Shropshire Council

Date: Monday, 15 July 2019

Time: 10.00 am

Venue: Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND

Contact: Amanda Holyoak, Committee Officer
Tel: 01743 257714
Email: amanda.holyoak@shropshire.gov.uk

HEALTH & ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

TO FOLLOW REPORT (S)

3 Minutes (Pages 1 - 12)

To confirm the minutes of the meetings held on 25 March 2019 and 20 May 2019 (to follow)

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SHOPSHIRE COUNCIL

HEALTH & ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Minutes of the meeting held on 20 May 2019
9.30 - 11.38 am in the Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND

Responsible Officer: Amanda Holyoak
Email: amanda.holyoak@shropshire.gov.uk Tel: 01743 257714

Present
Councillors Karen Calder (Chair), Kate Halliday, Madge Shineton (Vice-Chair), Roy Aldcroft, Simon Harris, Simon Jones, Heather Kidd and Paul Milner

1 Election of Chairman

Councillor Karen Calder was elected Chairman of the Committee.

2 Apologies for Absence

Apologies for Absence were received from Councillors Gerald Dakin and Tracey Huffer.

3 Appointment of Vice Chair

Councillor Madge Shineton was appointed Vice Chairman of the Committee.

4 Disclosable Pecuniary Interests

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

5 Minutes of the Last Meeting

Members noted that the minutes of the meeting held on 25 March 2019 would be presented to the next meeting of the Committee for approval.

6 Public Question Time

Gill George asked two questions (copy attached to signed minutes) relating to concerns around Cardiology waiting times and boarding of patients at Shrewsbury and Telford Hospital Trust.

Julie Davies, Shropshire CCG, reported that an item on Cardiology had been added to the agenda of a CCG meeting to be held in the next week and that she would be able to provide an update after that. The Chair explained that it was intended that the Joint Health Overview and Scrutiny Committee meeting would be meeting on a regular basis in future and as boarding was an issue that effected both Telford and Wrekin and Shropshire patients, it would form part of the Committee's work programme.

The Chairman welcomed Mrs McIntyre to the meeting who was present in relation to the West Midlands Ambulance Service item to ask questions following recent personal experience. It was agreed that she be invited to speak when that item was under discussion.

7 Member Question Time

Councillor Pam Moseley asked a question (copy attached to signed minutes) drawing attention to illegal drug distribution through 'County Lines' and the problems this was causing in Shropshire. She asked if the Committee would commission a Task and Finish Group to investigate the operation and impact of County Lines and to seek to identify what actions could be taken to reduce and mitigate the effects.

The Chair agreed that this would be a useful piece of work but felt it might be best placed within the Shropshire Community Safety Partnership. She said that she would discuss this in the first instance with the Chair of the Communities Overview Committee. Members felt it would be important for at least one member of the Health and Adult Social Care Overview and Scrutiny Committee to be involved in this work.

8 West Midlands Ambulance Service

The Chair welcomed Mark Docherty, Director of Clinical Commissioning and Service Development/ Executive Nurse, West Midlands Ambulance Service and also Julie Davies, Director of Performance and Delivery, Shropshire CCG

Mr Docherty gave a presentation providing background on the Trust, the key messages from its operating plan and details of activity, demand and performance. The Committee had also been circulated with an information pack in response to questions it had asked of the Service. (presentation and pack are attached to signed minutes).

Members of the Committee asked questions about:

- Mental health, particularly in view of the low amount of spending on mental health services;
- Ambulance delays at the hospitals.
- GP referrals to hospital, and whether those patients should go through A&E
- Whether it was possible to see the longest times it had taken to get an ambulance to patients in very rural areas, for example, SY21, SY15 and SY9. Although response times had improved, more progress was still needed.
- The request made by a member of the Committee and Dr Davies for information connecting ambulance response times to outcomes for patients
- Would it be possible for the Committee to receive exception reports to help gain an idea of the factors involved in delaying ambulances

- Whether there was any campaigning for larger numbers and signs in rural areas where it could be difficult to locate patients.

- Was it possible to integrate records with those of the hospitals and GP surgeries.

- Who was responsible for defibrillator repairs and payment for new pads

- There was an error on page 7 of the information pack in relation to postcodes

In response Mr Docherty said:

The bulk of ambulance work was related to frail elderly patients but there were increasing levels of mental health issues and the service was not traditionally geared up for this. Parity of esteem was needed for mental health. In Birmingham there was a mental health care available and access to police, a mental health social worker and a paramedic and this was a model it was hoped others would adopt.

In terms of ambulance delays, Members heard that neither Royal Shrewsbury Hospital or Princess Royal Hospital had the infrastructure for the number of ambulances that were attending. RSH had been designed to accommodate four ambulances an hour but sometimes there was as many as 10 an hour. Dr Davies said that the single Emergency Department would be designed to accommodate the number needed.

A patient referred to the hospital by the GP should not have to go through A&E. National Care Intensity Support was working on a capacity model to help identify what was needed for short stay patients, to remove pressure from A&E.

WMAS regarded the right response the most important thing for a patient. For a person in cardiac arrest it was not the response of the Ambulance Service that would save a life, it was early defibrillation and community first responders that made a big difference, rather than more ambulances on the road. Cardiac arrest survival was routinely measured and published monthly although this was not broken down by postcode as small numbers meant that patients could become identifiable. Data for other conditions was not available in this way. The Trust did record the longest times by postcode but there was always a reason for a long delay.

In terms of linking ambulance times to outcomes, this represented a huge piece of work and it was unlikely resource was available to produce this.

Mr Docherty explained that maintenance of defibrillators was a joint responsibility with communities, and that a set of replacement pads was inexpensive at £20. The British Heart Foundation was working on a national database of defibrillator sites. A Member reported that Parish Councils within her electoral division had taken responsibility for maintenance.

WMAS records went directly to GPs records but this was not the case with the hospitals and efforts were underway to achieve alignment.

The Chair invited member of the public Mrs Macintyre to speak who wished to ask a question in the light of recent personal experience about the level of confidence in the triaging system at the control centre, categorising of calls and communication with callers regarding how long an ambulance would take to arrive. Mr Docherty offered his condolences to Mrs McIntyre and said he was very sorry that there had been a delay in attending her husband. He explained that every single call was recorded and retained permanently so if there were any concerns the call would be retrieved and an independent audit conducted on how it was handled. He offered to audit the calls made and the resolution letter sent by the Trust.

Overall, he felt staff did an excellent job assessing which calls should be categorised as a higher priority and that the system in place was robust, serving most patients well most of the time. He acknowledged that there was always room for improvement and the Trust always wished to learn what it could from anything that had gone wrong. In response to a related question from the Chair he explained that ambulances could start their journey from anywhere within the region and were not retained at a static site, apart from at one of the 16 hubs where they were cleaned overnight. He also explained that he received a text message every time a delay occurred and all clinical staff within the Trust helped out if needed. The Chair felt that there might be lessons to learn from this case in relation to communication with callers regarding how long the wait might be.

Mr Voysey, representative of Healthwatch, reported that 20 comments had been received about WMAS in the last year, 7 had been positive, the rest negative with concerns raised about closure of ambulance stations and 2 about ambulance delays. Mr Docherty reported he signed off all formal complaints and that WMAS received approximately 1 complaint for every 8,000 cases dealt with. He asked all present to encourage patients to get in touch with the service if they were not happy about something, a Learning Review Group met on a monthly basis to consider errors and issues.

The Committee thanked Mr Docherty for attending the meeting and answering questions. They said that exception reporting would be welcomed for future meetings. Members praised the work of the Trust but as a scrutiny committee emphasised that it was their duty to look at what was not working and to see if anything could be done to help. The Trust was congratulated on the high percentage of flu vaccination uptake by staff.

Mr Docherty thanked the Committee for the invitation to attend and said that members would be welcome to visit the control centre if they thought that would be useful.

9 **Keeping Adults Safe in Shropshire**

The Chair welcomed Ivan Powell, Independent Chair of the Keeping Adults Safe in Shropshire Board. He provided a report and presentation (attached to signed minutes) and explained the four priorities of the Board and how they had been identified using the Joint Strategic Needs Assessment as a starting point, drawing on multi agency data and consulting with Healthwatch and the community through the citizens engagement sub group. The presentation also covered the number of contacts made in relation to safeguarding, the most common types of abuse, the age of individuals involved in enquiries and meeting desired outcomes following enquiries. The presentation also

covered training, safeguarding adult reviews, examples of multi agency reviews and areas of focus moving forward.

The Annual report covered the period to April 2018, it was not possible to publish it any earlier than November because adult safeguarding data collection was managed centrally by government. It was agreed that the best timing for the next report would be November 2019 or as soon as possible after then. The report had to be provided to the Health and Wellbeing Board but it was agreed that it was desirable for it also come to scrutiny, perhaps at the same time as the Children's Board report to a Joint meeting of the Health and Adult Social Care and People Overview Committee.

With reference to the member question asked earlier in the meeting with regard to county lines, and the priority moving forward of exploitation in Shropshire; Mr Powell referred to strategic governance arrangements around this issue and confirmed the view that this issue sat with the Community Safety Partnership. A county profile had been built up and the national crimes agency provided information on vulnerability mapping and profiling.

Members thanked Mr Powell for the informative report.

10 **Appointment to the Shropshire and Telford and Wrekin Joint Health Overview and Scrutiny Committee**

The following were appointed to the Shropshire and Telford and Wrekin Joint Health Overview and Scrutiny Committee:

Councillors: Karen Calder, Heather Kidd, Madge Shineton
Co-optees: David Beechey, Paul Cronin, Ian Hulme

11 **Health and Adult Social Care Overview and Scrutiny Committee Work Programme**

It was agreed that an item on the contribution of the Council's Regulatory Services on Health and Wellbeing would be welcomed at the next meeting.

An item on Child Poverty in Shropshire was suggested and it was confirmed that joint meetings with other Scrutiny Committees could be held.

The Scrutiny Officer reported that it was intended that a work programming session for all Committees would be held in June.

Members noted that the Joint HOSC's work programme included topics such as Children's and Adult's Mental Health Services, Midwife Led Unit Review, Future Fit.

Signed ..... (Chairman)

Date: .....

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SHOPSHIRE COUNCIL

HEALTH & ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Minutes of the meeting held on 25 March 2019
10.00 am – 12.42 pm in the Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND

Responsible Officer: Amanda Holyoak
Email: amanda.holyoak@shropshire.gov.uk Tel: 01743 257714

Present
Councillors Karen Calder (Chair), Roy Aldcroft, Gerald Dakin, Simon Harris, Tracey Huffer, Simon Jones, Heather Kidd and Paul Milner

43 Apologies for Absence

Apologies were received from Councillors Jane Mackenzie and Madge Shineton

44 Disclosure of Pecuniary Interests

None.

45 Minutes

The minutes of the meeting held on 12 November 2019 were confirmed as a correct record.

46 Public Question Time

Two members of the public attended the meeting to raise an issue regarding the closure of the chronic pain unit at Robert Jones and Agnes Hunt Hospital. The Chair explained that the Committee was unable to look at individual cases but could look at circumstances where there had been a service change. The Chair said she would look into the matter and decide on a way forward. Councillor Paul Milner and Tracey Huffer both said they wished to be involved in this matter and help identify if the Committee needed to do more any work in this area, particularly in relation to scrutiny of commissioning intentions and impact of CCG funding decisions.

47 Member Question Time

There were no questions from members.

48 Care Closer to Home

The Chair welcomed Lisa Wickes, Deputy Director of Performance and Delivery, Shropshire CCG.

She provided a report and gave a presentation (copy attached to signed minutes) on Care Closer to Home. The presentation provided information on: Shropshire's population; the current and very complex picture of arrangements for frail and elderly patients, as there

was no formalised prescribed local end to end path for frailty; A&E Emergency admissions and average cost of emergency care per patient by age group; an analysis of frail elderly admissions and numbers that it was thought could have been managed elsewhere if appropriate services had been available; a new care paradigm for older people and frailty; the vision for the Community Model of care – appropriate care, right place, right time; the three phases for delivery of this vision; confirmed pilot sites; Locality GPs; the intention of one phone call for one referral; demonstration of how the model might work with a patient example; the benefits to patients; the benefits to GPs; CCG partnership and next steps.

The report provided more detail on the three phases of implementation and timings and also alignment with Telford and Wrekin CCG and explained the collaborative working set up through a Memorandum of Understanding with providers.

Members were encouraged to watch 'Roy's Story', the NHS England film detailing the work of the Frailty Intervention Team at Royal Shrewsbury Hospital available on You Tube, link available from the following page:
http://www.shropshireccg.nhs.uk/news/unique-local-health-team-is-making-national-waves-and-it-s-a-community-team-based-in-the-hospital/

Phase 2 of the Care Closer to Home Programme involved the community based workforce working closely with GP practices across Shropshire to obtain a clear understanding of how many people over the age of 65 had complex care needs, and categorising need complexity into low, moderate or severe. Those categorised as severe were given the opportunity to work with a Case Manager who would coordinate services to meet needs, promote recovery and identify when people were deteriorating. This would enable preventative measures to minimise the occurrence of a health crisis. A Pilot implementation group had been established, although there were IT issues in relation to the Shared Care Plan and data sharing.

Phase 3 was made up of Hospital at Home, delivered by a multi-disciplinary team; Health Crisis Response Team, within a two hour response window. If the Health Crisis Response Team felt that a person was too unwell to be safely managed at home, they could admit the person to a Step Up bed or to the general hospital. Clarity on which aspects of phase 3 would require formal consultation would be ascertained as the models emerged from the design process.

The report set out the timings of the 3 phases.

In response to questions Lisa Wickes reported that:

- A redesign of Community Services would have been needed, regardless of Future Fit ;
- Phases 1 – 3 would predominantly target over 65s, but the vision was for an all age service;
- Children's services were constantly under review, many under 2 year olds had a length of stay of zero days
- The Governance Programme had Locality Task and Finish Groups running which were working up the detail of delivery in the rural areas. This was expected to be similar to the Staffordshire model.

- Phase 2 would involve teams working closer together and phase 3 would introduce completely new services which would enhance the community offer and provide sustainable communities.
- The Direction of Travel did seem to lead to one organisation but not there yet and work continued on similarities and differences between Shropshire and Telford and Wrekin
- The current cross border agreement with Wales meant patients were treated and payment was arranged afterwards and there was a need to push for the Powys model to be joined up too
- Savings would be made from avoiding admissions but the STP would be looking at a Business Case to offer up front funding
- Pilot sites would run for six months in the first instance and criteria for assessment was being developed by stakeholders in the Pilot Implementation Group.
- The majority of services were not currently 24/7 and many took their last referral at 4.30 pm in the community.
- Hospital at Home would run from 8am – 6pm but rapid response and crisis were 24/7
- Eventually all services would need to be 24/7 and demonstrator sites would be testing this
- Work was underway in relation to workforce and ensuring the most appropriate work was being undertaken by the most appropriate person, working to their competencies.
- In terms of beds, different types would be needed and some might need to be specialised. Beds needed to be accessible and available in different settings, with step up beds as well as step down, and a detailed piece of work was needed on this which would be completed when the Joint Strategic Needs Assessment was available.

The Chair observed that there appeared to be an appetite from Powys to work more closely and this should be encouraged. She also suggested that further consideration of the Staffordshire model might be useful.

The Chair thanked the Deputy Director for Performance and Delivery for attending and answering questions. The Committee requested an update in a year's time and particularly looked forward to a progress report in relation to the most rural parts of the county and on cross border issues.

49 **Adult Social Care Quality Assurance Framework**

The Head of Adult Social Care introduced the report before members, the purpose of which was to explain how learning gained from complaints, Local Ombudsman complaints, and other opportunities to apply learning to practice.

The Chair welcomed Jane Garner to the meeting, who had attended the last meeting of the Committee and whose questions at the last scrutiny committee meeting led the Committee to request a report explaining how Adult Social Care used a range of opportunities to continually review its service delivery, its standard of training and support for practitioners, communication within the whole system and learning from users of the service.

Ms Garner had subsequently met with the Director and a further meeting with service manager and practitioners had led to a number of actions being identified. Some things in the report reflected learning had already been underway and were not just identified as a result of Ms Garner's complaint.

Adult Social Care had developed and adopted a Quality Assurance Framework to be used across the whole directorate. This recognised that performance should not solely be reflected by statistics, performance outcomes, which although important, did not reflect practice standards. The framework established a learning loop so that learning could feed into training programmes and individual training and influence the design of practice procedures and pathways.

The report covered the background to this work and included the Assurance Framework at appendix 1. It also set out areas where improvements had been identified as required in terms of: navigating the Adult Social Care element of the website; communication with clear guidelines about process; timescales and who to contact; and working together with colleagues in other organisations. The expectation was that the person was placed a the centre of all practice and that this could be reviewed instantly. In Ms Garner's case there had been a breakdown in communication between the ICS team and the community team and hospital social worker now acted to maintain links. Factsheets would also be updated and more clarity provided around timescales, eg for assessments.

Members went on to ask question about signposting for carers and ease of access to information; how carers were signposted to the key point of contact in the hospital and how to increase the number of assessments. They heard that the IBCF had funded a post at Royal Shrewsbury Hospital to provide support to carers, and that the postholder wore an orange top to enhance visibility. Although there was not a similar post at Princess Royal Hospital, social workers from the Council were present there on a daily basis and fed back to this postholder. She was able to link into Let's Talk Local Sessions, arrange appointments and sometimes contributed to assessments herself.

A member referred to the Carers Hub at PRH and asked whether that model might be utilised in other settings. The new postholder was essentially running a hub at RSH, appointments were available at Let's Talk Local sessions and the establishment of carers clinics had been explored. Ms Garner confirmed that the presence of the new postholder at RSH would have led to a totally different experience and reiterated that carers were often under significant stress and just needed someone to talk to in order to identify their needs.

In response to questions, Members heard that it was intended to support self funders in future much more in terms of brokerage, this should be within the next 3 – 6 months, and

that it had not yet been decided whether to charge for this service. Identifying self-funders early on might also help prevent admissions.

A member asked about those who were not able to attend a Let's Talk meeting and required a home visit. The level of demand on the service meant that some would have to wait for that and members asked if there was any communication during the waiting period. It was confirmed that timescales were not usually provided as priorities on the list changed on a regular basis, but now those who managed the list contacted people on a regular basis to let them know they had not been forgotten and to check whether any information had changed. New letters were currently being drafted, jargon minimised, and a flow diagram, as suggested by Ms Garner, was being produced to help explain the process.

The Portfolio Holder also reported on work underway to provide GP Services with referral pathways to carers to access support.

The Chair thanked Ms Garner for her persistence, participation and help which would lead to an improvement in patient experience.

It was agreed that the Committee receive an annual report from the Principal Social Worker detailing learning gained from all audits and also learning gained from complaints with detail as to how this learning had influenced and changed practice. It was agreed that this should be in approximately a year's time and that Ms Garner be invited to attend to provide her view on progress.

50 **Work Programme**

Members noted that it was intended that the next meeting would be a single item agenda on West Midlands Ambulance Service. Other items raised for possible inclusion on the work programme were

The Scrutiny Officer reported that meetings to consider Health Trust Quality Accounts were being arranged in conjunction with Healthwatch. It was felt that perhaps a members seminar on the NHS Ten year Plan might be useful. Other areas for potential inclusion on the work programme included the contribution of regulatory services to health and wellbeing, review of 111 commissioning, and the chronic pain service,

The Chair reported that the work programme of the Joint HOSC included all areas of mental health provision, and it would be receiving regular updates on Future Fit.

Signed ..... (Chairman)

Date: .....

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