SHOPSHIRE COUNCIL

HEALTH AND ADULT SOCIAL CARE SCRUTINY COMMITTEE

Minutes of the meeting held on 20 February 2017
10.00 am - 12.26 pm in the Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND

Responsible Officer: Amanda Holyoak
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Present
Councillor Gerald Dakin (Chairman)
Councillors Madge Shineton (Vice Chairman), Peter Adams, Tracey Huffer, Pamela Moseley, Peggy Mullock and Peter Nutting

54 Apologies for Absence and Substitutions

Apologies were received from Councillor J Cadwallader.

55 Declarations of Interest

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

56 Minutes of the Last Meeting

It was agreed that the minutes of the meeting held on 30 January 2017 be confirmed at the next meeting of the Committee.

57 Public Question Time

Two public questions had been submitted by Mr J Bickerton as follows:

'Why haven't West Midlands Ambulance Service met the commitment they made at the introduction of Make Ready on 30 June 2011 when they said we would get a better service in Shropshire'

'It said in the Oswestry Advertiser that WMAS had been classed as outstanding. How does that apply to Shropshire and how are you going to get up to that standard'

In response the West Mercia General Manager explained how the Make Ready system improvements meant that there would be an ambulance ready for the crew to come back to after a job to get straight back into.

In response to the second question, it was confirmed that the CQC visit had been very thorough and had covered the whole region, including Shropshire. WMAS was the only ambulance service in the country to have been rated as outstanding.

In response, Mr Bickerton referred to poor response times in rural areas. WMAS officers said that for most patients, clinical outcome would be a more important measure than speed.

58 **Member Questions**

A Member question had been received from Councillor K Pardy –

'Can the chair tell me how many paramedics have resigned from the service in the eight months up until and including the 31st January 2017'

In response, WMAS officers reported that leavers in that time period had numbered 15. One had transferred to another ambulance service, 12 had gone to Shropdoc, one had left for personal reasons and one had retired.

Councillor Pardy expressed concern about the service losing paramedics to Shropdoc and asked if better working conditions had attracted them to that organisation and if so, what was WMAS doing to retain staff.

The Director of Clinical Commissioning and Strategic Development said there were pressures on staff retention throughout the NHS and all ambulance services. Having said that, he reported that ambulance staff did traditionally stay in service for a long time and many received long service awards. People were now having to work harder than ever and were out on calls for the entirety of their shift. WMAS had established a new career framework for paramedics and within two years this made them some of the best paid NHS staff compared to other health professions, including junior doctors. He referred to the frustration felt by staff when they were delayed for long periods of time at the hospital.

59 **West Midlands Ambulance Service**

The Chairman welcomed Michelle Brotherton - General Manager West Mercia, Mark Docherty – Director of Clinical Commissioning and Strategic Development and Pippa Wall, Head of Strategic Planning, West Midlands Ambulance Service (WMAS) to the meeting. He congratulated the service on achieving 'excellent' in the recent CQC inspection.

The Chairman said there some concern that this was not reflected in the more rural areas of the WMAS area. The Director reported that WMAS was the only acute organisation in the West Midlands to achieve the rating of excellent and was the only ambulance service to achieve all mandated targets in 2015 – 2016.

The aspiration was to have a paramedic in every front line vehicle for 95% of the time and the figure for Shropshire was 95.2%. He went on to present the information pack which had been supplied for the Committee and this provided: an overview of the service, CQC rating, Vision Strategic Objective and Strategic Values, detail of the two year operational plan; draft Quality Account priorities; activity, demand and performance information.

In response to a series of questions from Members, WMAS officers explained:

- At the peak time of day there would be 24 double crewed ambulances in Shropshire.

- There were no current paramedic vacancies and if one was to occur it would be filled immediately.
- The front line resource was being increased and there were 300 people in paramedic training
- Staff were not moved between areas for the purpose of hitting targets.
- The amount of ambulance resources coming into the county was always greater than that going out.
- 80% of the area covered by WMAS was classified as rural and issues around sparsity were recognised, the challenges in Shropshire being greater than other rural areas.
- The Air Ambulance helicopter was the asset of the Air Ambulance Charity and raised money for the platform, running costs and pilot, but WMAS supplied the clinical resource.
- The demand on the service was increasing, but major trauma cases were declining. It appeared that people were using the service in a different way and the conveyance rate was declining. If the service was used as it should be, the conveyance rate would be 100%

In response to a question about Mangar Elk lifting equipment, it was confirmed that there was one on every front line ambulance and that two people were required to use it. A Member suggested that this might be something that nursing homes could buy and then train their staff to use which might help avoid ambulance call outs.

A Member said it sounded as if WMAS was doing as well as it could internally and questioned why public perception was not more positive. The Director emphasised that the Service was under great pressure and additional winter pressures had been high this year despite the mild weather and absence of a big flu or norovirus outbreak. There were simply not enough resources and finances were stretched to the limits.

The Chairman asked if there was anything the Scrutiny Committee was in a position to help with WMAS officers said that the education of the public on appropriate use of the service was essential and any help in spreading that message would be appreciated. Access to primary care was a factor, also younger people demanded a more immediate response than had ever been expected before.

Vanessa Barrett, Healthwatch representative, commented that one of the services priorities of last year had been ‘to engage with rural communities’. Healthwatch was very keen to be involved with this work but not as much progress had been made as it would have liked. She added that Healthwatches across the region were well placed to help in developing dialogues in local communities around response times. The Director agreed that variation in response times was an important issue as was variation in conveyance rates.

A member asked if it was thought that changes to Minor Injury Unit availability and services might increase demand on WMAS, particularly as people often did not have transport to take them to Shrewsbury or Telford. The Director said that there was more of a link between access to GP services for frail elderly people particularly at weekends and Bank Holidays.

Members heard that activity was increasing at a rate of 4.7% a year but that WMAS was ready for this. The Director of Performance and Delivery, Shropshire CCG, confirmed that for 2015/16 the activity increase had been predicted at 4.5% and this had been fully funded. She expressed concern about the neighbouring CCGs who did not fully fund growth and the need for issues with regional commissioning to be addressed. The Director of Clinical Commissioning, WMAS reported that Shropshire CCG did a good job in commissioning and estimating growth in activity.

WMAS officers went on to explain the Ambulance Response Programme, a national response programme linking response times to clinical outcomes. The view was that the right response to the patient first time was the most important factor, even if this meant not attaining an 8 minute target. WMAS had been asked not to share the data in public until after the end of the pilot. The Committee looked forward to receiving more information once the trial was complete.

Members asked about handover challenge at the acute hospitals, and the reasons for the different performance at Royal Shrewsbury Hospital and Princess Royal Hospital. The Shropshire CCG Director of Performance and Delivery explained that there were different pressures on each hospital site and a shortage of beds at RSH.

WMAS officers added that handover delays presented a considerable challenge in Shropshire and far too much ambulance resource was being lost in these delays which were the result of complex circumstances. It was possible to cope with a long delay every now and again but these delays had been going on too often and for too long and the percentage of delays over 1 hour was significantly greater in Shropshire than other in areas.

Members heard that a root cause analysis was carried out on every single ambulance delay. Although Shrewsbury and Telford Hospital Trust had declared zero tolerance on over one hour ambulance delays there had been little progress. This was a priority area for all concerned. Corridor nurses did operate at the hospital when staffing levels permitted and there were also HALOs but this had still not been enough to cope with the unprecedented pressure. .

Members felt that in the face of the handover delays and inappropriate call out of ambulances, WMAS was doing well within the constraints it faced.

Physician Referral Unit

The Committee asked for an explanation as to why WMAS had withdrawn from the Physician Referral Unit which appeared to have been a scheme that was working well. The Director of Clinical Commissioning explained that although the scheme had been successful there had been concerns around doctors going beyond the scope agreed and attending trauma cases. WMAS had a well established and successful trauma model which was very tightly governed. It had offered to run a similar model to that in Worcestershire in which doctors would respond to calls in their own cars, blue lights would not be used and the response model would predominantly be a secondary response.

The Director of Performance and Delivery, Shropshire CCG, said the scheme had worked very well with some 300 – 400 hospital admissions prevented. She added that advice was

being sought in relation to the PRU appointments made and a decision would be made by the CCG on the scheme's future in mid-March.

Fire and Rescue Service

Ambulance service officers reported that the Chief Executive of WMAS had hosted a meeting before Christmas of Chief Fire Officers from the region and proposals had been discussed with regard to retained fire and rescue locations becoming part of the Community First Responder Service. Another meeting was planned for mid-March.

The Director of Public Health reported that Shropshire Fire and Rescue Service had indicated that it would be willing to pilot a scheme at no cost to others. Concerns had been expressed at the slow progress in taking proposals forward. WMAS officers commented that the scheme would not provide any financial benefit to the ambulance service and queried what would happen if Fire Officers were acting as CFRs at the time of a fire. One way of working together could be for the Ambulance Service to handle Fire and Rescue calls. The Committee said that they would want a progress update on developments in the near future.

WMAS officers went on to explain substantial developments with the Electronic Patient Record which were transformational and very much welcomed by the Committee. The CCG Director of Performance and Delivery identified some potential useful links to the High Intensity User Project.

The Committee thanked WMAS for all of its good work and the Chairman also expressed appreciation to WMAS officers for attending the meeting and answering questions.

It was agreed that the following areas be considered by the Committee in future:

- Physician Response Unit update
- Update on working with the Fire and Rescue Service
- Ambulance Response Programme - results be made available once evaluation is complete
- Handover times at hospitals (CCG, WMAS and SATH to be in attendance)
- Consideration of whether the Council had a role to play in encouraging the public to make correct use of WMAS

60 Shropshire CCG - Prioritisation and Value for Money Methodology

Julie Davies, Director of Performance and Delivery and James Aker, Associate Director of Commissioning, Shropshire CCG, circulated an update to the Committee on CCG Prioritisation and Value for Money methodology (a copy is attached to the signed minutes). In taking the Committee through the report, the significant financial constraints facing the CCG were outlined and particular attention was drawn to the CCG's aim to increase public, patient and stakeholder engagement.

The Structured approach taken to prioritisation was set out in the paper before members. It explained how the evidence base would be established and used as a basis for decision making. This information would be made available on the website to increase

transparency around decision making and give stakeholders and the public an additional opportunity to comment on accuracy or additional information needed.

Members asked how engagement would take place and heard that as broad an evidence base as possible would be sought. The CCG would link in with Healthwatch and Patient Groups and service providers to collect information. All the information normally required for a service review would be collected. A member suggested using Shropshire Association of Local Councils and the voluntary sector to pull strands together and contact hard to reach groups.

Members were referred to the scoring process using the Portsmouth Scorecard to help robust decision making and the fifteen categories of information to be collected. The approach would be used and modified as necessary once feedback was received.

The Director of Adult Social Care commented that it was heartening to hear about the involvement of stakeholders in the prioritisation process and asked if there was an opportunity to formally name co-commissioners in the methodology, for example in appendix 4. .

A member asked if the CCG had the financial resilience to deliver its priorities. CCG officers said that it did and referred to NHS England and Deloitte help in forming those initial priorities.
Another member asked if the methodology had been discussed or agreed with stakeholders. CCG officers referred to a difficult period of time when initial proposals were made in 2016. The new approach was an outcome of feedback received at that time, not least from the local authority. CCG officers confirmed that it was intended to work proactively with the Council's Director or Adult Services.

The Director Adult Services said it was fair to say that the Council and CCG were now working together more closely, but that it was right for Members to challenge this relationship and input of stakeholders into the methodology.

The Associate Director of Commissioning said he would be happy to respond to any questions or comments outside of the meeting.

The Chairman expressed the Committee's appreciation to the Director of Performance and Delivery and Associate Director of Commissioning for attending the meeting and responding to questions.

61 **Work Programme**

A member suggested looking at the location of Midwifery Led Units in the county.

Signed ..... (Chairman)

Date: .....