Joint Health Overview and Scrutiny Committee 18 October 2016 3.30 pm	Item Public

MINUTES OF THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE MEETING HELD ON 18 OCTOBER 2016
3.30 - 5.36 PM

Responsible Officer: Amanda Holyoak
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Present
Councillor (Leader)
Councillors Gerald Dakin (Co-Chair), John Cadwallader, Heather Kidd, Andy Burford (Co-Chair), Veronica Fletcher and Rob Sloan

1 Apologies for Absence

Apologies for Absence were received from Mr Rajash Mehta.

2 Disclosable Pecuniary Interests

Mandy Thorn indicated that she was a care provider and owned a care home in Shropshire.

3 Minutes

The minute of the meeting held on 5 July 2016 were confirmed as a correct record.

4 Joint HOSC Visit to Widnes and Runcorn Urgent Care Centres and Responses to Interim Questions

Members had been circulated with the key findings from the Joint HOSC visit to Widnes and Runcorn Urgent Care Centres, and also the responses from the NHS received to the questions submitted by the Joint HOSC Chairs on the Future Fit Programme following the meeting held on 5 July 2016. A copy is attached to the signed minutes.

5 Future Fit and Sustainability and Transformation Plan (STP)

Dave Evans, Future Fit Programme Director, confirmed that he was acting in the capacity or Chief Officer of Telford and Wrekin CCG as well as Interim Accountable Officer for Shropshire CCG for the meeting.

In providing a verbal update on the Future Fit Programme, he explained that:

- The Programme had not made a recommendation on a preferred option as intended at its last meeting due to the concerns expressed by a local authority regarding the process. The Programme Board had decided to take time to respond to the concerns raises.
- The intention was to reconvene the Board by the end of the first week of November to make recommendations to a joint meeting of both CCG Boards in the second week of November
- The West Midlands Senate review had just commenced and a draft report was expected mid to end of November, with a final report in December.

Simon Wright, Chair of the Sustainability and Transformation Plan Board, and Chief Executive of Shrewsbury and Telford Hospital Trust, reported that the latest iteration of the STP had just been submitted to NHS England. This was an ongoing piece of work, the Plan was not fixed and this submission represented a particular point on a journey. NHS England had been asked for clarification as to when these documents could be made public.

Committee Members asked what assurances could be provided that current services at the hospital trust were safe, particularly in relation to critical care and urgent and emergency care.

Mr Wright reported that recent appointments to the anaesthetic team had led to more resilience in intensive care provision. The level of intensive care cover at Royal Shrewsbury Hospital (RSH) was now about right and about 10% away from this level at Princess Royal Hospital (PRH). With regard to Emergency Care, the challenges linked to the medical work force remained. Nursing requirements were almost fully staffed, but two more were needed at Princess Royal Hospital (PRH). It was confirmed that the current service was safe.

SATH was in discussion with another hospital in the West Midlands and exploring the possibility of making consultant posts more attractive through working at a variety of locations, and to see if it could release any support to help bolster support at SATH, particularly at the PRH site.

He added that SATH was not currently in a position to deliver the A&E target that 95% of patients should be seen, treated, admitted or discharged in under four hours because of the lack of senior decision makers.

Members asked how close the Trust was to the ‘tipping point’ whereby safe services could no longer be maintained and one site would have to close at 10.00 pm at night, seven days a week for safety reasons. Mr Wright reported that the situation was precariously close to that point and planning was having to take place internally for that eventuality. Members asked how long SATH would be able to depend on locum cover and heard that there were three consultant locums and five substantive consultant posts spread across the two accident and emergency departments. The locums had worked for SATH for a long time and although change was not expected there was a risk that they may leave. The substantive posts were where the main risk lay at the current time and one consultant had recently resigned. Attempts were being made to persuade him to stay longer. Once he had gone, the number of consultants would lead to a 1 in 4 rota, and it would not be possible to function with both sites. It was not possible to secure locums to work out of hours.

A huge amount of work was going on with one particular acute hospital in seeking emergency consultant support for SATH. If they were able to release some support, it would be possible for the status quo to remain for at least another six months. If this support was not forthcoming, one site would have to close down at 10.00 pm.

The Co-chair said the Committee was aware that it would be PRH that would close at night and asked about women's and children's services after 10.00 pm. Mr Wright explained that a clinical impact assessment would be needed and SATH would have to work closely with West Midlands Ambulance Service. In terms of paediatric provision, SATH was satisfied that service would be unaffected by the change but it would cost more to provide this solution. Members noted that the number of admissions between 10pm and 8 am at PRH in a week was 8 -10 patients. This was the equivalent of one ward and there was not currently an empty ward at RSH.

The Committee asked how taking this measure would impact on ambulance turnaround time and what would be done about ward space capacity. Mr Wright explained that there were significantly less ambulance arrivals after 10pm and it would be important that ambulances were not queuing prior to 10pm. Members expressed concern that this would result in increase pressure on other A&E departments. Consideration was being given to transferring services between sites to provide the capacity needed, and to improve movement of patients who required complex discharge, including looking at an off-site location. It was explained that there were 3 locum staff working in A&E and 5 substantive consultants. The 3 locum staff had worked at the Trust for a long time but use of locum staff did introduce risk.

The Committee went on to ask what services would be provided by the proposed Urgent Care Centres at PRH and RSH and noted that these would cover children's visits, sprains, sports injuries, trips and falls and fractures, there was still work to do on finalising this. The current proposals for staffing were for Advanced Nurse Practitioners, Emergency Nurse Practitioners and GPs supported by the Acute Trust at both UCCs and Consultants located where the Emergency Department might be

Members asked where GPs might be recruited from for the Urgent Care Centres and who would employ the UCC GPs. Mr Evans replied that it was expected that these posts would offer a portfolio career in an emergency department alongside some primary care and research and would be attractive to a pool of enthusiastic newly qualified GPs looking for a different career structure from traditional primary care. Discussions were on going with the Trust regarding the employment of GPs.

The Chair asked when the Urgent Care Centre offer would be published. Mr Evans said the offer would be made far more explicit whilst going through Future Fit public consultation. In response to other questions about the co-location of GP practices at the UCC as seen at Widnes UCC, Mr Evans said that having a practice list alongside a Walk In Centre had not proved to be the most successful model and that the Urgent Care Centres would have dedicated GPs.

A member asked about the current position regarding recruitment of GPs in Shropshire in the face of many retiring and if more work would be taking place in primary care, who was going to deliver it. He also asked if work was on target for IT systems to communicate with one another.

Mr Evans explained that both CCGs were facing challenges around GP recruitment, there were not enough coming through the system to meet demand. However, both CCGs were clear about the direction of travel and neighbourhood locality work so that highly skilled GPs were focussed where their skills were needed. GPs have been placed at the front door at the A&Es and had diverted patients to primary care or community pharmacies. There was a significant number of patients seeing GPs who would be better served by another service and a need to ensure the availability of a well signposted range of services for people to go to. Delivery of Future Fit would need a comprehensive support programme of primary and community care and CCGs would work hard with practices to obtain that. The Committee was informed that there would be a change in the model of Primary Care and it would be necessary to adapt to this.

In response to a question about IT systems, it was reported that there was a data sharing agreement across all practices and summary care records were available in A&E. Mr Evans said the ideal solution would be for one electronic record owned by patients themselves. This would allow the voluntary sector and social care sector to also access it with the individual's permission.

A member of the Committee asked what diagnostic equipment would be available at the Urgent Care Centres. Mr Wright said it would include MRI, CT, Ultrasound, fluoroscope, scanners and x ray. Both Urgent Care Centres would have the same full range of diagnostic tools. In response to a question about transfers from a UCC Mr Wright said that any patients transferred from a UCC would be by ambulance.

Members referred to the visit to Runcorn and Widnes where there was a projected 8% drop in A&E attendances due to the effectiveness of the Urgent Care Centres. They asked about the Future Fit modelling regarding attendances at Urgent Care Centres and the Emergency Department, as different figures had been quoted at different times and this was confusing for the public who remained sceptical

Mr Wright said current profiling showed 70 – 80% of activity would take place in the urgent care centres in a model with two urgent care centres and a trauma department. Members noted that the Runcorn and Widnes Urgent Care Centres closed at 10.00 pm but the Urgent Care Centres at PRH and RSH would be open 24 hours a day, 7 days a week. Mr Evans explained that modelling had involved every case in A&E over a period of time being reviewed in terms of its appropriate setting in the future. Clinical discussions had taken place and would form part of the clinical senate review on how robust assumptions were. Members asked if this modelling could be shared with the Committee. Mr Wright said he would be happy to share this with Committee members.

Mr Evans added that there was some evidence that a significant proportion of those presenting at A&E could in fact be seen in primary care. When a GP had been on the door at PRH, 30 – 40% of patients had been diverted and there was confidence that the modelled figures were robust. The assumptions in the modelling would be challenged through the Clinical Senate process.

The Portfolio Holder for Adult Social Care, Shropshire Council, asked where the remaining 20 – 30% of activity would go, and where it went currently. Mr Wright said these would go to an acute site where an emergency admission could take place. It was anticipated that 50% of these would be treated and discharged within 8 – 12 hours, or up to 24 hours by means of an ambulatory process with acute physicians. Others might spend up to 3 days at the hot site.

In response to further questions, Mr Wright confirmed that patients might bypass both local hospitals and go elsewhere, for example, major head injuries, chest injuries, or heart attacks requiring stenting might go to centres of excellence outside of the county, such as Stoke or Birmingham.

The co-chair referred to concerns raised around the decision making process by Telford and Wrekin Council. He understood the Future Fit Programme Director would respond to these in due course and said that it seemed sensible for the Joint HOSC to be copied in to this response. He went on to say that the headline concerns were around the appraisal process including the composition of the non-financial appraisal panel, the fact that the impact assessment had not been available on the day the non-financial appraisal panel had met, the point scoring system, telephone survey and trauma unit status. He felt it was important for the Committee to flag these.

Mr Evans reminded the Committee that at this point no decision had been made, and the Board had not considered or made a recommendation. A decision would be made by both CCGs once a date was agreed, likely to be around the second week in November. He confirmed that Telford and Wrekin Council had written but had not raised specific concerns in the original letter, only general concerns. He had asked for specific concerns to be detailed and was happy to share any response made with Scrutiny Committee and also address any other areas raised by the Committee.

With regard to finance timescales and the deficit reduction plan the Committee asked when the finances for Future Fit would be confirmed bearing in mind the significant capital requirement for both options. Mr Evans said there was confidence approval would be given by NHS England and the Treasury as this formed part of the wider STP work, and consequences were built into the deficit reduction plan.

Mr Wright also referred to the joint work across organisations referred to in the deficit reduction plan, for example, the sharing of back office functions, removal of duplication, and managing resources to increase efficiency and effectiveness. Work was ongoing with Health Education England to look at developing new roles to make this happen. He also referred to best practice elsewhere, for example the use of IT in the Orkney Isles to reduce demand on expensive elements of service. Conversations in relation to the Deficit Reduction Plan would be held in a transparent fashion.

In terms of funding approvals, Mr Wright confirmed that the formal process would involve final approvals from the Treasury in April 2017 but indications that scheme would be funded would be available before that because of STP process. There was confidence that the submission would be in line with what was needed by NHSI, NHS England and the Treasury. The Committee asked if this confidence clear by the time of the consultation launch. Official approval would not have been received by then but there should be confidence.

A Member asked for confirmation that any substantial variation proposed for a patient service would be notified to the Scrutiny Committee and this was confirmed. He also asked how the Neighbourhood Work of the STP would feature in the Future Fit consultation document.

Mr Evans confirmed that the Neighbourhood work and Future Fit formed a work stream of the STP. Mel Duffy, Director of Strategy, Shropshire Community Health Trust, shared

some of the developments and explained that work was underway looking at services required in the community setting to support sustainable acute services and the shift of activity needed. Bespoke solutions in each locality were being developed. Full details would be available in March 2017 and would provide assurance that they would be of sufficient scale to take work away from the acute sector.

A Member asked for examples of how this would be delivered, bearing in mind the number of carers needed, the very rural nature of parts of Shropshire, and areas alongside a national border. The Director of Strategy said solutions would be tailored to specific communities, Shropshire Place Plans being the lowest community currency to build from. Work was still needed in South West Shropshire which provided specific challenges.

A Member asked for an example of a scheme particularly tailored for a rural area and whether best practice in other areas had been considered. She felt an upfront investment tied to the STP was needed and expressed concern about the lack of detail available on community and primary care services that will be designed through the Community Fit Programme and examples of best practice from other areas. The Committee heard about an increased level of urgent care provision at Bridgnorth, particularly for frail elderly patients so they were less likely to access acute provision. Mr Wright referred to community projects in Powys which had led to a 10% reduction in hospital admissions. There was lots of evidence that different approaches and preventative work in areas such as diabetes and managing falls worked well and would not necessarily lead to an additional demand for carers. It was agreed to share examples of schemes with the Committee.

A Member said it was important that the Committee had the detail of the services developed through the Neighbourhood Working.

A Member referred to issues around workforce capacity and asked how much engagement there had been with care providers, local authorities and the voluntary sector in relation to the STP particularly, as availability of domiciliary care staff would be essential in moving people out of hospital.

Mr Wright acknowledged that there had been to this point a poor track record of working together with other organisations. There was now an opportunity to think about the point of view of the people served rather than the perspective of individual organisations. Opportunities were opening up to use resources in a different way and there was improved working with the voluntary sector. He confirmed that Shropshire Partners in Care would be invited to attend a briefing from representatives of the Orkney Isles on delivery of services in tough geographic areas.

Mandy Thorn, co-opted Member of the Committee and provider of care services in the county, commented that local authorities were extremely good at engaging with both the private sector and the voluntary sector and commented that NHS organisations could learn a lot from them. Mr Wright said the Council Chief Executives were leading on the STP Neighbourhood work for this reason. Ms Thorn referred to the need to establish the future workforce and ensure the right care at the right time in the right place. She said there was a vast resource across Shropshire and Telford and Wrekin particularly in Care Homes which could offer outreach services. Ms Duffy reported that SPIC had been a member of the Neighbourhood Group since July and was involved in a piece of work on beds in community settings, to quantify needs and meet them more effectively.

The Chair asked if there were any plans to incorporate primary care into the Urgent Care Centres and also about minor injuries units in community hospitals. Mr Evans confirmed that although primary care practitioners would be involved in delivery in the new Urgent Care Centre model, it was not planned to deliver a primary care practice alongside the UCCs. He also confirmed that there would not be urgent care centres in the rural communities, there would be a different role for primary care in delivery, for example, he could envisage a primary care partnership delivering a minor injuries unit in a market town as part of the rural urgent care offer.

A Member asked about use of locums. Mr Wright said that one Emergency Department would offer an attractive working environment and he anticipated at least three A&E consultants would wish to work for SATH once the decision was taken to centralise an Emergency Centre on one site.

Another Member asked if a degree more openness in the process was needed to prevent leaks and misinformation causing undue concern. Mr Evans said he did not disagree and expressed disappointment that details from the non-financial appraisal panel had been leaked to the press which had led to anxiety amongst the population. There was a wish to publish the STP but a need to work within the process required by NHS England.

6 Consultation Programme for the Future Fit Programme

Bharti Patel-Smith - Director of Governance and Involvement, Shropshire CCG, gave a presentation (copy attached to the signed minutes) on the consultation process for the Future Fit Programme which was due to start in December.

Referring to the presentation, she explained the Communications and Engagement Plan was currently in Phase 2 – pre-consultation engagement and communication. Partners and key stakeholders would be involved in forming the consultation methodology and a detailed plan would be made available. Learning so far had shown that people liked face to face public workshops rather than large public meetings.

The Chair acknowledged that communicating with the public around Future Fit was a difficult job. He referred to the disappointing figure of only 14% of telephone survey respondents having heard of the Programme. Mr Evans said it was important not to rely on just one medium or on traditional communication methods, and there was a need to utilise as many different forms as possible, including Twitter, Facebook, large meetings, workshops and videos. He referred to recent learning gained from working with Young Health Champions.

A Member said the public were confused by Future Fit, for example, many did not realise that the two Urgent Care Centres would deal with 80% of cases. Other Members emphasised that the consultation document would need to present a clear picture avoiding jargon and data and using accessible language. It was also highlighted that it was important the document was accessible to and addressed the health issues for Black and Minority Ethnic communities. Mr Evans confirmed that the consultation document would cover a range of issues and comprise of a summary document and leaflets which were easy to understand.

Mrs Thorn was very concerned that Shropshire Partners in Care did not feature on the stakeholder map in the presentation. Mrs Patel-Smith apologised for the admission and confirmed that it would be added.

The Chairman said he understood that three levels of spend had been identified for the consultation and asked which level had been selected. Debbie Vogler, Future Fit Programme Director, said the Board had asked for more information before making a decision to ensure any money spent on consultation provided value.

The Co-Chair referred to the need for a clear message about Community Fit and the Neighborhood Care models to be presented in the consultation document.

It was agreed that further plans regarding the consultation be shared made available to the whole Committee, and not just the two Joint Chairs. This could be considered by the Committee at its 2 December 2016 meeting.

Mr Evans explained that a Joint Committee of the two CCGs would have delegated authority from both CCGs to make the decision to identify and agreed a preferred option. The Consultation Programme would be agreed by the Future Fit Programme Board. Decision making for the stage following public consultation had not yet been decided. It was likely that there would be another Joint CCG Board meeting.

The Co-Chair emphasised that it was important for the consultation document to be clear about how decisions would be made at the end of the process.
He also asked that clear reassurance be sought from West Midlands Ambulance Service that they could manage whichever configuration was agreed upon, especially in the light of concerns from Shropshire about ambulance response times.

He also requested that the Committee be permitted to see as much information as it could be allowed to see, and as soon as possible, including:

The STP; Clinical Senate report; Impact Assessment; the concerns expressed around the non-financial appraisal concerns and the response to those; regular updates, at least for the Co-Chairs on the tipping point to allow them to see how critical the situation is; detail on community fit and neighborhood working and any substantial variation or changes in service required to meet the deficit reduction plan.

The Committee thanked Mel Duffy, Debbie Vogler, Simon Wright and David Evans for attending the meeting.

It was agreed to take Chairs' Update as the next agenda item.

7 **Chairs' Update**

The Chair informed the Committee of a letter received from the Local Pharmaceutical Committee regarding funding for community pharmacy services. He reported that the Shropshire Health and Adult Care Scrutiny Committee had considered this matter earlier in the year. A letter had been sent to local MPs and a response received from the Minister of State for Community and Social Care was shared with the Committee.

The Committee agreed that a letter should be sent raising concerns about the proposed level of funding for community pharmacy services requesting information on the

implications for the area of Shropshire and Telford & Wrekin and also what consultation would be undertaken with the Committee if the reduction in funding resulted in a substantial variation in service.

The Chair also informed the Committee of a letter from NHS England Specialist Commissioning regarding services for patients with cystic fibrosis. The letter was circulated to committee members. It was agreed that the proposals did not raise any significant concerns but that clarification would be sought regarding the number of patients from Shropshire and Telford & Wrekin who would be affected.

9 **Joint HOSC Work Programme**

In addition to the work on the Future Fit Programme and the STP a member requested that a report on adult mental health services be brought back to the Committee. Members agreed it was important not to lose sight of this issue.

It was also agreed that the Committee wanted to understand the implications of the reduction in funding for community pharmacy services.

Signed …… (Chairman)

Date: ……