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 Monday, 27 April 2009 at 1.15 pm at Meeting Point House, Southwater Square, Telford

PRESENT – Councillor D R W White (TWC Health Scrutiny Chair) (Chairman), Ms D Davis (TWC), Councillor V A Fletcher (TWC), Councillor Y Holyoak (SC Health Scrutiny Chair), Mrs V Lindley (TWC), Councillor V Parry (SC) and Mr D Saunders (TWC)

Also Present – D Beechey (SC Health Overview and Scrutiny Panel co-optee); M. Shineton (SC Health Overview and Scrutiny Panel co-optee)

J MacDonald (Chair of the Clinical Leaders Forum / Programme Director: Strategy for Developing Health & Health Care)

Officers – V. Beint (Director of Community Services, Shropshire Council), A Smith (Scrutiny Manager, TWC),

JHOSC-1 APOLOGIES FOR ABSENCE

Councillors D. Gaskill (SC), A. McClements (TWC), E. Parsons (SC), S West (SC) and M Winckler (SC) and Councillor B. Craig (SC Portfolio Holder for Community Services)

JHOSC-2 DECLARATIONS OF INTEREST/PARTY WHIP

Although not a member of the Joint Committee, Councillor Shineton declared a personal interest as an Independent Healthcare councillor.

JHOSC-3 MINUTES OF THE MEETING HELD ON 3 APRIL 2009

The notes of the meeting held on 3 April 2009 were agreed as an accurate record of the meeting.

JHOSC-4 SHROPSHIRE, TELFORD & WREKIN HEALTH ECONOMY

The Chairman welcomed everyone to the meeting, and explained that the purpose of the meeting was to receive presentations on the progress of each of the six Care Pathways Groups. These clinician-led Groups were developing Models of Care as part of the on-going work to produce an over-arching strategy for health services across Shropshire and Telford & Wrekin.

i) Planned Care

Presentation by Claire Old (Director of Commissioning & Service Improvement, Telford & Wrekin Primary Care Trust)

In redesigning planned care, the focus was on taking a more holistic approach to the health and social care needs of individuals. A fundamental aim was that, wherever possible, there should be a shift away from providing planned care in hospital and a shift towards providing it in primary care. That meant hospital and primary care services working more closely together to ensure that patients received diagnosis and treatment at the right time, in the right place and from the right person.

One of the key changes in this Model of Care would be reducing the length of stay in hospital for in-patients, and minimising the need for overnight stays. Pre-assessment could be done by a doctor in the community – which would reduce the incidences of some patients being admitted un-necessarily. Many minor procedures could be dealt with in a day without the need for an overnight stay, with any subsequent nursing care being provided in the community. By providing faster, more efficient services, there would be shorter waiting times at each stage of the pathway and the disruption to people's lives could be minimised.

A number of stakeholders had been involved at all stages of the development of this proposed pathway, and patient involvement was critical.

- A number of Members expressed concerns at the likely impact of such changes on community services and the additional burdens it might place on local authority social care services.
Response – Claire Old referred to the experience for hip and knee replacements in Dudley, where services had been re-designed along similar lines. The length of stay in hospital had been reduced from 7-14 days to 3-4 days. It was acknowledged that the right skills needed to be available in the community, but that this could be achieved by training and working in different ways. For example, a "7 day workforce" was being looked at, which would help to move patients through the system without the delays caused by some services not operating at weekends.

- Members referred to the proposed shift in resources and skills from acute to primary care, and how this would be implemented given the financial situation in the NHS.

Response – in terms of finance, the national "payment by results" tariff system for acute care could be "unbundled" to provide resources for community care. For example, the money that was received for a current two day hospital stay could be used to pay for a one day stay, with the remainder of the money following the patient into the community.

- Reference was made to examples of patients being discharged from hospital in the early hours of the morning without means of getting home.
Response – this was regrettable, but occasionally at very busy times there was a need to move people. It would take time to change things, but an objective of any over-arching specification for health services would be to say that patients are not discharged in the early hours of the morning.

Val Beint informed the Committee that in the Shropshire Council area, a 6 week care package to enable rehabilitation back to the community was provided free of charge. It was important to focus on the outcomes, and to ensure that patients returned home with the support and care they needed.

ii) Maternity and New Born Care

Presentation by Andrew Tapp – Chair of the Maternity & Newborn Care Pathway Development Group

In developing their proposals, the Pathway Group had drawn on the regional framework for maternity and neo-natal care recently published by NHS West Midlands, as well as taking into account several key challenges such as the projected increases in the birth rate; the current absence of a midwife-led unit in the north east of Shropshire; midwifery staffing levels falling below levels recommended in the 'Maternity Matters' Strategy; improving the outcomes for particular patient groups; and the poor standard of estate and facilities at some sites . The proposed maternity care pathway did not suggest any major changes to the current model of care. There would still be a centrally located, consultant led maternity and neo-natal unit as the "hub" of the network, with six local midwife-led units linked to it. The midwife-led units included the existing facilities at Shrewsbury, Oswestry, Ludlow (with enhancements), Telford and Bridgnorth, and a new unit in Whitchurch or Market Drayton. It was proposed to deliver more antenatal and post-natal care in children's centres and midwife-led units, and to support more women in giving birth at one of these units or at home.

Under the proposals, hospital based inpatient and outpatient maternity and neonatal facilities would be significantly enhanced. For neo-natal services, clinical outcomes were excellent, but there were currently problems of lack of space, some staffing shortages and payments for these services was less than for other hospitals in the region. This latter situation had been partly resolved, although the costs might just be passed elsewhere. The concept of a single site for interdependent services was supported, as there were currently risks associated with having two A&Es unsupported by gynaecology or neonatology. A Workforce Development Plan would be completed for

increasing the numbers of midwives and support workers, along with additional senior and middle tier obstetricians.

- A number of Members referred to the issue of linkages between A&E and acute paediatric services, and whether ambulance crews should know which site to go to.
Response – Andrew Tapp stated that there was a fear in the context of the broader scenarios for future health service provision that some hospital-based maternity and new-born services would be separated from acute services. In terms of A&E, the main issue was the length of time in the processing of patients, which could increase the risks to patients.

- What effect was the EU Working Time Directive having on medical staff rotas?
Response – the service was currently short of one middle grade doctor, so the full effect was not quite known yet.

- What issues had arisen around the funding of the service, and the shortfall in income?
Response – It had been worked out that they had been systematically underpaid, and arbitration had failed to sort it out. An extra 300-400 cot days were required to get the funding up to what was needed. In the short-term, reducing the size of the contract would allow the service to cope but this was only passing on the problem elsewhere. So this was still very much an on-going "live" issue.

iii) Acute Care

Presentation by Simon Kenton, Chair of the Acute Care Pathway Development Group

The Group for this Pathway had focussed on a model of care that satisfied the needs and expectations of patients as well as reducing the inappropriate use of hospital A&E departments and unnecessary admissions. The aim was to enable patients to be seen in a primary care or community setting wherever possible, so that only those who required high-level specialist care were admitted to hospital. The service would be very much a partnership between acute hospitals, GPs, primary and community care, the ambulance service and local authorities.

It was proposed to introduce a 'triage' service at every point of access to emergency and urgent care in Shropshire, Telford & Wrekin. The 'triage' system would be delivered through proposed Urgent Care Centres (UCCs), which would be integrated with a number of care pathways. There would be 24/7 UCCs integrated with the two A&E departments at the Princess Royal and Royal Shrewsbury hospitals. These UCCs would seek to direct patients to the most appropriate service for treatment following assessment by an appropriate healthcare professional. Daytime UCCs with limited opening hours were proposed to be located at the current Minor Injury/Illness Units in

the Shropshire PCT area, and at a new health centre being developed in Telford.

Other proposals included rapid turn-around Acute Assessment Units at both Hospitals; the establishment of an integrated team at the hospital 'front door' and in the Acute Assessment Unit in order to follow patients through the pathway; and the development of care pathways for all common conditions so that patients move through the system smoothly and appropriately. A lot of work was currently being done to analyse the throughput and output of acute patients in order to inform the proposals for the new Model of Care.

- Members asked Mr Kenton to comment on reports and complaints that patients in A&E had been kept on trolleys, and that turn-around of patients at the PRH A&E unit was one of the worst in the region.
Response – Simon Kenton stated that capacity issues had been experienced during a peak in demand between mid January and March. More investment had been put in at both hospitals three months ago in order to try and improve turn-around of patients.

- Could re-assurances be given that the situation at the A&E units was not similar to the situation in Staffordshire, where a damning report had recently been issued into failings in patient care?
Response - There were issues in the current provision of acute care services, but that the situation was being closely monitored through an Urgent Care Network and regular daily meetings of professionals.

- Does the service meet the NHS target for patients being seen within 4 hours?
Response – the target was just met last year. The proposals being put forward for improving acute care would hopefully enable more challenging targets to be met.

iv) Children's Health

Presentation by Dr Richard Brough, Chair of the Children's Pathway Development Group.

Dr Brough gave a visual presentation to the Committee. He outlined the main elements of the local clinical vision for a world class service for children's health in Shropshire, Telford & Wrekin over the next five years.

To develop and improve the children's service it was proposed to focus on "Hospital at Home", "The Assessment Service" and "Inpatient Services":

Hospital at Home – a nurse-led service of supporting families and children at home (for non-serious injuries etc) to avoid admission to hospital if possible, and also to discharge child patients earlier from hospital to care at home.

The Assessment Service – to provide a high quality assessment to meet the current diverse needs but not to move to an admissions service.

Inpatient Services – to improve high-dependency services to provide adolescence care, consolidation of paediatric surgery on one site, and provide facilities for children with special needs & other specialist care services.

Outpatient Services and Transport requirements were also subject to improvement measures suggested.

During a question and answer session a number of points were raised including:-

- where would the nurses for the "Hospital at Home" service be based?
Response - it was explained that the current community based Children's Community Nurse Service would be used, but linked to a particular hospital.

- would this service be able to provide 24/7 coverage?
Response - this was desirable, but not possible.

- what was the financial cost of recruitment etc?
Response – there would be a steady move of existing CCNs to the new service but there would be an evolvement of the service over time to ensure continued robust services to children and their families. The Telford CCT would employ the staff as at present.

The staffing levels at the two CCTs were explained, particularly the vacancies that were expected up to and including August '09.

- how was a judgement made as to the suitability of the home environment for receipt of the child from hospital?
Response - it was explained that the current procedures would continue and child patients would only be sent home if appropriate circumstances prevailed.

The Wirral was quoted as an example where Children's services had adopted a similar pathway. The Chairman commented upon the need to further examine the service at Wirral, and a site visit was proposed.

v) End of Life Care

Presentation by Dr Wendy-Jane Walton - GPwSI in Palliative/End of Life Care,

Dr Walton conducted a visual presentation that outlined the ideas for improving care at the end of life in Shropshire, Telford & Wrekin over the next five years.

It was hoped that four key outcomes would be achieved, namely

1. Increasing the number of patients achieving choice in treatment options and place of death – by raising public awareness, using the End of Life Care

Team, providing a Directory of Services, and having Voluntary Sector involvement.

2. Increasing deaths in community settings by at least 14% by 2012/13 – by developing a GP Education Programme, using End of Life tools, supporting Carers in their role and providing a Hospice at Home Team.

3. Reducing the number of admissions to hospital for end of life care – by developing current systems to enhance the service, provision of training in clinical skills and competencies, supporting the workforce with 24/7 nursing and social care, and full support for Carers

4. Improving the quality of end of life experience for patients and carers – by providing a quality environment of privacy and dignity, providing clinical skills and competency, together with emotional, psychological & spiritual support.

Patients in all settings would be offered information on options that would be available to them for end of life care. A document entitled "Preferred Priorities for Care" was tabled for information and was available on the Web.

The Chairman commented that there was already an In-Depth Review being undertaken by Telford & Wrekin Scrutiny Members but the tabled document provided a further opportunity for opinion to be expressed about future proposals, and further discussions on the whole subject of End of Life Care would be merited on a future occasion.

The issue of Dementia was mentioned and it was considered that it be incorporated in the review process.

vi) <u>Long Term Conditions</u>

Presentation by Dr Jane Povey - Medical Director at Shropshire County PCT

Dr Tovey conducted a visual presentation that outlined the ideas for helping people of all ages in Shropshire, Telford & Wrekin to get healthy and stay healthy over the next five years. In line with the feedback received from patients, as well as the regional clinic group on long term conditions, the proposed pathway would aim to –
- Develop a system where people were willing and able to take responsibility for their own health;
- Help and support people to manage their own condition;
- Ensure that people were cared for closer to their own homes by the right professional with the right skills;
- Provide integrated health and social care that was adaptable to patients needs and provided in community settings.

There were proposals for priority action in six key areas – Diabetes, Heart Failure, Respiratory Disease, Strokes, Dementia, and Alcohol Misuse.

Members commented upon the valued service of Help at Home, provided to assist patients manoeuvre around home surroundings and obstacles etc.

Stakeholder events had been held to join up services but some were not well attended from the PCT

The Chairman commented that some social landlords undertook adaptations to properties and would be welcome of financial assistance from the PCT.

He also suggested that appropriate leaflets asking for patient feedback be issued with prescriptions at doctors' surgeries. It was suggested that discussions be undertaken with representatives of Patients Groups to obtain feedback on the idea.

The meeting closed at 5.16 pm

Chairman……

Date……