North Yorkshire County Council

Agenda

Meeting: Scrutiny of Health Committee

Venue: The Grand Committee Room, County Hall, Northallerton DL7 8AD (See location plan overleaf)

Date: Friday 1 July 2016 at 10.00 am

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Business

1. Minutes of the Scrutiny of Health Committee held on 22 April 2016

(Pages 6 to 14)

2. Any 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)**

- Sustainability and Transformational Plans update
- Better Health Programme (Durham, Darlington and Tees)
- Rural Services Network - Scrutiny on Access to Health Services in Rural Areas
- Funding of Community Pharmacies

Enquiries relating to this agenda please contact Bryon Hunter on **01609 532898 or e-mail bryon.hunter@northyorks.gov.uk**
www.northyorks.gov.uk

4. Public Questions or Statements.

Members of the public may ask questions or make statements at this meeting if they have given notice to Bryon Hunter, Principal Scrutiny Officer (*contact details below)* no later than midday on Tuesday, 28 June 2016. 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);
- 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. "Fit-4-the Future" – Transforming our Communities - Report of the Chief Officer, Hambleton, Richmondshire and Whitby Clinical Commissioning Group

Addendum: The role of the Lambert Memorial Hospital in future healthcare in Thirsk and District – Report from the Lambert Hospital Action Group

(Report not yet available)

6. Ambitions for Health : Transforming Health and Social Care Services in Scarborough, Ryedale, Bridlington and Filey - Report of the Chief Officer, Scarborough and Ryedale Clinical Commissioning Group

(Report not yet available)

7. Dying Well and End of Life Care – Report of the Scrutiny Team Leader, North Yorkshire County Council

(Pages 15 to 29)

8. Work Programme – Report of the Scrutiny Team Leader

(Pages 30 to 38)

9. 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

21 June 2016

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	

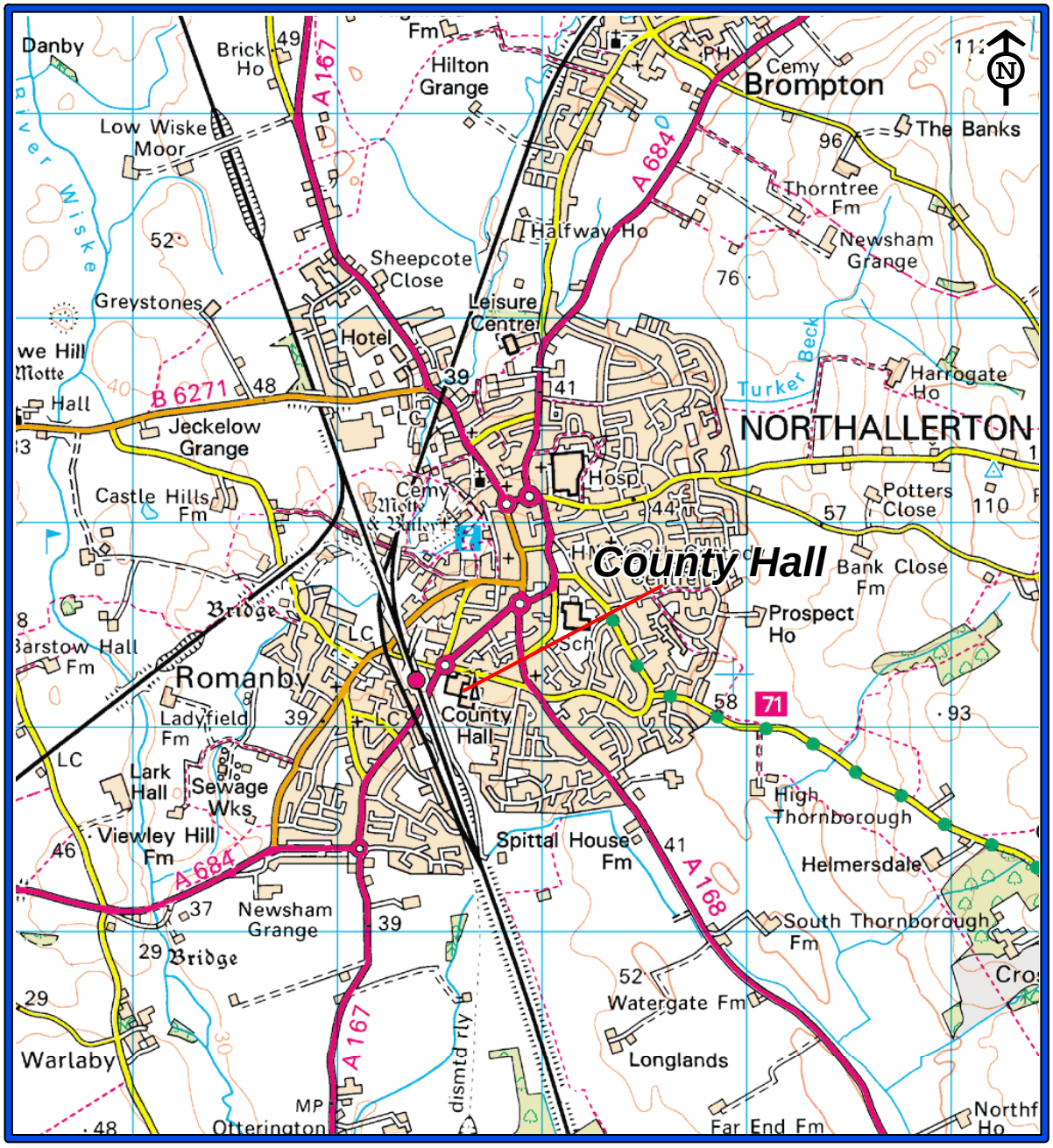
Members other than County Councillors – (7) Voting		
	Name of Member	*Representation*
1	HARDISTY, Kevin	Hambleton DC
2	CHILVERS, Judith	Selby DC
3	GARDINER, Bob	Ryedale DC
4	MORTIMER, Jane E	Scarborough BC
5	BROCKBANK, Linda	Craven DC
6	SEDGWICK, Karin	Richmondshire DC
7	GALLOWAY, Ian	Harrogate BC
Total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

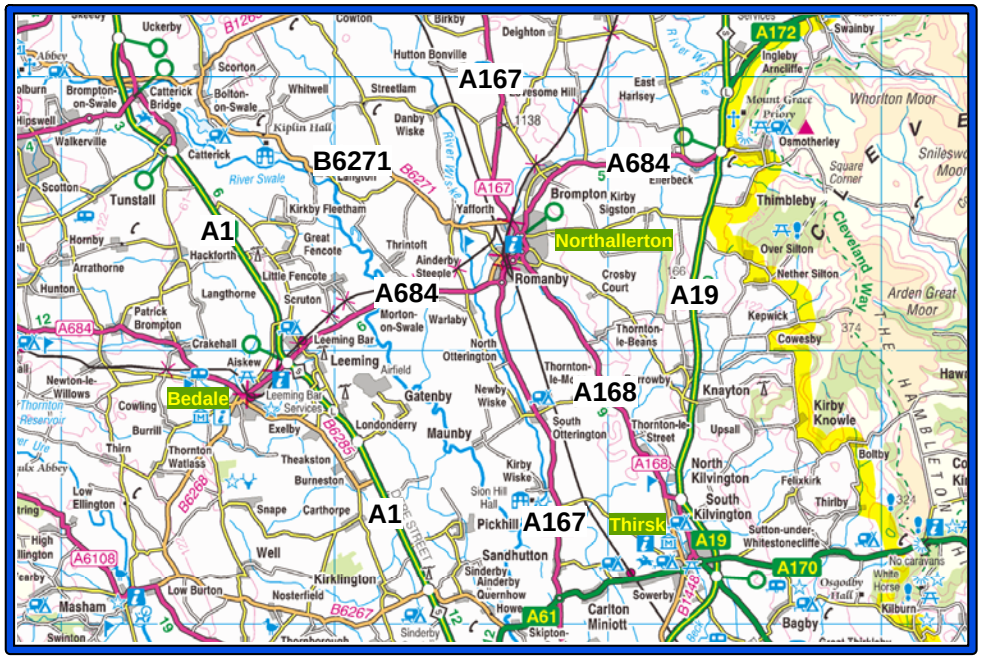
Con	**Lib Dem**	**NY Ind**	**Labour**	**Liberal**	**UKIP**	**Ind**	**Total**
8	**1**	**1**	**1**	**1**	**1**	**0**	

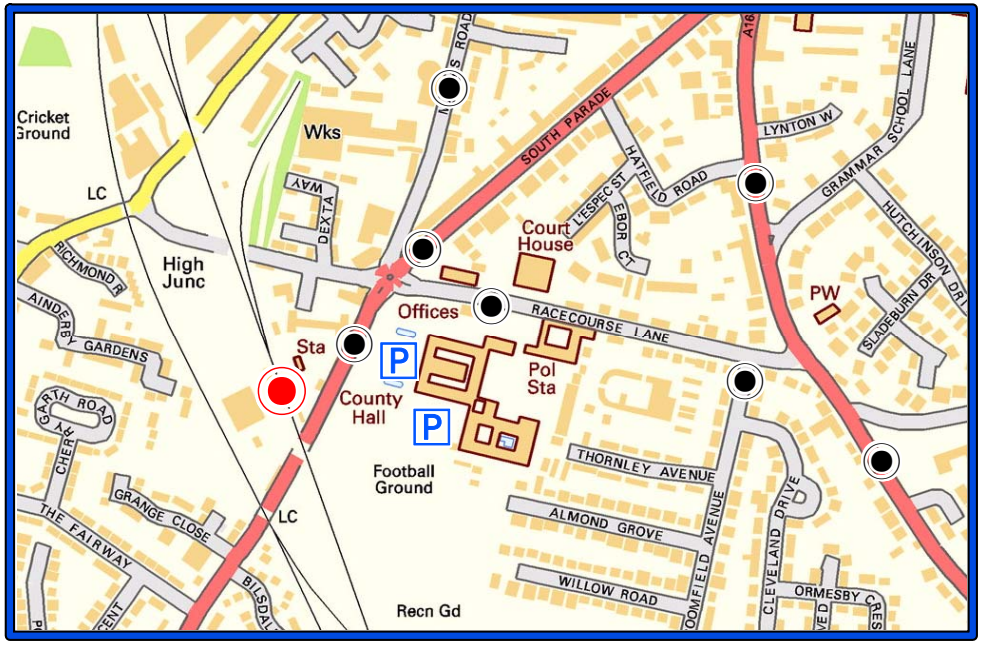
2. Substitute Members

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
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 22 April 2016.

Present:-

Members:-
County Councillor Jim Clark (in the Chair)
County Councillors: Philip Barratt, David Billing, Liz Casling, John Clark, Margaret-Ann de Courcey-Bayley, Shelagh Marshall OBE, Heather Moorhouse, Chris Pearson, David Simister and Michael Heseltine (as substitute for Val Arnold) and Caroline Patmore (as substitute for John Ennis)

Co-opted Members:-
District Council Representatives:- Judith Chilvers (Selby), Bob Gardiner (Ryedale), Jane E Mortimer (Scarborough), Linda Brockbank (Craven), Karin Sedgwick (Richmondshire)

In attendance:-
South Tees Hospitals NHS FT: Siobhan McArdle and Caroline Parnell
Hambleton Richmondshire & Whitby CCG: Janet Probert
Scarborough and Ryedale CCG: Simon Cox
Harrogate and Rural District CCG: Amanda Bloor
Vale of York CCG: Tracey Preece and Dr Andrew Phillips

County Council Officers: Richard Webb, Wendy Balmain and Lincoln Sargeant (Health & Adult Services) and Bryon Hunter (Scrutiny),

Members of the public: Dr Tim Thornton and Mr David Davies.

Apologies for absence were received from: County Councillors Val Arnold and John Ennis, Harrogate Borough Cllr Ian Galloway and Hambleton District Councillor Kevin Hardisty.

Copies of all documents considered are in the Minute Book

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97. Minutes of the Joint Sub-Committee of the Transport, Economy and Environment Overview and Scrutiny Committee and the Scrutiny of Health Committee on 22 January 2016

Resolved

That the Minutes of the meeting held on 22 January 2016 be taken as read and be confirmed and signed by the Chairman as a correct record.

98. Any Declarations of Interest

There were no declarations of interest to note.

99. Chairman's Announcements

County Councillor Jim Clark provided the Committee with an update relating to the following matters:-

- Craven Mental Health Forum – correspondence from Mr Milton Pearson (CEO, Craven Community and Voluntary Service) reading the Craven Mental Health Forum has been brought to the attention of Richard Webb, Corporate Director, Heath and Adult Service.

- Medicines management in the Scarborough and Ryedale Clinical Commissioning Group - group spokespersons have been briefed on new arrangements for reducing waste through improvements to the management of repeat medicines.

100. Public Questions or Statements

There were no statements or questions from members of the public that did not relate to an agenda item.

Correspondence relating to agenda item 7 had been received from County Councillor Gareth Dadd.

Public statements relating to agenda item 8 were received from Dr Tim Thornton, Mr David Davies and Joanne White.

101. North Yorkshire Sustainability and Transformation Planning Footprints - Summary Document (March 2016)

Considered -

The joint report of the Chief Officers of the Clinical Commissioning Groups covering North Yorkshire briefing the Committee on the Sustainability and Transformation Plans covering North Yorkshire.

Janet Probert advised Members that in 2016/17 the Clinical Commissioning Groups (CCGs) were producing Sustainability and Transformation Plans on both a CCG and larger STP footprint. Janet also commented that the STPs were based around acute pathways and took account of specialist pathways, for instance in the Hambleton and Richmondshire area, the specialist pathways for stoke, trauma and cardiology. All of these pathways lead to the specialist centres at the James Cook Hospital. This hospital and the pathways also serve the population of Teesside so it is entirely appropriate for the HRW CCG to work with other CCGs who commission similar services at that hospital. Janet emphasised that the CCG will continue to work locally across Hambleton and Richmondshire and that a layered approach to commissioning and planning services was essential. The STP will ensure that her CCG will have a voice and influence on behalf of North Yorkshire residents when specialist services are being planned even though those will be delivered outside of North Yorkshire. Similarly specialist services for other parts of North Yorkshire are provided by hospitals in Leeds and Hull.

Amanda Bloor advised Members that it would be important to ensure that STPs do not distract CCGs from their day job in terms of developing and new models of integrated care. Local plans will have primacy through the Harrogate and Rural District CCG Transformation Board.

Simon Cox commented that STPs will not undermine the work to take forward the Better Care Fund and work taking place with Health and Adult Service and Children's and Young Peoples Service will continue. He emphasised the need for the North

Yorkshire CCGs to be involved in the planning and being able to influence specialist/tertiary care which is delivered largely outside of the County.

Tracey Preece commented that Vale of York CCG is already working with other CCGs who are part of broader networks looking at specialist services, for instance, urgent and emergency care. The involvement of CCGs across a broad footprint would help to standardise levels of care.

Julie Warren acknowledged that North Yorkshire has been one of the most complicated areas to consider in term of STP footprints. But Julie emphasised that local services will remain locally planned and delivered.

County Councillor Jim Clark expressed concerns that the Harrogate and Rural District CCG would be part of a much larger West Yorkshire STP comprising 11 CCGs in total and whose population was 2.5 m. Councillor Clark also highlighted the significance of the real terms element of growth in CCG allocations for 2017/18 onwards being contingent upon the development and sign off of a robust STP during 2016/17. Councillor Clark also expressed concern about the viability of the CCGs covering North Yorkshire and whether they might be absorbed by larger CCGs which could have focus on issue outside of North Yorkshire due to population size and density at the expense of the County's rural and sparse population. He also referred to NHS England's guidance which highlighted that good STPs would receive priority in terms of access to funding. This posed the question what would happen to bad STPs.

Amanda Bloor advised Members that STPs were not about creating something new – specialist services were already being planned on these footprints. Amanda added that in fact the West Yorkshire STP was a two tier STP.

Julie Warren accepted that West Yorkshire is a large population pool but this whole initiative was not about CCG mergers but rather about the long term planning of hospital care. With regards to "good" versus "bad" STPs Julie commented that NHS England was waiting to see how Transformational Plans shaped up including how services and funding will go forward in the long term.

In response to Councillor Clark expressing concerns that the whole STP process was very centrally driven with an emphasis on effective leadership, Janet Probert commented that local plans will continue to have primacy but emphasised the need for specialist services to be planned by all the affected CCGs with the involvement of all affected patients. Rural issues are already taken into account, not just in terms of acute hospital care but also in terms of the work her CCG is doing with the Tees, Esk and Wear Valleys NHS Foundation Trust which covers a large geographical area.

Richard Webb advised Members that the main concern of local government was the way in which the process had been introduced in a very top down way and there were concerns that social care could be overlooked. He added that the initiative was very much driven by performance and financial viability across the acute sector. He also recognised the tensions in terms of having to plan specialist hospital services across large geographical areas while at the same time seeking to deliver integrated models of care locally.

Members of the Committee raised a number issues including:

- Governance arrangements in CCGs were already complicated and STPs introduced more bureaucracy into the system and undermined local accountability.

- The importance of ambulance services being involved in discussion around the development of pathways for specialist and emergency care.
- The possible impact on A&E units at the local district general hospitals serving North Yorkshire.
- The need to not lose sight of the importance of integrating primary, community an social care through new models of care, including the Vanguard projects.
- The need to ensure effective overview and scrutiny were established and how this could include joint committee being established for each STP area and comprising elected Members from all the affected local upper tier local authorities.

Councillor Philip Barrett expressed concern that arrangements in the Craven area had not been part of the discussions at this meeting.

Amanda Bloor acknowledged that the diagrams of governance arrangements were complicated but commented that the purpose of these diagrams were to illustrate how partnerships will work, not about how new services will be planned.

Amanda also reassured Members that she envisaged there would always be an urgent care facility at Harrogate Hospital.

Resolved -

a) That the report be noted.

b) That the Chairman be authorised on behalf of the Committee to write to NHS England summarising the issues raised at the meeting with a view to informing NHS England's engagement and consultation on the introduction of STPs.

102. Vale of York CCG Budget Situation and Financial Recovery Plan

Considered -

The report of Tracey Preece, Chief Finance Officer, updating the Committee on the development of the NHS Vale of York Clinical Commissioning Group's 2016/17 Financial and Operating Plans.

Tracey Preece guided Members through a presentation – Financial Plan 2016/17 – Final Submission Update - 18 April 2016.

Tracey highlighted that closing deficit position for 2016/17 is projected to be £13.3m which was an improvement of £3m from the plan that was considered by the CCG's Governing Body on 7 April 2016. This had been achieved through the removal of discretionary spend and increase risk within the plan. The long term financial plan still anticipates that this will be the last deterioration with the deficit held in 2017/18 and recovered over 2 years 2018/19 – 2019/20 with a return to surplus by the end of 2019/20. But this would need to be remodelled following 18 April submission of 2016/17 plan.

Tracey also highlighted that there is work to do in terms of mitigation plans for Quality, Innovation, Productivity and Prevention (QIPP). QIPP is a national, regional and local level programme designed to support clinical teams and NHS organisations to improve the quality of care they deliver while making efficiency savings that can be reinvested into the NHS. Tracy also mentioned that there is still work to be done in terms of agreeing the contract with the York Teaching Hospitals NHS FT and it was

likely that the CCG would be entering into a formal an arbitration process if the contract was not agreed by 25 April 2016. There is also work to be completed to finalise Better Care Fund plans.

Tracey and Dr Phillips summarised opportunities to learn from other CCGs, for instance to make savings in prescribing budgets, over the counter medications, eligibility for MRI scans and eligibility to elective surgery by being more evidence based and possibly linking eligibility to patient BMI index.

Julie Warren advised Members that NHS England would be carrying out a "deep dive" project into CCG's finances ad recovery plan.

Tracey acknowledged that as STPs become established there may be issues to overcome such as whether or not other CCGs in the STP feel that transition funding should be invested in the Vale of York CCG.

Members expressed serious concerns about the potential impact on front-line services in the CCG area and queried the level of management control, audit and governance that had allowed the situation to develop..

Dr Phillips commented that it is not easy to control the demand for health care but conceded that the CCG had never really been able to control the expenditure by the York Teaching Hospitals FT. The inclusion of the Vale of York in the ## STP would increase opportunities to commission services more intelligently rather than being driven by demand and the trust's finances.

Resolved -

a) That the report be noted.

b) That the CCG's recovery plan be supported.

c) That the planned engagement and consultation process with stakeholders and patients and the public due to commence shortly be noted.

d) That the committee expects to receive regular updates on the implementation of the recovery plan and on the progress of the engagement process.

103. "Fit-4-the Future" - Transforming our Communities

Considered -

The report of the Chief Officer, Hambleton, Richmondshire and Whitby Clinical Commissioning Group asking the Committee to examine the extent to which robust plans across health and social care have been put in place to support people, particularly as the winter period is approaching following the temporary closure of beds at the hospital.

County Councillor Jim Clark drew Members' attention to a letter from County Councillor Gareth Dadd which had been tabled at the meeting.

Janet Probert and Siobhan McArdle guided Members through the main points in the above report.

In response to the specific assurance that the Lambert will be considered as part of the CCG's plans for local health and social care in nay new configuration, which Council Dadd was asking the Committee to seek, Janet Probert commented that this would be the case and referred to the engagement work currently taking place. The importance of a local facility was a consistent theme coming out from that work. The possibility of some kind of different care model on the site had at this stage not been ruled out. Any development of the existing Lambert Hospital site would involve negotiations with NHS Property Services and Hambleton District Council and the CCG.

Siobhan McArdle described the need to provide a local facility and how thsi had to be tempered by the Trust's ability to recruit and pay for the required staff. The Trust was already facing massive challenges in terms of recruitment. Siobhan emphasised that the Trust is continuing its efforts to recruit nurses and that she is not ruling out the Lambert Hospital reopening albeit in a more modern form.

Janet commented that the meeting which Councillor Dad had organised had been a major turning point.

Resolved -

a) That the report be noted.

b) The CCG and the Trust be thanked for the level of engagement they have provided to the Committee on this matter.

c) That the CCG and the Trust to report to the Committee on the outcome of the engagement process with patients and the public as part of the Transforming our Communities initiative and on any plans for proceeding to a formal consultation.

104. Joint investigation undertaken by the Transport, Economy and Environment Overview and Scrutiny Committee and the Scrutiny of Health Committee to inform the Minerals and Waste Joint Plan, with regards to hydraulic fracturing, and to inform the Executive's response to the petition received by Ryedale Area Committee on 10 June 2015

Considered -

The report of the Chairman of the Transport, Economy and Environment Overview and Scrutiny Committee and the Chairman of the Scrutiny of Health Committee asking the Committee to discuss and note the information in the joint report of the Chairman of the Transport, Economy and Environment Overview and Scrutiny Committee and the Chairman of the Scrutiny of Health Committee and asking the Committee to consider the recommendations to the Executive as set out in the report.

Public Questions

Dr Tim Thornton and Mr David Davis read out the following statements:

Dr Tim Thornton
As a GP in Ryedale for over 30 years, I have concerns about how we can ensure that the communities can remain safe from the potential impacts from fracking.
We are dealing with a new process that is only about 10 years old and with only one episode having occurred in the UK. We will be dealing with fracking in a new regulatory framework and a new geology. There are many unknowns.
To protect communities and the environment around the fracking sites, we need to know what the hazards are, and for how far they might be significant. We can

only come to appropriate decisions regarding safe distances from habitation by Using Sound Science Responsibly. We need to look carefully at baselines and continue to monitor sufficiently regularly to detect changes to health and the environment before they becomes a problem.
Will this committee be recommending a prediction on the possible impacts of fracking with a Health Impact Assessment and also a detailed survey of health and well-being in the immediate area around the wells and further away? This will help to detect evidence of impacts – for good or bad.
Will this committee be recommending monitoring at various distances from wells to determine the interaction between wells and to give the basis for science to determine the distances from the well to habitation?
Using Sound Science Responsibly - one of the guiding principles of the NPPF.
http://www.publications.parliament.uk/pa/cm201012/cmselect/cmcomloc/1526/152607.htm
(The National Planning Policy Framework - Communities and Local Government Committee, December 2011)

Mr David Davis
Further to the report issued from the Joint Scrutiny Committee Meeting in January 2016 it is clear many issues were identified that were important in respect to informing the Minerals and Waste Joint Plan.

One of the most important areas is Public Health. One only has to look at the health data around the workforce in the oil and gas sector to see the effect this industry can have on health. Peer reviewed studies from overseas where this industry has proliferated is flagging up warnings that tell us further research is needed with regard to the health effects on people living in relatively close proximity of operating sites.

My questions revolve around many complex inter- related issues, including
1. The proximity of settlements to likely sites
2. The fact that this industry is allowed to degrade the air quality and create noise and disturbance. Both of these items are known to have harmful health effects.
3. The health data currently available
4. The additional data required to form an accurate baseline

So, should fracking take place in North Yorkshire
- How and when will a health baseline study be carried out?
- Who will carry out the study and how will it be reported?
- How will the subsequent baseline established feed in to the Minerals and Waste Joint Plan?

Ms Joanne White's statement was tabled at the meeting:

The report acknowledges the importance of M&WJP to protect and preserve the health of residents, the environment and existing economies. And also acknowledges the "unknowns".
There is however considerable information available about the unconventional gas industry and how it operates if we look abroad to countries like Australia and the US. There are commonalities, irrespective of different regulatory and legal regimes. And it is essential that those with responsibility for drafting the Plan take account of these commonalities and fully appreciate the difference between unconventional and conventional gas extraction - as there is a tendency for the industry and UKOOG to down play these important differences. The Plan must be reviewed but it must also be drafted with an eye to the future.

It is fact that this is a new industry only one well has been fracked unconventionally in the UK - as confirmed by DECC, and the EA.
It is fact that this industry cannot operate without lots of sites and lots of wells. The plan must stop over development.
We know from the Lancashire planning inquiry that each exploratory site is likely to take three years to complete, not the two years stated in Appendix 2. Production sites with more wells will take much longer.
In October 2015 Andrea Leadsom (Energy Minister) said that 100 to 200 wells would need to be drilled to see if shale gas could be successful. So just the exploratory phase may require up to 200 wells drilling and fracking.
Compare this scale to the six conventional wells Third Energy has in production in Ryedale.
North Yorkshire has a large licenced area so it would be reasonable to plan for a significant number of exploratory wells being in our Plan area.
The report refers to the cumulative issue of traffic. Again we know from the Lancashire inquiry that at times there will be 50 HGV journeys per day, per site and fracking requires large HGVs that are over 54' in length.
The report acknowledges the traffic impact of other extractive operations. Although in the North York Moors National Park - the new potash mine and its five-year construction, must also be considered. This adds to the "industrialisation" and transport load of the area and road network.
Should we be including in the Plan from the outset that traffic from fracking must not be permitted through the centre of settlements unless on an A Road?
The cumulative impact of waste is of great concern. We know from the Lancashire inquiry that only eight wells will take 70% of the available waste capacity. A waste expert at the Inquiry stated the EA had " not done a thorough job ..…... had left it open that capacity might not be available, it had specified process but not capacity"
At the same time it came to light that Cuadrilla may have underestimated the amount of flow back water it will produce.
We cannot be caught out. The Plan must be clear and robust. We cannot allow this industry at the expense of everything else.

Dr. Lincoln Sargeant advised Members that the British Geological Society is monitoring the environmental impacts of fracking and that this work would include establishing baseline data. Lincoln highlighted the need to have a large of amount of data for it to be statistically reliable and it would be difficult to build up sufficient data over collected at small distances apart. Lincoln also commented that there was currently no strong evidence that fracking would have an impact on health although he is working closely with NHS England on how the health impact of fracking can be monitored effectively.

Councillor John Clark commented that a leakage of, for instance benzene, affecting maybe 4 homes would have a low statistical impact but a massive impact on the residents of those homes.

Dr Thornton highlighted that high volume fracking industry is less than 10 years old and there is very little evidence of its impact under UK legislation and licencing arrangements.

Members commented that the chemical composition of fracking fluid before it enters the ground will be known, the composition of flow back fluid will not be known including whether or not it contains Naturally Occurring Radio Active Material, will not be known until it returns to the surface.

Members commented that whilst there could be a degree of confidence that all relevant agencies - including the police, emergency services, healthcare services,

housing and transport authorities, water companies - are already trained and equipped to deal with emergencies, fracking was a new industry and no one could be 100% confident that gaps would not occur in the responsibilities and activities of these agencies.

Members emphasised that the focus of their work on this matter had been entirely to inform production of the Minerals and Waste Plan in relation to issues that are within the scope of that Plan. They expressed broad support for the current draft report in terms of content. With regards to the format Members commented that the "Recommendations" should feature more prominently.

Resolved -

a) That the Chairman of the Scrutiny of Health Committee and the Chairman the Transport, Economy and Environment Overview and Scrutiny Committee, taking into account the views of the group spokespersons from both committees, be delegated responsibility to prepare a final joint report for submission to the Executive on 24 May 2016.

105. Work Programme

Considered -

The report of the Scrutiny Team Leader presenting the future Work Programme and inviting Members to comment/amend and suggest additional items to be included.

Resolved -

That the Work Programme be noted.

The meeting concluded at 12:50pm

B Hunter

North Yorkshire County Council

Scrutiny of Health Committee

1 July 2016

End of Life Care and "Dying Well"

Purpose of Report

1. The purpose of this report is to provide an initial framework for the Scrutiny of Health Committee to embark on an in-depth project to examine End of life Care Services with a view to informing the "Dying Well" priority in the North Yorkshire Joint Health and Wellbeing Strategy (JHWS).

Background

2. This report marks the first stage of an in-depth project which the Scrutiny of Health Committee is going to undertake into End of Life Care (EoLC) across North Yorkshire.

3. In July last year this Committee was consulted on the 2015 Update of the JHWS 2015-2020. The Committee felt there should be a greater emphasis on improving EoLC and supporting friends and relatives deal with bereavement and, in some cases, the longer term problems around isolation and loneliness. The Committee recommended that EoLC should be given greater prominence in the Strategy and that there should be a specific priority - "Dying Well".

4. These recommendations were accepted by the Health and Wellbeing Board.

5. The Public Health team, working with all key stakeholders locally, has recently completed a "deep dive" review of EoLC as part of a programme of work to refresh the Joint Strategic Needs Assessment (JSNA). The JSNA provides the evidence base for organisations to develop their plans in line with the ambitions set out in the JHWS, describing the local picture, in comparison to national data and policy and potential areas for improvement. The document also outlines variations across North Yorkshire: some of these may be appropriate to meeting the needs of local people, others may indicate opportunities for action.

6. Against a background of its involvement last year and work which is now taking place on the JSNA it is timely for the Committee to carry out further work on this topic. The Committee will be working proactively with all stakeholders to influence policy at an early stage rather than operating in the "traditional scrutiny mode" examining proposals from the NHS.

National review by the Care Quality Commission (CQC) - "*A different ending: Addressing inequalities in end of life care*", (Published: Monday 9 May 2016)

7. A national review by the Care Quality Commission (CQC) has found that people from certain groups in society are experiencing poorer quality care at the end of their lives than others because providers and commissioners do not always understand or fully consider their specific needs.

8. The review reports that only 67% of the 40 clinical commissioning groups (CCGs) it surveyed said that they had assessed the end of life care needs of their local populations – meaning that one in three had not.

9. Also, the CQC found that only 18% of the 40 CCGs had commissioned specific services for at least one of the population groups considered in its review – this includes people whose social circumstances make them vulnerable, older people, people with dementia, a learning disability, a mental health problem, or a chronic progressive illness other than cancer.

10. The impact of this could be that local health and care services are not fully equipped or ready to help these particular groups of people in their areas to get truly personalised care at the end of their lives.

11. This could lead to people's wishes not being met or them not having the full range of options of where they would prefer to be cared for and die available to them.

12. For example, an older person may be admitted to hospital in the last days of their life when they would prefer to die at home. While in some areas commissioners and providers are taking an equality-led approach, the review findings raise concerns that some might not be fulfilling their duties under the Equality Act 2010, which states that all public bodies have a legal duty to consider the needs of a range of equality groups when carrying out their day-to-day work.

13. In its national review, CQC is calling for action to make sure everyone has the same access to high quality, personalised care at the end of their lives, regardless of their diagnosis, age, ethnic background, sexual orientation, gender identity, disability or social circumstances.

14. The CQC's overview report is available at:

    http://www.cqc.org.uk/sites/default/files/20160505%20CQC_EOLC_OVERVIEW_FINAL_3.pdf

Methodology

15. The first stages will be for Committee to strengthen its understanding of EoLC services locally and to understand the needs of people who might be nearing the end of their life, including the impact the situation is having on their families and friends.

16. The project will include desk research in terms of pulling together national and local policy guidance, collating and analysis of statistics, and mapping the involvement of the relevant agencies and organisations – statutory and voluntary. Some of this work be undertaken "behind the scenes" by your Scrutiny Support Officer with support from colleagues in other parts of the County Council and from colleagues in NHS. The JSNA will inform much of that work.

17. Members' role will include exploring key issues with stakeholders. It is also envisaged that groups of Members will hold focus group sessions with recently bereaved friends/relatives.

18. Healthwatch North Yorkshire is also looking at EoLC. Joint work is being planned.

19. The project will be overseen by County Councillor Jim Clark, Chairman, working closely with the group spokespersons.

Joint Health and Wellbeing Strategy 2015 - 2020

20. The current version of the JHWS is available at: http://www.nypartnerships.org.uk/CHttpHandler.ashx?id=21125&p=0

21. An extract from the Strategy relevant to this project are shown in APPENDIX 1.

Saint Michael's Hospice, Harrogate

22. Saint Michaels' exists to improve the lives of people affected by terminal illness, both those living with it and their families and carers.

23. As a start of the Committee's engagement work with other agencies on this project Mr. Tony Collins, Chief Executive, will be attending the meeting to summarise the role of his hospice and that of the other hospices across North Yorkshire.

24. Mr. Collins' briefing will include information on mortality and end of life care statistics for North Yorkshire, activity and funding levels of the four North Yorkshire Hospices and agreed strategic directions of clinical commissioning groups and other commissioners. Mr. Collins will also summarise

examples/case studies of good and bad practice and guide Members though through the sensitive issues around EoLC.

25. Mr. Collins has indicated that he will be able to help with a bereaved relatives focus group as his hospice also run a comprehensive bereavement service for adults, children and young people. The hospice often brings together focus groups of the bereaved to examine strategic and policy matters.

26. Mr. Collins has also indicated that he will be able to help arrange for Members to meet with patients focus group, although this is notoriously difficult to navigate.

27. Information from Saint Michael's web site:

Facts and Figures

The difference Saint Michael's makes:

- Saint Michael's improves the lives of people affected by terminal illness and bereavement.
- 1 in 2 people know someone who has been cared for by a Hospice
- We serve the population of the Harrogate district.
- As this population ages, more people are living longer with serious illness, which means more people need our help.
- We currently care for more than 2000 people each year.

The services Saint Michael's offers:

- We offer physical, emotional, psychological, practical and spiritual care to our patients and their families.
- Our services are available to people living with any terminal illness or bereavement. Although a large number of cancer patients use our services, we also care for people with other illnesses, such as chronic obstructive pulmonary disease, Parkinson's, motor neurone disease and end stage heart and lung disease.
- The team at Saint Michael's makes around 18 home visits every day.
- Each year Saint Michael's Hospice offers around 2,700 day therapy sessions.
- We are currently helping around 500 local people live with lymphoedema
- Last year we offered 3,650 days of inpatient care
- Saint Michael's Just 'B' service currently has a caseload of 80 children, young people and adults living with bereavement caused by murder, suicide, disaster and terminal illness.
- All our services are free to patients and their families

The Saint Michael's team:

- Saint Michael's is supported by a volunteer workforce of around 600 people, giving their time, energy and skills for free
- Volunteers outnumber our staff by 6 to 1.
- Our patient care team include doctors, nurses, occupational therapists, physiotherapists, lymphoedema practitioners, bereavement support workers, psychologists, social workers and chaplains.

28. Additional information is shown in APPENDIX 2.

Recommendations

29. That Members:

a) offer any comment/advice on the methodology and on the issues that need to be take into account as part of this project;
b) consider the existing and potential role of hospices in EoLC;
c) note the additional support which has been offered to help the Committee engage with relatives and patients and consider how best to take that work forward.

Report From:

Bryon Hunter, Scrutiny Team Leader

North Yorkshire County Council, County Hall, NORTHALLERTON

23 June 2016

Background Documents: None

Dying well

Why is it important?

In North Yorkshire, although most people would prefer to die in their own home, around half die in hospital. The proportion dying at home will increase, but because of a rise in the death rate, the actual numbers dying in hospital will also increase unless we do something to change this.

There has been a substantial shift towards patient choice with people increasingly encouraged to be directly involved in shaping treatment plans for themselves and their relatives.

Death and dying is now beginning to be debated more openly. Nevertheless it still seems to be the case that, in practice, the discussion of death as an inevitable and, in some cases, imminent aspect of life is regarded as morbid and thus avoided.

Hospital cannot offer the individual the same comfort and familiarity that they might find if they were able to die in their own home and in their own bed, surrounded by the people that they love.

Encouraging conversations around quality of life, how and where a person might want to be cared for, as well as financial issues, helps to make sure the wishes of the person dying are followed. If family know about the dying person's wishes it can help them if they ever have to make decisions about care and can help to remove some of the stress at a difficult time.

This could include exploring options such as hospice care which can provide care for the dying and support for the family provided in a person's own home or elsewhere.

What have people told us that they want from this strategy?

"To consider how bereavement support is provided to grieving friends and relatives."

"Dying well is very important for all ages and providing support to friends and relatives should have greater prominence from all organisations"

What changes can you expect to see?

By 2020, you can expect to see:

- 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.

North Yorkshire County Council Scrutiny Committee
Background Information

The need in numbers
Nationally

- 500,000 people die each year and this is expected to rise by 17% in the next 15 years[1]
- The all-cause mortality is around 29% Cancer, 28% circulatory and 15% respiratory illness[2].
- The % of deaths in 85+ is expected to rise from 32% to 44%[3]
- It is estimated that ¾ of deaths in England are expected and therefore can be supported by end of life care; this is presently 355,000 people, rising to 440,000 by 2030.[4]
- It is estimated that 47% of these deaths are complex and will need the support of specialist end of life care services[5].
- Hospices
    - More than 220 in the UK[6]
    - 90% of hospice care is delivered through day services or at home[7]
    - Around 50% of people say they are concerned that there won't be enough hospice care available in the future[8]
    - The hospice sector supports at least 120,000 patients per year, rising to 360,000 when you consider the family members who are supported[9]. This is likely to be underrepresented due to unmet need[10].
- Over 60% of people would prefer to die at home[11]. However in a recent survey only 34% ranked this as a priority in care instead the priorities in care are 'having as much information as they wanted' and 'choosing who makes decisions about their care'[12].
- VOICES report key findings[13]
    - 43% of people reported that care in the last three months of life was outstanding or excellent.
    - Pain relief was inadequate for 53% of people who died at home, 32% who died in hospital, 25% in care homes and 13% in hospices.

[1] https://www.england.nhs.uk/wp-content/uploads/2014/11/actions-eolc.pdf
[2] 2014 ONS mortality stats
[3] Ibid
[4] Ibid
[5] Ibid
[6] https://www.hospiceuk.org/media-centre/facts-and-figures
[7] Ibid
[8] Ibid
[9] Ibid
[10] https://www.mariecurie.org.uk/globalassets/media/documents/policy/campaigns/equity-palliative-care-uk-report-full-lse.pdf
[11] http://www.dyingmatters.org/sites/default/files/files/NCPC_Public%20polling%2016_Headline%20findings_1904.pdf
[12] British Social Attitudes Survey: http://bsa- 30.natcen.ac.uk/media/36320/bsa_30_dying.pdf
[13] http://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/nationalsurveyofbereavedpeoplevoices/england2015

- Almost 16% of people reported that services were not well coordinated at the end of life
- Over 16% reported not receiving adequate support despite asking for it.
- 82% of people reported that their loved one died in the right place.

- It is estimated that there are 111,000 people in the UK who would benefit from end of life care but who are not receiving it.[14]
- There have been recognised gaps in services with only 21% of hospitals offering face to face 7 day a week end of life care services and 73% offer 5 days a week.

North Yorkshire End of Life Care

Tables 1/2.[15]

Area of usual residence	Population Number (thousands) All ages			Deaths (numbers) All ages			Rates Crude death rate (deaths per 1,000 population)	Age-standardised mortality rate[1]		
	Persons	Males	Females	Persons	Males	Females		Persons	Males	Females
UNITED KINGDOM	**64,105.7**	**31,532.9**	**32,572.8**	**576,458**	**279,171**	**297,287**	**9.0**	**1,001.9**	**1,176.3**	**867.4**
ENGLAND	**53,865.8**	**26,534.0**	**27,331.8**	**473,552**	**229,291**	**244,261**	**8.8**	**979.2**	**1,149.7**	**847.2**
North Yorkshire	**602.7**	**297.3**	**305.4**	**6,216**	**3,001**	**3,215**	**10.3**	**921.6**	**1,101.2**	**789.1**
Craven	55.5	26.8	28.8	636	288	348	11.5	879.2	1,029.4	769.5
Hambleton	89.9	44.5	45.4	882	405	477	9.8	862.6	958.6	780.7
Harrogate	158.2	77.4	80.8	1,494	731	763	9.4	833.1	1,055.1	678.4
Richmondshire	53.9	29.2	24.7	430	211	219	8.0	918.7	1,070.1	820.7
Ryedale	52.2	25.6	26.6	622	291	331	11.9	983.8	1,106.1	893.6
Scarborough	108.2	52.3	55.9	1,413	700	713	13.1	1,061.1	1,289.0	888.1
Selby	84.7	41.5	43.2	739	375	364	8.7	964.2	1,179.8	802.3

Area of usual residence	Age group All Ages		15-24		25-34		35-44		45-54		55-64		65-74		75-84		85 and over	
	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females
ENGLAND AND WALES[1]	**245,585**	**261,205**	**1,429**	**625**	**2,675**	**1,395**	**5,485**	**3,252**	**12,045**	**8,057**	**24,401**	**16,424**	**47,787**	**33,982**	**77,357**	**70,740**	**72,246**	**125,058**
North Yorkshire	**3,001**	**3,215**	**18**	**12**	**23**	**5**	**48**	**29**	**127**	**81**	**231**	**156**	**542**	**387**	**956**	**850**	**1,040**	**1,683**
Craven	288	348	2	0	0	0	7	2	6	3	19	16	47	39	95	99	111	189
Hambleton	405	477	3	2	8	0	4	0	19	8	32	25	81	55	124	141	130	244
Harrogate	731	763	3	5	3	1	8	7	27	19	62	28	119	68	239	187	267	444
Richmondshire	211	219	3	0	2	0	4	4	3	7	13	14	35	39	72	52	77	100
Ryedale	291	331	2	1	2	1	2	3	14	12	26	19	47	44	93	93	104	157
Scarborough	700	713	3	3	3	3	17	8	35	14	54	42	133	97	220	184	234	362
Selby	375	364	2	1	5	0	6	5	23	18	25	12	80	45	113	94	117	187

The population is 599,708[16] of which it is estimated from national statistics that we expect around 4800 people to die each year of which 3,600 will be expected and require end of life care services.

Number of deaths by usual residence	Apr-15[3]	May-15[3]	Jun-15[3]	Jul-15[3]	Aug-15[3]	Sep-15[3]	Oct-15[3]	Nov-15[3]	Dec-15[3]	Jan-16[3]	Feb-16[3]	Mar-16[3]	TOTAL	Seen at the hospice IPU (number (%)	Seen at the hospice DTU (number (%)	Seen within the community team (number (%)
North Yorkshire	**499**	**496**	**483**	**499**	**452**	**483**	**512**	**545**	**589**	**567**	**571**	**577**	6,273	-	-	-
Craven	52	58	38	56	40	49	46	45	66	58	68	55	631	-	-	-
Hambleton	54	66	71	82	62	83	81	69	77	76	92	90	903	-	-	-
Harrogate	139	118	133	128	125	113	135	132	154	152	138	141	1,608	170 (10.5%)	135 (8.4%)	611 (38%)
Richmondshire	38	33	36	40	26	34	40	37	42	37	44	36	443	-	-	-
Ryedale	40	55	46	42	38	49	46	51	51	57	37	68	580	-	-	-
Scarborough	102	119	100	95	102	104	111	129	118	112	119	108	1,319	-	-	-
Selby	74	47	59	56	59	51	53	82	81	75	73	79	789	-	-	-

[14] https://www.mariecurie.org.uk/globalassets/media/documents/policy/campaigns/equity-palliative-care-uk-report-full-lse.pdf

[15] http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-327606

[16] file:///C:/Users/edobson/Downloads/North_Yorkshire.pdf

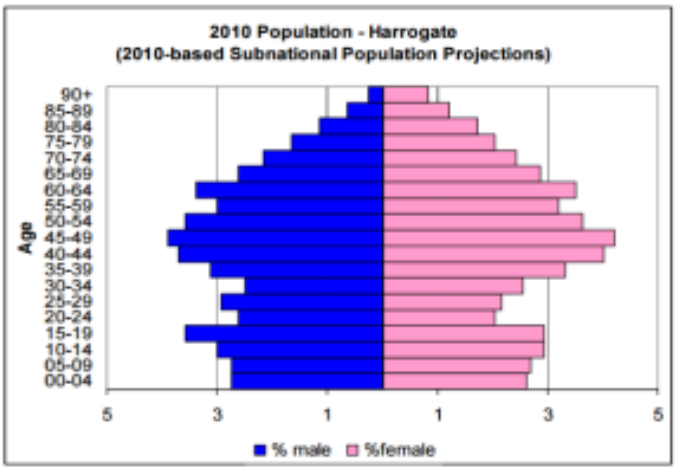
- North Yorkshire has a statistically higher than average[17]:
    - Older population (those above 65, 75 and 85) for males and females
    - Death rate
    - Percentage of deaths
    - Deaths in care homes
    - Deaths from heart disease
- North Yorkshire has a statistically lower than average[18]:
    - Deaths in hospital
    - Residents in urban localities
    - Deaths from respiratory disease
    - Deaths from liver disease
- In North Yorkshire there are 118,617 people over 65, 16,448 over 85. Given the working definition:

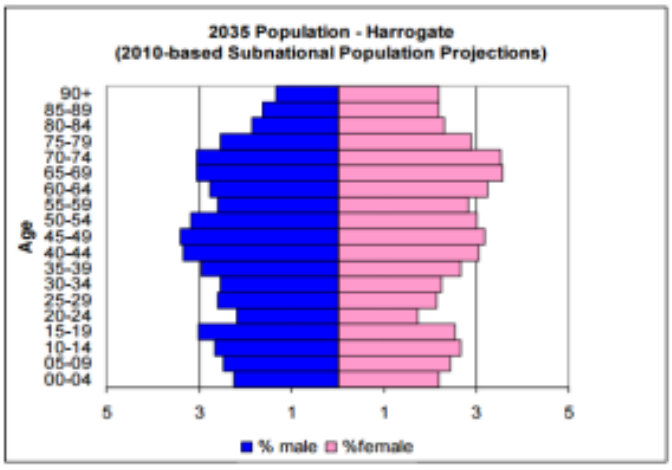
End of life care is care that:
Helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support[19].

We could state that while it has been estimated that 3600 will die within the population each year it is likely that from the 16,448 over 85 some end of life care service will be required and could be required for longer than the last months of life.

Harrogate and District

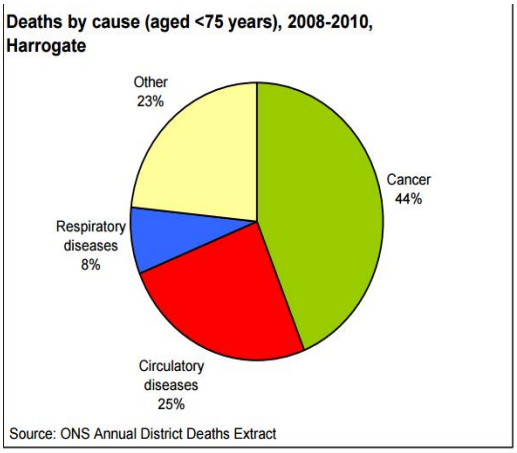
Harrogate has a population of 158,000 with a fairly rural makeup, population density of 121 per km, which is above the North Yorkshire average of 75 but significantly lower than the national average of 401[20]. The age structure of the Harrogate District is detailed below[21].





In the Harrogate District the death by cause is illustrated by the following[22]:

[17] Ibid
[18] Ibid
[19] http://www.ncpc.org.uk/sites/default/files/AandE.pdf
[20] http://www.nypartnerships.org.uk/CHttpHandler.ashx?id=18700&p=0
[21] Ibid
[22] http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-327606



The leading cause of death for those dying prematurely (<75 years) in Harrogate is Cancer, accounting for 44% of all deaths.

Hospices are value for money

Hospices provide value for money in two respects firstly the economics:

a) Hospices can support in the reduction of unnecessary admissions[23].
b) Hospices can reduced hospital deaths by 20% each year generating a saving of £80m to the NHS[24]
c) The palliative care funding review for England found:
    a. Extending 'specialist and core' services could result in net savings

Then the outcomes for end of life care provided through hospice care are comparably higher:

a) 88% drs and 85% nurses showed dignity and respect to patients and families in the last three months of life compared with 59% and 53% respectively for hospitals.[25]
b) 85% rated hospice care as good, excellent or outstanding compared to 69% in hospitals[26]

The evidence to note in value for money

a) A review found that home based end of life care services to be inconclusive on cost effectiveness[27].
b) Zimmerman[28] found that in 7 RCT's reviewing cost effectiveness only one study found significant cost savings, this study was based in the USA. The only UK study contained in this report noted that there was no significant difference.
c) SCIE said 'the NHS should have a better evidence based understanding of the relative costs of specialist and generalist care at the end of life, analysed according to place of care deliver'
d) There is a systematic lack of data around cost effectiveness[29]
e) Higginson et al (2009) found that the total costs for providing end of life care were £1789 less expensive than the control group but this was not statistically significant. [30]

[23] https://www.mariecurie.org.uk/globalassets/media/documents/policy/campaigns/equity-palliative-care-uk-report-full-lse.pdf
[24] https://www.hospiceuk.org/media-centre/facts-and-figures
[25] http://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/nationalsurveyofbereavedpeoplevoices/england2015
[26] Ibid
[27] Cochrane E, Colville E, Conway R (2008) Addressing the needs of patients with advanced non-malignant disease in a hospice day care setting, International Journal of Palliative Nursing, 14, 8, 382–387.
[28] Zimmermann C, Riechelmann R, Krzyzanowska M, Rodin G, Tannock I (2008) Effectiveness of specialized palliative care: a systematic review, JAMA, 299, 14, 1698–709.
[29] https://www.mariecurie.org.uk/globalassets/media/documents/policy/campaigns/equity-palliative-care-uk-report-full-lse.pdf

f) Day care services were inconclusive when examining their cost effectiveness[31]s.

Inequalities in end of life care

The CQC said 'commissioners and providers do not always consider the needs of everyone in their community'[32].

a) Malignant vs Non Malignant
    a. 88% of IPU and 75% of all referrals to hospices are for cancer despite this accounting for only 29% of deaths[33].
    b. There is a trend where non-malignant diagnosis are been referred 12% in 2008 and 20% in 2013. [34]
    c. This trend is translated into generalist end of life care where on average malignant diagnosis had 11.4 GP visits on average compared to 3.9 for non-malignant.[35]
b) Learning disabilities
    a. Less likely to have access to end of life care[36]
    b. Receive inadequate pain control[37]
    c. More likely to have their death described as not being planned for, uncoordinated and poorly managed.[38]
c) LGBTQIA+
    a. 1.6% of the population is thought to be LGBT but estimates have reached up to 6%.[39], this equates to around 800,000 people over the age of 65 who would be LGBT[40], meaning approximately 40,000 would die annually.
    b. LGBT have a higher likelihood of dying due to lifestyle risk factors such as smoking, alcohol and drug abuse which are attributed to stress from marginalisation and discrimination.[41]
d) BME
    a. Evidence to demonstrate that there is a lower uptake of end of life care services within this group.[42] Only 6.2% of BME access palliative care despite 14% population prevalence, this % drops further when you look at the over 65 age range to 4%[43].

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[30] Higginson IJ, McCrone P, Hart SR, Burman R, Silber E, Edmonds PM (2009) Is short-term palliative care cost-effective in multiple sclerosis? A randomized phase II trial, Journal of Pain and Symptom Management, 38, 6, 816–826

[31] Douglas HR, Normand CE, Higginson IJ, Goodwin DM, Myers K (2003) Palliative day care: what does it cost to run a centre and does attendance affect use of other services?, Palliative Medicine, 17, 7, 628–637.

[32] http://www.cqc.org.uk/sites/default/files/20160505%20CQC_EOLC_OVERVIEW_FINAL_3.pdf

[33] https://www.mariecurie.org.uk/globalassets/media/documents/policy/campaigns/equity-palliative-care-uk-report-full-lse.pdf

[34] Ibid

[35] Ibid

[36] Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD) (2013). http://www.bristol.ac.uk/cipold/fullfinalreport.pdf

[37] Ibid

[38] Ibid

[39] https://www.mariecurie.org.uk/globalassets/media/documents/policy/policy-publications/june-2016/reality-end-of-life-care-lgbt-people.pdf

[40] Ibid

[41] Ibid

[42] Calanzani N, Koffman J and Higginson IJ (2013). Palliative and end of life care for black, Asian and minority ethnic groups in the UK: demographic profile and the current state of palliative and end of life care provision. Public Health England, King's College London and Marie Curie Cancer Care.

[43] https://www.mariecurie.org.uk/globalassets/media/documents/policy/campaigns/equity-palliative-care-uk-report-full-lse.pdf

b. There is evidence that when they do take up end of life care there are poorer outcomes[44]

e) Homeless
   a. They die at 3 times the rate of matched controls in the general population[45]
   b. The average age of death is 40 – 44 years old[46]
   c. Over a third die in hospital[47]
   d. The most common cause of death is multiple organ failure[48]

f) Dementia
   a. 1/3 of people will die from dementia with complex physical and psychological needs[49].

g) Transitioning CYP
   a. There are at least 49,000 under the age of 19 living with life-limiting or life-threatening conditions, this number has doubled in the past decade[50]
   b. Over 2000 16 – 30 year olds die each year[51]

h) Geography
   a. People from deprived socio-economic areas experience poorer qualities of care.[52]

Collaborations to support end of life care

a) Herriot Hospice Homecare
b) Wilfward
c) Dementia Forward

Additional services

- Bereavement
  - Just 'B's caseload is currently 182 including the waiting list
  - Bereavement increases the risk of mortality and poor health which in Scotland was estimated to cost £20 million which when extrapolated to England was between £150 -£190 million[53].
  - The number of bereaved people is likely to increase with the increase in the proportion of elderly people[54].
  - The House of Lords reported that we are 'woefully unprepared' to deal with this[55].
  - Rising funeral poverty will impact where the average shortfall is £1277[56].
  - The National Council on Palliative Care said that just 54% of HWB had considered end of life care and of these very few had considered bereavement as a key driver[57].

[44] Ibid
[45] Office of the Chief Analyst, Department of Health (2010). Healthcare for single Homeless People. http://www.qni.org.uk/docs/healthcare%20for%20single%20homeless%20people %20NHS.pdf.
[46] Ibid
[47] Ibid
[48] Homelessness and End of Life Care (2013). Report by Marie Curie Cancer Care and St Mungo's
[49] Sampson EL, Burns A and Richards M (2011). Improving end-of-life care for people with dementia. British Journal of Psychiatry; 199(5): 357-9.
[50] http://www.york.ac.uk/inst/spru/news/appgBP.pdf
[51] Ibid
[52]http://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/nationalsurveyofbereavedpeoplevoices/england2015
[53] http://www.dyingmatters.org/sites/default/files/Life%20After%20Death%20FINAL(1).pdf
[54] Ibid
[55] Select Committee on Public Service and Demographic Change (2013) 'Ready for Ageing?' London: The Stationary Office.
[56] http://www.dyingmatters.org/sites/default/files/Life%20After%20Death%20FINAL(1).pdf

        - This led to Dying Matters to recommend 'Clarity about who is responsible locally for commissioning and providing bereavement support with better coordination and information about services'[58]
- Lymphoedema
    - Saint Michael's current caseload is approximately 480.
    - There is thought to be between 80,000 and 124,000 people living with Lymphoedema nationally which sits it alongside MS and HIV[59].
    - 25% of Lymphoedema is caused due to cancer[60]
    - 97.5% of those in receipt of specialist care stated that their swelling was controlled compared with less than 80% within non-specialist services[61].
    - For every £1 spent on lymphoedema treatments it is estimated that it would save £100 in reduced hospital admissions due to swelling and infection.[62]

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[57] NCPC (2013) Does Dying Matter to England's new Health and Well-being Boards?
[58] http://www.dyingmatters.org/sites/default/files/Life%20After%20Death%20FINAL(1).pdf
[59] Morgan, P.A., Franks, P.J., and Moffatt, C.J. (2005). Health-related quality of life with lymphoedema: a review of the literature. Int Wound J. Mar;2(1):47-62
[60] Lymphoedema: an underestimated health problem. C.J. Moffatt, P.J. Franks, D.C. Doherty, A.F. Williams, C. Badger, E. Jeffs, N. Bosanquet And P.S. Mortimer. J Med 2003; 96:731–738
[61] Lymphoedema: Service Provision and Needs in Scotland. Margaret C Sneddon University of Glasgow, funded by Macmillan Cancer Support. http://eprints.gla.ac.uk/50066/1/50066.pdf
[62] http://www.macmillan.org.uk/documents/aboutus/commissioners/lymphoedemaservicesanevidencereview.pdf

Terms of Reference Table
Board of Trustees

Abbreviation	Meaning
APM	Associate of Palliative Medicine
BME	Black, minority ethnic group
BOT	Board of Trustees
CAF	Charities Aid Foundation
CCG	Clinical Commissioning Group
CNS	Clinical Nurse Specialist
COG	Clinical Operational Group
CQC	Care Quality Commission
CYP	Child and Young Person
DTU	Day Therapy Unit
DV	Domiciliary Visit
EOLC	End of Life Care
HDFT	Harrogate District Foundation Trust
HtH	Help the Hospices
HWB	Health & wellbeing board
IMO	In Memory Of
IPU	In Patient Unit
LCP	Liverpool Care Pathway
LGBT	Lesbian, Gay, Bisexual or Transgender
MDT	Multi-Disciplinary Team
MND	Motor Neurone Disease
OACC	Outcome Assessment & Complexity Collaborative
PCT	Primary Care Trust
QIA	Queer, Intersex & Asexual
ROB	Robert Ogden Building
RCT	Randomised control trial
SLA	Service Level Agreement
SCIE	Social Care Institute of Excellence
SOP	Standard Operating Practice
SW	Social Worker
VVS	Volunteer Visitors Scheme

NORTH YORKSHIRE COUNTY COUNCIL

SCRUTINY OF HEALTH COMMITTEE

1 July 2016

Remit of the Committee and Main Areas of Work

Purpose of Report

1. 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

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

3. 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;

4. 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 Dates

5. The Committee meetings up to May 2016 are:

2016

- 2 September
- 18 November

2017

- 27 January
- 7 April

6. All of the above meetings will start at 10.00am and will be held at County Hall.

Areas of Involvement and Work Programme

7. The Committee's on-going and emerging areas of work involvement are summarised in APPENDIX 1.

Recommendation

8. 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.

Bryon Hunter
Scrutiny Team Leader

County Hall
NORTHALLERTON

21 June 2016

Background Documents: None

APPENDIX 1

NORTH YORKSHIRE COUNTY COUNCIL

Scrutiny of Health Committee – Work Programme/Areas of Involvement – 2016/17 (as at April 2016)

(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					Appendix 2
2. National Review of Congenital Heart Surgery (Adults and Children)					Councillor Jim Clark continues to represent North Yorkshire on the Yorkshire and Humber Joint Scrutiny of Health Committee
3. 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. First meeting is on Thursday 7 July 2016 at 2.00 p.m. at Hartlepool Borough Council Civic Centre.
4. Rural Services Network - Scrutiny on Access to Health Services in Rural Areas					
5. Funding of Community Pharmacies http://www.telegraph.co.uk/news/2016/05/29/3000-local-chemists-could-close-this-year-after-170m-subsidy-cut/					Period of involvement to be confirmed.
6. NY Mental Health Strategy	✓				

	2016		2017		Notes
Scheduled Committee Meetings	**2 Sep**	**18 Nov**	**27 Jan**	**7 Apr**	
Local Service Developments					
7. Hambleton, Richmondshire & Whitby CCG: Hambleton and Richmondshire - "Fit 4 the Future", including developments at the Lambert Hospital, Thirsk					https://www.hambletonrichmondshireandwhitbyccg.nhs.uk/transforming-our-communities
8. Ambition for Health and Out of Hospital Care in Scarborough and Ryedale					
9. Care Quality Commission Inspection - Harrogate and District NHS FT					Period of involvement to be confirmed.
10. Mental Health Service in York/Selby area + Bootham Hospital					http://www.tewv.nhs.uk/site/about/trust-news/Creative%20patients%20help%20t.15532168405269330 http://www.bbc.co.uk/news/uk-england-york-north-yorkshire-36293194 Update following transfer of services in this area to the Tees, Esk and Wear Valleys NHS FT in 2015. Period of involvement to be confirmed.
11. Vanguard/New Models of Care in Harrogate		✓			http://www.harrogateandruraldistrictccg.nhs.uk/who-we-are/health-and-social-care-partners-across-harrogate-and-rural-district-successful-with-vanguard-bid/
12. Vale of York CCG Financial Recovery Plan + Impact on services					
Public Health Developments					
13. Development of base-line data and an on-going monitoring system on the impact of Fracking.					

	2016		2017		Notes
Scheduled Committee Meetings	**2 Sep**	**18 Nov**	**27 Jan**	**7 Apr**	
14. Alcohol Misuse					Mid cycle briefing 29 July 2016
15. Suicide Prevention					Mid cycle briefing 29 July 2016
16. Annual Report – Director of Public Health		✓			
In-depth Project					
17. Dying well + End of Life Care	✓				Project to inform the Joint Strategic Needs Assessment/Health and Wellbeing Strategy: http://www.nypartnerships.org.uk/CHttpHandler.ashx?id=21125&p=0 Meeting on 2 September Will include discussion of the JSNA "deep dive" into EoLC.

North Yorkshire County Council

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28 April 2016

Moira Dumma
Director of Commissioning Operations
Yorkshire and the Humber
NHS England, Unit 3, Alpha Court
Monks Cross
York
YO32 9WN

Dear Ms. Dumma,

NHS Place Based Planning and its Implications for North Yorkshire

Please pass on my thanks to Julie Warren for attending the Scrutiny of Health Committee on Friday 22 April 2016 and for contributing to our discussions on Place Based Planning and Sustainability and Transformational Plans (STPs).

My Committee is taking a close interest in the implementation of the NHS Five Year Forward View published on 23 October 2014 which sets out three aims:

- better health,
- transformed quality of care delivery and
- Sustainable finances.

We are concerned by certain aspects of the NHS Planning Guidance - 2016/17 to 2020/21 published in December last year which will take forward these aims as North Yorkshire will be covered by 3 STPs as follows:

STP	PopN. (million)	Total number of CCGs	North Yorkshire CCGs included
West Yorkshire	2.5	11	• Harrogate and Rural District CCG • Airedale, Wharfedale and Craven CCG
Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby	1.3	6	• Hambleton, Richmondshire and Whitby CCG
Humber, Coast and Vale	1.4	6	• Scarborough and Ryedale CCG • Vale of York CCG

It is against this background that the North Yorkshire Scrutiny of Health Committee met on 22 April 2016 with a view to contributing to your process of engagement and to influence how STPs and healthcare services covering North Yorkshire will be taken forward.

As well as Julie Warren our meeting was attended by Janet Probert (Hambleton, Richmondshire and Whitby CCG), Amanda Bloor (Harrogate and Rural District CCG) and Simon Cox (Scarborough and Ryedale CCG). As part of a separate agenda item on the Vale of York CCG's financial situation Tracey Preece and Dr Andrew Phillips also summarised the work that is taking place in that CCG as part of the wider Humber, Coast and Vale STP.

Taking into account the discussions and information published by NHS England I would like to highlight the following issues which my committee feel are significant for North Yorkshire and require addressing:

Sparsity and Rurality

It will be essential that healthcare services in North Yorkshire are not unduly influenced by the challenges faced in providing services in the urban areas of Middlesbrough, Leeds, Bradford and Hull. Relative to North Yorkshire these areas have a much greater population and a greater population density. The challenges in these areas are entirely different to those of providing services to the rural and remote communities of North Yorkshire where we have a reliance on medium sized district general hospitals, a history of the NHS financial deficits, low local government funding settlements and an under investment in community health services.

It is proposed that STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards. Due to the factors associated with sparsity this funding may be concentrated in more densely populated urban areas.

Integration of Care

We support the focus is on the 9 NHS 'must dos', of which acute / NHS service performance and finance are the main priorities. This reiterates the triple aims set out in December's NHS Planning Guidance (health and well-being, care and

quality and finance). These aims and “must do” are largely seen through the lens of the cost impact on the NHS – virtually nothing about social care.

The importance of maintaining a “whole system” approach looking across all aspects of care – prevention and public health, primary care, community, hospital care, mental health and social care – is important too and we need to be assured that the local chapters of STP plans address these issues and, crucially, that North Yorkshire’s CCGs receive a fair share of the funding they need to address the challenges in the County.

“Primary Care at Scale”

Guidance from NHS England highlights the opportunities presented by planning primary care at scale including opportunities for developing new integrated models of care which are more local/closer to where people live and would help to reduce referrals into secondary care.

Generally, primary care in the County has a good reputation and enjoys high satisfaction levels. With the right focus, investment and development, experience from within North Yorkshire and elsewhere, indicates that primary care can play a bigger role in providing alternatives to hospital services eg. through diagnostic testing, primary care outpatient and treatment services, telemedicine and other support.

The County Council’s Public Health function and our Stronger Communities team are already working closely with community groups and volunteers for them to take on a greater role in direct service provision, not just as a way of making savings, but as a way of improving the sustainability of local communities and promoting and active citizenship. General wellbeing is being improved. Primary care at scale could facilitate a more integrated and co-ordinated approach to what the County Council is trying to achieve and give greater impetus to social prescribing initiatives in which there is less of a clinical approach and a greater emphasis on social and emotional needs which are important to all of us, particularly for people with long term conditions.

Primary care at a greater scale could give telehealth more impetus. It would also provide significant potential to reduce prescribing costs through economies of scale.

While there could be significant benefits, as described above, there will be issues to consider in terms of accountability and governance. For instance, it will be important to ensure conflicts of interest between GP federations and CCGs are managed and there is openness in terms of with whom CCGs are trading and the value of contracts is openly declared.

Wider Planning and Organisational Context

STPs will need to be flexible enough to take account of possible planning and organisational structures arising out of devolution and combined authorities.

At a local level STPs must not undermine the success of local Health and Wellbeing Boards who have all published their own Health and Wellbeing Strategies, overseen investment via the Better Care Fund and brought forward new models of care, including "Vanguards".

Governance and Accountability

STPs are creating another tier across the NHS and local government. It is difficult to see how democratic accountability in the NHS is being enhanced when leadership of the STPS sits out-with established local and County wide accountability arrangements.

Maintaining effective overview and scrutiny across the STP boundaries is likely to require the setting up of joint committees drawn from the relevant upper tier local authorities.

Please accept this letter from the North Yorkshire Scrutiny of Health Committee as part of the general engagement work on STPs and I look forward to a formal response to the issues I have raised.

Finally, I would be grateful if the Senior Responsible Officers would contact Bryon Hunter (contact details shown below) with a view to setting up a process under which the North Yorkshire Scrutiny of Health Committee can receive regular updates collectively from all STPs to include how you will:

a) address the specific issues of rural, coastal and market town healthcare in North Yorkshire;

b) ensure that the specific needs of people in North Yorkshire get a fair share of the Transformation Fund linked to STPs.

Yours sincerely

County Councillor Jim Clark
Chairman, North Yorkshire Scrutiny of Health Committee

Copy to:

North Yorkshire County Council
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CCGs
Janet Probert, Simon Cox, Amanda Bloor, Helen Hirst, Colin Renwick

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