work with the younger population, who are both able to support the older generation now and who will also become the adult and elderly population of the future.

4. National context and drivers for change

As well as local commissioning knowledge, there is a wide range of policy, evidence and good practice drivers emerging nationally, which are influencing our local plans. These include The Five Year Forward View for Mental Health (2016), Mental Health Crisis Care Concordat (2014), Prime Minister's Challenge on Dementia 2020 (2015), North Yorkshire Mental Health Strategy 2015-2020 (2015) and Building the Right Support (2015).

The NHS Shared Planning Guidance asked every local health and care system in England to come together to create their own ambitious local plan for accelerating the implementation of the Five Year Forward View (5YFV). These blueprints, called Sustainability and Transformation Plans (STPs), are place-based, multi-year plans built around the needs of local populations. They provide the local vehicle for strategic planning, implementation at scale and collaboration between partners. The STP which includes Hambleton and Richmondshire acknowledges that service cannot continue to be delivered in their present form. They are unable to address the key challenges of health and

wellbeing, care and quality, and finance and efficiency which we are currently facing. The strategy is a 'system -wide' solution based on effective earlier intervention and prevention through to more integrated community models of care.

4.1 Prioritise prevention and early intervention

Prevention and early intervention is widely recognised as being essential to improving health and wellbeing and in securing a sustainable health and care system for the future. A range of current national policies, including Sir Michael Marmot's report on health inequalities ('Fairer Society, Healthy Lives' February 2010) have given renewed emphasis on the promotion of wellbeing, the prevention of ill health and early intervention. Evidence shows that partnership working between primary care, local authorities and the third sector to deliver effective universal and targeted preventive interventions can bring important benefits. Public health services have transferred to Local Authorities and North Yorkshire Council is leading the development of a prevention strategy, which includes access to information and advice at an early stage at its heart.

4.2 Management of Crisis

In 2014, the CCG as one of the partner organisations in North Yorkshire and York made a declaration to put in place the principles of the national Crisis Care Concordat to improve the system of care and support so that people in crisis because of a mental health condition are kept safe. The aim is to help them to find the help they need − whatever the circumstances − from whichever of our services they turn to first.

Partner organisations agreed to work together to prevent crises happening whenever possible, through intervening at an early stage. A commitment was made to ensure the needs of vulnerable people in urgent situations are met, getting the right care at the right time from the right people to make sure of the best outcomes and avoiding hospitalisation where possible.

4.3 Provide more personalised care

The Government and the Department of Health is rolling out a personal health budgets policy nationally in the NHS. A personal health budget is an amount of money to support a patient with identified healthcare and wellbeing needs and is planned and agreed between the patient and their local NHS/social care team. At the centre of a personal health budget is a patient care plan. This plan helps patients decide on their health and wellbeing goals together with the local care team who support them. It also sets out how their budget will be spent to enable them to reach their goals and keep healthy and safe.

4.4 High quality care for all

In recent months the NHS has had to address the outcomes of recent reviews into significant failures of the health and care system. The CCG is fully committed to doing this and ensuring we foster a culture of compassionate care in which patients are genuinely and consistently at the centre of everything the service provides. The key reports published include:

- Transforming Care, the Government's final report on Winterbourne View; and
- The public inquiry chaired by Robert Francis QC on Mid Staffordshire NHS Foundation Trust and Patients First and Foremost, the Government's initial response.

4.5 Provide sustainable housing models to meet future needs of local communities

Vulnerable and older people require homes and opportunities that meet their particular needs, foster self-determination and support a good quality of life. The needs of older and vulnerable people can be met in a variety of settings, such as shared specialist supported housing, extra care housing, care settings, as well as through general housing. We recognise that vulnerability can be a temporary or a permanent state and therefore a wide range of solutions need to be available.

4.6 Continue to improve financial efficiency of services

Poor mental health carries an economic and social cost of £105 billion a year in England. Analysis commissioned by NHS England found that the national cost of dedicated mental health support and services across government departments in England totals £34 billion each year, excluding dementia and substance use. Nationally, both the NHS and Local Authorities face pressure on budgets and the need to make continued efficiencies if they are to remain in financial balance. In times of financial constraints, public services, including mental health services have to make efficiency savings at a time when demand for services is likely to rise. It is imperative that the CCG, together with its partners, ensures that each pound that is spent on mental health services delivers the maximum amount of value possible for the people who access services. A key way in which to do this is to ensure that existing investment is targeted at evidence-based prevention and early intervention for mental disorders. This can have economic benefits that go far beyond the health sector and present opportunities for innovation within mental health service provision; for example rebalancing services towards cost-effective community-based care alternatives.

Beyond the economic cost of £105 billion a year, poor mental health is destroying lives. Prevention was the public's number one priority for NHS England's Mental Health Taskforce in its public engagement stage. The Taskforce reported that 75% of people experiencing mental health problems are not using health services. This may be due to stigma, inadequate provision and people using their own resources to manage their mental health. The wider determinants of mental health issues are evident in schools, workplaces, communities and housing.
In summary we need to maximise opportunities to get better value from the NHS budget, delivering services of high quality with improved outcomes.

5. The Case for Change: 'i.e. what's not working locally'

The latest JSNA told us that the number of people with mental health related illness and their outcomes are broadly worse than that of the national picture. In order to respond in a meaningful and effective way we need to look at how we organise mental health services and how all partners work together.

The current service provided by Tees Esk and Wear Valleys NHS (TEWV) is delivered by a range of community teams that support the age orientated model defined by the Royal College of Psychiatrists. Crisis response and intensive home treatment are a separate service offer and are currently commissioned to respond to those between the ages of 16-65. All people who require assessment under the Mental Health Act (MHA) receive this through the consultant body and appropriate mental health practitioner (AMHP) in the respective services. Those who are detained by the Police under Section 136 of the MHA are managed through the Section 136 suite at the Friarage mental health unit. Currently the gap in crisis and intensive home support potentially results in people being detained under the MHA or admitted to hospital when an enhanced community package with social care may be a better option.

The population is currently serviced by two in-patient wards at the Friarage Hospital, separated for adult and older people. Both are mixed-sex and on the first floor which limit privacy, dignity and open access to outside spaces. These have been factors commented on by MHA and Care Quality Commission (CQC) inspection in the past. For people with a learning disability, this is commissioned locally through the contract with TEWV.

There are a number of recruitment and workforce retention issues specific to the locality that needs to be considered in future service re-design.

Access to alternative care settings for older people with organic mental health problems is limited in the area, resulting often in failures in packages of care. This has subsequent knock –on effects relating to inappropriate admission to acute and mental health secondary care beds and delayed transfers of care from these settings. Work is needed to look at how services can deliver enhanced care to support patients and carers in the place where people want to live, as it widely recognised that admission to hospital is detrimental to patients with organic mental ill health. This is an area of particular importance as the North Yorkshire prevalence is higher than the national average.

Service users will require a wide range of services which they will access at different times and to different extent depending on circumstances. Many patients already have a very good experience of care and may feel that services are already working effectively. However, when we look across the system as a whole, it becomes apparent that there are clear challenges and historical service gaps. The rationale to expand and close service gaps therefore needs to be considered on three levels; that of the service user, effective evidenced-based care and from an economic perspective.

If we look at the information that we learn from in our day-to-day systems (GP and patient survey, complaints, comments and compliments), our patients and partners have already given us the following key themes and messages:

- Eliminate privacy & dignity issues.
- Why do we have mixed sex accommodation?
- I don’t know where to send referrals to?
- Single point of access would be good.
- How do we improve responses/communication between professionals?

- Where is crisis support for our young & older people?
- Patient referrals are 'bounced' back.
- Less handovers between teams.
- 'Not about beds – I have one'.

This next section takes a subject by subject view of the opportunities for improving services in the local area, explaining why the issues raised are important, and highlighting where improvements need to be made in order to realise HRW CCG's over-arching vision. It is essential that these services place the patient at the centre of care and are commissioned and delivered so as to provide an integrated and co-ordinated experience of care.

5.1 Access routes to services

Primary access into secondary metal health is via the patient's general practitioner into the respective age/specialist community teams. Organised into five main areas, Hambleton & Richmondshire are serviced by the following teams. Table 1 shows a summary of the access to secondary mental health.

Working Age Adult	Older persons	Learning Disabilities
Operates 7days a week offering: • 4 hour response to people in crisis 24/7 for people aged 16-65years, plans in place to expand initial response to all ages. • Assessment by primary care or community teams within 4 weeks of referral. • Lead service for the assessment under Section 136 of the Mental Health Act. • Benefits of integration with social care staff and AMHP. • Lead referral point for people with first suspected episode of psychosis (14-65years) with the national 14days access standard. • Additional capacity to support those with long-term mental health • 7 days service to provide Intensive home support • 12 inpatient beds • IAPT offers a service to those with high and low intensity needs meeting the expected prevalence standards and close to the national average for recovery. • Armed forces and veterans have access to a dedicated resource based with the MOD campus	Operates 7 days a week offering • Assessment by community teams within 4 weeks of referral. • Care home liaison • Community Memory service • 8 inpatient beds • Acute hospital liaison providing 1hour response to ED (8-8) and inpatient liaison within 72hours of referral	Operates Monday to Friday with planned expansion to 7days to support those with increased care needs in the community. • Assessment by community teams within 4 weeks of referral. • Out of hours on call support planned to support all age crisis service. The service is not commissioned to provide first diagnosis of ASD or ADHD. There is no inpatient facility within the locality.

We have an opportunity to create a new access route, linked with the national agenda for eReferrals, simplifying access to Improving Access to Psychological Therapies (IAPT)through single speciality community teams. In addition, the ongoing work of the mental health crisis care concordat there is the ambition to have a single telephone response and assessment service for all ages 24/7.

5.2 Health and social care integrated community teams

We have the opportunity to improve access to mental health services by:

- Early detection and home based interventions providing effective intensive home support
- Recovery focused community services
- Step up and step down models of care in our community using care home liaison and specialist rehab in the community
- Access to 'fit for purpose' estate

Any future model of mental health services must be underpinned by a resilient interface with community and neighbourhood services - building capacity within community-based services to reduce demand and release capacity from the acute sector and in-patient beds – whilst in parallel moving towards a 'place-based' approach where health and social care mental health services intervene earlier to prevent escalation and direct people to a broad range of appropriate provision; including social, private and third sector.

5.3 GP practices

GP practices across the CCG have the highest patient satisfaction rating in the country and are working efficiently to provide a wide range of services in primary care. Nevertheless, practices will need to undergo some significant development in the next few years. There is a national move through the updated GP contract towards some level of seven day working, proactive identification of at-risk individuals through risk profiling, and identifying lead professionals for complex vulnerable patients. There are also drives elsewhere in the country for primary care to support more early mental health interventions in the primary care setting by skilling up their own staff.

5.4 Voluntary sector / local communities

Services provided from the voluntary sector play a vital role in supporting people in their own communities. However, services may often be fragmented, disconnected and dependant on short-term funding. The result is that services do not always work effectively together and staff working in statutory organisations may not know what services exist and so are unable to sign-post patients to them effectively. Services are also patchy or incomplete in some areas, with unequal access depending on where a person lives to services such as: voluntary transport, support for shopping or home laundry, social opportunities, befriending, etc. In Hambleton and Richmondshire the offer by the voluntary sector is limited by many of the national partners not having a presence in the locality. There is an opportunity through work with our housing partners to look at alternative supported living settings for people with enduring mental health needs, as well as working with

them to provide supportive places for people to attend when they have emerging mental health needs.

5.5 Information management and technology

While in recent years there have been great advances in the opportunities available through IM&T, some significant obstacles remain. Currently there are no consistent systems and processes for using the NHS number as a single patient identifiable number across all health and social care organisations to help co-ordinate care, using safe and secure e-mail addresses to share information, obtaining shared consent, and limited capability to access different provider record systems in common locations, let alone a single common shared IM&T solution between health and social care.

5.6 Transport

Funded transport to access health and social care services is not an automatic right and is dependent on clinical need. Patients and service users therefore need a range of options to access available services, dependant on circumstance.

In Hambleton and Richmondshire, emergency and patient transport services are provided by Yorkshire Ambulance Service NHS Trust. There are also voluntary transport schemes operated by the voluntary sector.

5.7 Police partners

Our Police partners play a vital role in responding to people who are in need of mental health support, not only through the help they give through 101 or 999 calls but also as a primary response to those with high risk behaviours and require detaining under the MHA. Potential for closer working with Police for those who are most vulnerable and high users of all services need to be an essential part of this work.

6 The overarching vision for Hambleton and Richmondshire

Hambleton, Richmondshire and Whitby Clinical Commissioning Group's overarching strategic vision is *'to commission (buy) first class healthcare which improves the health and well-being of everyone living in Hambleton, Richmondshire and Whitby*'. For people with mental health issues, this means looking at a wide range of services, including those which respond to and rehabilitate patients when they are in crisis, as well as considering a range of more proactive services, both through statutory services and the voluntary sector, which can promote health and independence and hence improve well-being.

The intention is to make a real impact on population and system health outcomes, including:

- Enabling people to enjoy the maximum possible good health for as long as possible.
- Increasing community productivity and improved patient outcomes

- Reducing the overall number of admissions to hospitals and average bed days (and lengths of stay) for those admissions.
- Reducing the number of long term placements in residential and care homes.

The priorities set out below are drawn from the feedback from our service-users and stakeholders, national and international evidence and our local commissioning knowledge of how well the current health and social care system is performing.

Our ambition is to transform key elements of mental health provision and the following high level requirements have been identified:

- Simplify access
- Access at the point of need
- Care as close to home as possible for the majority of people
- Access to specialist acute care when required
- Effective use of resources in the locality
- Management of deteriorating patients in community
- Sustainable service offer
- Evidence-based model of care

We want to deliver this ambition by:

- Investing in the provision of a recovery orientated approach in the community close to patients' homes; so that the majority of people receive their care in the community
- Providing assessment and treatment to patients and carer support when they need it, whatever time of day or night
- Supporting access to specialist assessment and treatments such as inpatient care, when required
- Providing evidence-based treatment in the most appropriate care setting
- Retaining our local identity to ensure we can continue to work closely with general practice
- Delivering services in high quality fit for purpose buildings across inpatient and community services.

7 Implementation and way forward

Our vision for Hambleton, Richmondshire and Whitby was first documented in discussion documents in 2013 ("Fit 4 the Future"; reconfiguring older people's services in Hambleton and Richmondshire – vision and case for change). Since this time we have been refining our vision and case for change through extensive public and stakeholder engagement and service prototyping to influence our direction of travel. This included a range of locally based 'Transforming Our Communities' public consultation events held between July 2015 and May 2016.

Following this work HRW CCG and partners are now developing a communications and engagement strategy around our Transforming Mental Health vision to engage with patients, carers, stakeholders and partners in Hambleton and Richmondshire. This strategy will be guided and influenced by the following principals:

1. Care and support is person-centred; personalised, coordinated and empowering.
2. Services are created in partnership with citizens and communities.
3. Focus in on equality and narrowing inequality.
4. Carers are identified, supported and involved.
5. Voluntary community and social enterprise, and housing sectors are involved as key partners and enablers.
6. Volunteering and social action are key enablers.

At the heart of the principles is the assertion in the NHS Five Year Forward View that 'a new relationship with patients and communities' is key to closing the three gaps identified by the NHS Five Year Forward View: health and wellbeing, quality of care and treatment, finance and efficiency.

These principles require the NHS to ensure that there is a move away from paternalistic, fragmented health and social care services and that the focus is on supporting people better to manage their health and wellbeing. It is for NHS organisations to ensure that the focus is on ensuring people have as much choice, voice, control and support as they want in decisions that involved their health and care. Growing evidence shows that involvement is the key to improving outcomes and improving the experience of care.

Creating services in partnership with the public and communities and using a co-design approach to design services means working with all sectors of the community including voluntary, community and social enterprise sectors along with patient participation groups, carers and other agencies.

The Key messages are:

- The challenges we face:
    - Rurality - resulting in inequity of access
    - Adverse effects of hospitalisation on patients with a mental illness
    - Workforce challenges
    - Some lack of public understanding around mental health services and services required
- The way in which healthcare can be delivered is changing and evolving. In the last 15 years, there have been great advances in medical knowledge and technology. This has enabled more services to be provided outside of hospitals, in GP practices and community-settings, while hospitals increasingly focus on the most seriously ill patients
- HRW CCG has already consulted on older people's community services and during engagement, mental health provision was highlighted by the public as an area to address
- Caring for mental health patients is now able to change. We have evidence to show that hospital stay is not always the best place to care for adult patients with a mental illness

- Because of national challenges facing the NHS and local authority financial climate there is an increasing need to use resources effectively and efficiently. We must achieve the best outcomes for our patients within the available budget
- The public tell us that they want to see more services being provided at home or as close to home as possible.
- We need to review the type of services that are available in community settings and those that are delivered in hospital. We also need to look at integrating some services and providing others so that more can be delivered locally, close to where people live.

We intend to carry out a triple phased engagement process. Phase 1 will be the listening phase, to take place between February and March 2017. This phase will be about gathering views and suggestions from patients, carers, clinical staff and other stakeholders.

Key questions will include:

1. What do we need to do to care for more people in the community?
2. How do we improve the care of those with increased need or in crisis?
3. What do we need to do to reduce the need for hospital admission and keep the length of stay to a minimum?

Phase 2, between March and May 2017 will cover reporting and options development. This will involve reviewing feedback from the listening phase, responding to queries and developing consultation options.

Phase 3 is the formal 12 week consultation period involving locality based engagement events between mid-May and mid-August 2017. The purpose of these events will be to:

- Make and confirm people's understanding of the case for change
- Present and confirm whether people agree the overall vision
- Discuss the choices the CCG will need to make in order to implement the vision.

In addition to the engagement events, a detailed consultation document will be distributed widely across Hambleton and Richmondshire as well as being available on line and upon request.

Following the engagement, there will be a post consultation period between July and September 2017, when outcomes will be decided and feedback provided to all stakeholders.

8 Conclusion

This document is intended to provide information and provoke discussion. It starts to set the scope of both the challenge and the opportunity relating to commissioning mental health services in the Hambleton and Richmondshire area. It also confirms the central idea that people with mental health issues are more likely to remain safe and well in their own homes and communities if we can

strengthen the care and support that they receive there. If we do this successfully, then admission to hospital can in some cases be avoided and the overall cost to NHS and social care services reduced.

Perhaps inevitably, the solutions largely lie in the reconfiguration and integration of community services. However, the exact scale and formal proposals for what needs to be developed will require extensive local discussion with service users, their carers, partner organisations and other stakeholders.

A detailed programme of engagement events will be undertaken in 2017 to start to turn this vision into a reality.

We thank you for reading this document and we look forward to hearing your views.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

NHS
Hambleton, Richmondshire and Whitby
Clinical Commissioning Group

Appendix 2

NHS Hambleton, Richmondshire and Whitby CCG

Tees, Esk and Wear Valleys NHS Foundation Trust

Transforming Mental Health Services
Hambleton and Richmondshire

Communications and engagement strategy

2016/2017

Version control

Date	Version	Change	Author
13.12.16	V1	Initial draft	Georgina Sayers
13.01.17	V2	Second draft	Georgina Sayers
17.01.17	V3	Amendments	Georgina Sayers
18.01.17	V4	Amendments	Georgina Sayers

Contents

Introduction and purpose of document

This paper sets out a joint communications, engagement and consultation strategy intended to form the basis of an informed discussion about the transformation of mental health services in Hambleton and Richmondshire.

Partners involved in the joint strategy are NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group (HRW CCG), Partnership Commissioning Unit (PCU) who procure mental health services on behalf of the CCG, Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) who are the mental health service provider and North Yorkshire County Council. We will also work closely with South Tees Hospitals NHS Foundation Trust (STHFT) due to the Friarage Hospital.

This document provides a framework for the engagement and consultation process and includes but is not limited to:

- The aims and objectives of the strategy; including some high level key messages,
- Current legislation on the 'Duty to Involve 'and the 'Equality Act 2010',
- The key principles for communication, engagement and consultation,
- Proposals for the engagement process including a clear action plan,
- The work required preparing for consultation and any additional resources required to deliver the strategy and plan,
- The action plan details the work required for all aspects of communication, engagement and consultation. This is essential to support good practice and to fit in with guidance such as that from the Cabinet Office and 'Compact',

There will be a period of 12 weeks for the consultation (which may be extended due to the summer holidays). Prior to this, there will be a pre-consultation period of engagement.

Background

NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group (HRW CCG) is responsible for commissioning a majority of the healthcare services received by its population.

In 2013 HRW CCG published its case for change in *Fit 4 the Future*. This outlined the CCG's vision for the development of community services in the coming years. Public and stakeholder engagement undertaken during this time demonstrated support for the case for change, with a real understanding from the public for the need to change. Key themes and messages included:

- Keeping people in their own homes for as long as possible.
- More information for patients and their carers.
- Better patient transport.
- Facilitating social interaction.
- More support for carers.
- Utilise new technologies as part of the solution.

In line with *Fit 4 the Future* and the outcomes of the '*Transforming our Communities'* consultation, it is now the ambition of the CCG to transform mental health services aimed at developing a modern, recovery-focused model. This will be called 'Transforming Mental Health' with a focus on Hambleton and Richmondshire localities.

It is widely recognised that improved mental health and wellbeing is associated with a range of better outcomes for people of all ages and backgrounds. These include improved physical health and life expectancy, better educational achievement, increased skills, reduced health risk behaviours such as smoking and alcohol misuse, reduced risk of mental health problems and suicide, improved employment rates and productivity, reduced anti-social behaviour and criminality, and higher levels of social interaction and participation. This has an impact across all statutory and non-statutory providers and it is important therefore that services work together across the system to shift the focus from illness to wellness.

The NHS Shared Planning Guidance asked every local health and care system in England to come together to create their own ambitious local plan for accelerating the implementation of the Five Year Forward View (5YFV). These blueprints, called Sustainability and Transformation Plans (STPs), are place-based, multi-year plans built around the needs of local populations. They provide the local vehicle for strategic planning, implementation at scale and collaboration between partners. The STP which includes Hambleton and Richmondshire acknowledges that services cannot continue to be delivered in their present form. They are unable to address the key challenges of health and wellbeing, care and quality, and finance and efficiency which we are currently facing. The strategy is a 'system -wide' solution based on effective earlier intervention and prevention through to more integrated community models of care. The STP which includes Hambleton, Richmondshire and Whitby can be found here:
https://www.hambletonrichmondshireandwhitbyccg.nhs.uk/sustainability-and-transformation-plan

Hambleton and Richmondshire has a predominantly rural area with a local population that is increasing and ageing, with significant in-migration from other parts of the UK in the pre-retirement and the recently retired age groups.

In respect of the current provision of mental health services, most people receive their care and treatment in a community setting. Adults and older people requiring in-patient services are admitted for assessment and treatment, in the main, to the Friarage Hospital, Northallerton. Other or specialist intensive mental health is provided in Teesside or Darlington.

The essence of mental health care is that early intervention, through better education, awareness and care planning can help people to self-manage and prevent deterioration of their condition. Similarly improved support for family and carers, speedier access to support services, the use of new technologies and caring for people at home where possible all bring improved outcomes for people and help them to maintain good mental health.

In this process therefore, it is vital that services do not only consider the treatment of people already diagnosed with mental health conditions, but also consider preventative strategies aimed at the wider population, supported through Public Health services.

A full 'Transforming Mental Health' case for change document can be found in Appendix 1.

Strengths and challenges

We have learnt from our engagement to date that ***our strengths*** as a health care system are:

1. Strong communities that support each other.
2. Good self-care and resilience with good informal networks.
3. Lots of projects that work well to improve care.
4. Staff that are dedicated and committed to the area.
5. Multi-professional team working.
6. Good communication with our population and a feeling of being empowered.
7. High regard for our GPs, urgent care and mental health working together.
8. Excellent care and service at the Friarage Hospital.

Some of ***our challenges*** identified from engagement include:

1. Perception that the Friarage Hospital will be closed.
2. Difficulties with transport.
3. Rurality of the area.
4. Poor IT and communications infrastructure which is not joined up.

5. Workforce challenges.
6. Some lack of public understanding around mental health services and services required.
7. Need for modern, evidence based services and care for patients with a mental health illness.

Key Principles

We will adhere to the following principles of good practice*:*

- **Open** – decision makers are accessible and ready to engage in dialogue. When information cannot be given, the reasons are explained.
- **Two-way** – there are opportunities for open and honest feedback, and people have the right to contribute their ideas and opinions about issues and decisions.
- **Timely** – information arrives at a time when it is needed, relevant to the people receiving it, and able to be interpreted in the correct context.
- **Clear** – communication should be in plain English, jargon free, easy to understand and not open to interpretation.
- **Targeted** – the right messages reach the right audiences using the most appropriate methods available and at the right time.
- **Credible** – messages have real meaning, recipients can trust their content and expect to be advised of any change in circumstances which impact on those messages.
- **Planned** – communications are planned rather than ad-hoc, and are regularly reviewed and contributed to by senior managers and staff, as appropriate.
- **Consistent** – there are no contradictions in messages given to different groups or individuals. The priority to those messages may differ, but they should never conflict.
- **Efficient** – communications and the way they are delivered are fit for purpose, cost effective, within budget and delivered on time.
- **Integrated** – internal and external communications are consistent and mutually supportive.

- **Corporate** – the messages communicated are consistent with the aims, values and objectives of NHS Hambleton, Richmondshire and Whitby CCG and Tees, Esk and Wear Valleys NHS Foundation Trust.

Aims and objectives of this strategy

The overarching aims and objectives of this strategy are:

- To underpin providing adult mental health services for adults and older people.
- To raise awareness and understanding of why it is important that HRW CCG and TEWV has a plan to deliver sustainable and viable mental health services closer to home in the future.
- To ensure that appropriate mechanisms are in place so that the public, key stakeholders and partners feel engaged and informed throughout the process so they can influence the future model.
- To contribute to shaping public, and health services' staff, expectations of mental health services across Hambleton and Richmondshire.
- To provide a framework by which HRW CCG and TEWV, who are both involved in the consultation are able to deliver consistent messages through a coordinated approach to communications and engagement activity.
- To maintain credibility by being open, honest and transparent throughout the process.
- To monitor and gauge public and stakeholder perception throughout the process and respond appropriately.
- To be clear about what people can and cannot influence throughout the engagement and consultation phases.
- To achieve engagement that is meaningful and proportionate, building on existing intelligence and feedback such as previous engagement/consultation activities, complaints, compliments etc.
- To provide information and context about the proposals in clear and appropriate formats that is accessible and relevant to target audiences.
- To give opportunities to respond through a formal consultation process.
- To maintain trust between the NHS and the public that action is being taken to ensure high quality NHS services in their local area.

- To demonstrate the NHS is planning for the future.

Legislation – our statutory requirements

Any reconfiguration of services requires a robust and comprehensive engagement and consultation process. NHS organisations are required to ensure that local people, stakeholder and partners are informed, involved and have an opportunity to influence any change.

This document is guided and influenced by the "Six Principals for Engaging People and Communities; definitions, evaluation and measurement". The principals are:

1. Care and support is person-centered; personalised, coordinated and empowering.
2. Services are created in partnership with citizens and communities.
3. Focus in on equality and narrowing inequality.
4. Carers are identified, supported and involved.
5. Voluntary community and social enterprise, and housing sectors are involved as key partners and enablers.
6. Volunteering and social action are key enablers.

At the heart of the principles is the assertion in the NHS Five Year Forward View that 'a new relationship with patients and communities' is key to closing the three gaps identified by the NHS Five Year Forward View: health and wellbeing, quality of care and treatment, finance and efficiency.

These principles require the NHS to ensure that there is a move away from paternalistic, fragmented health and social care services and that the focus is on supporting people better to manage their health and wellbeing. It is for NHS organisations to ensure that the focus is on ensuring people have as much choice, voice, control and support as they want in decisions that involved their health and care. Growing evidence shows that involvement is the key to improving outcomes and improving the experience of care.

Creating services in partnership with the public and communities and using a co-design approach to design services means working with all sectors of the community including voluntary, community and social enterprise sectors along with patient participation groups, carers and other agencies.

The document supports the need to focus on equality and ensuring that includes all the groups protected under the Equality Act 2010, as well as people who are less likely to use services and those who have the lowest health outcomes. Identifying and supporting carers and ensuring they are involved in this part of the process.

Key messages

It is our ambition to support people to live fulfilling and meaningful lives in their community, irrespective of symptoms or diagnosis of mental illness (a recovery-focused approach)

We will achieve this by:

- Providing more recovery-focused services in the community, closer to patients' homes.
- Making sure patients and their carers get the treatment and support they need, when they need it (any time, day or night).
- Supporting access to specialist assessment and treatments such as inpatient care, when required.
- Providing evidence-based treatment in the most appropriate care setting
- Mental health services and general practitioners (GPs) continuing to work closely together to provide local services for local people.
- Delivering inpatient and community services in high quality, fit-for-purpose buildings.

The key messages are:

- The ways in which mental health care can be delivered is changing and evolving. More people are now able to receive the mental health care and treatment they need at home and hospital admission is becoming the exception rather than the norm.

- HRW CCG has already consulted on older people's community services and during engagement, mental health provision was highlighted by the public as an area to address.

- Because of national challenges facing the NHS and local authority financial climate there is an increasing need to use resources effectively and efficiently. We must achieve the best outcomes for our patients within the available budget.

- The public tell us that they want to see more services being provided at home or as close to home as possible.

- We need to review the type of services that are available in community settings and those that are delivered in hospital. We also need to look at integrating some services and providing others so that more can be delivered locally, close to where people live.

- Reassurance around the future of the Friarage Hospital.

Stakeholders

For the purpose of this strategy, the definition of stakeholders is anyone who will be affected (either positively or negatively) by a proposed change to mental health services locally, those who have an opinion on the proposed changes and those who could influence other stakeholders.

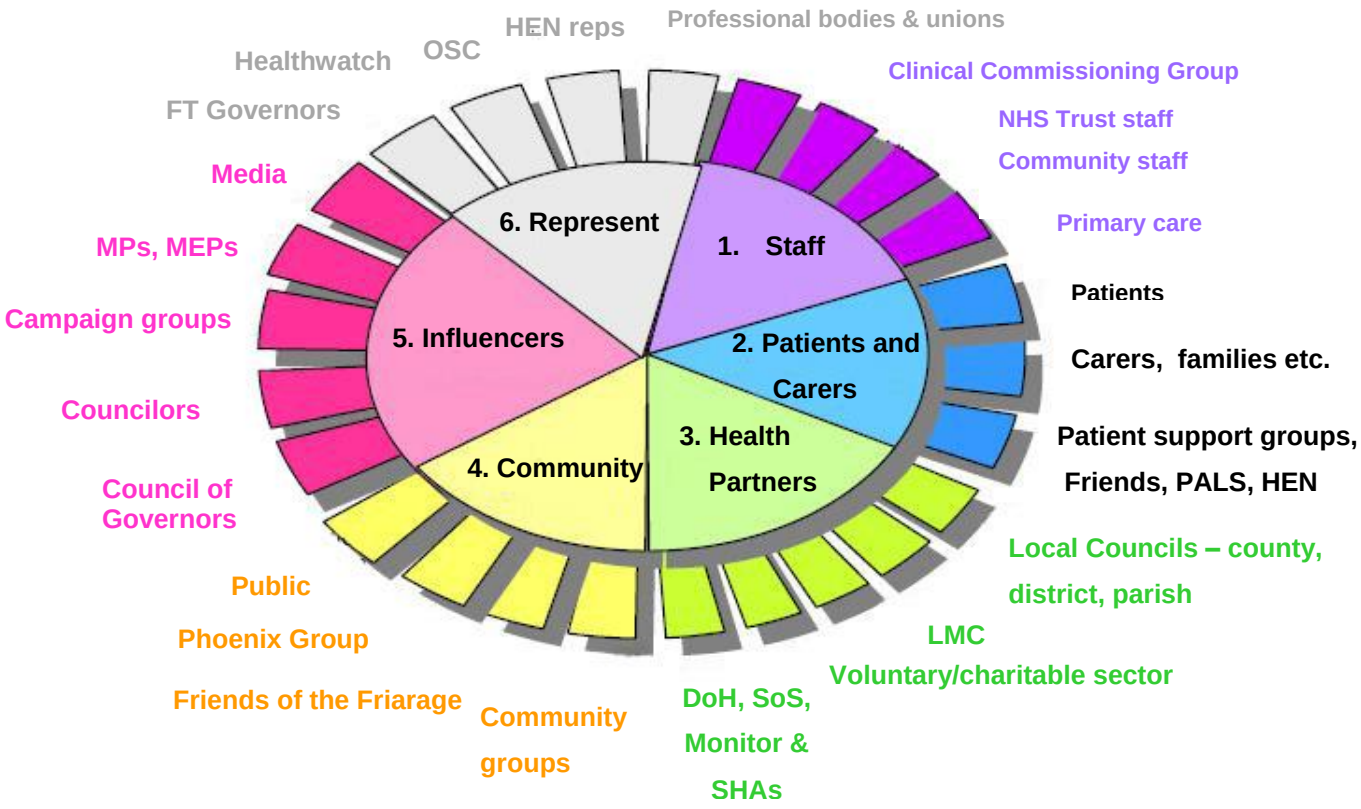
There are a wide range of stakeholders who will have varying degrees of interest in and influence on the acute care services agenda.

Broadly, those stakeholders fall into the following categories:

- Internal (CCG and Trust staff)
- NHS partners (including GPs) and local authorities
- Service users and their carers
- The local community
- Political audiences
- Governance and regulators
- Under-represented groups

Please refer to Appendix 2 for further detail on stakeholders

Stakeholder Segmentation



Communication and Engagement Process

The three phased plan to build a better future was approved by the HRW Transformation Board, which is made up of the following members:

- NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group (HRW CCG)
- South Tees Hospitals NHS Foundation Trust (STHFT)
- Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)
- York Hospitals NHS Foundation Trust (YHFT)
- County Durham and Darlington NHS Foundation Trust (CDDFT)
- Harrogate & Rural District NHS Foundation Trust (HDFT)
- Humber NHS Foundation Trust (HFT)
- Yorkshire Ambulance Service NHS Trust (YAS)
- Hambleton District Council (HDC)
- Richmondshire District Council (RDC)
- Scarborough Borough Council (SBC)
- North Yorkshire County Council (NYCC), through the Joint Health and Wellbeing Board (JHWB) and the Scrutiny of Health Committee.
- Heartbeat Alliance - GP Federation
- Community and voluntary sector organisations
- NHS England Area Team – North Yorkshire and Humber

Engagement Process

The engagement stage forms part of the early discussions and is about gathering detailed information to support the health economy to develop the formal public consultation proposal for service change. It will operate via a three-phased approach.

Phase one: Listening (February 2017 and March 2017)

This listening phase (or pre-engagement phase) will involve:

- the in-depth gathering of views and suggestions from identified patients and carers.

- revisiting existing staff, patient and public views based on previous consultation feedback (including customer feedback, complaints, suggestions and previous surveys).
- reviewing the ways in which those people, and the wider general public, think adult mental health services can be improved or changed.
- the view of clinicians and other professionals in relation to current in-hospital mental health provision across Hambleton and Richmondshire.
- the public in developing the options criteria to assess potential health services scenarios to go forward for modelling and then as potential options for consultation.

Key questions will include:

1. What do we need to do to care for more people in the community?
2. How do we improve the care of those with increased need or in crisis?
3. What do we need to do to reduce the need for hospital admission and keep the length of stay to a minimum?

In addition, this engagement will lay the groundwork for discussions during the formal consultation.

Phase two: Reporting and options development (March 2017 - May 2017)

This important phase is an opportunity to review feedback, respond to queries and review reoccurring themes from the listening events. It will also be an opportunity to build on any gaps in the listening phase.

This information helps to develop the formal consultation options. These options will be informed by public feedback and clinical evidence and will be shared for formal consultation during the final phase.

During this phase, authorities such as NHS England and the North Yorkshire Scrutiny of Health Committee will continue to be updated along with our key stakeholders.

Phase three: Formal consultation (Mid May 2017 until mid-August 2017)

Following the engagement, there will be a formal consultation period of 12-14 weeks. The consultation will provide:

- the public with the opportunity to comment on the options that are taken forward from the appraisal and scoring process.
- a balance between clinical and public perspectives within the models going forward as potential options for consultation.
- engagement around the equality impact assessment conducted by HRW CCG.
- validation of the equality impact assessment.

A consultation document which outlines the case for change and questions will be distributed widely across Hambleton and Richmondshire, available online and upon request.

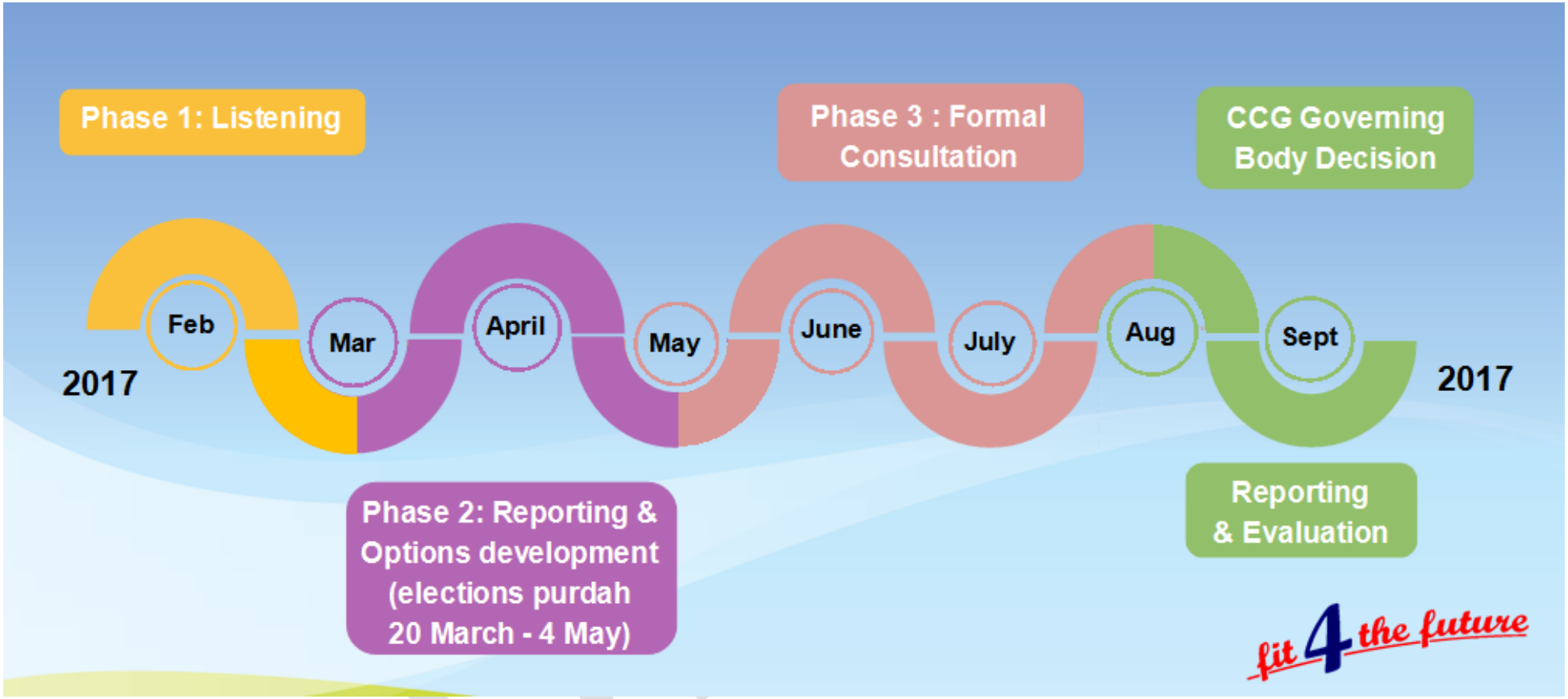
There will be a range of mechanisms and activities to gather feedback and views including:

- Opportunities for formal and informal discussion in appropriate and accessible locations.
- Presentations to a wide range of groups and audiences (pro-active and on request).
- Staff briefings and meetings.
- Information in prime community and health settings.
- Information on relevant websites.
- Media relations.
- Posters in a range of community venues throughout the health economy including health settings, libraries etc.
- Information distributed and shared through public partners publications and information points.
- Feedback forms and questionnaires.
- Social media.

Post consultation

Once the outcome of the consultation process has been decided feedback will be provided to all key stakeholders using agreed channels.

Engagement and Consultation Timeline:



Methodology

We want to involve as many people as possible in our consultation so we intend to use a variety of approaches to let people know about the consultation and to provide people with the opportunity to have their say. We aim to:

- Publish a full consultation document.
- Brief North Yorkshire County Council (NYCC) Scrutiny for Health Committee both prior and during the consultation.
- Hold a number of pre-consultation listening events to help shape the options included in the consultation.
- Hold public consultation events across the CCG footprint.
- Utilise existing CCG, Trust and community events.
- Meet with consultant physicians at the Friarage Hospital to discuss the proposals.
- Attend a number of meetings with local groups such as the Phoenix Group and the Friends of the Friarage.
- Attend a number of NHS staff briefings.
- Circulate stakeholder briefings (to include MPs, councillors and Health Engagement Network members).
- Present to representatives of NYCC, Hambleton Forum, Hambleton/ Richmondshire District Scrutiny Committees.
- Produce a short video describing the purpose of the consultation.
- Conduct a survey, both online and in paper form.
- Present the consultation to the Council of Members (representing each of the 22 GP Practices).
- Involve local GPs through email correspondence and regular locality meetings.
- Distribute copies of a summary consultation document both in hard copy and PDF.
- Produce and distribute posters advertising the listening and consultation and events.
- Launch a dedicated webpage (both CCG and Trust websites).
- Issue proactive media releases and statements where appropriate.

- Respond to media enquiries, direct public/ stakeholder enquiries and MP letters.
- Post a number of dedicated tweets using #TransformingMentalHealth
- Post a number of Facebook posts.
- Include features in public and GP newsletters.
- Utilise existing 'feedback' email address: hrwccg.feedback@nhs.net

Previous engagement and consultation

Listening and consultation events held across Hambleton and Richmondshire during the 'Transforming Our Communities' consultation on community services are listed below. Overall, 885 members of the public attended these events.

Date	Venue	Location
22/03/2016	Thirsk School	Thirsk
30/03/2016	Golden Fleece	Thirsk
31/03/2016	Thirsk & Sowerby Town Hall	Thirsk
04/04/2016	Thirsk Market Place	Thirsk
07/04/2016	Thirsk Auction Mart	Thirsk
12/04/2016	Osmotherley Coffee Morning	Osmotherley
12/04/2016	Thirsk Auction Mart	Thirsk
13/04/2016	Northallerton Market Place	Northallerton
14/04/2016	Sandhutton & Breckenbrough	Thirsk
20/04/2016	East Thirsk Community Hall	Thirsk
09/05/2016	Golden Lion Hotel	Northallerton
10/05/2016	Friarage 'Hub'	Northallerton
13/05/2016	Stokesley Market Stand	Stokesley
16/05/2016	Thirsk Market Stand	Thirsk
17/05/2016	Bedale Market Stand	Bedale
20/05/2016	Leyburn Maket Stand	Leyburn
23/05/2016	Hawes GP practice	Hawes
26/06/2016	Thirsk Truck Gathering	Thirsk
07/07/2016	Thirsk Library	Thirsk
10/07/2016	Northallerton Carnival	Northallerton
12/07/2016	Coffee Morning, Osmotherley	Osmotherley
16/07/2016	Sowerby Summer Fete	Sowerby
21/07/2016	Thirsk Library	Thirsk
23/07/2016	Emergency Services Show	Richmond
25/07/2016	Thirsk Market	Thirsk
27/07/2016	Borrowby Show	Thirsk
02/08/2016	Lambert Medical Centre	Thirsk
03/08/2016	Northallerton Market	Northallerton

04/08/2016	Civic Centre	Northallerton
04/08/2016	Civic Centre	Northallerton
06/08/2016	Osmotherley Show	Osmotherley
10/08/2016	Danby Show	Whitby
11/08/2016	Thirsk Health Centre	Thirsk
16/08/2016	Glebe House Bedale Surgery	Bedale
18/08/2016	Meadowfields Extra Care Housing	Thirsk
22/08/2016	Thirsk Garden Centre	Thirsk
24/08/2016	Egton Horse & Agricultural Show	Whitby
30/08/2016	Friarage Entrance	Northallerton
01/09/2016	Thirsk Library	Thirsk
05/09/2016	Topcliffe Surgery	Thirsk
05/09/2016	Topcliffe Surgery	Thirsk
07/09/2016	Muker Show	Dales
08/09/2016	Civic Centre	Northallerton
08/09/2016	Civic Centre	Northallerton
12/09/2016	Stokesley Health Centre	Stokesley
15/09/2016	Thirsk Leisure Centre	Thirsk
19/09/2016	The Friary Surgery	Richmond
20/09/2016	Friarage Entrance	Northallerton
21/09/2016	Thirsk Health Centre	Thirsk
26/09/2016	Great Ayton HC	Richmond
27/09/2016	Meadowfields Extra Care Housing	Thirsk

Engagement already undertaken with a focus on mental health:

Date	**Audience**	**Location**
05/07/2016	Consultants and managers	The Friarage hospital
13/07/2016	Consultants and managers	The Friarage hospital
09/08/2016	Service users/carers/staff	The Friarage hospital
10/08/2016	Consultants and managers	The Friarage hospital
09/09/2016	Service users/carers/staff	The Friarage hospital
14/09/2016	Consultants and managers	The Friarage hospital
05/10/2016	TEWV and NYCC staff	The Friarage hospital
10/10/2016	Service user/carer/staff/charity/3rd sector/general public	The cricket club Richmond
12/10/2016	Consultants and managers	The Friarage hospital
09/11/2016	Consultants and managers	The Friarage hospital
09/11/2016	TEWV and NYCC staff	The Friarage hospital
11/11/2016	Service users/carers/staff	The Friarage hospital
07/12/2016	TEWV and NYCC staff	The Friarage hospital
07/12/2016	TEWV and NYCC staff	The Friarage hospital
13/12/2016	Service users/carers/staff	The Friarage hospital
15/12/2016	Consultants and managers	The Friarage hospital
04/01/2017	TEWV and NYCC staff	The Friarage hospital

04/01/2017	TEWV staff inc D&D and TEES NYCC staff service users	The Friarage hospital
11/01/2017	Consultants and managers	The Friarage hospital
13/01/2017	Service users/carers/staff	The Friarage hospital

Communications and Engagement Action Plan

NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group (HRW CCG) key players and spokespeople:

- Janet Probert – Chief Officer (JP)
- Dr Charles Parker – local GP and Clinical Chair (CP)
- Dr George Campbell – local GP and Governing Body member (GCa)
- Dr Mark Hodgson – local GP and Governing Body member (MH)
- Gill Collinson – Chief Nurse (GC)
- Beverley Hunter – Head of Mental Health, Partnership Commissioning Unit (BH)
- Lisa Pope – Deputy Chief Operating Officer (LP)
- Abi Barron – Head of Strategy, Community Care (AB)
- Georgina Sayers – Communications and Engagement Manager (GS)

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) key players and spokespeople:

- Mr Colin Martin – Chief Executive (CM)
- Dr Nick Land – Medical Director (NL)
- Adele Coulthard, director of operations, North Yorkshire (AC)
- Julie Jones – Head of Communications (JJ)

South Tees Hospitals NHS Foundation Trust (STHFT):

- Siobhan McArdle – Chief Executive (SM)
- Amanda Marksby – Head of Reputation (AM)

1. Phase one – announcing the start of engagement

Audience	Mechanism	Attended/actions by	Date
NHS England	Attend formal meeting to discuss consultation process	JP/BH/LP	17.01.17
OSC	Attend formal meeting to discuss and present on consultation proposals	JP/BH/AB	27.01.17
CCG/PCU staff TEWV staff STHFT staff Governing Bodies HEN Reps	Briefings circulated	GS/JJ/AM	
MPs OSC Councillors	JP to brief via telephone/meeting prior to circulation of briefing: • Rishi Sunak MP • Kevin Hollinrake MP • Health Overview and Scrutiny Committee (OSC) Cllr Clark / Daniel Harry	JP	
Clinical stakeholders	Briefing circulated to clinical stakeholders including: • GPs • Pharmacies • Dentists • TEWV adult and MHSOP inpatient and community staff • NHS partner organisations (if clinical) Include dates, venues and timings and public and clinical/stakeholder engagement events.	GS/JJ/AM	
Wider stakeholders	Briefing circulated to wider stakeholders including: • County and Local Councillors • Parish Councillors • Voluntary sector organisations • Non NHS partner organisations • PPGs • Health Engagement Network members • Trust governors • Trust members • Service users and carer groups • Healthwatch Include dates, venues and timings and public/stakeholder engagement events.	GS/JJ/AM	
Media contacts	Media release to Hambleton & Richmondshire media contacts to include dates,	GS	

	venues and timings of public engagement events. Offer interviews with senior CCG/PCU/TEWV representatives.		
Wider public	Create dedicated website page Post on social media channels Include information in relevant newsletters Create posters and circulate Create video and circulate Update FAQs	GS/JJ/AM	

Public listening events/meetings

Date	Time	Location
TBC	TBC	TBC

2. Phase two – confirming purdah and options development

Audience	Mechanism	Attended/actions by	Date
NHS England	Attend formal meeting to update on consultation process and feedback from engagement	JP/BH/AB	
OSC	Attend formal meeting to update on consultation proposals and feedback from engagement	JP/BH/AB	
CCG/PCU staff TEWV staff STHFT staff Governing Bodies HEN Reps	Briefings circulated to include feedback from engagement events and next steps	GS/JJ/AM	
MPs OSC Councillors	JP to update and feedback from engagement via email to: • Rishi Sunak MP • Kevin Hollinrake MP • Health Overview and Scrutiny Committee (OSC) Cllr Clark / Daniel Harry	JP	
Clinical stakeholders	Update on engagement feedback circulated to clinical stakeholders including: • GPs • Pharmacies • Dentists • TEWV adult and MHSOP inpatient and community staff • NHS partner organisations (if clinical)	GS/JJ/AM	
Wider stakeholders	Update on engagement feedback circulated to wider stakeholders including: • County and Local Councillors • Parish Councillors • Voluntary sector organisations • Non NHS partner organisations • PPGs • Health Engagement Network members • Trust governors • Trust members • Service users and carer groups • Healthwatch	GS/JJ/AM	
Media contacts	Media release to Hambleton & Richmondshire media contacts to include confirmation of period of purdah. Include key themes from engagement and next steps. Offer interviews with senior CCG/PCU/TEWV representatives.	GS	

Wider public	Update website page Post on social media channels Include information in relevant newsletters Update FAQs	GS/JJ/AM	

3 – Phase three – announcing options and formal consultation

Audience	Mechanism	Attended/actions by	Date
NHS England	Attend formal meeting to present consultation options	JP/BH/AB	
OSC	Attend formal meeting to present consultation options	JP/BH/AB	
CCG/PCU staff TEWV staff STHFT staff Governing Bodies HEN Reps	Briefings circulated to include consultation options, event details and next steps	GS/JJ/AM	
MPs OSC Councillors	JP to brief via telephone/meeting to include consultation options, event details and next steps to: • Rishi Sunak MP • Kevin Hollinrake MP • Health Overview and Scrutiny Committee (OSC) Cllr Clark / Daniel Harry	JP	
Clinical stakeholders	Briefings circulated to include consultation options, event details and next steps: • GPs • Pharmacies • Dentists • TEWV adult and MHSOP inpatient and community staff • NHS partner organisations (if clinical)	GS/JJ/AM	
Wider stakeholders	Briefings circulated to include consultation options, event details and next steps: • County and Local Councillors • Parish Councillors • Voluntary sector organisations • Non NHS partner organisations • PPGs • Health Engagement Network members • Trust governors • Trust members • Service users and carer groups	GS/JJ/AM	

	• Healthwatch		
Media contacts	Media release to Hambleton & Richmondshire media contacts to include consultation options, event details and next steps. Offer interviews with senior CCG/PCU/TEWV representatives.	GS	
Wider public	Update website page Post on social media channels Include information in relevant newsletters Update posters and circulate Update video and circulate Update FAQs <u>Email</u> Use the feedback email address for this project which can be accessed by a range of people to enable continuous monitoring and response. <u>Questionnaire</u> Survey monkey questionnaire linked to website. Hard copies available. <u>Web presence</u> Update the website page. <u>Social media</u> Use CCG Facebook and Twitter profiles to signpost to information and engagement opportunities. **Off line engagement** Background documents and hard copy questionnaires to be used at public events and distributed to key local venues e.g. libraries, GP practices	GS/JJ/AM	

Public consultation events/meetings

Date	Time	Location
TBC	TBC	TBC

Reporting and evaluation

Audience	Mechanism	Attended/actions by	Date
NHS England	Attend formal meeting to present results of consultation	JP/BH/AB	
OSC	Attend formal meeting to present results of consultation	JP/BH/AB	
CCG/PCU staff TEWV staff STHFT staff Governing Bodies HEN Reps	Briefings circulated to include consultation options, event details and next steps	GS/JJ/AM	
MPs OSC Councillors	JP to brief via telephone/meeting to include consultation options, event details and next steps to: • Rishi Sunak MP • Kevin Hollinrake MP • Health Overview and Scrutiny Committee (OSC) Cllr Clark / Daniel Harry	JP	
Clinical stakeholders	Briefings circulated to include consultation options, event details and next steps: • GPs • Pharmacies • Dentists • TEWV adult and MHSOP inpatient and community staff • NHS partner organisations (if clinical)	GS/JJ/AM	
Wider stakeholders	Briefings circulated to include consultation options, event details and next steps:	GS/JJ/AM	

	• County and Local Councillors • Parish Councillors • Voluntary sector organisations • Non NHS partner organisations • PPGs • Health Engagement Network members • Trust governors • Trust members • Service users and carer groups • Healthwatch		
Media contacts	Media release to Hambleton & Richmondshire media contacts to include consultation options, event details and next steps. Offer interviews with senior CCG/PCU/TEWV representatives.	GS	
Wider public	Update website page Post on social media channels Include information in relevant newsletters Update posters and circulate Update video and circulate	GS/JJ/AM	

Post decision communications

Audience	Mechanism	Attended/actions by	Date
NHS England	Attend formal meeting to present results of consultation	JP/BH/AB	
OSC	Attend formal meeting to present results of consultation	JP/BH/AB	
CCG/PCU staff TEWV staff STHFT staff Governing Bodies HEN Reps	Briefings circulated to include consultation options, event details and next steps	GS/JJ/AM	
MPs OSC Councillors	JP to brief via telephone/meeting to include consultation options, event details and next steps to: • Rishi Sunak MP • Kevin Hollinrake MP • Health Overview and Scrutiny Committee (OSC) Cllr Clark / Daniel Harry	JP	
Clinical stakeholders	Briefings circulated to include consultation options, event details and next steps: • GPs	GS/JJ/AM	

	• Pharmacies • Dentists • TEWV adult and MHSOP inpatient and community staff • NHS partner organisations (if clinical)		
Wider stakeholders	Briefings circulated to include consultation options, event details and next steps: • County and Local Councillors • Parish Councillors • Voluntary sector organisations • Non NHS partner organisations • PPGs • Health Engagement Network members • Trust governors • Trust members • Service users and carer groups • Healthwatch	GS/JJ/AM	
Media contacts	Media release to Hambleton & Richmondshire media contacts to include consultation options, event details and next steps. Offer interviews with senior CCG/PCU/TEWV representatives.	GS	
Wider public	Update website page Post on social media channels Include information in relevant newsletters Update posters and circulate Update video and circulate	GS/JJ/AM	

Materials required:

- Full consultation document (PDF and hard copies).
- Summary consultation documents (PDF and hard copies).
- Easy-read consultation summary documents (PDF and hard copies).
- Presentation slides.
- Survey/questionnaire – online and hard copies.
- FAQ document – living document produced in house as required.
- Other evidence or case for change documents – produced in house as required.
- Dedicated webpage to host information, FAQ, link to online survey – hosted on CCG website.
- Feedback form/mechanisms including social media.
- Video – development in partnership between CCG and Trust.

Sharing Information

Information will be made available that is relevant and accessible to the public and patients. This will include the consultation document that will be prepared.

Information will also be made available via online, digital and social media channels to facilitate discussion and feedback amongst stakeholders who are more likely to engage via these channels.

Communications/engagement management and responsibilities

A communications and engagement working group comprising representatives from CCG and Tees, Esk and Wear Valleys NHS Foundation Trust led by Gill Collinson and reporting to community transformation programme board will oversee the practical implementation of plans relating to this plan. The following resources will be in place to manage this communications and engagement process:

Communications and engagement planning	CCG/ TEWV
Production of reports and consultation document	PCU
Implementing the consultation plan	PCU
Presenting to NYCC Scrutiny for Health	CCG/ TEWV
Presenting to Community Transformation Board	Gill Collinson/ Lisa Pope
Management of Comms and all enquiries	CCG / PCU
Decision following consultation	CCG Governing Body
Dissemination of decision	CCG / TEWV

Budget

Insert budget allocation for consultation (CCG and Trust).

Risk and Mitigation

Risk and risk mitigation will be managed by the Community Transformation Programme Board and escalation to the HRW CCG weekly Senior Management Team meetings. Risk will be placed on the HRW CCG corporate risk register.

Insert PESTEL analysis

Reporting and Feedback

Representatives from the CCG, TEWV and PCU will re-group on a monthly (or weekly as the consultation develops) basis to review:

- progress against the agreed timelines.
- the action log.
- the risk register.
- the effectiveness of the communications and engagement strategy.
- effectiveness in line with the wider programme strategy.

A communications and engagement working group will meet formally on a monthly basis to discuss issues. This may move to weekly as the consultation progresses.

Evaluation and monitoring

This communications and engagement strategy will be evaluated at four stages of the process:

- At the end of the phase one listening stage.
- At the end of phase two consultation stage.
- In the middle of phase three consultation stage.
- At the end of phase three consultation stage.

The CCG will formally log all communications and engagement activity. This includes materials circulated, feedback, survey responses and number of event delegates.

Appendix 1: Legislation

The process for involving people requires a clear action plan and audit trail, including evidence of how the public have influenced decisions at every stage of the process and the mechanisms used.

Section 242 of the NHS Act 2006 sets out the statutory requirement for NHS organisations to involve and consult patients and the public in:

- The planning and provision of services.
- The development and consideration of proposals for changes in the way services are provided.
- Decisions to be made by NHS organisations that affect the operation of services.

Section 244 of the NHS Act 2006 requires NHS organisations to consult relevant Overview and Scrutiny Committees (OSC) on any proposals for a substantial development of the health service in the area of the Local Authority, or a substantial variation in the provision of services.

Section 2a of the NHS Constitution gives the following right to patients:

"You have the right to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services."

In addition the Secretary of State for Health has outlined four tests for service change:

Support from GP Commissioners	Engagement with GPs, particularly with practices whose patients might be significantly affected by proposed service changes
Clear clinical evidence base	The strength of the clinical evidence to be reviewed, along with support from senior clinicians from services where changes are proposed, against clinical best practice and current and future needs of patients
Strengthened patient and public engagement	Ensure that the public, patients, staff, Healthwatch and Health Overview and Scrutiny Committees are engaged and consulted on the proposed changes
Supporting patient choice	Central principle underpinning service reconfigurations is that patients should have access to the right treatment, at the right place and the right time. There should be a strong case for the quality of proposed service and improvements in the patient experience

The Gunning Principles

Before 1985 there was little consideration given to consultations until a landmark case of Regina v London Borough of Brent ex parte Gunning. This case sparked the need for change in the process of consultations when Stephen Sedley QC proposed a set of principles that were then adopted by the presiding judge. These principles, known as Gunning or Sedley, were later confirmed by the Court of Appeal in 2001 (Coughlan case) and are now applicable to all public consultations that take place in the UK.

The principles are:

- **Consultation must take place when proposals are still at a formative stage**

  Consultation should be at a stage when the results of the consultation can influence the decision-making (and Gunning 4).
- **Sufficient reasons must be put forward for the proposals to allow for 'intelligent consideration'**

  A preferred option may be included and this must be made obvious to those being consulted. Information and reasons for the proposals must be made available to allow for consultees to understand why they are being consulted as well as all the options available and what these mean. Equality Impact Assessment to be completed and sit alongside the consultation document
- **Adequate time must be given for consideration and response**

  There is no set timeframe recommended but reasonable steps must be taken to ensure that those consulted are aware of the exercise and are given sufficient time to respond.
- **The outcome of the consultation must be conscientiously taken into account**

  Decision-makers must be able to show they have taken the outcome of the consultation into account – they should be able to demonstrate good reasons and evidence for their decision. This does not mean that the decision-makers have to agree with the majority response, but they should be able to set out why the majority view was not followed.

Best practice and managing risk

This strategy takes account of NHS England good practice guidance - Transforming Participation in Health and Care - 'The NHS Belongs to us all' by:

- Engaging communities with influence and control e.g. working with CVS and Healthwatch.
- Engaging the public in the planning and delivery of service change e.g. engage early and build on insights.
- Providing good quality information.
- Providing a range of opportunities for participation.
- Working with patients and the public from the initial planning stages.

In summary, any reconfiguration of services requires a robust and comprehensive engagement and consultation process. The risk of not following these procedures could result in a Judicial Review. A number of public bodies across the UK have been taken to Judicial Review and deemed to have acted unlawfully in the Public Sector Equality Duty – usually linked to the four Gunning Principles.

As well as documented evidence of GP support, the case for change will need to:

- State clearly the benefits for patients, quality and finance.
- Demonstrate that the clinical case conforms to national best practice.
- Be aligned to commissioners' strategic plans.
- Be aligned with the recommendations of *Healthy Ambitions.*
- Have clear details of option appraisals.
- Provide an analysis of macro impact.
- Be aligned with QIPP work streams.

The Independent Reconfiguration Panel (IRP), whose role is to advise ministers on controversial reconfigurations, recommends that those considering proposals for significant health service changes should:

- Make sure the needs of patients and the quality of patient care are central to the proposal.
- Consider the role of flexible working in the proposals – this may involve developing new approaches to working and redesigning roles.
- Assess the effect of the proposal on other services in the area.

- Give early consideration to transport and site access issues.
- Allow time for public engagement and a discussion phase before the formal consultation – people want to understand the issues, so involving them early on will help when it comes to the formal stage.
- Obtain independent validation of the responses to the consultation.

The IRP has also identified a range of common themes:

- Inadequate community and stakeholder engagement in the early stages of planning change
- The clinical case has not been convincingly described or promoted
- Clinical integration across sites and a broader vision of integration into the whole community has been weak
- Proposals that emphasis what cannot be done and underplay the benefits of change and plans for additional services
- Important content missing from the reconfiguration plans and limited methods of conveying them
- Health agencies caught on the back foot about the three issues most likely to excite local opinion - money, transport and emergency care.
- Inadequate attention given to responses during and after the consultation.

Consultations should influence final proposals and it is important to be able to show that they have. Clearly, not all these recommendations will be applicable to all engagement and consultation exercises, but the basic principles of early involvement, and being able to demonstrate that responses have influenced the final outcome, are.

Commissioners and providers should also consider how their engagement and consultation activity impacts upon a wide range of service users including those protected groups identified within the Equality Act.

Appendix 2: Stakeholder plan

Stakeholder Group	Stakeholder	Stakeholder Prioritisation Category	Communication Method(s)
Internal	CCG Governing body	**Key Player**	Face to face meetings
Internal	CCG Staff	**Key Player**	Face to face meetings and briefings
Internal	GPs	**Key Player**	Face to face meetings and briefings
Internal	Staff-side representatives	**Active Engagement and Consultation**	Face to face meetings/briefings
Internal	Staff affected by changes	**Active Engagement and Consultation**	Team and individual briefings/meetings with line managers/ Q&As/ existing internal comms channels
Internal	FT Governors	**Active Engagement and Consultation**	Meetings / briefings
Patients & Public (charities)	Charitable organisations and highly interested groups	**Active Engagement and Consultation**	Face to face meetings and briefings/engagement events and activities
Patients & Public	General public	**Keep Informed Engage and Consult**	Public meetings/ media releases/ website/information stands/ posters/info distributed at prime settings/consultation and engagement documents

Stakeholder Group	Stakeholder	Stakeholder Prioritisation Category	Communication Method(s)
Patients & Public	Affected service user groups	**Active Engagement and Consultation**	Meetings with identified service user groups/ engagement events/ consultation events
Patients & Public	GP Patient Participation Groups	**Keep Informed and engaged via practices**	Meetings/briefings
Patients & Public	Healthwatch	**Active Engagement and Consultation**	Meetings and presentations/ongoing briefings and updates/ consultation and engagement documents
Patients & Public	Protected groups, voluntary and community groups, third sector	**Active Engagement and Consultation**	Meetings with identified groups/ engagement events/ consultation events
Patients & Public	Health Engagement Network	**Active Engagement and Consultation**	Briefings
Political Audiences	Local MPs	**Key Player**	Regular briefings/letters/ meetings
Political Audiences	Local Councillors	**Active Engagement and Consultation**	Regular correspondence updating on progress /OSC/engagement and consultation documents
Political Audiences	Overview and Scrutiny Committees	**Key Player**	Meetings & presentations/ regular briefings
Media	Local and regional media	**Keep Informed**	Pro-active and re-active press releases and statements/ interviews / briefings/ paid-for advertorials and supplements

Stakeholder Group	Stakeholder	Stakeholder Prioritisation Category	Communication Method(s)
Partners	Councils	**Key player**	Briefings as required/ engagement and consultation documents
Partners	Local Medical Committee	**Active Engagement and Consultation**	Meetings & presentations/ regular briefings
GPs	GPs	**Active Engagement and Consultation**	Meetings & presentations at clinical council/ regular briefings
Governance & regulators	NHS England	**Keep Informed**	Briefings via regional office
Governance & regulators	Overview and Scrutiny Committee	**Key Player**	Regular Briefings/ Consultation Documents
Governance & regulators	Local health and Wellbeing Board	**Key Player**	Meetings/briefings

North Yorkshire County Council

Scrutiny of Health Committee

27 January 2017

End of Life Care and 'Dying Well' – draft report for comment

Purpose of Report
This is the draft of the final report on the in-depth scrutiny of End of Life Care in North Yorkshire that has been undertaken by this committee since July 2016.

Members are asked to review the draft report and identify any gaps or omissions, inaccuracies, areas for further investigation and to assure themselves that the recommendations are specific, realistic and relevant to the evidence base presented in this report.

Background

1. At the 1 July 2016 Scrutiny of Health Committee meeting, the initial framework for this piece of in-depth scrutiny was agreed by Members. Since then, evidence has been gathered from a wide range of sources to better understand the current provision of End of Life Care in North Yorkshire and identify any areas where improvements could be made.

Draft report

2. The draft report is presented today for the committee to review. The report is not yet complete, as there is some outstanding evidence to gather and some lines of enquiry still to pursue.

3. The report has been through a peer review process and will be sent after this meeting to all those people who have contributed to it for comment. Final amendments will be made to the report in January and February 2017 and any additional evidence gathered during that period.

4. Following the discussions at this Committee meeting, the intention is to take a final version of this report to the Committee Mid Cycle Briefing on 3 March 2017 for sign off. The final, agreed version of the report will be taken to the meeting of the North Yorkshire Health and Wellbeing Board on 17 March 2017.

Recommendation

5. Members are asked to review the draft report and identify any gaps or omissions, inaccuracies, areas for further investigation and to assure themselves that the recommendations are specific, realistic and relevant to the evidence base that has been built up in the report.

Report author:
Daniel Harry
Scrutiny Team Leader
North Yorkshire County Council
10 January 2017

North Yorkshire County Council

Scrutiny of Health

In-depth scrutiny on End of Life Care in the county

Draft report for review and comment

Section 1 – Background, objectives and methodology

Background

In July 2015 the North Yorkshire Scrutiny of Health Committee was consulted on the 2015 update of the North Yorkshire Joint Health and Wellbeing Strategy (JHWS) 2015-2020. The Committee concluded that there should be a greater emphasis on improving End of Life Care and supporting friends and relatives deal with bereavement and, in some cases, the longer term problems around isolation and loneliness.

The Committee recommended that End of Life Care should be given greater prominence in the Strategy and that there should be a specific priority of 'Dying Well'. This recommendation was accepted by the Health and Wellbeing Board.

The Joint Health and Wellbeing Strategy 2015–2020 was revised to include the 'Dying well' theme. Under this theme a number of improvements to the quality of end of life care services and interventions are listed that will be progressed by 2020, as below:

- A greater range of support options for people in their last years of life
- More people receiving support for themselves and their families at the end of life
- More people dying at home or in the place that they choose
- Greater numbers of trained staff and carers with deeper understanding about the range of issues in end of life care
- Adoption of new and emerging best practice and principles around end of life care (Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020 - www.endoflifecareambitions.org.uk)
- End of life care being planned in an effective and sensitively appropriate way, and for staff to be adequately trained.

A copy of the North Yorkshire Joint Health and Wellbeing Strategy 2015–2020 is available here - http://www.nypartnerships.org.uk/CHttpHandler.ashx?id=21125&p=0

The role of the Scrutiny of Health Committee

The role of the Scrutiny of Health Committee is to review any matter relating to the planning, provision and operation of health services in the County.

The aim is to act as a lever to improve the health of local people, ensuring that the needs of the local people are considered as an integral part of the delivery and development of health services.

This includes:

- Focus on action to achieve health improvement
- Examine healthcare in the context of the wider determinants of health
- Examine how health services address the needs of local communities
- Address health inequalities
- Ensure that local health and health related issues are being tackled jointly and in a coordinated way across agencies.

The extended scrutiny of end of life care services and interventions in the county supports the aim to ensure that 'the needs of local people are considered as an integral part of the delivery and development of health services'.

Objective

The objective of this piece of extended scrutiny work has been to engage with a broad range of commissioners, service providers, patients and the public to better understand the current provision of end of life care in North Yorkshire and identify any areas where improvements could be made.

Recommendations for any improvements will be reviewed at the Scrutiny of Health Committee on 27 January 2017. The intention is then for the final version of the report to be signed off at the committee's Mid Cycle Briefing on 3 March 2017. Thereafter, the report would be formally submitted to the North Yorkshire Health and Wellbeing Board at their meeting of 17 March 2017.

Methodology

The approach taken has been extended scrutiny over a 6 month period. The project has been overseen by the Committee Chairman in consultation with the group spokespersons.

The project was launched at the Scrutiny of Health Committee meeting on 1 July 2016 and a project plan endorsed at committee on 2 September 2016.

The approach has included:

- Desktop research into national guidance, policy and best practice
- Written reports and presentations to the full committee
- Expert witnesses
- Visits to hospices
- Consultation/focus group discussions with stakeholders, carers and patients.

Children and adults

Whilst the majority of people who die are older people, in North Yorkshire typically 85 years of age or older, children, young people also die and so the end of life care services that are on offer to them and their families have also be considered within the scope of this extended piece of scrutiny.

Work plan

The following version of the work programme was endorsed by the Scrutiny of Health Committee on 2 September 2016:

Date	Action
July 2016	Committee meeting on 1 July - project launch, initial meeting, and engagement with Hospices.
	Mid Cycle Briefing on 29 July - identification of issues (lines of enquiry) to explore at focus group meetings.
August 2016	Further research and contacts, refinement of the project plan and preparation for 2 September committee meeting.
September 2016	Committee meeting on 2 September - update on Joint Strategic Needs Assessment and evidence from 'expert witnesses'. Joint Strategic Needs Assessment (JSNA) report 'Dying Well: an Overview of End of Life Care in North Yorkshire' report and presentation - Victoria Turner, Specialty Registrar in Public Health. Contribution from Alex Bird, Chief Executive Officer, Age UK North Yorkshire – Health and Wellbeing Sponsor for Health and Wellbeing Strategy priority of 'Dying Well'.
October 2016	Mid Cycle Briefing on 14 October – CCG perspective – overview of the current and planned provision and commissioning of End of life care services by the 5 CCGs in North Yorkshire.
	21 October – North Yorkshire Wider Partnership Conference workshop on End of Life Care
November 2016	10 November 2016 – site visit to Saint Michael's, Harrogate - convened by Tony Collins. 16 November 2016 – site visit to St Catherine's Hospice, Scarborough - convened by Mike Wilkerson.

Date	Action
	A joint press release to be issued, by NYCC and NY Healthwatch, inviting people to share their experiences of End of Life Care. Responses to be gathered and analysed by NY Healthwatch.
	Committee meeting on 18 November – update on programme of work, outcome of site visits and evidence from 'expert witnesses'. Expert witness – Clair Holdsworth, Deputy Director of Clinical Services, Martin House - Hospice Care for Children and Young People.
December 2016	Mid Cycle Briefing on 16 December – early draft of report for discussion.
	13 December 2016 – site visit to St Leonard's Hospice, York - convened by Emma Johnson.
	Healthwatch to undertake a survey and analysis of findings to feed into December early draft report.
January 2017	Healthwatch to undertake 'Enter and View' visits and feed the analysis of findings into the report in February 2017. Early January 2017 - circulate report to partners and contributors for comment, additions and amendments. Committee meeting on 27 January – draft report for review.
February 2017	Finalisation of report.
March 2017	Report to Scrutiny of Health Mid Cycle Briefing for sign off on 3 March 2017 Report to Health and Wellbeing Board on 17 March.

Definition of terms

End of life care - End of life care is for people who are considered to be in the last year of life, but this timeframe can be difficult to predict. End of life care aims to help people live as well as possible and to die with dignity. End of life care continues for as long as it is needed. End of life care includes the palliative management of pain and other symptoms.

Palliative care - Palliative care is generally for people living with a terminal illness where a cure is no longer possible. It can also be used by people who have a complex illness and need their symptoms controlled. The goal of palliative care is to

help the person and everyone affected by their illness to achieve the best quality of life.

Own home – The definition of 'own home' is broad as people in the last 12 months of their life may be living in a range of different settings, which they may call home. These could include: a home that they own or rent; the home of a relative or friend; a residential care home; a nursing home; and a hospice. It may be more useful to refer to 'familiar surroundings'.

Section 2 – Literature review

Introduction

There is a wide range of research, policy, strategy, guidance and best practice on the subject of end of life care. This reflects the position of the UK as an international lead in the provision of end of life care services and interventions. This also reflects the momentum that has been gained since the publication of the 2008 National Strategy for End of Life Care.

The literature review summarises the key issues identified in a range of documents that have been identified as the most significant. It is, by necessity, exclusive.

National data and needs assessments

Office for National Statistics (July 2016) Statistical bulletin: Deaths registered in England and Wales: 2015
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregistrationsummarytables/previousReleases

The annual data on death registrations highlights:

- There were 529,655 deaths registered in England and Wales in 2015, an increase of 5.6% compared with 2014
- Age-standardised mortality rates (ASMRs) increased in 2015 by 5.1% for females and 3.1% for males; a change to the general decrease in rates in recent years.
- In 2015, mortality rates for respiratory diseases (including flu) increased notably for both males and females.
- Cancer was the most common broad cause of death (28% of all deaths registered) followed by circulatory diseases, such as heart disease and strokes (26%).
- The infant mortality rate remained at 3.9 deaths per 1,000 live births in 2015.

Office for National Statistics (2015) National Survey of Bereaved People (VOICES)
https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/nationalsurveyofbereavedpeoplevoices/previousReleases

This national survey has been run for 5 years. The summary findings from the 2015 survey are as below:

- 3 out of 4 bereaved people (75%) rate the overall quality of end of life care for their relative as outstanding, excellent or good
- 1 out of 10 (10%) rated care as poor
- Overall quality of care for females was rated significantly higher than males with 44% of respondents rating the care as outstanding or excellent compared with 39% for males
- 7 out of 10 people (69%) rated hospital care as outstanding, excellent or good which is significantly lower compared with care homes (82%), hospice care (79%) or care at home (79%)
- Ratings of fair or poor quality of care are significantly higher for those living in the most deprived areas (29%) compared with the least deprived areas (22%)
- 1 out of 3 (33%) reported that the hospital services did not work well together with GP and other services outside the hospital
- 3 out of 4 bereaved people (75%) agreed that the patient's nutritional needs were met in the last 2 days of life, 1 out of 8 (13%) disagreed that the patient had support to eat or receive nutrition
- More than 3 out of 4 bereaved people (78%) agreed that the patient had support to drink or receive fluid in the last 2 days of life, almost 1 out of 8 (12%) disagreed that the patient had support to drink or receive fluid
- More than 5 out of 6 bereaved people (86%) understood the information provided by health care professionals, but 1 out of 6 (16%) said they did not have time to ask questions to health care professionals
- Almost 3 out of 4 (74%) respondents felt hospital was the right place for the patient to die, despite only 3% of all respondents stating patients wanted to die in hospital.

Nuffield Trust (2014) Exploring the cost of End of Life Care
http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/end_of_life_care.pdf

The Nuffield Trust conducted research into the costs associated with non-hospital care services and how people were using them at the end of their lives. Key findings include:

- Hospital costs were by far the largest cost elements of end-of-life care. These averaged over £4,500 per person for those who died, during the final 90 days of their lives. The bulk of this cost was due to emergency hospital admissions. Hospital costs increased rapidly in the last few weeks of life.
- Approximately two thirds of patients saw their GP at least once during the last three months of life, and there were an average of four to five GP visits per person in this time – costing an average of £147 per patient
- Just over a quarter of patients used local authority funded social care during the last 90 days of their life, but the high costs of nursing and residential care meant this averaged out at £1,010 per person who died.

A health economics report is being written by Public Health England and University of York on the costs of end of life care. At the time of writing, this report had not been published.

The Choice in End of Life Care (2015) Programme Board 'What's important to me - A Review of Choice in End of Life Care'
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/407244/CHOICE_REVIEW_FINAL_for_web.pdf

The Choice in End of Life Care Programme Board was a multi-agency group tasked by Government to provide advice on improving the quality and experience of care for adults at the end of life and those around them.

The programme board agreed the following commitment for the provision of end of life care services.

Each person who may be in need of end of life care is offered choices in their care focused on what is important to them and that this offer is:

- made as soon as is practicable after it is recognised that the person may die in the foreseeable future
- based on honest conversations with health and care staff, which supports the person to make informed choices
- consistently reviewed through conversations with health and care staff.

A total of 30 recommendations were made covering: the individual; family and carers; workforce; health and social care; Government; society and community.

Royal College of Physicians (May 2014) National care of the dying audit for hospitals
https://www.rcplondon.ac.uk/projects/outputs/national-care-dying-audit-hospitals

The 2013/14 audit involved a case note review of a sample of all patients dying in hospital. A total of 131 trusts (90% of those eligible) submitted data to the organisational audit. The key findings were:

- Less than a quarter of hospitals had face-to-face palliative care services 7 days per week
- The provision of mandatory training on end of life care for doctors and nursing staff was low
- Documentation of key decisions, assessments and needs in case notes was either inconsistent or key actions were not being taken. For example, there was evidence of only 21% of patients being asked about their spiritual needs
- Local surveys of bereaved relatives showed that 24% did not feel they were involved in decisions about the care and treatment of their family member at all
- Three quarters of bereaved relatives surveyed felt adequately supported during the patient's last 2 days of life.

Local data and needs assessments

North Yorkshire Joint Strategic Needs Assessment

The North Yorkshire Joint Strategic Needs Assessment (JSNA) provides an overview of the current and future health and wellbeing needs of the people of North Yorkshire. It does not look at the particular needs of individual people but seeks to identify where needs are not being met as well as they could be. Specifically, it sets out to answer the following:

- What do people need?
- What are we doing already?
- Is it working?
- Are there things we should be doing but are not?
- Are we targeting services properly?

At the Scrutiny of Health Committee meeting on 2 September 2016, Dr Victoria Turner, Public Health Registrar, presented the findings of the JSNA review of end of life care, as summarised below:

Headline data
Place of death in North Yorkshire in 2013:

- In 2013 there were 6,197 deaths in North Yorkshire across all age groups (1.03% of the total population)
- Of these, 22.2% (1,375) deaths occurred at home
- 26.4% (1,636) deaths occurred in a care home
- 5.8% (358) deaths occurred in a hospice
- 43.3% (2,681) deaths occurred in hospital
- 2.4% (147) deaths occurred in other places.

The top three causes of death in North Yorkshire in 2013:

- Cancer – 27%
- Circulatory disease – 31%
- Respiratory disease – 13%.

Unmet need
Areas of potential unmet need identified:

- Access to preferred place of dying
- Integration of end of life care into all care pathways, particularly for illness pathways other than cancer
- Co-ordinated IT system to enable greater data sharing
- Access to inpatient hospice facilities – there are none in Craven, Hambleton, and Richmondshire. Also, there is no children's hospice within North Yorkshire
- Training in palliative care
- Out of hours access
- Holistic care.

Areas for further investigation
It also highlighted areas for further assessment and/or investigation, as below:

- Training, particularly for those people working in more general palliative and end of life care, such as social workers, care home staff and primary care staff
- Accuracy of recording on the palliative care register
- Information on patient experience at a North Yorkshire level
- Preferred place of death - what proportion of those who express their preference actually die there?
- Assessment of non-health needs, such as social care, spiritual care, legal assistance, general wellbeing advice and emotional support
- Access to services among different socioeconomic groups
- Detailed funding arrangements
- Cost-effectiveness of End of Life Care.

The full report entitled 'Dying Well: an Overview of End of Life Care in North Yorkshire - Joint Strategic Needs Assessment - July 2016' is available on the North Yorkshire County Council website – http://hub.datanorthyorkshire.org/dataset/2cb529f6-4715-4c2d-9364-a770deb03472/resource/21e21b0d-54a1-4eb0-9665-bddf2efa24ac/download/eolc-jsna-report-13-07-16.pdf

National strategy

Ambitions for Palliative and End of Life Care - 2015
The key policy document that has been issued by the Government in the past 5 years is the National Palliative and End of Life Care Partnership (2015) 'Ambitions for Palliative and End of Life Care: a national framework for local action 2015-2020' - http://endoflifecareambitions.org.uk/

This national framework, aimed at local health and social care and community leaders, builds upon the Department of Health's 2008 Strategy for End of Life Care. It has a strong emphasis upon local delivery, partnership, collaboration and co-operation.

The delivery of the national framework is not supported by additional funding. Instead, the emphasis is upon inspiring a wide range of agencies and organisations to drive forward improvements in end of life care.

The national framework has six positive ambitions for palliative and end of life care:

1. Each person is seen as an individual – Honest conversations, Systems for person centred care, Clear expectations, Access to social care, Helping people take control, Integrated care, Good end of life care includes bereavement.
2. Each person gets fair access to care – Using existing data, Community partnerships, Generating new data, Unwavering commitment, Population based needs assessment, Person-centred outcome measurement.
3. Maximising comfort and wellbeing – Recognising distress whatever the cause, Addressing all forms of distress, Skilled assessment & symptom management,

Specialist palliative care, Priorities for care of the dying person, Rehabilitative palliative care.
4. Care is co-ordinated - Shared records, Clear roles and responsibilities, A system-wide response, Everyone matters, Continuity in partnership
5. All staff are prepared to care – Professional ethos, Support and resilience, Knowledge based judgement, Using new technology, Awareness of legislation, Executive governance
6. Each community is prepared to help – Compassionate and resilient communities, Public awareness, Practical support, Volunteers.

These ambitions are founded upon:

1. Personalised care planning
2. Education and training
3. Evidence and information
4. Co-design
5. Shared records
6. 24/7 access
7. Those important to the dying person
8. Leadership.

Strategy for End of Life Care - 2008
https://www.gov.uk/government/publications/end-of-life-care-strategy-promoting-high-quality-care-for-adults-at-the-end-of-their-life

The intention of the 2008 Strategy was to raise awareness of the importance of end of life care provision and increase access to high quality care for all people approaching the end of life.

Adopting a whole system and care pathway approach, the strategy defined a set of minimum expectations around a 'good death' as being

- Being treated as an individual, with dignity and respect
- Being without pain and other symptoms
- Being in familiar surroundings
- Being in the company of close family and/or friends.

The strategy outlined what its successful implementation would mean for patients and carers, as follows:

- The opportunity to discuss your personal needs and preferences with professionals who can support you, have them recorded in a care plan and acted upon
- Coordinated care and support
- Rapid specialist advice and clinical assessment
- High quality care and support during the last days of your life
- Services which treat you with dignity and respect both before and after death
- Appropriate advice and support for your carers at every stage.

To achieve this, services will be:

- Well planned and coordinated
- Quality assured and delivered to a high standard
- Monitored and assessed to ensure quality
- Informed by the experience of others who have been in a similar situation to you.

The strategy is credited with having managed to reverse the upward trend of people dying in hospital. Also, that it generated momentum and energy, which led to significant improvements in end of life care.

Reference - Department of Health (2008) End of Life Care Strategy - Promoting high quality care for all adults at the end of life

One chance to get it right - 2014
In 2014 the Leadership Alliance for the Care of Dying People published a report setting out an approach to caring for dying people that should be applied system wide, in all settings. In summary, the Priorities for Care are that, when it is thought that a person may die within the next few days or hours:

- The possibility is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed
- Sensitive communication takes place between staff and the dying person, and those identified as important to them
- The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants
- The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible
- An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

The Leadership Alliance, a partnership of 21 organisations from health, social care and the community and voluntary sector, was set up in response to the independent review of the Liverpool care Pathway for the Dying Patient (LcP), which reported in July 2013.

Reference - Leadership Alliance for the Care of Dying People (2014) 'One chance to get it right - Improving people's experience of care in the last few days and hours of life'.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_right.pdf

Actions for End of Life Care - 2014
This national policy statement set-out a series of commitments for the period 2014-16, based upon a 'House of Care' model, as below:

- People who are living with progressive, life-limiting conditions must be at the centre of any decision, plan or action for their care or treatment
- Health and care professionals build and sustain their commitment to working in partnership with each other, and with the people they care for and those close to them
- Consistent, coordinated care is a crucial component of person-centred care, especially for people with progressive, life-limiting conditions, and those close to them
- Improve the commissioning of palliative and end of life care services so that people living with progressive, life-limiting conditions, and those close to them, can receive the best possible care which matches their level of need and, as far as possible, preference.

It pre-dates the 2015 national framework and represents a restatement of much of the 2008 Strategy.

Reference - NHS England (2014) Actions for End of Life Care: 2014-16
https://www.england.nhs.uk/wp-content/uploads/2014/11/actions-eolc.pdf

Clinical guidance and best practice

NICE commissioning guidelines - CMG42 (December 2011) 'Guide for commissioners on end of life care for adults'
https://www.nice.org.uk/guidance/qs13/resources

The guidelines identify a number of areas in which clinical practice and quality can be improved:

- Reducing inequalities and improving identification through de-stigmatising death and dying and encouraging healthcare professionals and people with end of life care needs and their families and carers to engage in open conversations
- Improving the quality of care including care after death, through holistic assessments and timely interventions in the right place by a knowledgeable, caring and competent workforce
- Increasing choice and personalisation through care planning and advance care planning, including advance statements and advance decisions to refuse treatment and provision of resources that enable these choices to be achieved.
- Ensuring care is coordinated and integrated across all sectors involved in delivering end of life care
- Improving the psychological, physical and spiritual well-being of people with end of life care needs and their carers through access to an appropriately trained and resourced workforce
- Timely access to information and support to enable people with end of life care needs and their families and carers to make informed decisions
- Timely provision of continuing NHS healthcare funding to support people to die in their place of choice

- Supporting carers and ensuring access to an assessment of need as set out in the Carers and Disabled Children Act 2000 and the Carers (Equal Opportunities) Act 2004
- Timely access to generalist and specialist palliative care services on the basis of need and not diagnosis. This includes the provision of community based support and access to specialist advice (which may be via telephone) 24 hours a day, 7 days a week
- Reducing unnecessary hospital admissions and length of stay by developing capacity to deliver expertise to the person's usual place of residence through pathway redesign and workforce development. This includes supporting staff in social care settings such as care homes and domiciliary workers; supporting relatives and friends who are caring for a person with end of life care needs; and providing the necessary clinical expertise, medicines and equipment
- Improving cross-boundary and partnership working, through close working between health and social care services to ensure flexible and integrated services that have the infrastructure to enable this (for example shared IT networks). This should improve care coordination, minimise unnecessary duplication and reduce costs
- Improving knowledge and skills in generalist and specialist palliative care settings, and in social care settings including independent residential and nursing homes and domiciliary workers.

Care Quality Commission (May 2016) 'A different ending: End of life care review' - Addressing inequalities in end of life care
http://www.cqc.org.uk/content/different-ending-our-review-looking-end-life-care-published

The report found that there were significant variations in end of life care and that a number of groups were under-represented:

- people with conditions other than cancer
- older people
- people with dementia
- people from Black and Minority Ethnic (BME) groups
- lesbian, gay, bisexual and transgender people
- people with a learning disability
- people with a mental health condition
- people who are homeless
- people who are in secure or detained setting
- Gypsies and Travellers.

Specific actions that have been identified to enable everyone to access the care that they need:

1. Leaders of local health and care systems to work together to develop a plan for delivering good quality, equitable end of life care for everyone in their community.
2. Commissioners and providers to fulfil their duties under the NHS Constitution, the Health and Social Care Act 2012 and the Equality Act 2010 to reduce

inequalities, eliminate discrimination and advance equality when developing, arranging or delivering end of life care.

3. Commissioners and providers to ensure that staff who care for people who may be approaching the end of life, including care home staff, have the knowledge, skills and support they need.
4. Hospices to champion an equality-led approach, engage communities, deliver equitable end of life care, and support others to do the same.
5. GPs to ensure that everyone with a life-limiting progressive condition has the opportunity to have early and on-going conversations about end of life care, and is
given a named care coordinator.

Non-governmental guidance and best practice

End of Life Care Coalition 'On the Brink: The Future of End of Life Care'
http://endoflifecampaign.org/wp-content/uploads/2016/02/End-of-Life-Report-WEB.pdf

The following are identified as making a difference:

- Well-funded high quality care available both inside and outside hospital for all who need it
- Investment in palliative care specialists and generalist health and social care professionals with the knowledge, understanding and time to deliver choice and provide high quality care for people at the end of their lives
- Access to good quality advice and support, including out of hours, to provide families and carers with practical assistance and guidance if the person they are caring for has a change in symptoms or needs additional help
- Fully co-ordinated and integrated care across all teams and services supporting a person at the end of their life, including fair access to social care, using appropriate care plans in a joined-up way
- Training for all health care professionals, so they know how to support someone approaching the end of their life confidently and sensitively
- A higher proportion of the medical research budget dedicated to developing better ways of caring for terminally ill people and their families.

Together for short lives 'Charter'

'Together for short lives' is a UK charity that represents all children and young people who are expected to have short lives.

- Every child and family member should be treated with respect and dignity
- The child and family should be offered an individual care and support package that is built around their unique needs
- A multi-disciplinary team should work together to support the family, and communicate with the child and family in an open and honest manner
- Children and families should always be listened to, and be encouraged to talk through their wishes and care choices

- At all stages of care, from diagnosis to death and bereavement, families should be provided with accurate and relevant information that they can understand
- Where possible, children should be cared for in the family's place of choice – in hospital, a hospice, or at home
- Emotional, psychological and spiritual support should be offered to the child, and those close to him or her
- Children and young people should be given the opportunity to access education and employment that is right for them
- The child and family's wishes concerning end of life care should be discussed and planned for well in advance
- Support and care should extend to all family members, friends and all those involved with the child.

Further information is available from the Together for short lives website, as follows http://www.togetherforshortlives.org.uk/

Summary of key findings from the literature review

There are a number of themes that have been identified in the literature review, as below:

- The majority of people, about 75%, experience good quality end of life care, whether that is at home, in a care home or in a hospital. However, 25% do not.

- Whilst most people state that the preferred place of death is their own home, most people, 43%, die in hospital. It is recognised, however, that a person's view on where they would like to die depends on the nature and progress of their disease and how their quality of life and ability to exercise personal choice can best be supported. Often, this will mean that a hospital bed is preferred to their own home.

- In 2013/14, less than a quarter of hospitals had face-to-face palliative care services 7 days per week and mandatory training for doctors and nurses on care of the dying was not universally provided or taken up.

- The question that should be posed is not one of 'where would you prefer to die' but 'what would you like to have in place to make your death the best it can be for you and those around you?'

- There remains a reticence to openly discuss death and make plans and decisions about how someone will live out the last 12 months of their life. This reticence is cultural/societal and so inhibits the ability of patients, carers and health and social care staff to plan care packages and make informed choices.

- There are an excessive number of unplanned hospital admissions for people in the last months of their life. Typically, these admissions are via Accident and Emergency Departments. This reactive approach is not in keeping with good quality care and effective symptom management and can generate unnecessary costs to the health system.

- Care is not consistently co-ordinated throughout the health and social care system. The wishes of an individual are not routinely recorded and shared as a personalised care plan, which can be accessed by all relevant health and social care agencies and organisations.

- Not all health and social care staff are trained and in assessment and symptom management.

- There is a shortage of specialist end of life care and palliative care knowledge and experience within health and social care services.

- Family members and carers are not routinely involved in dying people's care.

- Out of hours support for patients and their carers, when in their own home, is varied and inconsistent. As a result, many people who could be supported to live in their own home during their last 12 months of life are unable to.

- There is only limited assessment of non-health needs, such as social care, spiritual care, bereavement support, legal assistance, general wellbeing advice and emotional support.

- There is not consistent and fair access to end of life care services and interventions, with variations in access to among different socioeconomic groups.

- There are no inpatient hospice facilities in Craven, Hambleton, and Richmondshire district council areas.

- Over time, end of life care services and interventions have been based around people suffering from terminal cancer. There are a number of other terminal diseases for which end of life care pathways need to be developed and improved.

- There is no new Government funding and securing additional local funding will depend on whether end of life care is a local priority.

Section 3 - Organisations Giving Evidence

County Council – Health and Adult Services

Ian Spicer - (Interim) Assistant Director, Care & Support, attended a Mid Cycle Briefing of the Scrutiny of Health Committee on 14 October 2016 and provided an overview of the role that the County Council plays in supporting adults in the last months of their life. In particular, what is currently in place and where there were further opportunities for joint working and/or service improvements.

Existing approach

- A service specification is in place for independent care Homes and Nursing Homes that sets out some minimum standards for end of life care and for the promotion of dignity.
- There is a commitment to promote choice and for people to be enabled to plan the last 12 months of their life, including where they would prefer to die.
- The key role that carers have to play is recognised, as is the need to provide consistent support to them.
- A new role within Health and Adult Services (HAS) has been created, 'Practice lead', which has responsibility for end of life care, amongst other. The focus here will be upon promoting good practice and high quality assessments of need, under the new model for care and support that HAS adopted.

Service improvements

- There are opportunities for joint training and staff awareness across the health, social care and community sector.
- There could be closer working with hospices in the county, drawing upon their extensive experience of end of live care service development and implementation.
- Improvements could be made in end of life care planning, particularly following any changes in placement.

County Council – Children and Young People's Services

Emma Thomas, Children's Commissioning Manager – Healthy Outcomes, attended a Mid Cycle Briefing of the Scrutiny of Health Committee on 14 October 2016 and provided an overview of the role that the County Council plays in supporting children and young people in the last months of their life.

Children are subject to the 'continuing care' process of assessment. A continuing care package will be required when a child or young person has needs arising from disability, accident or illness that cannot be met by existing universal or specialist services alone.

'Together for short lives' is a UK charity that represents all children and young people who are expected to have short lives. The aim of the charity is to help children and families make the most of their time together. Together for short lives has produced a summary of how end of life care for children and young people is different to adults, as below:

- The number of children who die is small
- Many of the conditions are extremely rare with diagnoses specific to childhood
- Palliative care may last only a few days, weeks or months, or may be delivered on and off for a number of years.
- Many of the conditions are genetic
- Children's palliative care embraces the whole family
- Children's palliative care providers need to be aware of and respond to the continuing physical, emotional and cognitive development throughout childhood Provision of education and play when a child is seriously ill is essential.

Further information is available from the Together for short lives website, as follows http://www.togetherforshortlives.org.uk/

Clinical Commissioning Groups

Representatives from the five Clinical Commissioning Groups that commission services in North Yorkshire attended a Mid Cycle Briefing of the Scrutiny of Health Committee on 14 October 2016, to discuss end of life care provision in the county. The key issues identified are summarised as below.

Key challenges

- Both a dispersed population and a dispersed system of health and social care resources having an impact on the effective delivery of packages of end of life care in people's homes
- Lack of domiciliary care and difficulties in commissioning Fast Track Continuing Healthcare
- Fragile market of specialist and generalist health and social care providers
- End of life care for people who are frail, have dementia or a number of different conditions
- Delivery of an equitable approach across the county that reflects local needs, infrastructure and services
- Shortages of trained health and social care staff who can support delivery of end of life care
- Need to better understand the 'disease trajectories' and what specific conditions, other than cancer, mean for people's end of life care
- Need to provide support for carers and families, once a package of end of life care has been put in place. Otherwise, the package of care can fail as carers and families struggle in the final days of a loved one's life.

Key infrastructure

- Strong working relationship between the Acute Trust and the CCGs
- Electronic Palliative Care Coordination System (EPaCCS) – question as to whether this will ever be put in place across North Yorkshire
- Community nurses play a key role in delivering and coordinating community-based end of life care
- Reliance upon the community and voluntary sector
- The 111 directory is helpful but only if kept up to date
- Rapid relief teams as a replacement for fastrack, in some areas.

Sustainability Transformation Plans

- Concerns that end of life care may not be a priority under the new planning regime
- CCGs and need to ensure that, despite the large geographic coverage of the STPs, a local approach to end of life care is implemented
- STPs are focussed upon the centralisation of specialist services but end of life care is best provided locally and in the community
- The STPs may offer some economies of scale and enable the provider market to be strengthened.

Engagement

- Some patients and carers are fiercely independent and do not accept the care or support that they need until it is too late for an end of life care package to be put in place
- Need to ensure that health and social care practitioners are trained in and have confidence in having discussions with people, as they approach the last year of their life, about their choices
- Queries about how you identify someone as being in the last year of their life
- If you get it right for one person, then others will hear of it and it will increase confidence amongst service users and providers.

Examples of local good practice

- Gold line 24/7 service for patients thought to be in their last year of life and their carers. Covers Airedale, Wharfedale and Craven (AWC) CCG and 2 Bradford CCGs
- System 1 – shared across GPs, hospitals, community nurses and hospices in AWC CCG area
- Use of step up and step down beds and commissioning of nursing home beds for end of life care – Hambleton, Richmondshire and Whitby (HRW) CCG
- Joint work with pharmacies to ensure access to medication – Harrogate and Rural District (H&RD) CCG
- PalCall Service – nurse led out of hours helpline in Scarborough and Ryedale (S&R) CCG

Possible next steps

- Create a forum for commissioners and providers of end of life care to meet and work through shared challenges, share best practice, coordinate activity and tackle gaps in provision
- Retain a strong focus on commissioning community based palliative care in people's homes
- Agree a shared vision for the outcomes that we collectively want to achieve for end of life care in North Yorkshire. The focus is upon outcomes and standards and not processes.
- Join up the health and social care workforce strategies
- Review level of support, information and advice provided to carers of people who are nearing the last 12 months of their life
- Articulate the financial argument in favour of supporting people to die in their own home
- Clarify care home training needs
- Review fast track commissioning arrangements/intentions
- Agree realistic targets to work to for people dying in the place of their choosing
- Strengthen links with Yorkshire Ambulance Service.

Hospices

Tony Collins, Saint Michael's Hospice

Tony Collins, Chief Executive, Saint Michael's Hospice, Harrogate presented a report to the Scrutiny of Health Committee on 1 July 2016. The key points raised are summarised as below.

A copy of the full report is available on the North Yorkshire County Council website. http://democracy.northyorks.gov.uk/committees.aspx?commid=23&meetid=3368

North Yorkshire End of Life Care
North Yorkshire has a statistically higher than average:

- Older population (those above 65, 75 and 85) for males and females
- Death rate
- Percentage of deaths
- Deaths in care homes
- Deaths from heart disease.

North Yorkshire has a statistically lower than average:

- Deaths in hospital
- Residents in urban localities
- Deaths from respiratory disease
- Deaths from liver disease.

It has been estimated that 3,600 will die within the population each year. It is likely, however, that from the 16,448 people over 85 years of age, some end of life care service will be required and could be required for longer than the last months of life.

Value for money
Taken from a number of sources, including Hospice UK and Marie Curie, evidence suggests that Hospices are value for money. Hospices provide value for money:

- Hospices can support in the reduction of unnecessary admissions
- Hospices can reduced hospital deaths by 20% each year generating a saving of £80m to the NHS
- The palliative care funding review for England found extending 'specialist and core' services could result in net savings.

Bereavement increases the risk of mortality and poor health. In Scotland, this cost was estimated to be £20 million, which when extrapolated to England was between £150 and £190 million.

There is estimated to be between 80,000 and 124,000 people living with Lymphoedema in the UK. Lymphoedema is a swelling that develops as a result of an impaired lymphatic system. This may be as a result of the lymphatic system not developing properly or through damage or trauma, such as cancer. For every £1 spent on Lymphoedema treatments it is estimated that it would save £100 in reduced hospital admissions due to swelling and infection.

Clair Holdsworth, Martin House
Clair Holdsworth, Deputy Director of Clinical Services, Martin House gave a presentation on end of life care to the Scrutiny of Health Committee on 18 November 2016.

Clair gave an overview of the service provided by Martin House, how palliative and hospice care for children and young people differs from that provided to adults, and some of the issues encountered by children, young people and their families when seriously ill and in need of palliative care. Specifically:

- The need for care and services that is right for their age – from neonates to young adults
- Short breaks, with nursing and medical support when required
- To be able to continue with their education and have the opportunity to participate in social activities and be with their friends
- Specialist support for siblings
- Bereavement support for the family.

Clair Holdsworth stated that a piece of research had been undertaken that suggested that there were 398 children in North Yorkshire that needed specialist palliative and hospice support. It is understood that this is an under-estimate and that the real figure is likely to be around 560.

Clair Holdsworth noted that the main referral routes were via consultants and social care.

A number of challenges were identified, as below:

- Recruitment of qualified/skilled staff – albeit that in-house training schemes are in place to up-skill workers
- Shortages of some specialist staff within the NHS locally, which creates gaps in community-based service provision
- Identifying 'hard to reach' children and young people
- A shortage of counselling services for children in the community.

Voluntary and Community

Alex Bird, Age UK North Yorkshire
Alex Bird, the Voluntary Sector Representative on the North Yorkshire Health and Wellbeing Board and the Sponsor for the End of Life Care Theme, gave a presentation on end of life care to the Scrutiny of Health Committee on 2 September 2016. The key issues identified are summarised as below:

The End of Life (EoL) for everyone is a time of significant vulnerability both for the person who is dying, and the family/friends they choose to have around them.

Everyone should have the right to high quality palliative care when they have a terminal illness, regardless of their condition, where they live, or their personal circumstances.

The UK has been ranked as the best country in the world for palliative care on offer but access to care is patchy and one in four people who need palliative care miss out each year.

Whether a dying person is cared for at home/hospital/care home/hospice- right to expect that their pain will be managed actively, treated with respect and compassion, and that they are listened to.

National approach
The "Review of choice in End of Life Care" was published in 2015 and set out the elements of EoL Care that people most care about and where people felt choice should play the greatest role.

In July 2016, the Government unveiled a new national commitment on EoL care setting out its vision for improving care for dying people and their families. The key components of personalised care are set out that everybody should expect to receive.

Key partners
Local ownership and accountability will be critical to help achieve the central government vision. Key partners will be the CCGs and the Health and Wellbeing Board. As well as these named players, other important partners include Care Homes, Hospices, voluntary organisations e.g. Macmillan, Marie Curie, Sue Ryder as well as local community based charities and most of all, individuals and the families and carers.

Some key issues identified by people at the EoL include:
- Discrimination and lack of understanding by care and support services
- Religious and spiritual needs
- Assumptions about sexuality or gender identity and family structures
- Varied support networks
- Unsupported grief and bereavement
- Increased pressure on carers.

Recommendations
Making good EoL care happen is not the responsibility of one persons or organisation. It happens because professionals and organisations work together, share information and focus on the individual's needs. Some key aspects include:

- Training for staff
- Work with national and local charities e.g. MacMillan, Sue Ryder, Hospices
- Ensure that literature and materials about EoL services reflect all diverse groups
- Share examples of local excellence in EoL care
- Strengthen accountability and transparency (June 2018- new Clinical Priority Area) and leadership
- Equality - understand, acknowledge and action variations in EoL care.

As providers, funders and leaders we all have a role to play in helping to deliver improvements and to use our influences to help more people achieve their wishes and preferences at the end of life.

Other

A workshop on 'End of Life – Dying Well' was held at the North Yorkshire Wider Partnership Conference on 21 October 2016. The workshop was hosted by Alex Bird, the Voluntary Sector Representative on the North Yorkshire Health and Wellbeing Board. The key issues raised from the group discussions at the workshop are as summarised below:

Key questions

- How do we effect cultural change and encourage people to plan for the last 12 months of their life?
- Processes as an enabler for choice and not a barrier?
- Pain management well covered but what of practical day to day needs of people that ensure a high quality of life in their last months and days?
- Can we agree a common set of performance indicators and targets?
- Do we need a Charter for North Yorkshire that sets out a shared set of principles and goals?
- Is there a role for the private sector in end of life care provision?

Challenge 1 – about 80% of people want to die in their own home but only about 20% do. How do we close the gap?

Challenge 2 -for the 20% that opt to die elsewhere, do they get the care that they wanted?

Areas for development

- Training a range of health and social care staff to enable them to have difficult conversations with people about how they want their last 12 months of life to be
- Look at the disease pathways for non-cancer diseases so people are better able to help people plan their last 12 months of life
- Sharing of best practice like 'Goldline'
- Support for carers, including pre-bereavement work
- Documenting, sharing and adhering to an end of life care plan with all those who need it
- End of life care for people who are learning disabled
- Role of GP in having the initial conversation with patients about their end of life care
- Care home and residential nursing home policy and practice
- Awareness of the range of different needs of people at the end of life, including cultural and religious.

Other

- A hospice can play a key role in helping to stabilise someone who has deteriorated before then returning them home
- Death cafes enable a broad range of people to work through some of the practicalities around end of life care
- Voluntary and community sector often have a key role to play but can find it difficult to connect with and work with the NHS and other public sector services.

The presentation from the workshop can be accessed here - http://www.nypartnerships.org.uk/CHttpHandler.ashx?id=35439&p=0

Hospitals

A number of questions, informed by the overview of CQC reports in section 4, were sent by email to the Chief Executives of the three main hospital trusts in the county: Harrogate and District NHS Foundation Trust; York Teaching Hospital NHS Foundation Trust; and Airedale NHS Foundation Trust. The replies that have been received to date are included below:

Dr Ros Tolcher, Chief Executive, Harrogate and District NHS Foundation Trust
The Specialist Palliative Care (SPC) team take a lead role in delivering and supporting others to provide End of Life Care (EoLC) in both the hospital and community setting. The team ethos within the organisation is to work collaboratively with many agencies across health and social care and would value the opportunity to discuss this further.

Is there a strategy or plan for the delivery of End of Life Care?
A draft work programme for EoLC has been drawn up and is due to be ratified at the HDFT End of Life Steering Group meeting towards the end of January. This piece of work reflects comments from the most recent CQC report and feedback from clinicians and service users. Its content is structured around and informed by the national framework document Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020 which emphasises the need to make decisions and deliver services based on local need.

Are specialist End of Life Care services available 7 days a week?
Currently there is a SPC service which provides advice and support for patients in the hospital and community Monday to Friday 08:30-17:00. Out of hours there is access to telephone advice for health care professionals from Saint Michael's Hospice. This is provided by hospice nurses, the hospice doctor on call, or the consultant on call as appropriate.

The team has compiled an options paper on a 7 day per week service which describes the evidence for delivering such a service and the investment required to meet this. This paper will aid discussions with the Trust and the Clinical Commissioning Group (CCG) about moving towards this in the future.

Are all staff able to identify anyone who might benefit from specialist End of Life Care services?
For all staff to identify patients who may benefit from EoLC every time requires an appropriate level of education and training and we recognise that more is required. Training in EoLC is not mandatory for community and hospital staff at present. The SPC team does however, plan to appoint a Clinical Nurse Specialist in the near future who will lead on education and will develop a comprehensive education and training strategy for all staff groups in the hospital and community, the aim being that all staff are prepared to care for patients at the end of life.
Health care professionals are able to use the SPC team referral criteria to help guide them in their decision making. The community SPC Clinical Nurse Specialists aim to

attend all the Gold Standards Framework / Palliative Register meetings at GP Practices to guide Primary Care teams in whom to include on the register and in managing the patients effectively in a timely and responsive manner.

To what extent are hospital staff able to access End of Life Care plans that have been developed by GPs and others?
GPs aim to create care plans for the 2% of patients most likely to have unplanned hospital attendances. This 2% will include some patients who are approaching the end of life. If a care plan is created, a template is completed on SystemOne and the patient is given a paper copy, but the plan is not shared with the hospital (most hospital staff cannot access SystemOne). So the plan will only be accessed if a paper copy comes in to hospital with the patient; this does not often happen.

There is an opportunity to improve communication around end of life decisions and discussions by enabling shared access to patient information by using an Electronic Palliative Care Coordination System (EPaCCS). A business case has been put forward to the Harrogate and Rural District CCG Clinical Executive/Senior Management Team, but there is no definite plan currently to take this forward. The introduction and implementation of EPaCCS is a key area for improvement in the End of Life work plan.

Is there an issue relating to the breakdown of End of Life Care in the community and unplanned hospital admissions?
We do not currently collect data on unplanned hospital admissions related to a breakdown of care in the community, although a significant issue would be captured via incident reporting. It is therefore difficult to draw clear conclusions.

Fast track services are not currently commissioned through HDFT as they are provided by independent providers which are booked through the Partnership Commissioning Unit on behalf of the CCG. They are frequently unable to source care packages. Care is sometimes picked up by the Community Care Teams wherever they have capacity as an interim.

There are delays in discharging patients in the last weeks of life in a timely manner for the above reasons. Anecdotally, patients are waiting several days to a week or so for discharge home, often due to care packages being unavailable. Again this is a key area of exploration for the EoLC work programme.

Are there any obvious gaps in services that prevent Hospitals from playing a fuller role in End of Life Care planning and delivery? What more could be done to fill such gaps?
There are actions that can be taken to enhance care planning and delivery and these have been discussed: for example

- Funding and provision of a 7 day face to face assessment SPC service,
- Implementation of EPaCCS across the locality and consideration of solutions to share information between community and hospital setting,
- Timely rapid discharge home to die (last weeks /days of life) from hospital and further collaboration with social care.

We would welcome the opportunity for a fuller discussion around commissioning of services in the community around End of Life Care. We hope this information is helpful and look forward to further discussions.

Replies are awaited from York Teaching Hospital NHS Foundation Trust and Airedale NHS Foundation Trust.

Local Medical Committee

The following questions were sent to YORLMC, the Local Medical Committee for North Yorkshire, on 6 January 2017.

In response, a series of telephone interviews were conducted, in the week commencing 16 January 2017, with YORLMC representatives, as summarised below:

Do GPs routinely discuss End of Life Care with patients in the last 12 months of their life?
Yes. GPs play a key role is starting a discussion with patients who are in their last 12 months of life, their families and carers about the type of care that can be made available to them. There is a strong focus on symptom control (all symptoms and not just pain), a collaborative approach and providing support to family members and carers.

Are End of Life Care plans developed with GPs and shared with all relevant partner agencies?
Yes. End of Life Care Plans are initially developed by GPs, District Nurses and Macmillan Nurses with the patient, family members and carers. These are then shared with partner agencies and organisations. Regular Gold Standards Framework / Palliative Register meetings are convened by GPs and attended by community ad hospital based nursing staff.

There can be difficulties associated with sharing the care plans with all those that need to see them, particularly at a point of crisis. There is no common means across all health and social care agencies in the county that has been adopted that allows the sharing electronic versions of care plans in a format that can be updated.

A software system, called the Medical Interoperability Gateway, is available that can connect health and social care organisations and enable the sharing of patient records (in a read-only format).

Are there any obvious gaps in services that prevent GPs from playing a fuller role in End of Life Care planning and delivery?
There are a number of gaps in services and care pathways, as outlined below:

- District Nurses - the District Nurse Service in the county is not 24/7. Service provision ends each day at 10pm. North Yorkshire is one of only 2 areas in the country not to have a 24/7 service.

- Do Not Attempt Resuscitation (DNAR) forms are only applicable to people suffering from a cardiac arrest. For people with other conditions, a Living Will or Advance Directive is needed. If not, then people may well be admitted to hospital contrary to what they have previously requested for their care.
- Macmillan Nurses – there is a shortage of Macmillan Nurses.
- Hospice admission – further work could be done to clarify the admissions procedures for hospices, particularly out of hours and for respite care.
- Respite care – there is a shortage of respite care.
- Psychological therapies – there are significant gaps in the provision of psychological therapies and support for people who are dying and their carers and family members.
- Palliative care drugs – there are concerns that there is insufficient access to and availability of palliative care drugs from community pharmacies, particularly out of hours.
- Patient records - there is no common means across all health and social care agencies in the county that has been adopted that allows the sharing electronic versions of care plans in a format that can be updated.

Any additional comments?
Out of hours GP services have a key role to play in the delivery of End of Life Care Plans, particularly at a point of crisis. Links with other health and social care services who operate out of hours are good but more could be done to look at how the out of hours system works and to improve patient outcomes.

GPs regularly conduct reviews of the quality of End of Life Care that has been provided, as part of the Significant Event reporting system. This provides opportunities for lessons to be learned and services to be improved.

Local Pharmaceutical Committee

Jack Davies, attended a meeting of the North Yorkshire Scrutiny of Health Mid Cycle Briefing on 16 December 2016 to discuss Government changes to the funding of community pharmacies. The following possible impacts of reduced funding were highlighted:

- Reduced opening hours and staffing levels
- End free services, such as the home delivery of medicines
- Reduced investment in facilities and services
- Reduced stock held on the premises, with the result that people may not be able to get the medicine they need then and there.

The reduction in stock and the end of free services, such as home delivery of prescriptions could impact upon the availability of and access to palliative care drugs, particularly at a time of crisis.

Jack Davies also suggested that an independent community pharmacy was contacted to further understanding of the role that they play in supporting the delivery of end of life care services in the community.

A telephone interview was conducted with an independent community pharmacy in the county on 6 January 2017. The outcome of the interview is summarised as below:

What role do community pharmacies play in End of Life Care and supporting people in their own home?
The key role is one of ensuring that palliative care drugs are available as and when needed. The pharmacy also operates a free delivery scheme, as part of its general business operation, of prescriptions to people in the community. This includes palliative care drugs.

Are community pharmacies involved in care planning and do they work with the GP and Hospital?
There is no role for community pharmacies in palliative care planning but the pharmacy works closely with local GPs and District Nurses to ensure that the drugs that are needed are made available promptly and often out of hours.

Are community pharmacies able to maintain a sufficient stock of palliative care drugs?
The pharmacy is commissioned under the Palliative Care Drugs Service to maintain a stock of a locally agreed list of palliative care medicines. A small number of community pharmacies will be commissioned to provide this service across any given area, with a view to maintaining sufficient coverage. Individual community pharmacies may also have stocks of various palliative care drugs.

Follow up questions with Jack Davies revealed that a Palliative Care Drugs Service is only commissioned by the Vale of York and Scarborough and Ryedale CCGs. It was noted, however, that a number of community pharmacies elsewhere in the county have volunteered to maintain sufficient stocks of palliative care drugs.

Summary of key findings

There are a number of themes that have been identified, as below:

- There are opportunities for joint training and awareness raising on end of life care planning across health, social care and the voluntary sector that are not currently being realised.

- Hospices have been providing end of life care in the county for over 30 years and have built up years of specialist knowledge and expertise that could be used to support training and awareness raising.

- Whilst end of life care for people with terminal cancer is well established, it is not for people suffering from other terminal diseases. Further work is needed to better understand the 'disease trajectories' and what this means for end of life care planning.

- Good practice or best practice is not routinely shared across agencies and organisations in the county and there is no place or forum for work to be co-ordinated at a county-level.

- There is no agreed set of principles or standards for the provision of end of life care in the county, against which the performance of organisations and agencies can be judged and for which people can be held accountable.

- The financial arguments supporting co-ordinated end of life care and enabling people to die in their own homes are well known but not used as part of the evidence for service development. Investment in community based end of life care services and interventions will save hospitals significant amounts of money, reducing demand for beds and reducing unplanned admissions through Accident and Emergency.

- The broader welfare and wellbeing needs of people in the last 12 months of their life are not always being met. Whilst medical needs such as symptom control and pain relief are well understood, in many cases basic quality of life issues are not addressed. For example, bathing.

- The lack of one single IT system for the creation, sharing and updating of end of life care plans across key agencies and organisations results in unplanned admissions to hospital through Accident and Emergency. It also results in the Ambulance Service making journeys that could have been avoided.

- A number of Delayed Transfers of Care that are attributed to short falls in community based provision relate to people in the last months or weeks of their life. This can lead to the breakdown in an end of life care plan and significant distress to the patient, their family and carers.

- The business case for an Electronic Palliative Care Coordination System (EPaCCS) has been developed by Harrogate and District NHS Foundation Trust and a number of other organisations but it is unclear whether there is the necessary support to implement such a system countywide.

- A seven day a week Specialist Palliative Care Service is not routinely provided in hospital. Out of hours support, information and advice is provided through a number of routes, including hospices. Harrogate and District NHS Foundation Trust are currently reviewing options for a seven day a week Specialist Palliative Care Service.

- Training in end of life care is not mandatory for community and hospital staff at present.

- It is not clear whether there is sufficient availability of and access to palliative care drugs across the county. A Palliative Care Drugs Service is commissioned by 2 of the 5 CCGs in the county. In the other 3 CCG areas voluntary arrangements are in place for the stocking of palliative care drugs. Service user evidence gathered as part of this extended piece of scrutiny suggests that there are gaps in availability and access, gaps that are often filled by people going to Accident and Emergency.

- In the next 3 to 5 years, changes to Government funding to community pharmacies may result in a reduction in the range and coverage of a number of pharmacy services, including free home delivery. This may, in turn, impact upon the viability of some community based end of life care plans.

- There are gaps in the provision of community nursing. The District Nurse Service in the county is not 24/7 and at present the service provision ends each day at 10pm. There is also a shortage in Macmillan Cancer Nurse provision.

- There may be a need for some awareness raising about the need for a Living Will or Advance Directive, as opposed to the use of Do Not Attempt Resuscitation (DNAR) forms

- There are gaps in out of hours provision across agencies and organisations that provide elements of end of life care. There may be value in undertaking a system wide review to better understand the gaps and their impacts.

Section 4 – Care Quality Commission

Care Quality Commission inspection reports

The Care Quality Commission (CQC) regularly conducts both announced and unannounced inspections of hospitals. Inspection reports include an assessment of the quality and effectiveness of End of Life Care. The elements relating to End of Life Care are summarised below.

Harrogate District Hospital Quality Report 27/07/2016
http://www.cqc.org.uk/location/RCD01
This report followed an inspection from 2 to 5 February 2016. End of Life Care was rated as 'good' overall and for the criteria of safe, effective, caring and well-led. The criteria of responsiveness was rated as 'requires improvement'. The issues that were identified by the CQC are summarised below:

- A strong culture of incident reporting
- Participated in the National Care of the Dying Audit of hospitals
- A care planning process had been developed and was being used based on current national guidance
- Working with the Clinical Commissioning Group and community teams to develop a five year strategic plan for end of life care
- Face to face specialist support for end of life care was not available 7 days and week
- Staff are not able to identify everyone who might benefit from palliative care team support because of work pressures in the hospital and the limited palliative care cover available
- There was no locally agreed service plan in place for end of life care with commissioners.

Scarborough Hospital Quality Report 08/10/15
https://www.cqc.org.uk/location/RCBCA
This report followed an inspection over the periods 17 to 20 March 2015, 30 to 31 March 2015 and 11 May 2015. End of Life Care was rated as 'good' overall and for the criteria of safe, effective, caring, well-led and responsive. The issues that were identified by the CQC are summarised below:

- Specialist nurses and medical staff provided specialist support in a timely way that aimed to develop the skills of non-specialist staff
- Staff were caring and compassionate and responsive to patients' needs
- Good use of auditing to identify and improve patient outcomes
- A vision and strategy for end of life care services was in place
- Development of a number of initiatives, such as non-cancer end of life care.

The York Hospital Quality Report 08/10/15
http://www.cqc.org.uk/location/RCB00
This report followed an inspection over the periods 17 to 20 March 2015, 30 to 31 March 2015 and 11 May 2015. End of Life Care was rated as 'good' overall and for the criteria of safe, effective, caring, well-led and responsive. The issues that were identified by the CQC are summarised below:

- Good use of auditing to identify and improve patient outcomes
- A vision and strategy for end of life care services was in place
- Consistent leadership
- Development of a number of initiatives, such as non-cancer end of life care.

Airedale General Hospital Quality Report 10/08/16
http://www.cqc.org.uk/location/RCF22
This report followed an inspection over the periods 15 to 18 March 2016, 31 March and 11 May 2016. End of Life Care was rated as 'good' overall and for the criteria of safe, effective, caring, well-led and responsive. The issues that were identified by the CQC are summarised below:

- Seven day face to face specialist palliative care support available to patients was in place
- Staff were trained and demonstrated a consistently good knowledge of end of life care issues
- Pain was well managed
- The Gold Standards Framework was in use throughout the hospital to support the development of good quality end of life care
- An electronic palliative care coordination system was in use
- Positive multidisciplinary team work and a high standard of collaborative working internally and externally
- There was below the national minimum staffing recommendations for hospital specialist palliative care doctors.
- A lack of engagement with Black and Minority Ethnic (BME) communities.

Darlington Memorial Hospital Quality Report 29/09/15
http://www.cqc.org.uk/provider/RXP

This report followed an inspection over the period 5 and 6 February 2015. End of Life Care was rated as 'requires improvement' overall and also 'requires improvement' for the criteria of safe, effective and well-led. The issues that were identified by the CQC are summarised below:

- Staff were caring and compassionate
- Monitoring of the safe use of syringe drivers for end of life medication was not being recorded consistently
- Mental capacity assessments were not being recorded
- Development of pastoral and spiritual services were planned
- Specialist palliative care regularly attend wards to support staff to develop skills a round end of life care
- Staffing difficulties had impacted on the ability of the specialist palliative care team to develop the service.
- A focus on preferred place of care for patients at the end of life wishing to be at home.

James Cook University Hospital Quality Report 28/10/16
http://www.cqc.org.uk/location/RTRAT
This report followed an inspection over the period 8 to 10 June and 21 June 2016. End of Life Care was rated as 'good' overall and for the three criteria of safe, effective and well-led. The issues that were identified by the CQC are summarised below:

- Patients were provided with an end of life care service that was safe and caring
- A culture of incident reporting
- Clear, well documented and individualised care of the dying documents
- Mandatory training in place with 100% compliance
- A clear vision for the service but no overall strategic lead for palliative care
- Poor performance against the 2015 National Care of the Dying Audit criteria, achieving only two of the eight organisational indicators.

Hull Royal Infirmary Quality Report 29/07/15

This report followed an inspection over the period 28 to 29 January 2015. End of Life Care was rated as 'good' overall and for all of the criteria. The issues that were identified by the CQC are summarised below:

- A dedicated palliative care team are in place that consists of palliative care consultants, specialist nurses and an end of life care facilitator. The team was available Monday to Friday with a helpline service during evenings and weekends
- Individual wards had end of life care champions
- Patients received safe and effective end of life care, which involved patients and relatives/carers
- Care was flexible and responsive to individual needs and there were good systems to facilitate preferred place of care.
- There was a retrospective end of life case review group, which met regularly to review care practice and identify areas for learning.

St James University Hospital Leeds Quality Report 27/09/2016
This report followed an inspection over the period 28 to 29 January 2015. End of Life Care was rated as 'good' overall and for all of the criteria. The issues that were identified by the CQC are summarised below:

- Safety incidents were investigated when things went wrong and lessons learned were widely shared
- There was clear guidance for staff to follow within the care of the dying person individual care plan when prescribing medicines at end of life
- There were some very good examples of record keeping in the individual care plans.

Summary of key findings

People living in North Yorkshire access a broad range of hospitals depending upon where they live and what treatment they are undergoing. The CQC reports vary in the breadth and depth of their assessment of end of life care and interventions provided at the hospitals but offer an insight into some of the key issues faced in a busy clinical environment.

- Face to face specialist end of life care is not available 7 days a week across all hospitals.

- Strategies for the delivery of end of life care services and interventions in hospitals are either in place or under development.

- Non-cancer end of life care is either in place or under development.

- Staffing pressures had impacted in some hospitals upon the consistency and quality of end of life care being offered.

- The quality and suitability of mortuary services was highlighted as a concern in a number of cases, in particular the room where the body of someone who has recently died is viewed by bereaved relatives.

Anecdotal evidence gathered as part of this extended piece of scrutiny suggests that there may be a conflict between resource management and end of life care in a hospital setting. Where someone in the last days of their life is admitted to a busy hospital ward, there have been cases where good quality of end of life care has not been provided.

Section 5 – site visits to hospices

Structured visits were undertaken to three hospices in North Yorkshire and York. These hospices were selected on the basis on being the major providers of hospice care to in-patients, day patients and community patients.

The hospices visited were:

- St Michael's Hospice, Harrogate – 10 November 2016
- St Catherine's Hospice, Scarborough – 16 November 2016
- St Leonard's Hospice – 13 December 2016

The visits were undertaken by members of the Scrutiny of Health Committee along with the Chair of the Scrutiny of Health Committee and the Scrutiny Team Leader. The visits tended to have the following format:

- 10.00am – Welcome and introductions
- 10.10am – Meetings with staff
- 11.00am – Meetings with in-patients and day patients (where possible)
- 12.00noon – Informal discussions – to involve a number of people from social work, bereavement support, a carer, community team leaders and fundraising
- 1.00pm – Site tour
- 1.45pm - Reconvene for wrap up questions and discussions.

What follows is a summary of the key issues identified at all three site visits:

Funding

- Savings to the system that the hospices in North Yorkshire make cannot be realised and funding cannot be diverted as it is all taken up by the larger acute trusts
- A large proportion of funding is unpredictable and high risk. This makes service planning difficult year on year. Budget deficits are likely in 2017/18 and beyond, if the funding position is not improved. There will then be a review of services to ascertain a sustainable delivery model for the future
- Do not want 100% public funding as need to retain independence, aim for 35% public funding. Currently around 20%.
- Strong argument for 'invest to save'

Service delivery

- Wide range, including: bereavement counselling; Occupational Therapy; in-reach into residential and nursing homes; hospice at home; neurology nursing; community Macmillan nurses
- Concerns over the long term impacts of reductions in both NHS and social care services and budgets
- A large number of volunteers support the delivery of hospice services both at the Hospice itself and in the wider community
- There are shortages of skilled staff across health and social care, which has a knock on effect to the services provided by the hospice as they take up more of the slack and fill gaps
- Need for more respite care for carers – this makes community based packages of support more robust and less likely to breakdown
- Need to start thinking collectively about the patient of the future, what their needs will be and what options will be available to them. Likely to have dementia and not be a cancer patient

- Community based bereavement services make significant savings for mental health services
- Pain control best managed in a hospital or hospice, less well at home.

Out of hours
- There is very little routine out of hours care in place across health and social care. Hospices and other organisations often fill the gaps, particularly at the weekend, but this is not sustainable in the long term. The lack of out of hours care often results in unplanned admissions to hospital, unnecessary ambulance journeys and increased stress upon the patient and carers
- PALCALL in Scarborough and Ryedale offers 24 hour support for carers of people undergoing community based palliative care (similar to Goldline in Airedale, Wharfedale and Craven)

Referrals
- Most referrals, approximately 50% to 80%, are from GPs and hospitals and are typically people with terminal cancer. More could be done to highlight the hospice services and interventions that are available to people with other terminal diseases.

Education and training
- The hospices deliver a range of formal, accredited training courses, professional development and mentoring and coaching
- Training for nursing and residential care homes helps ensure that more people are able to die in their home, as opposed to a hospital
- Considerable programme of education run by the hospice: communication skills; advanced care planning; symptom management; ceilings of care; palliative care.

Coordination
- Lack of a forum for commissioners and providers of End of Life Care to meet and plan through a system wide approach
- Lack of places for people to be discharged to from hospital.
- There is no single case record management system in place that enables all relevant organisations to access the care plans of patients in their last months of life. This can result in unplanned admissions to hospital, unnecessary ambulance journeys and increased stress upon the patient and carers
- Hospices are part of the solution and can help support the wider health and social care system through establishing good practice norms and educating.

Sustainability and Transformation Plans
- End of life care does not feature in the STP planning process, at present
- STP may present an opportunity for system-wide commissioning.

Approach
- Overly focussed on the place of death and not the quality of the last 12 months of life. Key questions to ask :
    - How do you want to die?
    - Where do you not want to die?
    - What experience do you want of dying?

- What things will be important to you?

Summary of key findings

There are a number of themes that have emerged, from the visits to the three hospices, relating to the gaps in services and areas for improvement. These include:

- High quality and wide ranging end of life care is provided by hospices on an in-patient basis and in the community at little or no cost to the public sector. The majority of hospice funding, typically 80%, comes from retail, fundraising, donations and legacies.

- Hospice funding is increasingly unpredictable and under stress. A number of hospices are planning to run a budget deficit in 2017/18. This will impact on the range of services that hospices can provide.

- Hospices have responded to gaps in provision and developed services that meet new and emergent needs, such as community based support and nursing for neurology and lymphedema.

- There is uncertainty about what impact increasing demand for health and social care services, shortages of skilled health and social care workers and budgetary pressures in health and social care will have upon the demand for hospice services and interventions.

- The delivery of community-based services in the county is expensive due to the travel costs and times associated with accessing rural areas.

- Informal and formal education and training is provided by hospices to health and social care workers. More education and training could be done with providers of residential care and nursing homes but there are limited resources and providers of residential and nursing care under significant financial stress.

- The type of patient that health and social care organisations is working with is changing. In the longer term, people in the last months of their life are likely to be suffering from a number of long term conditions, including dementia. More needs to be done to plan the countywide response to this changing disease profile and the development of end of life care services and interventions for people with dementia.

- Carers are critical to the effective delivery of any end of life care plan. More could be done to provide support and respite for carers in the community.

- Hospices often serve as a default out of hours service to support end of life care in the community, as most health and social care services are not commissioned on a 7 day basis.

- There is no one single IT system for the creation, sharing and updating of end of life care plans across key agencies and organisations. This creates unnecessary

delays and inefficiencies and care lead to breakdowns in continuity of care provided.

- GPs are key to the provision and co-ordination of End of Life Care. They are already stretched and there are emergent shortages of GPs.

- The discussions are end of life care have tended to focus upon the where people want to die, with a working assumption that dying in your own home is the preference. However, the question could better be asked as to what things do people need to have in place to make their death the best it can be for them and those around them?

Section 6 – patients, carers and family members

Focus groups
Convened by Tony Collins, Chief Executive, Saint Michael's, Harrogate - Bereavement counselling – 23 November 2016

Case study 1 – bereaved wife
- Key role played by the GP in supporting the family and providing continuity of care in the community
- Concerns raised about the level of care that can be provided on busy hospital wards to people in the last days of life
- Concerns raised about the ability of District Nurses to provide support when and where needed
- Concerns about the ability of the Hospital to provide continuity of care in the community and respond to changes in patient condition
- Difficulties in maintaining an uninterrupted supply of prescribed palliative care drugs
- Multiple visits to A&E.

Case study 2 – bereaved teenage son
- Excellent standard of hospital care
- Stress upon the immediate family leading to family breakdown after the death of the mother
- School not able to provide the necessary support, leading to a disrupted education and unresolved emotional problems associated with grieving and loss
- Key role of the grandmother in providing support.

General
- There are some concerns about the quality of end of life care provided in some cases in hospitals. Concerns that this may not be picked up as part of CQC inspections
- 'Just-B' bereavement service receives no funding from CCGs or local authorities and the service covers Harrogate District only
- Most referrals to 'Just-B' are from GPs

- Most people who attend the 'Just-B' service are grieving for loved ones who did not 'die well'.

The website for 'Just-B' can be found here - http://justb.org.uk/wordpress/

Summary of key findings

The openness and willingness of patients, carers and family members to speak with the members of the Scrutiny of Health Committee was much appreciated. Some of the key issues raised are highlighted below:

- There is only limited bereavement support that can be accessed in a timely way in the county. This is provided in part by the NHS and in part by the voluntary and community sector.

- The way in which the death of a close family member is experienced can have a significant impact upon the mental wellbeing of someone who has been bereaved. Where support is not available, it can lead to a disrupted education, job loss and family breakdown.

- It is unclear what systems are in place to identify children and young people in school who have been bereaved and what support is in place or can be accessed by them.

- There is a question as to whether general CQC inspections of a hospital are able to assess the quality of end of life care services.

Section 7 – Areas for further investigation

It has not been possible to undertake a complete and exhaustive assessment of the state of end of life care in the county. As such, there are a number of areas for further investigation, as below:

Schools

The role that schools have to play in identifying and supporting children and young people through the last months of a parent or sibling's life is unclear. As is the ability of the school to provide or access appropriate bereavement support for a child or young person.

Former service personnel

The Armed Forces Community Covenant for North Yorkshire has as one of its aims to 'encourage local communities to support the armed forces community in their areas, and vice versa'. There is a question as to whether former service personnel in the county have specific needs around end of life care and whether these are currently being met.

Equality and diversity
There is further work to be done to understand and address the barriers that exist to people accessing end of life care services and interventions, specifically for Lesbian Gay Bisexual and Transgender people, Black and Minority Ethnic groups, gypsies and travellers, people who are homeless.

Patient and family and carer experience
There is an opportunity to do further work with Healthwatch North Yorkshire to gather the views of patients, family members and carers on end of life care services and interventions in the county. The results of this could then inform targeted 'Enter and View' visits.

Respite care for carers
The critical role that carers have to play in the delivery of community based end of life care plans in widely acknowledged. What is not clear is the extent to which the needs of carers are identified and opportunities for respite care provided.

Befriending
Befriending and support to patients, carers and family members as part of end of life care has been seen in some cases to be beneficial. Further work could be undertaken to better understand the benefits of befriending and whether it has a role to play in end of life care provision in North Yorkshire.

Private sector
The role of private sector providers of end of life care services and interventions has not been fully explored. Nor has the potential for markets for private sector providers to be developed.

Yorkshire Ambulance Service
The role of the Ambulance Service in the delivery of end of life care planning and the costs incurred when packages of community-based care breakdown.

Section 8 – Conclusions and recommendations

Conclusions

There is a wealth of national and international guidance, best practice and policy produced by governmental and non-governmental bodies and institutions and there are a wide range of agencies and organisations involved in the commissioning and provision of services and interventions. The challenge when undertaking this piece of in-depth scrutiny has been to keep a focus on adding value to the work that has been done to date and highlighting areas for improvement or further investigation that are realistic and achievable.

Some of the key conclusions from this piece of in-depth scrutiny are as below:

- People are neither used to nor comfortable with discussing death. This is a societal issue that has far reaching consequences for people in the last months of their lives. More can be done to encourage individuals, carers and family

members and health and social care staff to talk about death and to encourage people to make plans for their own. This could include formal training for health and social care professionals.

- The discussion about end of life care has become overly focussed upon the place of death and a choice between hospital or home. The real question is perhaps one of what things do people need to have in place to make their death the best it can be for them and those around them?

- The majority of end of life care services and interventions that are commissioned and provided are medically based. There are a range of practical and spiritual needs that are important to quality of life and dignity that can be overlooked as they are not clinically driven. For example, being able to have a hot bath.

- The type of patient for whom end of life care services and interventions are provided is changing. More people are presenting with a range of complex, long term conditions, including dementia.

- The support that is given to people in the last 12 months of their life is overwhelmingly provided by carers and close family members. Where carers are themselves unsupported, there is an increased risk that an end of life care plan will breakdown and emergency access to health and social care services required.

- Bereavement counselling and other psychological therapies are not widely available or accessible to people in need.

- Whilst hospital may be the appropriate place for many people to die, there are significant costs associated with end of life care in hospital and unplanned or emergency admissions associated with the breakdown of a community-based end of life care plan.

- There is a strong financial case to support increased funding for multi-agency community-based end of life care packages on the basis of an 'invest to save' argument. It is recognised, however, that the realisation of such system wide savings is often difficult.

- North Yorkshire is a rural county that is sparsely populated. This can make the provision of end of life care services in the community expensive. New ways of working may be required to meet the challenges posed by rurality.

- There is no new Government funding to support changes to the way in which end of life care services are commissioned and provided in the county. Any changes, therefore, are dependent upon securing additional local resources, which will in turn depend on whether end of life care is a local priority.

- At present, there is no shared vision or strategy for end of life care in the county. The commissioning and provision of services is often undertaken on a unilateral basis, with co-ordination at an operational level being dependent upon local

relationships between agencies and organisations. There is no county forum with a specific or sole remit for co-ordinating the development and delivery of end of life care services and interventions.

- Hospices have over 30 years of experience of providing end of life care both on an in-patient basis and in the community. This specialist knowledge and expertise could help inform the development of a co-ordinated approach across the county.

- The planning and co-ordination of care for people in the last 12 months of their life is hampered by the lack of a common electronic system for sharing and updating care plans and patient notes.

- The health, social care and voluntary and community system is under increasing stress and strain. When a system is under stress it is often the case that the focus becomes increasingly upon resource management and core business. For the provision of end of life care services and interventions this creates a risk that many aspects of good practice will not be adopted or will be overlooked. At worst, this can mean that people in the last days or weeks of their life are not treated with the dignity or respect that they deserve.

- The provision of 7 day services and/or out of hours care remains a challenge in health and social care in general and it is also the case for end of life care.

- There are a number of examples of good or best practice in the county that are not being applied across the board, such as the Gold line 24/7 service operated by Airedale NHS Foundation Trust, PALCALL and community based 'death cafes'. This represents a missed opportunity.

- End of life care does not stop at the point in which a patient dies. The way in which family members and carers experience the death of a loved one and how that person is treated after their death will have a lasting impact.

Recommendations

The following recommendations are made for consideration by the North Yorkshire Scrutiny of Health Committee:

1. That a multi-agency forum is established for commissioners and providers of end of life care in the county to enable:

    - greater co-ordination of service planning and delivery across health, social care and the voluntary sector
    - the agreement of some common standards and principles for equitable end of life care, possibly in the form of a charter or a similar statement of intent
    - the identification of a set of outcomes to be achieved with milestones and a mechanism in place for tracking progress against those milestones
    - sharing of good and best practice
    - the identification of areas for service improvement

- patient and carer representation and involvement and opportunities for co-design
- health and social care strategic planning to be influenced.

2. That a local financial analysis of community-based end of life care and bereavement services be undertaken, with a view to assessing what efficiency gains could be made within the health and social care system. The methodology to be informed by the Public Health England and University of York health economics report on the costs of end of life care.

3. That a multi-agency programme of training in end of life care and care for the dying be developed and implemented, covering as a minimum:

   - Communication skills and honest conversations
   - Advanced care planning, including holistic care
   - Symptom management
   - Palliative care.

   Consideration also to be given as to how this training could be targeted at different priority groups of health and social care workers across the county.

4. That existing joint work between the NHS and the County Council on health and social care workforce planning, takes into account the need for skilled, specialist staff to co-ordinate end of life care and palliative care.

5. That a way of enabling the sharing and updating of end of life care plans and patient notes electronically is developed for all health and social care agencies and organisations in the county.

6. That a local analysis of 'the patient of the future' is undertaken that looks at the changing disease profile of people in their last 12 months of life and what this means for the development and delivery of end of life care.

7. That a system-wide analysis is undertaken of the current provision of out of hours, specialist end of life care and palliative care, including access to palliative care medication, to assess where there may be gaps in provision and suggest what could be done to fill any such gaps.

8. That agencies and organisations work together to promote a culture of open and honest discussions about death and planning the last 12 months of someone's life.

9. That the areas for further investigation listed in Section 7 of this report are looked into further.

In making these recommendations, it is recognised that the health and social care system is under increasing financial strain and that there is no new funding available. There are, however, efficiency gains to be made from a change to the way in which

end of life care services and interventions are commissioned and provided in the county, which will also improve outcomes for patients, carers and family members.

Following the discussions at the Committee meeting on 27 January 2017, the intention is to take a final version of this report to the Mid Cycle Briefing on 3 March 2017 for sign off.

The final, agreed version of the report will be taken to the meeting of the North Yorkshire Health and Wellbeing Board on 17 March 2017.

Daniel Harry
Scrutiny Team Leader
North Yorkshire County Council
18 January 2017

Acknowledgements

North Yorkshire County Council
Scrutiny of Health Committee
27 January 2017

Diabetes prevention in North Yorkshire: Briefing

Purpose of report
The purpose of this report is to provide Members with a summary of the national issues raised in a recent Care Quality Commission review of diabetes care and support and highlight what this means at a local level in North Yorkshire. This includes an overview of activity to prevent the onset or and screen for diabetes.

Members are asked to review the report and identify any areas for further scrutiny.

Introduction

1. The Care Quality Commission published a review of people's experiences of community diabetes care and the support they are provided to self-manage their condition in September 2016. This review highlighted the increasing numbers of people living with diabetes and the costs to health and social care. http://www.cqc.org.uk/sites/default/files/20160907_CQC_Diabetes_final_copyrightnotice.pdf

2. There are several different forms of diabetes. The greatest increase has been amongst people with the most common form which is type 2 diabetes. Type 2 diabetes is typically associated with older age, obesity and genetic factors including ethnicity. The review notes that "when diabetes is not well-managed, it can lead to serious complications such as heart disease, kidney disease, stroke, amputations, and blindness." These are costly both to the individual affected and to health and social care systems. Approximately £10 billion is spent by the NHS on diabetes each year – 10% of the NHS budget for England and Wales. Eighty per cent of these costs go on treating complications.

3. In response to this review NYCC Health Scrutiny requested a briefing about the prevention, identification and treatment of diabetes in North Yorkshire

Prevalence in North Yorkshire

4. Often people will not realise they have diabetes for some time. It can develop gradually and symptoms such as tiredness, thirst and needing to urinate more frequently may be ascribed to aging or other diagnosed long term conditions. As a result there will be people living with diabetes who are undiagnosed.

5. The numbers of people living with diabetes are estimated using models calculating expected numbers. Actual prevalence figures are drawn from primary care records. Nationally prevalence is estimated at 8.6% in 2016, with 6.5% registered. In Yorkshire and the Humber 6.8% are registered as having diabetes. North Yorkshire is estimated to have 43,965 people (8.79%) with diabetes, but

29,254 (6%) are registered. The figures for individual CCGS are outlined in the table below.

Diabetes Prevalence rates - 2016

		Estimated		Registered		Undiagnosed	
CCG Name	CCG Code	Number	Rate	Number	Rate	Number	Rate
AWC	E38000001	11835	9.2%	8,778	6.91%	3057	2.26%
HRW	E38000069	10980	9.1%	7,167	6.02%	3813	3.11%
HaRD	E38000073	10913	8.1%	7,562	5.71%	3351	2.39%
S&R	E38000145	9526	9.6%	6,509	6.61%	3017	2.95%
VoY	E38000188	21783	7.3%	15,907	5.46%	5876	1.87%

Source: NCIN, QOF

6. It was estimated in 2015 that 12.4% over 16 year olds in North Yorkshire have non-diabetic hyperglycaemia versus 11.4% average for England. Non-diabetic hyperglycaemia, also known as pre-diabetes or impaired glucose regulation, refers to raised blood glucose levels, but not in the diabetic range. People with non-diabetic hyperglycaemia are at increased risk of developing Type 2 diabetes. They are also at increased risk of other cardiovascular conditions.

Relevant NYCC activities

NHS Health Checks

7. The NHS Health Check programme targets all individuals aged 40-74 without previously diagnosed cardiovascular disease (CVD), diabetes or chronic kidney disease (CKD) to offer appropriate lifestyle interventions and treatment to reduce their overall risk and to reduce substantially the risk of premature death or disability.

8. The programme is also intended to raise awareness of alcohol consumption above recommended levels and of dementia in those aged 65-74.

9. At present, NYCC commissions GP practices to deliver the NHS Health Check programme (risk assessment, risk awareness and risk management), within the primary care setting, to the eligible population across North Yorkshire. Individuals deemed to be at high risk of diabetes will be offered further tests as part of their assessment. In addition, brief personalised evidence based lifestyle advice is given to all individuals with lifestyle risk factors (regardless of their CVD risk) which includes smoking cessation, increasing physical activity, healthy eating and weight management. Similarly, for those who are eligible for lifestyle interventions, healthcare practitioners will recommend onward referral into lifestyle services.

10. For quarter 1 of 2016/17, of those individuals whom were offered a health check, 39.9% received a health check across North Yorkshire. This is slightly less than the current England average of 45.6%.

Quarter 1 Data 2016-17	NYCC	England
Total eligible population 2016-2017	193918	15402612
Number of people who were offered a NHS Health Check	8758 (4.5%)	682388 (4.4%)
Number of people that received a NHS Health Check	3491 (1.8%)	310904 (2%)
Percentage of people that received an NHS Health Check of those offered	39.9%	45.6%

Source: PHE, 2016

11. Currently, we have 70 practices offering the programme to their registered populations across the patch. As primary care colleagues are the main point of contact for the programme, we heavily rely on practices to promote the service and encourage patient participation. We see variance across the patch for invitations sent and uptake of an appointment following the offer of a health check. As commissioners we liaise with our practices to offer support and advice where their numbers appear low – this provides us with an opportunity to understand some of the concerns that practices may have in delivering the programme.

12. Anecdotal feedback informs us that, practices have competing pressures with issues around workforce and capacity and therefore, the programme does not always take priority.

13. NYCC launched an NHS Health Check pilot outreach service in November 2015. The aim of this pilot service was to identify and reduce the risk of cardiovascular disease by improving access to the NHS HC service, for those at higher risk, particularly those whom live and work in the farming community and those living in Scarborough. This pilot service ended in November 2016, and a full evaluation of the outreach pilot programme will be undertaken in January 2017.

14. We have renegotiated our service specification from April 2017 with the Local Medical Committee and are working to incentivise greater access to the programme as well as providing motivational skills training for practice staff.

Tier 2 weight management

15. North Yorkshire County Council currently provides grant money to the seven district councils to pilot a tier 2 weight management programme. The weight management programme in each district is for anyone aged 18 years or above with a body mass index of 25 or above. The programme delivered in each district is a 12 week group programme that includes nutrition and physical activity, underpinned by behaviour change strategy.

16. The grant funding will cease 30th June 2017. North Yorkshire County Council intend to formally procure a new tier 2 adult weight management service from 1st July 2017 as a five year contract.

National Diabetes Prevention Programme (NDPP)

17. The NDPP will offer a structured approach to preventing the onset of diabetes to those at risk who may have been identified through the NHS Health Check programme, opportunistically through primary care of through other local pathways.

18. CCGs within North Yorkshire have been involved in the bidding process for the NDPP that have been submitted on an STP footprint. To date West Yorkshire STP (including Harrogate and Rural CCG and Airedale, Wharfedale and Craven CCG) have been successful in the bidding process for NDPP funding for phase 2 of the national roll out. The STP are currently putting together a prospectus for local delivery of this programme and will embark on the process of recruiting a provider.

19. The remaining STPs are currently reviewing their position in order to join national roll-out of the programme. Humber, Coast and Vale STP which includes Scarborough & Ryedale and Vale of York CCGs is in discussion with NHS England about participating in the prevention programme.

Role of schools in preventing diabetes

Change4 Life

20. Change4Life is a national evidence based prevention and health promotion campaign designed to change the health behaviour of individuals. NYCC align with Change4Life Campaigns occurring in January (nutrition related) and July (physical activity related) and raise awareness of the campaigns among partner agencies, providing a call to action for them to assist in sharing the campaign messages with our residents and increasing sign ups to the Change4Life website. Partners who support the campaigns include the Prevention Service, 5-19 Healthy Child Programme Service and Healthy Choices Service.

21. Change4Life messages have been delivered via a number of mediums to residents within the county including, press releases, social media posts, local radio interviews/advertising, and distribution of campaign resources via schools and partner organisations. From September 2016 Reception and Year 6 children being measured in the NCMP receive Change4Life resources as part of a new national initiative in schools called “Our Healthy Year”.

Food for Life

22. The Food for Life Partnership (FFL) is a school based programme that encourages children, families and the community to eat healthily and make sustainable food choices. North Yorkshire County Council’s Energy Traded Service have recently received public health funding to deliver the Soil Association’s nationally recognised FFL programme in 20 targeted schools across the county during the 2016-2018 academic years.

Healthy rating scheme

23. From September 2017, the Department of Health have introduced a new voluntary healthy rating scheme for primary schools to recognise and encourage the contribution to preventing obesity by helping children eat better and move more. The scheme is taken into account during Ofsted inspections. Locally, there is a real opportunity to support primary schools to sign up to the healthy rating scheme and pioneer change within the school setting.

Management of diabetes

24. CCGs and hospital trusts in North Yorkshire are working together to improve diabetes care across North Yorkshire. Key issues include access to structured education programmes and care quality with particular emphasis on reducing complications such as amputations, sight loss and cardiovascular diseases including stroke, kidney failure and heart disease.

25. Motivating lifetime lifestyle choices around physical activity and healthy eating are key in preventing, identifying and managing diabetes. These are affected by individual's motivations and health literacy as well as access to sources of support.

Recommendation

The Committee is asked to consider the report and identify areas for further scrutiny.

Clare Beard
Public Health Consultant
December 2016.

North Yorkshire County Council
Scrutiny of Health Committee
27 January 2017

Funding of Community Pharmacies – update on discussions at Mid Cycle Briefing on 16 December 2016

Purpose of Report
This report provides members with details of discussions that took place at the Scrutiny of Health Mid Cycle Briefing on 16 December 2016 regarding changes to the Government funding of Community Pharmacies. This was in response to a Notice of Motion that was put to County Council on 9 November 2016.

Background

1. A new contract for community pharmacies was imposed by the Government in October 2016, despite widespread opposition from professional bodies, including the Pharmaceutical Services Negotiating Committee. In 2016/17, Government funding has been cut by 4% and 2017/18 will see a reduction of 3.4%. Further cuts are expected thereafter.

2. Whilst there are no planned closures of community pharmacies at this stage, it is anticipated that the services that they provide will change, as funding is reduced. If the reduction of Government funding continues, then there is a risk that a number of community pharmacies will be forced to close over the next 3 to 5 years.

Notice of Motion

3. A Notice of Motion was discussed at County Council on 9 November 2016, as below:

> Motion 4 – North Yorkshire County Council notes that 121 Pharmacies in North Yorkshire offer a range of services such as dispensing prescriptions, disposal of unwanted medicines and supporting self-care. Pharmacies play an important role in promoting wellbeing such as healthy eating, smoking cessation, exercise, flu vaccination, sexual health, falls supervised consumption and more. Advice and support services are also available to care homes North Yorkshire County Council is greatly concerned about Government imposed threats to pharmacies as a result of cuts in the budget of £170m nationally to take effect from October 2016. This is a 6% cut in cash terms but could effectively mean a cut of 12% during the financial year which could potentially close up to a quarter of pharmacies, with an increased focus on warehousing dispensary and online services.
>
> Service cuts in pharmacies put more residents at risk as well as putting pressure on GPs and on hospital services and therefore increasing NHS costs. A fully funded community pharmacy service is cost effective and is in the interest of patients and carers.
>
> North Yorkshire County Council:
> agrees to write to the Secretary of State for Health, NHS England and Hambleton, Richmondshire and Whitby, Harrogate and Scarborough and Ryedale Clinical Commissioning Group detailing the concerns and demanding an immediate reversal of these proposals.
>
> Proposed by County Councillor David Billing
> Seconded by County Councillor Eric Broadbent

4. The Notice of Motion was discussed and the decision was taken to refer the matter to the North Yorkshire Scrutiny of Health Committee for investigation.

Scrutiny of Health Mid-Cycle Briefing – 16 December 2017

5. Jack Davies, Chief Executive Officer, Community Pharmacy North Yorkshire (LPC) gave a presentation to the Mid-Cycle Briefing outlining the changes to funding that had been introduced by the Government and the potential impacts.

6. The potential short term and long term impacts of the changes to community pharmacy funding that were discussed are summarised, as below:

- Around 23 pharmacies will be protected from the full effect of funding reductions for the first two years but there is uncertainty about what level of protection will be in place thereafter.
- At this stage, there are no planned closures of community pharmacies but the services that they provide are likely to change, as funding is reduced. Concerns have been raised that some community pharmacies will have to:
    - Reduce opening hours and staffing levels
    - End free services, such as the home delivery of medicines
    - Reduce investment in facilities and services
    - Reduce stock held on the premises, with the result that people may not be able to get the medicine they need then and there.
- There is also likely to be an impact upon GPs and A&E, as patients who would have previously used their community pharmacy end up being forced to go elsewhere.
- It is likely that over the next 3 to 5 years a number of community pharmacies in North Yorkshire will either be merged or close. The concern is that this will be in the more deprived or rural areas of the county.

7. In response, Members raised the following issues:

- Community pharmacies are businesses and as such a degree of competition is to be expected and encouraged.
- In some areas of the county there are a number of community pharmacies all on the same street. As such, it may make sense for there to be some rationalisation of provision and a re-distribution of funding.
- There is a concern is that any closures or mergers will be in the more remote areas of the county or those that are more deprived.
- The reduction in free services may have a significant impact upon both patients and carers.
- The consequent reduction in the provision of tests and screening, as part of a national programme of prevention and early intervention, could lead to increased costs to the NHS in the longer term.
- The funding cuts seem to run contrary to previous NHS advice focussed on encouraging people to use community pharmacies, instead of going to the GP or A&E.

8. The Mid Cycle Briefing resolved:

- To maintain a watching brief on the impact of Government reductions to community pharmacy funding over the next 2 years, with regular updates to the Scrutiny of Health Committee.

- To work with Public Health and other agencies and organisations to consider ways in which the potential impact of the reductions in funding can be better understood, in particular:

    - The impact upon GPs and A&E
    - The impact upon vulnerable people
    - The impact upon people living in the more deprived areas of the county.

Responding to the Notice of Motion

9. The details of the discussions at the Mid Cycle Briefing and the actions that Members resolved to take will, subject to committee approval, go to the Executive at their meeting of 28 March 2017. From there, they will go to the County Council at their meeting of 17 May 2017, as part of the Executive Report.

Recommendation

1. To maintain a watching brief on the impact of Government reductions to community pharmacy funding over the next 2 years, with regular updates to the Scrutiny of Health Committee.

2. To work with Public Health and other agencies and organisations to consider ways in which the potential impact of the reductions in funding can be better understood, in particular:

    - The impact upon GPs and A&E
    - The impact upon vulnerable people
    - The impact upon people living in the more deprived areas of the county.

Daniel Harry
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Tel: (01609) 533531
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17 January 2017

NORTH YORKSHIRE COUNTY COUNCIL
SCRUTINY OF HEALTH COMMITTEE
27 January 2017

Remit of the Committee and Main Areas of Work

Purpose of Report

The purpose of this report is to highlight the role of the Scrutiny of Health Committee (SoHC) and to review the work programme taking into account current areas of involvement and decisions taken in respect of earlier agenda items.

Introduction

1. The role of the Scrutiny of Health Committee is to review any matter relating to the planning, provision and operation of health services in the County.

2. Broadly speaking the bulk of the Committee's work falls into the following categories:

    a) being consulted on the reconfiguration of healthcare and public health services locally
    b) contributing to the Department of Health's Quality Accounts initiative and the Care Quality Commission's process of registering NHS trusts
    c) carrying out detailed examination into a particular healthcare/public health service.

3. The Committee's powers include:

    - reviewing and scrutinising any matter relating to the planning, provision and operation of health services in the local authority's area
    - requiring NHS bodies to provide information within 28 days to and attend (through officers) before meetings of the committee to answer questions necessary for the discharge of health scrutiny functions
    - making reports and recommendations to local NHS bodies and to the local authority on any health matters that they scrutinise;
    - requiring NHS bodies to respond within a fixed timescale to the health scrutiny reports or recommendations;
    - requiring NHS bodies to consult health scrutiny on proposals for substantial developments or variations to the local health service
    - referring contested proposals to the Secretary of State for Health.

Scheduled Committee and Mid Cycle Briefing dates

4. Forthcoming committee dates are:

    - 10am on 7 April 2017
    - 10am on 23 June 2017
    - 10am on 22 September 2017
    - 10am on 15 December 2017.

All the meetings will be held at County Hall.

5. Forthcoming Mid Cycle Briefing dates are:

- 10.30am on 3 March 2017
- 10.30am on 28 July 2017
- 10.30am 3 November 2017
- 10.30am 26 January 2018
- 10.30am 27 April 2018.

These are not public meetings and are attended by the Spokespersons for the political groups.

Areas of Involvement and Work Programme

6. The Committee's on-going and emerging areas of work involvement are summarised in Appendix 1.

Recommendation

7. That Members review the Committee's work programme, taking into account issues highlighted in this report, the outcome of discussions on previous agenda items and any other healthcare developments taking place across the County.

Daniel Harry
Scrutiny Team Leader
North Yorkshire County Council
4 January 2017

Appendix 1

NORTH YORKSHIRE COUNTY COUNCIL

Scrutiny of Health Committee – Work Programme/Areas of Involvement – 2016/17 (as at January 2017)

(Note: Shading denotes period of on-going involvement/monitoring but without confirmed dates for items to the committee;
✓ = Confirmed agenda item)

	2016		2017		Notes
Scheduled Committee Meetings	**2 Sep**	**18 Nov**	**27 Jan**	**7 Apr**	
Strategic Developments					
1. Implications on health and care services of Sustainability and Transformational Plans across North Yorkshire		✓	✓	✓	Stock-take report to OSC on 18 November 2016 STP lead officers to MCB on 16 December 2016 Follow up to MCB discussions and stock-take report on 27 January 2017 Follow up on 7 April 2017.
2. Rural Services Network - Scrutiny on Access to Health Services in Rural Areas	✓				Rural Services Network to publish their response in December or January
3. NY Mental Health Strategy	✓			✓	Follow up at 7 April 2017, particularly with regard to issues raised at 2 September 2016 meeting.
4. CQC Diabetes Review - explores the quality of care for people with diabetes in England - www.cqc.org.uk/mydiabetesmycare			✓		The review discovered that people at high risk of developing Type 2 diabetes were not always identified and supported to become healthier.
5. Funding of Community Pharmacies			✓		Initial review at 16 December MCB Follow up at 27 January 2017 committee meeting.
Local Service Developments					
6. Hambleton, Richmondshire & Whitby CCG: Hambleton and Richmondshire - "Fit 4 the Future", including developments at the Lambert Hospital, Thirsk		✓		✓	Follow up on use of Lambert and continuity of care at 7 April 2017 committee
7. Hambleton, Richmondshire & Whitby CCG: Transforming our Communities – mental health services.			✓		Suggested by Janet Probert
8. Hambleton, Richmondshire & Whitby CCG – future plans for Whitby Hospital					Follow up to discussions at 14 November 2016 committee meeting – suggested by Janet Probert 3 March 2017 MCB

	2016		2017		Notes
Scheduled Committee Meetings	**2 Sep**	**18 Nov**	**27 Jan**	**7 Apr**	
9. Better Health Programme (Durham, Darlington and Tees) https://nhsbetterhealth.org.uk/					NYCC has been allocated 3 seats on a joint scrutiny committee comprising councillors from all the local authorities across the affected area to consider any service reconfiguration. The BHP is now merged into the STP process (see item 1).
10. Ambition for Health and Out of Hospital Care in Scarborough and Ryedale					Engagement to start in April 2017.
11. Care Quality Commission Inspection – Yorkshire Ambulance Service – 13/09/16					Awaiting outcome of inspection.
12. Mental Health Service in York/Selby area and Bootham Hospital		✓			3 March 2017 MCB – feedback on consultation
13. NY Healthwatch Annual Report 2015/16		✓			For information only.
14. NY Independent Health Complaints and Advocacy Annual Report 2015/16		✓			For information only.
Public Health Developments					
15. Development of base-line data and an on-going monitoring system on the impact of Fracking.					Lincoln Sargeant leading discussions with Public Health England on support for monitoring. Update to 3 March 2017 MCB
16. Annual Report – Director of Public Health		✓			
In-depth Project					
17. Dying well and End of Life Care	✓	✓	✓		Committee meeting on 27 January – draft report for discussion and sign off (subject to requested amendments). Report to Health and Wellbeing Board on 17 March 2017.

Meeting dates 2017/18

Meeting				
Agenda Briefing	20 June 2017 10.30am	19 September 2017 10.30am	12 December 2017 10.30am	13 March 2018 10.30am
Scrutiny of Health Committee	23 June 2017 10.00am	22 September 2017 10.00am	15 December 2017 10.00am	16 March 2018 10.00am
Mid Cycle Briefing	28 July 2017 10.30am	3 November 2017 10.30am	26 January 2018 10.30am	27 April 2018 10.30am