**SHROPSHIRE COUNCIL/TELFORD & WREKIN COUNCIL**

**JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE**

**Minutes of a meeting of the Joint Health Overview and Scrutiny Committee held on Friday 5 February 2016 at Addenbrooke House, Telford at 1.30pm**

**PRESENT** – Cllr A Burford (TWC Health Scrutiny Chair) (Chairman), Cllr G Dakin (SC Health Scrutiny Chair), Mr D Beechey (SC Co-optee), Cllr J Cadwallader (SC), Cllr V Fletcher (TWC), Mr R Mehta (TWC Co-optee), Mr B Parnaby (TWC Co-optee), Mr D Saunders (TWC Co-optee) and Cllr R Sloan (TWC)

**Also Present** –

F Beck (Executive Lead – Commissioning, Telford & Wrekin CCG)
F Bottrill (Scrutiny Group Specialist, TWC)
D Evans (Accountable Officer, Telford & Wrekin CCG)
A Hammond (Deputy Executive, Telford & Wrekin CCG)
A Holyoak (Committee Officer, Shropshire Council)
L Noakes (Director of Public Health, Telford & Wrekin Council)
T Parker (Communications & Engagement Lead, Midlands & Lancashire Commissioning Support Unit)
A Smith (Executive Lead Governance & Performance, Telford & Wrekin CCG)
P Smith (Democratic Services Team Leader, TWC)
R Thomson (Director of Public Health, Shropshire Council)
S Wright (Chief Executive, SaTH)

## JHOSC-1 APOLOGIES FOR ABSENCE

Apologies were received from Cllr T Huffer (SC), Mr I Hulme (SC Co-optee) and Mrs M Thorn (SC Co-optee)

## JHOSC-2 DECLARATION OF INTERESTS

None

## JHOSC-3 MINUTES

**RESOLVED – that the minutes of the meeting of the Joint Health Overview and Scrutiny Committee held on 15 December 2015 be confirmed as a correct record and signed by the Chairman.**

## JHOSC-4 CHILDREN and ADOLESCENT MENTAL HEALTH SERVICE

Further to the report to the last meeting, Anna Hammond (as the Senior Responsible Officer for the Project) and Tamsin Parker (Project Communication Lead) provided an update to the Committee on the project to

design a new 0-25 Emotional Health and Wellbeing Service. Midlands and Lancashire Commissioning Support Unit had been engaged to develop and implement the Communication and Engagement Strategy for the service re-design. As agreed at the last meeting, the Joint Chairs had met with AH to look at the draft Strategy. There was a tight timetable for the project, with the aim of completing the initial outreach and consultation work by 17 March 2016 prior to a market testing exercise. The current provider was aware of the intentions, and a contract termination notice would be served at the end of March. The new contract would begin on 1 April 2017. The finalised Communication and Engagement Strategy was attached to the agenda for Committee endorsement and sign-off.

The Communication and Engagement Strategy outlined the main stakeholders, key messages and frequently asked questions. The Strategy would be adopting an "Experience Led Commissioning (ELC)" approach to help develop an outcomes based specification which reflected the outcomes most valued by children, young people and their families. A team of people would be interviewing service users and their families/carers, as well as meetings/visits to local support groups and children's homes. The team was working with the two local authorities to identify and target any 'difficult to reach' groups or individuals. ELC also had access to a database held by Oxford University which collated feedback from similar exercises and research across the country. In addition, there would be general engagement work with stakeholders and use of social media to raise awareness of the consultation. There would be a pre-market provider engagement event on 19 March 2016 to be attended by children and young people, professionals and potential bidders for the new service, at which the outcomes would be finalised.

The Committee then asked a number of questions regarding the Communication and Engagement Strategy:

*Would the Youth Offending Service and Youth Justice Panel be consulted?*
AH stated that they would look at these areas, but that they might need to look at other pieces of work linked to young offenders. Mental health services for the Youth Offending Service were procured separately by NHS England.

*The House of Commons Select Committee report on Children's Mental Health was due soon. During the evidence sessions Ministers had indicated that there would be changes to the service – was there going to be anything coming out of that which might impact on the service re-design?*
AH stated that she was not specifically aware of that report, but there were a lot of things happening nationally and some flexibility had been built into the timetable in order to be able to respond to any national developments.

The Chair suggested that possible changes to national requirements could be added to the risk outlined in the report.

*Healthwatch had been carrying out a survey with children and young people, which might provide information relevant to the Strategy.*

TP reported that they might be working with Healthwatch on an analysis of their survey results.

*How would children and young people be able to feed back their views?*
TP stated that they were initially focussing on the targeted engagement work, as referred to earlier. However, there would also be opportunities for young people to provide general feedback at drop-in events or through surveys etc

*Within the new service, would there be help available in schools for children affected by mental health problems – particularly in smaller primary schools that did not have the capacity to provide specialist support?*
AH reported that this would be part of the service specification. However, they had already secured some money to take this forward and were already starting to work with schools. The Severn Alliance group of schools was involved in the consultation and the CCG would also work with Headteachers. The new service would recognise the role of universal workers.

*How would parents' expectations for the new service be managed?*
AH explained that part of the consultation and engagement exercise was to ask parents what worked best for them. Parents often didn't know where to find out information about these services, and part of the work would be around guiding them to the right access points to the service.

*It was suggested that ELC could work with 'Fresh' – an organisation that represented people within the nine protected characteristic groups.*

The Committee was pleased with the report and the approach set out in the final Communication and Engagement Strategy to focus on the outcomes that were valued by children, young people and their families. However, there was a need to ensure that expectations were managed. He also added that, as there would be an emphasis on universal workers, it would be important to monitor where there were particularly high or low numbers of referrals from specific organisations – as this might indicate if there were problems.

The Chair stated that the JHOSC would wish to scrutinise the service specification for the new contract, as it was likely to represent a substantial variation in service. TP advised that the development of the specification would probably be around mid-April 2016.

**RESOLVED – that the Communication and Engagement Strategy for the development of the new 0-25 Emotional Health & Wellbeing Service be endorsed.**

## JHOSC-5 111/OUT OF HOURS SERVICE

The Chair expressed frustration that the Committee had only received the Engagement and Equality Analysis Report a short time before the meeting, which made it difficult for proper scrutiny to be carried out. He reminded

Members that this exercise was about the service, not specific providers, and that the Committee needed to examine the options for moving forward so that current satisfaction levels were continued and enhanced.

Alison Smith and Fran Beck from Telford & Wrekin Clinical Commissioning Group presented an update on the procurement of 111/Out of Hours services for Telford & Wrekin and Shropshire.

AS explained that since the last JHOSC meeting when the Engagement Plan was supported, the CCGs had undertaken an extensive engagement programme to seek views and comments on both the current service and on preferences for the future delivery of the service and how it was accessed. Due to consent issues, it had been difficult to engage directly with recent service users from protected characteristic groups. However, they had been encouraged to respond to the online survey. Both Healthwatch groups supported the engagement activities through promoting the survey and listening events. The engagement period ended on 22 January, so there had not been much time to analyse the results and produce a report.

AS then provided a summary of the engagement feedback and response to the four questions that had been at the heart of the engagement exercise:

- Understanding and knowledge of the NHS 111 service and its functions.
While the questionnaire survey indicated a high level awareness of the existence of NHS 111, there was a varied level of awareness amongst protected characteristic groups and a general lack of clarity on the function of the service.
- Understanding and knowledge of the Out of Hours (OOH) Service and its function.
The levels of awareness of OOH were similar in the questionnaire responses to that for NHS 111, but feedback from other sources (eg the older population) indicated that there was a greater degree of knowledge of the OOH GP service.
- Experiences of accessing these services and opinions on possible improvements.
In relation to NHS 111, there were a number of messages for commissioners in terms of low levels of trust and satisfaction reported by those who had used the service. In relation to OOH, 94% of respondents who had used OOH stated that they were satisfied with the service they had received. There were strong opinions in favour of maintaining a separate OOH service, with particular value placed on the skills/local knowledge of the call handler. Both services could be improved if response times were better, and for NHS 111 there were views that the volume and relevancy of questions asked by call handlers should be reviewed. Having access to appropriate patient records was also deemed important for dealing with individuals with complex health needs.
- Preferences on potential change in phone number as a result of integration of services.

There were a number of different views expressed, but with a majority of survey respondents being against the use of NHS 111 as the single telephone number to access urgent care services.

FB then explained the national model for accessing urgent care services. Providing NHS 111 for the whole population was a "must do" for CCGs, and it must be functionally integrated with (at least) Out of Hours Services. In other parts of the country the NHS 111 service was working well where it had become embedded or joined-up with other services. Locally, the current model was relatively complex and involved some duplication. In order to meet national standards, the CCGs would like to move to a model that would merge some of these functions and to make it a simpler process – eg: a call made to the 111 number could not be transferred directly to the OOH service. The preferred model was to have a 111/Regional clinical hub (which would provide specialities such as dentistry), a Local clinical hub, and then the different pathways to accessing urgent care. For this to work there would need to be integrated processes for call handling and initial assessment, telephone clinical advice and face-to-face treatment services. This model would also dovetail with the Future Fit vision, and there might be the opportunity to streamline with other services. However, there would be challenges in bringing about these changes immediately.

Both CCG Boards would be meeting on 10 February to consider the feedback from the engagement exercise and to look at options for how to ensure NHS 111 and OOH services met the commissioning standards for integrated urgent care. The procurement of the NHS 111 service would proceed along the regional timescales, so this would start in October 2016. The four options for the procurement of the OOH service were that:

1) it should run to the same timetable as the 111 service
2) it should start in April 2017;
3) it should start in April 2018;
4) it should start in April 2019.

Under options 2, 3 and 4, the current OOH provider would continue to provide the OOH service until the procurement process was completed. During this period the OOH number would change to 111.

David Evans, Accountable Officer – Telford & Wrekin CCG, advised that the preferred option would be for a new fully integrated service to commence in April 2018, which would give time for further work on the model and for procurement of the new service. In the interim, it was proposed that the current OOH contract with Shropdoc be extended for a further two years to March 2018.

Members of the JHOSC then expressed views on, and asked a number of questions about the future provision of the NHS 111 and OOH services:

*Would there still be separate numbers for NHS 111 and Shropdoc OOH service up until April 2018?*

FB stated that if the current OOH provider's contract was extended by two years, there would be a process (with appropriate publicity campaign etc) to move towards a single number.

*Would the specification for the new regional NHS 111 contract include provision for the OOH service, and how far could local needs be incorporated into a regional structure/solution?*
FB confirmed that it would, but that there needed to be a balance between getting functional integration and not being too overly prescriptive on the solution. So there would be some flexibility on how the integrated service would be structured and provided. But ultimately, they did not want a disjointed service, and this would be reflected in the specification.

*There were risks in moving to a single number for urgent care, and it was important that any solution/option needed to link to the Future Fit programme and what came out of that.*
FB advised that they would be working with the Shrewsbury & Telford Hospital Trust and others in order to get an effective multi-disciplinary approach to joining up urgent care services and a systems-based solution. This exercise was not about saving money, but in finding a simpler and more effective model.

*Would a possible two year delay in meeting the commissioning standards for integrated urgent care be acceptable to NHS England?*
DE stated that as long as they could demonstrate that Shropdoc could work with the new regional NHS 111 provider, then the proposed contract extension for the current OOH provider should be acceptable to NHS England. There was a strong case for allowing sufficient time for the OOH service to be properly integrated with other urgent care services and the Future Fit outcomes.

*It was important that the introduction of a single contact number was properly handled and that people were fully aware of the situation.*

DE agreed that there needed to be a smooth transition. There would probably be a move towards the 111 number (with national advertising and other publicity) and so within six months the Shropdoc number would probably be shut off. FB added that if the model worked as envisaged, the number became less important.

*How would it work in practice for the 111/OOH service to have access to patient records? Who would be responsible for putting that information on the system?*

DE advised that currently Shropdoc could look at doctors' notes and the hospitals could access a patient summary record. So things were further forward than they were, but additional work would need to be done with the NHS 111 provider and others. It was proposed there would be "flags" in the system to identify those patients with complex needs, end of life patients etc

*In terms of the location of call handlers, it would help if the 111 and OOH services were in the same place or there was some kind of joint contact/working. It was important that the current high satisfaction levels with the current OOH provider were not lost, and that once the decision had been made by the CCGs it should be communicated to the public.*
DE stated that the value that people placed on a locally provided service was recognised. However, it also needed to be recognised that the current system was not perfect and sometimes led to increased pressure on hospital services. The OOH service had not been tendered for in the past 20 years and, irrespective of the 111 service, it needed to be tested against the market in terms of best value for public money.

*Would the service provided by 111 be able to respond appropriately to children who were ill and whose condition could deteriorate very quickly?*
DE referred to criticism of the 111 service in one area of the country as a result of the death of a child. He had not read the report, but from media coverage of the case it appeared that there were a number of stages at which there were different options during the episode of care, and it was not just the final conversation. He also highlighted the issue that it was important to help all clinicians to better identify sepsis.

Having received the presentation and heard the answers to questions, the Committee were supportive of the preferred option 3 for a delay until April 2018 in the introduction of a fully integrated 111/OOH urgent care service for the reasons outlined, and for the extension of the contract for the current OOH provider in the interim. The support of the Committee was subject to the following points:

- patient safety is the priority and that the high quality of the OOH service should be maintained;
- the procurement of the OOH service should take into account the development of the Community Fit Programme and the Rural Urgent Care Centres;
- the OOH call handlers should continue to be co-located with the OOH clinicians until the procurement process is completed. It is on this basis that the Committee recognise that this is not a substantial variation in service;
- further information being provided on how the integration of the 111 and OOH services would be specified in the contracts at key stages in this process.

**RESOLVED – that Option 3 be supported and recommended to the CCG Boards, subject to the points set out above.**

## JHOSC-6 DEFICIT REDUCTION PLAN FOR THE LOCAL HEALTH ECONOMY

The Chair stated that the update report from the SaTH Finance Director attached to the agenda had intended to be an information only item. But as the SaTH Chief Executive and the Accountable Officer - Telford & Wrekin CCG were present, there was an opportunity for the Committee to ask any questions.

The report explained that Pricewaterhouse Coopers (PWC) had been commissioned to work with local health organisations to provide an independent assessment of the scale of the financial challenge that needed to be addressed. PWC would be consolidating each of the medium term financial plans of the four provider organisations working within the Local Health Economy (LHE) and the two Clinical Commissioning Groups into a single LHE Income and Expenditure account. This would then allow review and challenge of the assumptions underpinning these plans to ensure there was a consistent and coherent financial plan across all parties. This process would include engagement with Shropshire and Telford & Wrekin Councils to consider the challenges also facing social care. The ultimate outcome of this work would be a LHE income and expenditure account to 2020/21 that provided a consolidated assessment of the financial deficit to be addressed.

This approach would also support the local health system in fulfilling the requirements of the new NHS Shared Planning Guidance which expected NHS organisations to work together within localities to create a 5 year Sustainability and Transformation Plan.

In terms of timescales, a first assessment of the scale of the challenge was expected to be available by mid-February 2016, with the work completed in early March. An interim update would be provided at the next JHOSC meeting.

*Would this work affect the timescales for the Future Fit programme?*
SW advised that there was no slippage in the timelines for Future Fit, and it was still expected to reach a decision on the preferred option in the early summer. The work on the capital expenditure elements was being refined within the agreed project timetable.

*Would hospital services still be resilient until Future Fit was resolved?*
SW stated that he believed urgent care services were more resilient now than they had been for a couple of years, partly due to an additional A&E consultant and two other intensive care workers. But it was accepted that key staffing levels were still below where they needed to be.

*What was the current position on nursing levels?*
SW stated that they continued to be compliant on staffing levels, and 54 nurses had recently been recruited from overseas. But this continued to be a national issue.

*Was there confidence that PWC would be able to complete their work within the timescales referred to in the update report?*
SW stated that he believed the work would be completed on time. But after that, there would be a lot more detailed work to be carried out.

The meeting closed at 3.15 pm.

**Chairman……**

**Date……**