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TELFORD & WREKIN COUNCIL/SHROPSHIRE COUNCIL

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Minutes of a meeting of the Joint Health Overview and Scrutiny Committee held on Wednesday, 26 March at 9.30am at Wellington Civic Centre, Wellington, Telford

PRESENT – Councillor D White (TWC Health Scrutiny Chair) (Chairman), Councillor G Dakin (SC Health Scrutiny Chair), Mr D Beechey (SC Health Scrutiny Co-optee), Ms D Davis (TWC Health Scrutiny Co-optee), Cllr S Jones (SC), Cllr J Minor (TWC) and Mr R Shaw (TWC Health Scrutiny Co-optee)

Also Present –

Cllr A R H England (Cabinet Member: Adult Social Care, TWC)
Cllr L Chapman (Portfolio Holder: Adult Services, SC)

Mr D Evans – Joint Programme Senior Responsible Officer
Ms C Morton – Joint Programme Senior Responsible Officer
Mr P Spilsbury – Future Fit Programme Director
Mr B Gowans – Joint Chair of Future Fit Clinical Design Group

Mr A Osborne – Director of Communications, Shrewsbury and Telford Hospital NHS Trust
Ms D Vogler – Director of Business and Enterprise, Shrewsbury and Telford Hospital NHS Trust
Ms J Thornby – Director of Governance & Strategy, Shropshire Community Health NHS Trust

Mrs F Bottrill (Scrutiny Group Specialist, TWC)
Stephen Chandler (Director of Adult Services, SC)
Clive Jones (Assistant Director: Family and Cohesion Services, TWC)
Miss D Moseley (Democratic Services Support Officer, TWC)
Mr M Stevens (Committee Officer, SC)
Paul Taylor (Interim Director: Health, Care & Wellbeing, TWC)

JHOSC-28 APOLOGIES FOR ABSENCE

Mrs J Gulliver (TWC Health Scrutiny Co-optee), Cllr T Huffer (SC) and Mrs M Thorn (SC Health Scrutiny Co-optee)

JHOSC-29 DECLARATIONS OF INTEREST

None

JHOSC-30 UPDATE ON FUTURE FIT

David Evans (Telford & Wrekin CCG) presented a report which updated the Committee on the progress of the Future Fit Programme. He reminded Members of the Programme scope and structure. This focussed on the future provision of Acute and Community hospital services for Shropshire, Telford and Wrekin and Wales. It was recognised that there are key dependencies with primary care, community health services and the demands for A&E. The Committee were informed that Mike Sharon had been appointed as Programme Director, he had experience of major NHS reconfiguration in West Birmingham and Sandwell.

He updated the Committee on the completion of Phase 1 which included the approval of the Programme Execution Plan including Case for Change and Principles for Joint Working; development of acute and community hospital activity projections; extensive work on emerging clinical model; initial engagement activities; assessment of recurring affordability envelope & capital investment capacity; development of the Assurance Plan; drafting of the Risk Register & Benefits Realisation Plan and completion of the Gateway Zero Review and production of the associated Action Plan. The Gateway Zero Review gave the programme an amber rating and did not identify any significant risks. This review was at the early stage of the programme and the Joint Programme Senior Responsible Officers were satisfied with this.

Phase 2 was now underway which focussed on the development of models of care through a comprehensive and inclusive engagement plan, for which additional resources had been agreed. Although timescales were subject to further discussion, it was anticipated that formal consultation at Phase 3 of the Plan would begin prior to the local and general elections in 2015 due to the urgency of establishing the future of emergency services and creating conditions for the recruitment and retention of key staff.

Mr Evans concluded by outlining the future phases of the programme and invited the Committee to formally endorse the Case for Change and Principles for Joint Working.

Questions on all aspects of the presentation were dealt with following all presentations as detailed under minute number JHOSC-34.

RESOLVED that the Case for Change and Principles for Joint Working be endorsed

JHOSC-31 FUTURE FIT CLINICAL MODEL OF CARE

Caron Morton (Joint Programme Senior Responsible Officer) presented the emerging clinical model of care setting out the guiding principles and emphasising that large scale change must be fit for purpose for at least twenty years. More than 90 clinicians had been involved in the work to develop a

clinical vision for the acute sector. She went on to explain the model for urgent care which included a single emergency care centre and some urgent care centres. She acknowledged that securing the right outcomes for patients was time dependent and focussing emergency care in one centre would remove delays by ensuring that experts were available to provide opinions at all times. Currently, the majority of A&E visits were for minor injuries and these would be referred to urgent care centres so that the emergency care centre could be focussed on the highest level critical incidents.

Turning to the model of care for long term conditions, Ms Morton highlighted the need to maintain patients' quality of life following deterioration in condition, integration between specialist, GP and community team, greater self-care and ease of access.

Planned Care, ie non-urgent care, focussed upon patient empowerment, reduction in stages of care with cases dealt with to minimise the length of hospital stays and more dealt with on a day case basis.

Ms Morton continued by noting that a number of key principles and components of models of care were repeated in slightly different but synergistic forms across all three care areas: reablement, increased levels of care when needed and ensuring care was properly planned.

The next steps in the process were to refine the emerging models of care through a process of testing which would include sub-groups with increased patient involvement, exploration of cross- cutting themes, alignment with the evidence base, JSNAs and Health & Wellbeing Board Strategies and activity modelling.

Questions on this aspect of the presentation were dealt with under minute number JHOSC-34.

JHOSC-32 <u>FUTURE FIT BENEFITS REALISATION PLAN</u>

Peter Spilsbury (Programme Director) presented the Benefits Realisation Plan which was discussed at the Future Fit Programme Board on 10 March 2014. He explained he worked for the Commissioning Support Unit that was supporting the Future Fit Programme. He had experience of NHS reconfiguration at the new University Birmingham Hospital, the Right Care Right Here Programme in Sandwell and the Fit for the Future Programme in North Staffordshire.
A comprehensive initial draft had been developed and further drafts would be informed by patient & public views and focus on the measurable benefits expected directly as a result of the model, this work will be reported to the Committee. Members were invited to consider how programme success against the following benefits might be measured:-

- Highest quality of clinical services with acknowledged excellence;
- A service pattern that will attract the best staff and be sustainable clinically and economically for the foreseeable future;

- A coherent service pattern that delivers the right care in the right place at the right time, first time, coordinated across all care provision;
- A service which supports care closer to home and minimises the need to go to hospital;
- A service that meets the distinct needs of both our rural and urban populations across Shropshire, Telford & Wrekin and in Wales , and which anticipates changing needs over time;
- A service pattern which ensures a positive experience of care; and
- A service pattern which is developed in full dialogue with patients, public and staff and which feels owned locally.

Questions on this aspect of the presentation were dealt with under minute number JHOSC-34.

JHOSC-33 <u>EVALUATION CRITERIA AND PROCESS</u>

Peter Spilsbury (Programme Director) advised the Committee that the Programme Board would agree the evaluation criteria and process prior to identification of options, that there was a commitment to transparent & objective decision making and a desire to maximise benefits for the whole population. The consequences of options to be considered were for specific local populations and minority and deprived groups. The rationale & weighting criteria would be explicit. It was anticipated that the first draft of the criteria and process would be considered by the Programme Board in May 2014 and it would also be provided to the Committee for endorsement.

Questions on this aspect of the presentation were dealt with under minute number JHOSC-34.

JHOSC-34 <u>FUTURE FIT ALIGNMENT WITH OTHER STRATEGIC PLANS</u>

Caron Morton (Joint Programme Senior Responsible Officer) advised Members that Future Fit aligned with:-

- CCG 5 year strategic plans
- Better Care Fund
- Re-design of primary care service
- Re-design of community health services
- Plans for sustaining A&E services in the short to medium term

Ms Morton highlighted the Programme Board's close working relationship with NHS England and Members and noted that sustainability was a key issue and, as implementation was not likely to occur before 2018, short to medium term solutions were also required. She said there was real excitement generated among clinicians by this once-in-a-generation opportunity.

At the conclusion of the presentation, the Committee asked a number of questions and put forward comments as follows:

Members noted recent press reports regarding a new build emergency care centre and local opinions that this was the only option. However, Members were concerned as to whether this was a financially viable option and did not want to see the community's expectations raised and time and resources used to develop this if it was not financially viable. Members also queried what Plan B was if a new build was not financially viable.
Response – David Evans noted that the programme was still in the early stages and whilst it was recognised that there was a preference for one emergency care centre, no consideration as to where it should be located had been undertaken. Further work needed to be carried out to evaluate the clinical model and engage with stakeholders. It was too early in the process to even suggest a ball-park figure as the clinical model needed further work regarding beds, range of services, community hospital services and delivery. Regular updates would be made at each stage of the programme.

Caron Morton reminded the Committee that the preferred option needed to be viable for at least twenty years and serve the needs of the population. She advised Members that every £10m borrowed resulted in £1m revenue.

Bill Gowans commented that from a clinical design perspective, the preference for one emergency care centre should not be predicated on site or cost but on deliverability and consolidating the work force to provide maximum efficiency and quality.

Noting current £40m outstanding maintenance costs, Members asked what budget savings would be made.
Response - David Evans indicated that during the process to develop the Outline Business Care evaluation of non-financial benefits, eg access etc, and financial benefits would be appraised. There was a backlog of maintenance issues but the overall revenue consequences for the plans was not yet apparent. if the plans were not sustainable, some review would be required but it was too early to judge at this stage and the process needed to be followed through further. Caron Morton added that some modelling was required on costs but clinicians had been asked to focus on designing the model of care initially and affordability would come later; the project was fundamentally clinically-led in order to maintain integrity.

It was noted that the SaTH currently experienced problems attracting staff to A&E where 10 consultants were required but currently only 7 were employed. How would this project address recruitment?
Response - Caron Morton advised that prospective candidates would see a vibrant, innovative centre with the right support from equipment and colleagues and scope for research. Currently there was a very high workload making for difficult rotas. Consultants felt that the proposals would help recruitment as candidates would see that although they would initially begin work at a split site, the dynamic of the department would be changing.

Members asked how the Case for Change would be rolled out to the public at large and it was suggested that two public exhibitions (one Telford-based, one Shrewsbury-based) would be useful to reach and engage with people who

were not service-users. There was nothing in the report that addressed why the general public had not yet been engaged and it was felt that an opportunity had been missed as the proposals could generate a lot of excitement. It was stressed that it is essential that the public understand the case for change before solutions are presented.
Response - Adrian Osborne advised that the Programme Board were keen to engage the Community. At the start of the project, there had not been significant funds available for communication and initial engagement was focussed where people were already meeting, ie Parish Councils and Patient Groups. This had already generated some rich intelligence. However, a significant uplift in resources for engagement had now been agreed.

Members were excited by the proposals but recognised that a behavioural change was required if individuals were to be responsible for their own health. Some thought as to how difficult groups within the wider community could be reached was required, and examples were given of possible engagement by midwives, antenatal classes and job centres.
Response - David Evans agreed that responsibility to influence and alter behaviour lay within the room as part of the Programme. More joined up working was required and the example of teenage pregnancy, increasing breast feeding rates and reducing smoking during pregnancy was cited.

Caron Morton advised that this was part of a 5-year strategy to change lifestyles and required an integrated approach. It was acknowledged that patient empowerment was a national challenge.

Additionally, Bill Gowans said that this could also be addressed through patient focus groups. Clinician's questions were predicated on behaviours and focussed on the prevention agenda and wants -v- needs led service.

Members felt that patient representatives and groups would readily engage in the process but what methods would be used to engage others?
Response – Caron Morton stated SaTH's Youth Drive had been very successful and the Programme had looked at youth engagement. Engagement had taken place at Parish Council meetings as there was a sense that people did not engage with big exhibitions as they did not feel they could go.

Concern was expressed that Shropshire Patients Group had not yet heard about the Programme and rumours were beginning to circulate. It was important to involve patients to get their buy-in; patients were aware of resource issues but would want to help shape services and could be involved in 'spreading the word'.
Response – Caron Morton advised that greater investment was now available to progress consultation; the scale of the project required a significant input and the next phases would include more patient engagement. She stated she would be disappointed if any 'spin doctors' were involved in the project which was informed by credible clinicians. David Evans added that the Future Fit

Project was funded by the two CCGs which had only engaged Peter Spilsbury and his team at to work on the project.

Joined up working was seen as essential to the success of the Project, especially in the area of Adult Care and it was noted there was no representatives from the field of social work to feed into the process. How would joined up working be achieved to create an holistic service.
Response - David Evans emphasised that the project was not about cost shunting, it was about creating the right model of care for patients. It was important to try to stop people getting sick in the first place but, once they were sick, how could the best possible clinical care be delivered? The Better Care Fund had made significant progress in bringing together health and social care in a very short space of time.

Bill Gowans confirmed that Local Authorities were well represented as part of the clinical design work being undertaken. Caron Morton stated that social workers, for example, were viewed as clinicians.

Members recognised that the Future Fit Programme had taken years to complete and asked if any changes were planned that would relieve the immediate pressure on A&E, for example could the urgent care centres be rolled out first?
Response – Caron Morton advised that looking at the care pathways, the current thinking was that if a better outcome was available for patients and it was not reliant on buildings, then that should be available now. However, some care needed to be exercised in the consideration of urgent care centres as SaTH had inherited an inequitable system. Services needed to meet needs and moving too soon also had associated risks.

Bill Gowans attempted to illustrate the complexities and pitfalls by advising that urgent care centres, as minor injury units, were often passed over in favour of A&E. Patient perspective was key to addressing this, urgent care centres needed to be viewed as part of the hospital and there needed to be confidence in the treatment provided. This required layers of planning, collaboration and integration.

Clarification was sought about how emergencies would be determined.
Response – Caron Morton advised that clinicians would now turn to this aspect of the care model and 28 meetings had been scheduled. Where cases were treated would be dependent on clinical adjacencies as it was acknowledged that emergencies were time critical and consultants needed to be in close proximity. Communication with patient groups, ShropDoc and ambulances would be key.

David Evans stated that in very simplistic terms, life threatening cases would go to the emergency care centre and non-life threatening cases would go to the urgent care centre.

Bill Gowans added that fragmented and inconsistent care centres could cause problems and it was important that all urgent care centres did the same thing so that their services were recognisable from the degree of diagnostics, through to staffing and opening times.

Where does Future Fit fit with the national model?
Response – Caron Morton stated that there were high level trauma centres across the country and the urgent and emergency care centre model was supported by Professor Keith Willett (National Director for Acute Episodes of Care) in light of NHS England's Review of Urgent and Emergency Care.

David Evans pointed to the example of the Stroke Unit and the knowledge that patients experienced better outcomes from one unit sites. SaTH had consolidated its stroke services in the previous summer and latest results demonstrated a clear level of improved service and access times.

Adrian Osborne noted that A&E was often the door to other services and, therefore, it was acknowledged that some services would need to be provided on the same site to see improvement to patient outcomes. Planning between the NHS, its partners and politicians would need to take place on the basis of a population of 400k-500k.

Peter Spilsbury commented that local leaders would be supported in their delivery by a strong evidence base which was published on the website. This would help to keep people informed. He observed that a remarkable level of clinical leadership would be required to make the Programme work. In other areas of the country external consultants were brought in to develop models but in this instance a bespoke model would be created. Meetings were led by clinical leaders which resulted in a radically different dynamic that took time but could not be over-valued. He felt that this was a distinguishing feature of this process that the people who were designing the model of care are the people who will have to make it work.

Were there any models from elsewhere in the country that could be drawn upon to inform the project?
Response – Caron Morton stated this aspect was part of Peter Spilsbury's remit and whilst it was important to look at evidence and intelligence from elsewhere, there was a unique challenge in Shropshire, Telford & Wrekin with a complexity that did not exist in other counties.

Bill Gowans considered that even if the best international evidence was brought together, the solution would be disappointing. It was important to look at local evidence and get a consensus on the right thing to do, then look at bridging any gaps and secure buy-in. He felt there would be inevitable polarisation with regard to split sites or a single site and the rest was an 'iceberg under the water' but it was essential that the model of care worked or urgent care would not either. He felt there was a danger that past mistakes could be perpetuated.

When would the financial models be available?

Response - Peter Spilsbury suggested that costings could be available by the following spring. The models of care needed further testing so that clinicians descriptions could be converted into numbers, then that would be converted into facilities, sizes and cost options. There was a highly robust and technical set of processes to meet the national requirements so this stage could not be rushed.

It was important that services were fit for purpose. Would future reports include configurations of services outside urgent/emergency care?
Response – Bill Gowans stated that although the scope of Future Fit was around hospital and community-based hospital services it was important to 'paint the whole canvass' to make sense and offer certainty. Peter Spilsbury advised that financial modelling would look at the whole system.

Would financial modelling only look at public sector services? What about, for instance, social service requirements for beds in private nursing homes?
Response – Caron Morton noted that elements of the private sector worked in conjunction with the NHS, for example Nuffield, but whilst all services had to be paid for, the crux was what proportion was required for the hospital. David Evans agreed that these services would be factored into the discussions.

The Chairman noted that potential sites for the emergency care centre had not been considered but that if services in Telford & Wrekin and Shropshire were to be unified, siting would be crucial. He noted the consultation period was set for January to March 2015 which would be a politically sensitive period due to the May 2015 local and general elections. He personally hoped that work would continue with the best interests of the whole community at heart and that there would not be a political divide. He asked what was the impact of waiting to consult on the proposals until after May 2015 to prevent electioneering? The Committee felt that it was important that all the facts were publicly available before the election to prevent false claims.
Response – Debbie Vogler stated that SaTH was managing the workforce challenge alongside local and national challenges and working with CCGs regarding the critical care and medical workforce as a whole but may need to implement mitigatory interim measures.

Caron Morton advised that consideration had been given to pre-election protocols and the difficulties of consulting prior to the election. However, it was considered that essentially delaying the provision of services for three months was not in the best interests of the local community and that the Senior Responsible Officers were prepared to shoulder the inevitable pressure that would result. Consultation would not take place until the project was at an appropriate stage, but it did not feel right to delay for an election.

The Chairman impressed upon the Senior Responsible Officers that quick and clear responses to any claims made during the pre-election period would be essential.

Debbie Vogler stated that the sooner consultation could take place, the better. Pre-engagement was scheduled for October/November and it would be natural to move to formal consultation after that.

What level of consultation was taking place in October/November 2014?
Response - Caron Morton stated that this period would involve an extended period of public engagement which would then be followed by a 12 week formal consultation in December – March.

David Evans considered that engagement during October/November would build upon the current discussions, setting out the case for change and further refinement, enable time to take account of clinicians' work so that options for consultation could be offered.

Paul Taylor (Interim Director: Health, Care & Wellbeing, TWC), Clive Jones (Assistant Director: Family and Cohesion Services, TWC) and Stephen Chandler (Director of Adult Services, SC) commented on the Local Authority perspective on the Better Care Fund. Paul Taylor felt that it would be useful for a discussion to take place around the Better Care Fund and its holistic approach so that there was no detraction from Future Fit. Clive Jones considered that the presentation given by Caron Morton had shown that the Future Fit Programme was engaging with the Better Care Fund and would enhance service provision and model solutions. Stephen Chandler felt that this was a very exciting time in an environment that would get the right solution. He noted discussion about communication and agreed this was a key aspect in increasing public confidence in Future Fit. He considered that part of the journey in redesigning services and stopping old practices was about fitting the model into the broader strategic environment and resources; however, the fact that financial constraints would have a significant impact could not be ignored.

Members considered that the positive case for change had been made and could be endorsed together with the principles of joint working. The initial programme timetable was also supported.

JHOSC-35 JOINT HOSC WORK PROGRAMME

Caron Morton invited the Committee to consider receiving further reports throughout the scope of the programme.

RESOLVED – to receive further reports on the following matters:-

Evaluation Criteria & Process
Clinical Model of Care
Benefits Realisation Plan
Selection of short list of Options
Selection of Preferred Option
Consultation Document
Outline Business Case (Confirming Preferred Option)

The Chairman thanked everyone for attending and concluded the meeting at 11.43am

Chairman……………..…………………………

Date………..……………………………………