# SHOPSHIRE COUNCIL

## HEALTH AND ADULT SOCIAL CARE SCRUTINY COMMITTEE

**Minutes of the meeting held on 24 October 2014**
**10.00 - 11.55 am in the Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND**

**Responsible Officer**: Amanda Holyoak
Email: amandaholyoak@shropshire.gov.uk Tel: 01743 252718

**Present**
Councillors Gerald Dakin, David Minnery, John Cadwallader, Tracey Huffer, Simon Jones, Heather Kidd, Pamela Moseley, Peter Nutting and Madge Shineton

### 26 Apologies and Substitutions

Apologies for absence were received from Mrs P Mullock. Mr P Wynn substituted for her.

### 27 Disclosable Pecuniary Interests

Members were reminded that they must not participate in the discussion or voting on any matter in which they had a Disclosable Pecuniary Interest and should leave the room prior to the commencement of the debate.

### 28 Minutes of the Meeting held on 15 September 2014

The minutes of the meeting held on 15 September 2014 were confirmed as a correct record.

### 29 Public Question Time

Five questions were received from Members of the Public. Three were taken under this agenda heading and two which related directly to agenda items were taken at the appropriate time.

*Peter Gillard – Monitoring Private Providers of NHS Service*

Mr Gillard's question asked what steps the Scrutiny Committee would take to ensure adequate level of patient safety and quality by private providers. He referred to recent press coverage of private companies delivering ophthalmology services. *(a full copy of his question and the response provided is attached to the signed minutes)*

The response from the Chairman referred to the: recently extended scope of Scrutiny Committees to cover all providers of health services, commissioned by NHS England, CCGs or Local Authorities; working with Healthwatch to get an impression of services overall and the Committee's ability to question commissioners and providers regarding patterns and trends. Healthwatch Shropshire had not received any comments to date related to the two private firms mentioned in the press report.

By way of a supplementary question, Mr Gillard said that a problem in one part of the country might indicate a systemic problem which should warrant a look by the Scrutiny

Committee. The Chairman reported that he was a Member of the Healthwatch Intelligence Committee and action would be taken where necessary.

Dr Julie Davies, Shropshire CCG, added that the companies in question were sub contracted by Shrewsbury and Telford Hospitals NHS Trust (SATH) and subject to regular monitoring for clinical quality as all providers were.

*Gill George – Paediatric Care in the Community*

Ms George had submitted a question asking if the Committee had considered the implications for community services of the consolidation of Women's and Children's acute services, and whether the Committee believed there was currently adequate provision in the community, particularly within the community paediatric nursing team – to adequately support children with long-term health needs.

The written response provided details of the Assurance Panel established as part of the process for considering the merits of changing the women and children's services within the county. The local CCGs would be reviewing the new service model and community services across the county as part of Future Fit.

By way of a supplementary question, Ms George referred to there being only 10 whole time equivalent community paediatric nurses and said she did not believe they had the resources to properly do their job. Children's nurses could be a lifeline and she felt it would be appropriate to look at the level of provision.

*Gill George - SaTH Recruitment and Retention*

Ms George had submitted a question in relation to SaTH Recruitment and Retention, drawing attention to the results of the 2013 Staff Survey.

The response from the Chairman highlighted action taken by the Joint Health Overview and Scrutiny Committee related to low morale and difficulty recruiting. The Joint Chairs had in the last week made a submission to the Care Quality Commission (CQC) to inform its current inspection of SATH. This had included comments around low morale and difficulty recruiting as evidenced in the most recent staff survey. The response referred to discussions around Future Fit focused on securing the appropriate staffing levels for all hospital services and also referred to national issues around recruitment and retention in the NHS.

By way of a supplementary question Ms George expressed concern that the figure of 48% for 'if a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation' represented a potential clinical risk and suggested that the Committee might want to consider this. In response the Chairman referred to regular meetings he held with SATH and the CCG. The CQC inspection report was awaited and action would be taken as needed.

30 **Member Question Time**

Member questions had been submitted by Mr M Bennett and Mr C Mellings, both relating to the performance of the West Midlands Ambulance Service. It was agreed to take these at the appropriate point on the agenda.

31 **West Midlands Ambulance Service Performance**

The Chairman had invited Dr Julie Davies, Director of Strategy and Service Re-Design, Shropshire Clinical Commissioning Group, to the meeting to give the presentation to the Committee on Ambulance Performance which she had made to the CCG Governing Body meeting on 24 September 2014. (A copy of the presentation is attached to the signed minutes).

She explained that the current performance levels for Ambulance performance standards within Shropshire CCG fell short of the national standards and in response to concerns around this she had been asked to consider what investment would be required to provide Shropshire with the same standard of service as received in urban areas. A number of external agencies had reported on this issue and suggested that rural counties should expect a lower level of ambulance performance than urban areas, due to the geographical difficulties and lower activity numbers.

In partnership with Shropshire Clinical Commissioning Group, West Midlands Ambulance Service had agreed to look at this issue and model some scenarios based on three questions asked by the CCG:

- What resources would be required by the WMAS within Shropshire to achieve all performance standards *within every postcode sector?*
- What resources would be required by the WMAs within Shropshire to attain all the performance standards for the *CCG as a whole*
- What is the level of performance that can be expected within the Shropshire CCG with the level of resource currently available?

Dr Davies reported that addressing questions 1 and 2 would require massive increases in staff, facilitated posts, ambulance and rapid response vehicle fleet in different proportions for both questions. This was completely unaffordable within current resources and there was not a workforce available to recruit from in such large numbers.

The best performance that could be achieved within current resources was outlined. Members of the Committee agreed that it would be useful to benchmark this against similar rural locations. Dr Davies reported that equivalent data had been requested from NHS England but was proving difficult to obtain. Some preliminary benchmarking information had been obtained from Lancashire and Cumbria. The Committee asked for sight of benchmarking information as it was received by the CCG.

The presentation also covered the assumptions made in answering the questions, the extent of current CFR coverage, and listed the actions being taken to improve performance.

In response to questions, Dr Davies referred to cross border issues which were putting pressure on the West Midlands Ambulance Service. These included lengthy delays to transferring patients at Wrexham Maelor Hospital, in some cases leading ambulances having to travel from Wrexham Maelor to Royal Shrewsbury Hospital. She confirmed that the CCG was actively seeking a meeting with Wrexham hospital. The reduction of minor injuries facilities at Chirk which had also resulted in a significant increase in Welsh patients using the Minor Injuries Unit at Oswestry.

She confirmed that there were monthly meetings between WMAS, the CCG and patient representatives which covered any clinical incidents or NHS to NHS concerns.

From the 1 November 2014 there would be a new Non-Emergency Patient Transport Service and it was intended to develop this service as a point to help re-route GP direct admissions away from WMAS. It was also intended to work with communication team to encourage the public to use 999 in the best way. Calls were always triaged for clinical urgency, red category calls would get the fastest response.

In summary – the CCG Board had endorsed the option of best performance achievable within current resources as an interim measure until benchmarking information was received and validated. It had approved the actions set out to achieve this and further incremental improvements over and above this as soon as possible, supported the development of a communications plan with WMAS and patient representatives to improve public awareness and responsible use of ambulance resources within the county and supported the further development of the work into a rural strategic plan for ambulance services to align with Future Fit.

*Public Question – Peter Gillard – Ambulance Response Times*

Mr Gillard's question suggested that the CCG should put a more robust business case with an examination of clinical risk at the forefront and should consider the effect of incremental resources in improving response times. He said that there was no ability within the health economy to understand the clinical impact on delayed ambulance resources. (a full copy of the question is attached to the signed minutes)

The Chairman clarified that the Committee was not being asked to endorse the contents of the presentation or the decision made by the CCG. He had been present at the CCG Governing Body meeting and had asked the presentation to be made to the Committee to ensure it was informed of current developments, and keep it appraised of these performance issues.

Dr Davies reported that Shropshire CCG had been one of the only CCGs that had put in the requested additional funding for growth (4.5%) which represented a big investment particularly compared to other CCGs in the West Midlands who had forecast no growth and were now facing up to 10% in increased activity above the level contracted.

Gail Fortes-Mayer, Regional Commissioner, explained that establishing a linkage between clinical outcomes and delayed admission was not just a local challenge, and that no-one possessed that information nationally.   She said care had to be taken in linking response time targets to patient outcomes as in some instances it might become possible to hit targets but at the cost of patient outcomes.

Barry McKinnon, Regional Manager, WMAS, commented that performance standards were timed to the clock and that it might be possible to hit 90% of life threatening calls on target but still not get a successful clinical outcome.  He said that clinical outcomes were more important to the Ambulance Service than hitting a time target.

In response to a question regarding clinical outcomes between the populations of rural areas and inner city areas, the Regional Commissioner explained that rural counties did as well, if not better than urban areas with often greater access to paramedics who were able to stabilise patients whilst awaiting an ambulance.

A Member of the Committee with a rural electoral division asked if there had been any adverse effects following the location of stroke services at Princess Royal Hospital. Feedback from SATH had been that there had been improved clinical outcomes.  The WMAS Area Manager said that Ambulance Service had not recorded any adverse outcomes to patients in its care since the move. Not all patients from Shropshire were taken to Princess Royal Hospital, some from the South of the County were taken to Hereford County Hospital.  He commented that if more services became centralised this would impact on the available transport resource to meet targets.

A Member of the Committee pointed out that the Committee was able to scrutinise the Ambulance Service throughout the year through receipt of monthly monitoring figures. Receipt of the Quality Accounts also gave the Committee an opportunity to consider issues in more depth.  She felt that the key issue was the level of skill of paramedics who responded to calls, rather than travelling distance to hospitals.  She felt a higher emphasis on paramedic skills and quality was needed, rather than additional ambulances.

The Committee asked about out of hours services, and the relationship between WMAS and Shropdoc.  The Area Manager confirmed that WMAS used both 111 and Shropdoc pathways as appropriate.

A Member reported his experience in calling 999 following an incident he had been involved with where it had been hard for the Ambulance Service to identify the location of an accident.  He asked if it was possible to identify the location of a call using mobile phone signals.  The Area Manager explained that the system in the Control Room involved progress through flowcharts.  It was possible to triangulate position using mobile phone signals over certain masts but not all the time.  Mobile phones did not automatically provide identification and this was being addressed.

Although the control room was located in Dudley and some operators not familiar with Shropshire he commented that he himself had worked for many years in Shropshire and was not aware of many locations in the county.

A Member commented on the significant issues faced in rural areas of the county and encouraged further efforts to improve response times in these areas.  Bishop’s Castle,

Chirbury & Worthen and Clun had in particular very poor response times. She expressed gratitude to the CCG for additional funding, as the service had been previously underfunded, and also high regard for the level of training of paramedics. However, she expressed concern about the coverage and use of Community First Responders as they were only able to deal with certain types of eventuality and therefore should not be used to fill gaps. She asked if there was any prospect of upskilling Community First Responders so that they could for example attend road traffic accidents which were prevalent on rural roads. She also commented on delays in training and Dr Davies asked her to forward any information on this.

She also enquired about the 300 defibrillators mentioned in the presentation and commented that rural parishes in the South West area of Shropshire would gratefully receive them as to date they had needed to fundraise for their own.

She went on to emphasise the need for information on waiting time, response time, travel time and clinical outcome, and urged that action be taken to encourage this. The Regional Commissioner said that Clinical Senates across the West Midlands had formed a Strategic Clinical Network and suggested that Dr Kiran Patel, Medical Director, was the most appropriate person for Dr Davies to contact with regard to this issue. It was also agreed that the Committee write to Councillor Cecilia Motley, Shropshire Council's spokesperson for rural affairs, to ask how best to provide its support with the push for appropriate funding for rural services.

With regard to issues raised around Community First Responders, Dr Davies reported that the CCG was not of the view that they could replace paramedics, but as providing additional help and support. It was looking at rural areas in other parts of the county that had experienced substantial benefit from Community First Responders supplementing the Ambulance Service, for example, in Herefordshire.

At this stage the Councillor for Oswestry East was invited to put his question which referred to public dissatisfaction in Oswestry with the response times of ambulances and referring to instances of long waits including one of 90 minutes. He asked what response would be made to public concern over response times and vehicle availability and how residents would be reassured about the service provided to them.

The WMAS Area Manager said the Service was aware of the occasion involving a 90 minute wait, which was unacceptable. Unfortunately there were occasions where spikes in activity exceeded the resources available and on this occasion there was no ambulance in the area able to respond. He confirmed that contact had been made with the Welsh Service to request help but they had not been able to provide an ambulance. However this was an unusual occurrence and WMAS Managers who were trained paramedics could also be sent out when necessary at times of exceptional demand.

He explained that Ambulances had been put back in to Craven Arms, Oswestry, Market Drayton and Bridgnorth but this had caused a drop in performance in real terms as Rapid Response Vehicles were ringfenced to these areas and an ambulance would leave the area once they had picked up a patient to convey them to hospital.

He reported that serious consideration was being given to providing both a 24 hour ambulance and a Rapid Response vehicle in at Oswestry, but until staff were recruited it would not be possible to put a car in.

Members commented that the ambulance turnaround times at Wrexham Maelor Hospital were not included in the WMAS statistics circulated monthly and that having access to these would help provide a bigger picture. Dr Davies said that this information had been requested from Welsh providers, but they were not obliged to supply it. She reported that there had not been any consultation around closing the Minor Injuries Unit in Chirk on this side of the border or offer from the Welsh Commissioners to compensate for the extra demand on Oswestry services. The CCG was seeking to address this issue.

The Councillor for Wem was invited to put his question regarding performance in the SY4 area and asking for more detail particularly around the use of the Rapid Response Vehicle. The waiting time between arrival of a rapid response vehicle and ambulance was sometimes considerable.
He also asked when feedback and outcomes of the pilot at Wem would be available.

The Area Manager explained that work was underway with the CCG on the best way to resolve issues. The trial of a Rapid Response Vehicle in the area for a month had not worked due to not being able to obtain the necessary staff. It was now intended to trial a week in November with a 24 hour car to see if there would be any real gains. With regard to ambulance back up times, these would improve once extra staff were in place.

The Chairman commented on dramatic improvements in this area since concerns were raised several months previously.

The Committee expressed appreciation of access to performance information by postcode and
Dr Davies confirmed that the CCG and WMAS looked at postcode area performance at monthly meetings and had identified SY4 area as needing improvement.

A member of the Committee said she understood that the Future Fit roll out would mean that Ludlow would lose its minor injuries unit which would lead to more demand for ambulances. Dr Davies commented that no decisions had been made yet regarding the future of any of the Minor Injury Units as part of the future of Urgent Care. The purpose of Future Fit was to meet needs of the patient with the most appropriate level of care and therefore any change proposed which would lead to more inappropriate demand on the 999 service would not be acceptable.

Members asked if English GPs, A&E and Minor Injury Services received any compensation for being a net provider of services to the people of Wales. It was confirmed that English Commissioners would pay for provision of A&E and Minor injury services on a host basis and which resulted in a six figure sum cost pressure for local English CCGs. This was due to the arrangement between the government in Westminster and the Welsh Assembly and had recently been raised in a consultation.

Members asked if there was any record of outcomes from the 'hear and treat' process whereby if a patient could be conveyed safely to hospital a 999 ambulance was not used. The Area Manager gave an example of an ambulance being called to a doctors surgery

but the patient had driven themselves home expecting to be collected from there. Dr Davies confirmed that this sort of incident was to be addressed through a communications plan to promote responsible use of ambulance resources within the county.

The Chairman thanked Dr Davies and Mr McKinnon for attending and responding to questions. The Committee would continue to monitor performance by postcode.

32 **NHS 111 Service**

Emma Pyrah, Commissioning and Redesign Programme Lead for Unscheduled Care, Shropshire CCG outlined proposals for reprocurement of NHS 111 Service ( a copy of the report is attached to the signed minutes).

Referring to the Public Question submitted by Healthwatch, Vanessa Barrett, Healthwatch Representative, commented that the 111 number was not well known in Shropshire, and that there was lots of confidence around Shropdoc. Healthwatch were keen to obtain assurance that there would be no dimunition of access to Shropdoc with any re-procurement of 111.

Emma Pyrah explained how the 111 number had worked in parallel with Shropdoc after the 111 service had failed. There would be a recommendation to the CCG Board in November to retain the parallel numbers.

The Chairman asked if on contacting Shropdoc as opposed to 111, whether local doctors were more informed with regard to local services. The Committee heard that the 111 call handler had access to the same pathway as the ambulance service and there were clinicians available. If the pathway involved out of hours it would be passed on to Shropdoc as appropriate. It was confirmed that the directory of services that had been made available to NHS Direct was still in operation at 111 Centres and CCGs were being encouraged to use this.

In response to a question it was confirmed that the CCG paid for 111 and Shropdoc and that the Joint Project Board were recommending that both be maintained and the outcome of Future Fit would influence services in the future.

The location of the 111 call handler was raised and whether they would have appropriate local knowledge. A member felt that resources should be concentrated on Shropshire and this comment was noted.

The Healthwatch representative commented that Shropdoc was purely for out of hours whereas 111 was essential for all other times. The Regional Commissioner explained that the 111 journey was now implemented on the ED desk, so if it was triaged to A&E it could be re-triaged which meant that 50% had been diverted from A&E to other services.

Questions were asked about how patients living adjacent to borders would be triaged and also about telephony, in cases where people had Welsh telephone codes. These issues were addressed through the design of the Directory of Services. Members were encouraged to phone the 111 test line and feedback on experiences.

It was agreed that a visit to the Ambulance Service and 111 in Dudley would be useful for the Committee early in the new year.

Mrs Pyrah and Mrs Fortes-Mayer were thanked for attending for this item.

The Chairman reminded the Committee that the Shropdoc telephone number was 08444 068888

The meeting finished at 11.55 am.

Signed ........................................ (Chairman)

Date: ........................................