Better Health Programme Joint Health Scrutiny Committee

At a meeting of **Better Health Programme Joint Health Scrutiny Committee** held in Committee Room 2, Town Hall, Darlington on **Thursday 9 March 2017 at 2.00pm.**

Present:
Cllr J Robinson (Durham County Council) Chair

Councillors –
Councillors W Newall, H Scott and J Taylor (Darlington Borough Council)
Councillor O Temple (Durham County Council)
Councillors R Cook and R Martin-Wells (Hartlepool Borough Council)
Councillor B Brady (Middlesbrough Council)
Councillor C Dickinson (North Yorkshire County Council)
Councillor R Goddard (Redcar and Cleveland Borough Council)
Councillors S Bailey and L Hall (Stockton-on-Tees Borough Council)

Officers –
Peter Mennear (Stockton-on-Tees Borough Council)
Jenny Haworth and Stephen Gwillym (Durham County Council)
Joan Stevens (Hartlepool Borough Council)
Alison Pearson (Redcar and Cleveland Council)
Daniel Harry (North Yorkshire County Council)

Better Health Programme –

Alan Foster
Edmund Lovell
Dr Stewart Findley
Nicola Bailey
Dr B Posmyk

Local Authority and CCG Representatives

Dr. Jenny Steel, Primary Healthcare Darlington Lead, Darlington CCG
Edward Kunonga, Director of Public Health, Middlesbrough Borough Council
Jane Robinson, Director of Adult and Health Services, Durham County Council
Suzanne Joyner, Director of Children and Adults Services, Darlington Borough Council
Patrick Rice, Assistant Director of Commissioning and Adults, Redcar and Cleveland Borough Council
Mike Webster, Assistant Director for Contracting, Procurement and Quality Assurance, North Yorkshire County Council
Lesley Jeavons, Director of Integration, Durham County Council/North Durham and DDES CCG
Graham Niven, Chief Finance Officer, Hartlepool and Stockton CCG
Sue Reay, Better Care Fund Transformation Team, Stockton on Tees Borough Council
Gill Collinson, Chief Nurse, Hambleton, Richmondshire and Whitby CCG

Also in attendance – Councillor L Tostevin (Darlington Borough Council)

1. **Apologies**

Councillors J Blakey and W Stelling (Durham County Council)
Councillors S Akers-Belcher (Hartlepool Borough Council)
Councillors E Dryden and J Walker (Middlesbrough Council)
Councillors J Blackie and J Clark (North Yorkshire County Council)
Councillors N Cooney and M Ovens
Councillor A Mitchell (Stockton-on-Tees Borough Council)

2. **Substitute Members**

Councillors O Temple (Durham County Council)

3. **Declarations of interest**

None recorded.

4. **Minutes of the meeting on 19 January 2017**

AGREED that the minutes of the meeting held on 19 January 2017 be confirmed and signed by the Chair as a correct record subject to the inclusion of Councillor R Martin Wells as being in attendance.

5. **Better Health Programme – Local Authority Public Health and Social Care considerations**

Consideration was given to the report of the Principal Overview and Scrutiny Officer, Durham County Council which referenced previous presentations made to the Better Health Programme Joint Overview and Scrutiny Committee in respect of the process of developing the Better Health Programme and the overarching Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby STP.

During the course of these presentations, the Committee had asked for confirmation of and details regarding the involvement of local authority public health and Social Care service providers in the development of the BHP and STP.

Members were advised that representatives from the local authorities within the BHP footprint were in attendance to provide the Committee with a series of presentations which set out the involvement of local authority public health and social care directors in drafting the Durham, Darlington and Teesside; Hambleton, Richmondshire and Whitby STP and the neighbourhoods and communities' element of the Better Health programme. The presentations also included information on the progress of addressing how health and social care services were being integrated to ensure that there is a seamless care pathway from the acute hospital to community and neighbourhood based provision.

(i) South Tees System Integration – Keeping People Healthy

Edward Kunonga, Director of Public Health, Middlesbrough Borough Council gave a presentation regarding the South Tees system Integration programme. Reference was made to the establishment of a Regional STP Prevention Group covering both STPs which sought to address health and wellbeing gaps and promoted the upscaling of ill-health prevention and health promotion across the North East. The group included key representatives from within local authority public health, Public Health England, NHS Acute Hospitals Foundation Trusts, Fire and Rescue Services and the community and voluntary sector.

The South Tees system Integration programme set out primary and secondary prevention targeted at population, organisations, community and individual levels. Edward Kunonga explained the references to primary, secondary and tertiary interventions as being before any signs of ill health (Primary); identifying those at risk of developing or in the early stages of illness (Secondary) and after an acute injury or illness (Tertiary).

The presentation set out a number of examples of such prevention projects and reference was made to the context of delivering such prevention activity against the backdrop of a range of wider determinants of health which included education, employment, environment and housing factors.

Specific reference was made to the Middlesbrough Prevention Strategy for Adults and Older People currently out for consultation and to a similar strategy proposed for Redcar and Cleveland.

Assurances were given to the Committee that similar work was being developed across the Region.

The presentation concluded with examples of the metrics identified to gauge the success of outcomes from the prevention strategies and projects together with health summary statistics for Middlesbrough and Redcar and Cleveland boroughs.

Cllr J Robinson referred to joint work that was being undertaken within County Durham by the County Council and County Durham and Darlington Fire and Rescue service in respect of initiatives such as home safety visits which were geared to making every contact count with residents to ensure that those in need of support services were identified and appropriate and timely support provided to safeguard against the need to access more acute health services.

(ii) Social Care perspective across the Better Health Programme/STP footprint

Jane Robinson, Director of Adult and Health Services, Durham County Council gave a presentation setting out key principles in respect of health and social care integration; discussions and involvement of Directors of Social Care within the production of draft STP documents and a series of reflections from the Directors of Social Care services on progress made to date and what should happen next.

She stressed that the integration of health and social care is a legislative requirement and key policy driver where the integration of services will promote the wellbeing of adults with care and support needs or of carers in its area; contribute to the prevention or delay of the development of needs of people; and improve the quality of care and support in the local authority's area, including the outcomes that are achieved for local people.

The presentation acknowledged that the STP development process was NHS led and that local authorities were not initially around the table. This meant that STPs lacked insight into the wider contributions local authorities could make; the impact of proposals on council services particularly social care and public health and the gaps and challenges existing in social care. Jane Robinson indicated that this lack of initial engagement had been acknowledged nationally and locally and governance arrangements had been revised to include local authority representation on the STP Board through Social Care and public health directors.

Reference was made to the importance of health and social care integration within the neighbourhoods and communities' workstream of the BHP/STP and that a joint health/social care workshop was planned for the near future and that a report form that event could be brought back to this Committee if members wished.

Jane Robinson stressed that the role of local authority directors within the STP/BHP governance arrangements was to highlight key social care issues and not to endorse STPs. She also acknowledged the recognition of care market issues and the positive work referenced in the previous presentation on potential public health interventions at scale.

In presenting the perspectives and reflections of the Directors of Social services across the STP footprint, Jane Robinson made reference to several key messages including:-

- The clear role for local authorities in shaping services and outcomes, prevention, commissioning and scrutiny of the development of plans and associated proposals for communications, engagement and consultation;
- The engagement of local government as a key partner on issues such as transport and travel, capital opportunities and equalities/rurality proofing;
- The need for clarity on the purpose of STPs – service development and improvement vs financial savings/reductions;
- The need for investment in primary and community care if hospital services change;
- Clear messages about where the money/funding flows across and between Acute health provision to community health and integrated health and social care;
- The need for greater connectivity across STPs – given County Durham is in 2 and North Yorkshire in 3;
- Where children's services are in the NHS debate;
- The inclusion of social care in the workforce development needs identified within the BHP/STP.

Jane Robinson concluded the presentation by emphasising how important the use of local authorities' knowledge and experience in service modelling and commissioning against a backdrop of austerity can be in the development of the STP/BHP and any associated proposals for service change.

In the discussion which followed, Cllr J Robinson asked what political input had been made within the STP development process; what involvement has taken place with Local Authority Directors of Social services on the financial modelling for the STP and finally the potential impact of the anticipated reduction in Public Health grant to local authorities?

Jane Robinson, Durham County Council stated that regular presentations on both STPs covering Durham were considered by the County Council's Health and Wellbeing Board as a standing item on their agenda. Directors of Adult social care have been asked for and provided information into potential local authority social care funding gaps although no figures have been provided. This is being examined across all local authorities. Colleagues within Durham County Council's public health team are examining options for the potential modelling of health promotion and ill health prevention across a range of service disciplines.

Mike Webster, North Yorkshire County Council stated that his authority was keen to integrate resources into health and social care integration plans but not necessarily finance. He acknowledged that public health was a key issue and was committed to monitoring the strain on public health budgets.

Suzanne Joyner, Darlington Borough Council confirmed that there was political input in to the STP via the Council's Health and wellbeing Board and also that she was providing information into the BHP/STP development in respect of potential local authority social care funding gaps. Where Darlington differed was around Public Health resources. She stated that Darlington BC's MTFP proposals would see the reduction of the Public Health resource down to the statutory level required. She confirmed that the Director for Public Health in Darlington was working with peer colleagues on this issue.

Patrick Rice, Redcar and Cleveland Borough Council stated that it was difficult to see what the potential impacts are across public health and social care. He stressed that whilst the upscaling of prevention and health promotion services and projects regionally may be desirable, this could prove difficult to achieve within finite staffing resources.

Cllr Scott asked if members would get the chance to input into the neighbourhoods and communities element of the STP/BHP whilst welcoming the need to acknowledge and reflect around the connectivity across the 2 STPs. Jane Robinson reiterated her previous comments regarding the proposed neighbourhoods and communities group workshop and the opportunity to bring a progress report back to this Committee on its work.

Councillor Tostevin asked how ready the NHS Community service provision and health and social services were to support the potential impacts of STP/BHP acute hospital service reconfiguration. She sought assurances that a robust strategic plan for NHS/LA community health and social care service integration would be developed. She suggested that such a plan would undoubtedly influence the acceptability of any acute hospital reconfiguration

proposals. Jane Robinson stressed that there was lots of work being done around community hubs; teams around practices and health and social care integration across all localities and were geared towards local models.

Dr Jenny Steel, Clinical lead for the neighbourhoods and communities group stated that the group has recognised that integration of health and social care services are not a "one size fits all" but rather that the group would prefer to retain those services that work well in specific localities and also ensure that best practice and learning was shared. She put out a health warning to the extent that if acute reconfiguration happened within the next six months then locality based community services may not be geared up to cope with any potential additional demands on the service.

Dr Posmyk indicated that in respect of health and social care integration requirements, Hartlepool and Stockton CCG and the ongoing work in respect of the Hartlepool Matters project would pick up the needs for local service delivery and associated structures would be developed accordingly.

(iii) New models of Care : Integrated Community Hubs

Dr Jenny Steel, gave a presentation setting out the Integrated Community Hubs new model of care being developed in partnership by Darlington Borough Council and County Durham and Darlington NHS Foundation Trust. She advised members that Darlington BC had the lowest rates of delayed discharge in the region. She indicated that partners recognised existing and potential future workforce pressures particularly linked to the need to increase the offer in respect of community health services.

Dr Steel highlighted a number of background issues that were contributing to the pressures placed upon health and social care around:-

- How staff at services disposal are utilised and if this was done effectively;
- Management of long term conditions;
- Differing needs of the population and the loss of the "nuclear family";
- High levels of ill-health amongst the population and the need to promote wellbeing;
- Fragmentation of services and difficulties of patient information flow through the health and social care system;
- Care Home market fragmentation;
- The under-utilisation of community assets and the Community and voluntary sector.

Reference was made to the development of functionally integrated holistic teams made up of community services, allied health professionals, local authority social care, specialist nurses and the VCS all linked to GP practices. These teams would be based around a community hub population of between 30-50,000 and provide a bespoke service with one focussed single point of access.

Dr Steel suggested that the development of these integrated Community Hubs would shift the current default position from GPs referring into acute hospital settings because of the absence of an integrated service to one where

services are wrapped around the patient in their own homes. However to achieve this, new contracting and funding arrangements would need to be developed and agreed so that where acute hospital services are reconfigured, investment into community services is made at the same time.

Dr Steel then highlighted the Healthy New Towns project in Darlington which had quickened the pace for implementing the Integrated Community hub model across Darlington. She indicated that Darlington had been selected as one of ten demonstrator sites for NHS England's Healthy Towns programme.

Reference was made to NHS England's Five Year Forward View and the commitment made therein to dramatically improve population health, and integrate health and care services, as new places are built and take shape. This commitment recognised the need to build over 200,000 more homes in England every year, and invited Expressions of Interest from developments across the country. The Healthy New Towns programme will be working alongside the ten housing developments across the country to offer challenge, inspiration and support to build healthy communities.

The project involves the development of 2500 residential units and aims to close the gaps in health, care and finances facilitating closer working across the local authority and health providers/commissioners. The project focused on three key areas:-

- **Regeneration-** Including economic well-being, healthy travel and estates regeneration (new buildings);
- **New models of care-** Including the development of a care hub, cultural change and standardisation;
- **Digital technology-** Including patient self-management modules and teleconsulting.

The project sought to deliver four outcomes for the population of Darlington:-

- **Narrowing the gap-** on things like life expectancy and social inclusion;
- **Economic growth-** in relation to job prospects and people being attracted to Darlington;
- **Digital enablement-** to support informed and engaged digital channels of information e.g. access and share information and make decisions on health and wellbeing choices;
- **Sustainable efficient and effective care services**-To increase planned care and maximise the impact of the Darlington pound (the way in which the money available for Darlington is used).

In response to a question from Councillor Cook regarding the safeguards needed for those who may be socially isolated when being discharged from acute hospital care, Dr Steel emphasised the importance of raising awareness of having robust and integrated health and social care services which included rehabilitation and re-ablement at or closer to patients' homes.

(iv) Discharge Management

Lesley Jeavons, Director of Integration gave the Committee a presentation setting out work undertaken to date to improve the discharge management function from acute health to social care. She referenced that work had been

undertaken between Durham County Council and the NHS since 1998 when the first integrated team comprising health and social care professionals had been established. This had involved the County Council, County Durham and Darlington NHS Foundation Trust and Tees, Esk and Wear Valleys NHS Foundation Trust but not GPs.

Further development of integrated working was supported across all partners and the Health and Wellbeing Board and had led to the development of a newer model of integrated care incorporating 13 "teams around practices". The appointment of a Director of Integration across NHS and the County Council had resulted in decision making permissions being given to that postholder across the NHS and local authority to unblock healthcare pathways.

Reference was made to the Emergency Care Improvement Programme and to an associated peer review involving County Durham and Darlington NHS Foundation Trust looking across the whole Health and social care system. The review had identified 4 key improvement areas of leadership (via the Local A&E Delivery Board); doing today's work now; preventing inappropriate admissions to hospital (Assess to Admit) and Discharge to Assess. An operational delivery group consisting of CCG, Foundation trust and Adult social care representatives was established to oversee the improvement programme.

Lesley Jeavons referred to National Audit Office findings which stated that two thirds of hospital bed days are occupied by people over 65 and that there had been an 18% rise in emergency admissions for older people over the last four years. In view of research which suggested that 10 days of bed rest for healthy older people can equate to 10 years of muscle ageing with attendant loss of function, this highlighted the importance of reducing inappropriate admissions and also ensuring that hospital stays were kept to a safe minimum as "Time is everything" to people with frailty.

The discharge to assess process aimed to achieve active recovery with teams of nurses, occupational therapists, physiotherapists, rehabilitation assistants and social workers working together to undertake assessments in an active setting. This was achieved by identifying funding and supporting people to leave hospital when safe and appropriate to do so, continuing their care and assessment out of hospital. In a similar vein to other integrated approaches, the DTA approach resulted in supporting people to go home being a default pathway with alternatives made available for people who cannot go straight home. All steps were taken within the process to ensure assessment is rapid, effective, safe and able to mobilise required services such as rehabilitation and re-ablement.

Lesley Jeavons reported that the early pilot of the DTA process had not been as successful as originally hoped as there had been an incorrect focus within the original process which had now switched to pulling people from hospital wards when appropriate and safe to minimise their stay. Whilst the DTA process was much more effective front of house within the hospital environment, a whole system approach to this was needed with more responsive community services essential to its further success.

Members were informed of a range of additional initiatives which complimented the DTA process including the use of discharge co-ordinators; more focussed multi agency disciplinary team meetings; the use of discharge lounges at UHND and the introduction of a senior review process which sought to escalate issues up to senior management.

Councillor Robinson referred to concerns raised at a number of County Durham Adults Wellbeing and Health Overview and Scrutiny Committee meetings regarding excessive delays in ambulance turnaround times at A&E departments and suggested that the discharge to assess process could free up much needed beds for speedier admissions. He also raised concerns around the move from Acute Hospital beds to step down intermediate care beds where these may be within different STP footprints – the example given was for Acute Stroke at UHND. In response, Stewart Findlay, DDES CCG stressed that any requirements for such step down arrangements would be made on the basis of need and appropriateness and not be restricted by STP footprint boundaries.

Councillor Newall referenced the recent closure of the discharge lounge at Darlington Memorial Hospital and what impact that would have upon any discharge to assess process within the hospital. Dr Steel indicated that the discharge lounge had not closed but was not available on a 24/7 basis. Councillor Newall asked if it was intended that the lounge would return to 24/7 operation in the future and Dr Steel confirmed that this was to be tested during County Durham and Darlington FT's "perfect week".

Councillor Taylor suggested that the hours of operation for DMH's discharge lounge were changed because of blockages being experienced in the discharge system but suggested that there was a problem within the Trust/CCG around managing messages in respect of the facility. Dr Steel indicated that discharge lounges were not suitable for all patients and work was ongoing to streamline all of the discharge processes. She indicated that the use of discharge lounges, where appropriate did free up beds on inpatient wards.

Councillor Martin Wells reiterated the importance of having appropriate staff in post to deliver health and social care services in both acute and community settings. He considered one of the key issues facing the Better Health Programme was winning over public confidence and trust in both politicians and the NHS.

Councillor Scott referred to the 2015/16 Quality Accounts for County Durham and Darlington NHS Foundation Trust which included discharge summaries and post discharge surveys as key priorities within the document. She asked when the Discharge to assess pilot would be subjected to evaluation and suggested that the results of the evaluation be considered at a future meeting of this Committee.

(v) Integrated Personalised Commissioning

Graham Niven, Chief Finance Officer, Hartlepool and Stockton CCG and Sue Reay, Better Care Fund Transformation Team, Stockton on Tees Borough Council gave a presentation in respect of integrated personalised Commissioning.

Members were informed that Integrated Personal Commissioning was a new voluntary approach to joining up health and social care for people with complex needs. It was a mechanism of utilising Personal Health Budgets and the STP has committed to increasing the use of these to enable improved choice and control of peoples' care

Developed between NHS England and the Local Government Association, the Integrated Personal Commissioning Programme was announced in July 2014 and Stockton-on-Tees was the only area in the North East of England invited to join the first wave of demonstrator sites for the programme.

The Integrated Personal Commissioning programme will offer service users with complex needs the ability to tailor their support and care in ways that are effective, beneficial and meaningful to their lives; giving the individual a say in the way their care budget is spent to achieve better health, care and independence.

Local authorities and NHS service providers are offered support to address systematic barriers to change, and the voluntary and community sector will be a key partner in designing and delivering effective, target oriented approaches to supporting individuals, encouraging cultural change and aiding their service users.

The Integrated Personal Commissioning programme facilitates a shift in power to individuals and their carers in self-determination of their health and care with the programme being aimed at individuals who have high levels of need, who often have health, social care and support needs where a personalised approach would address barriers and problems identified in the current, traditional care provision.

The Stockton on Tees IPC partnership consists of Catalyst (Stockton on Tees) a CVS Organisation; Hartlepool and Stockton-on-Tees CCG; North Tees and Hartlepool NHS Foundation Trust and Stockton-on-Tees Borough Council. The programme's cohort of patients focussed on people aged over 65 with Long Term Conditions. Phase 1 consists of people with respiratory conditions particularly COPD. The second phase focusses on people with diabetes.

Key achievements identified for the programme so far included:-

- Creation of an integrated care plan with Adult social care, Primary Care, Community Services, Acute Services and the VCSE
- Creation of IT solutions with online accessible care plans that can be shared with professionals
- 163 Integrated Personalised Care and Support plans completed with a target set of 4000 for the next 12 months
- 24 new Personal Health Budgets
- Linked dataset – the first in the country to allow health and social care data to be used together for secondary use purposes
- Developed community assets and peer support with the VCSE – a new Breath Ease group has been established in partnership with NTHFT and Age UK

Graham Niven reported that in partnership with the nations IPC and local leadership, Stockton was selected for the Nesta 100 day challenge aimed at increasing integrated personalised commissioning across the area. The Challenge was launched in January 2017 with three multi-disciplinary teams focussed on improving care and outcomes for frail people aged 65 and over.

Sue Reay then explained the Stockton wellbeing model of care which provides a multi-disciplinary service for holistic assessment to over 65s for early intervention and prevention prior to the formal assessment process for a social care package. The single point of access model involves an initial triage process prior to a programme of up to six weeks' support and services aimed at early intervention. She indicated that since the model of care had been introduced in 2015 only 5% of people had gone on to receive a social care package.

Reference was also made to the McKenzie Group practice pilot which uses a multi-disciplinary team approach to look at admission avoidance in Hartlepool pulling together district nurses, GPs, community matrons, therapy staff, social acre and primary care co-ordinators.

In the discussion which followed, Councillor Martin Wells asked how the CVS organisation would receive support to deliver the programme. Graham Niven indicated that they had access to Better Care Fund resources. In response to a question from Cllr Scott, Mr Nixon stated that at the moment it was only IT systems that were linked/shared rather than budgets although should a health and social care service need be identified as part of the project, then there were resources available across a range of funding streams to provide options/choice to patients on their preferred care plan options.

In response to a query about the need for data sharing permissions to be obtained regarding patient data, it was reported that this was due to existing data protection and information governance regulations.

(vi) Supporting the Frail Elderly

Gill Collinson, Chief Nurse, Hambleton, Richmondshire and Whitby CCG and Mike Webster, Assistant Director for Contracting, Procurement and Quality Assurance, North Yorkshire County Council gave a joint presentation to members regarding work being undertaken to support the frail elderly across North Yorkshire.

Reference was made to the "Fit 4 the future" clinical summit held on 25 November 2015 in partnership involving Hambleton, Richmondshire and Whitby CCG, South Tees Hospitals NHS Foundation Trust, HeartBeat Alliance, North Yorkshire County Council and Tees, Esk and Wear Valleys NHS Foundation Trust.

The event brought together over 200 clinical professionals including GPs, hospital consultants, nurses, therapists and social care colleagues from across Hambleton and Richmondshire to discuss, influence and help shape how health and social care can be delivered effectively and sustainably in the future.

The key objectives of the event were:

- to understand the challenges that face this health economy with a focus on Rural Care, Urgent Care, Technology in Health and Care of the Frail Elderly, from a range of perspectives,
- to bring clinicians and other professionals together to share views and experiences
- to identify the key opportunities for resolving the challenges and to start to create a shared vision of care delivery across Hambleton and Richmondshire.

Members were informed of a number of achievements which had resulted from the summit which included:-

- £2.7m in investment in primary/community care
- Trusted relationships across primary, community, secondary and social care
- Regular locality Multi-disciplinary Team meetings
- Implementation of new model of integrated locality working across 8 localities,
- New model of community step up/step down bed provision
- New adult social care model beginning in April 2017

Mike Webster indicated that there were two key elements to the changes proposed, namely that things will be done differently and that there will be efficiencies delivered to reflect the reductions in local authority budget reductions and austerity.

Reference was made to the Assessment pathway project which sought to transform the social care offer and to the principles underpinning the project. Mr Webster reported that to ensure people were safe and independent they would have greater access to re-ablement resources to reduce or delay their need for care and support, and provide them with access to appropriate equipment.

Mr Webster stated that the need for additional health services, including admissions to hospital will be prevented, reduced and delayed. He suggested that Carers will be healthy and experience wellbeing and will report improved quality of life, feeling safe and a feeling of choice and control. It was also envisaged that people will report improved quality of life and satisfaction in their level of social contact and also be able to exercise both choice and control over decisions which impact them personally.

The way in which services operate would be informed by service users and carers as partner-experts by experience with all new services being designed through co-production. These services will be commissioned on an integrated basis with the NHS and delivered at or near to home, based around identifiable communities and clusters of GP practices.

Gill Collinson then presented the new pathway supporting the frail elderly which centred on getting people back to their homes as early and safely as possible. Issues considered included the desire of patients to choose to end their life at home and what NHS/Social Care providers and commissioners

could put in place to facilitate this. Reference was made to the health/social care providers being too risk averse in acceding to such requests.

Key features of the new Frailty operating model included a single Customer Service Centre (CSC) which would be dedicated point of access for the public, an initial point of contact for professionals into adult social care in North Yorkshire and, where possible, maximising opportunities to respond to enquiries at this point, which will include Adult Social Care Professionals being based in CSC, on-line assessments for some areas, validation of assessment and resolution at CSC (e.g. simple equipment).

Independence and re-ablement provision would focus on supporting individuals to maximise their independence, including preventing unnecessary hospital admission and premature admission to long term residential care, providing early well planned safe discharge from hospital and a rapid response to urgent need. This would include a period of re-ablement for those known to services who are identified as having re-ablement potential

Planned Care and Support services would support people with long term social care and support needs as well as supporting their carers through better care co-ordination, support interventions and through commissioned services. The provision of support will include Deprivation of Liberties, Best Interest Assessments and Safeguarding Investigations (enquiries).

Members were advised that in view of the rurality of the area covered by the Frailty pathway, there were concerns about the robustness of the independent care provider sector. Therefore a more defined structure over provider services had been proposed, which includes Elderly Persons Homes, Respite Services, Day Centres, and Personal Care at Home Services linked to Extra Care schemes. The Personal Care at Home (PCAH) Service will be a defined and separate service from the Re-ablement Workers.

Members were advised that along with the other presentations given, the key to the success of the Frailty pathway was the ability of integrated health and social care teams and service provision to admit people to hospital when clinically necessary and to discharge patients back to their homes/community service provision when appropriate and safe to do so.

In response to a question from Councillor Cook, Mr Webster confirmed that the new frailty care pathway was due to commence in April 2017.

The Chairman then thanked all of the officers present for their presentations and input in to the session and then invited the Committee to consider the recommendations within the report of the Principal Overview and Scrutiny Officer. At the conclusion of the discussions its was

AGREED that:

1. The information in the report and presentations be received and comments made by the Committee noted;
2. A report on the outcomes from the Communities and Neighbourhoods workshop referenced in Jane Robinson's presentation be brought back to a future meeting of this Committee;

3. The evaluation report into the Discharge to Assess pilot being undertaken within County Durham referenced in Lesley Jeavon's presentation be brought back to a future meeting of this Committee

6. Better Health Programme – Developing a communications and engagement plan to support public consultation

Consideration was given to the report of Edmund Lovell, Communications and Engagement lead for the Better Health Programme which outlined preparations for the development of a communications and engagement plan to support statutory public consultation for the Better Health Programme.

The report set out the context within which consultation in respect of the Better Health Programme would take place, including the relationship between the BHP and the Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby STP. The public consultation would now take place from September 2017 to avoid the summer period.

Members were reminded that the NHS Act 2006 (as amended by the Health and Social Care Act 2012) sets out duties for CCGs around involvement and consultation. As such, NHS organisations have to ensure that patients and the public are properly involved in the planning and development of health services. They must also consult with the relevant local authorities' overview and scrutiny committees over any changes which could be considered to be substantial variations in the way services are provided. Organisations must also ensure that engagement and consultation activities are in line with the Equality Act 2010.

Mr Lovell indicated that when planning any service changes NHS organisations must also undergo a comprehensive programme of assurance by NHS England, which includes complying with four tests, two of which have implications for involvement and consultation (i.e. the first and fourth tests). The four tests are:

- Strong patient and public engagement
- Consistency with current and prospective need for patient choice
- Clear clinical evidence base
- Support for proposals from commissioners.

Reference was made to a series of reports and presentations given to the Better Health Programme Joint Health OSC to date regarding engagement activity that had been carried out to date. Members were advised that learning from all of this engagement activity was being used to shape a communications and engagement plan for formal public consultation.

Mr Lovell indicated that the objectives of the communications and engagement plan for consultation would include:

- Ensuring that public and stakeholders have an opportunity to comment on proposals for change, so that feedback can be used to inform the decision making process
- Making sure that the consultation is inclusive and provides opportunities for involvement by a diverse range of stakeholders and the public
- Including the public and stakeholder voice in the BHP
- Ensuring a high level of awareness and understanding of why changes are being proposed
- Ensuring that all steps are taken to maintain public confidence in the process, and in the future shape of services
- Meeting statutory requirements around consultation.

He also stated that some key messages were being developed which will be included in all public information supporting the consultation. These have been subject to discussions with clinical leaders and they are now being 'road-tested' with representatives from patient and community groups, whose comments will be taken into account. Their views are also being sought on how best to present these messages (i.e. in terms of format and visuals). The aim is to ensure that these messages are easy to understand for the general public and that they are presented in a way that is helpful.

The Joint Committee was invited to consider and comment on the proposals set out within the report in respect of the methodology for consultation, communications and engagement. Mr Lovell advised that a pre-consultation business case for the STP and the Better Health Programme element of that, together with options for future service provision and the results of the engagement activity undertaken so far would be produced.

The methodology set out how consultation would be undertaken with patients, carers and the public; NHS Staff and organisations and statutory bodies, including health scrutiny committees. For patients, carers and the public, a number of methods would be used including formal consultation documents; summary leaflets/flyers/posters; short video presentations; weblinks to further supporting information; structured public engagement events utilising a range of community assets and supported by the Community and Voluntary sector; targeted drop in sessions and roadshows; local and regional media, an advertising campaign and a digital media strategy.

Councillor Martin Wells emphasised that the most important aspect of the consultation process was to clarify exactly what was being consulted upon and to manage public expectations of the process and avoid any element of confusion. The frequent and interwoven references to STPs, the Better Health Programme, Not in Hospital services, Neighbourhood and community services all needed to be clearly set out within all consultation, communications and engagement material. He also suggested getting lay peoples' views on the proposed consultation material when drafted.

Mr Lovell sought the Committee's input in ensuring that the correct messages were being put out as part of the consultation process as well as the draft documentation when finalised.

Cllr Bailey suggested that when consideration was being given to the locations for roadshows, formal consultation events and drop in sessions, local Councillors be engaged in this process.

Cllr Temple encouraged the Better Health Programme Board to ensure that there was sufficient clarity within the consultation documents and that they set out the rationale for change as there was some scepticism amongst Councillors and the general public that these changes were being driven by financial pressures. Accordingly, and given the absence of any degree of detail surrounding the cost implications for the NHS and Local Government of the STPs and Better Health programme proposals, he asked that relevant financial information was included within the consultation documentation.

Councillor Tostevin highlighted concerns about the cost of the engagement activity undertaken so far. Mr Lovell stated that the costs of this work had been budgeted at £500,000 for 2015/16 and that the actual costs of the work was under budget.

In response to a query form Councillor Cook regarding the number of people who had participated in the engagement activity so far, Mr Lovell indicated that the Programme Board were happy with these numbers although it was expected that numbers would increase once formal consultation was commenced and clarity given on potential service changes.

Agreed that

(i) the report be received;
(ii) assurances be sought from the Better Health Programme Board that the Better Health Programme Joint Health OSC will be engaged in the development of consultation, engagement and communications plans for statutory public consultation;
(iii) a further report providing details of the draft communications, engagement and consultation plans and associated documentation be brought to a meeting of this Joint Committee in June 2017.

7. Chairman's urgent items

The Chairman had no urgent items.

8. Any other business

There had been no items identified.

9. Date and time of next meeting

The Principal Overview and Scrutiny Officer, Durham County Council reported that in view of the forthcoming mayoral and Council elections and the onset of purdah, it was anticipated that the next meeting of the Committee would be held in early June 2017. He asked that constituent authorities advise him of

their appointed representation to the Joint Committee as soon as possible to enable an early meeting of the Committee to be convened.

The meeting ended at 4.45 pm.