SHROPSHIRE COUNCIL,TELFORD & WREKIN COUNCIL

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Minutes of the meeting of the Joint Health Overview and Scrutiny Committee held on Tuesday 6 March 2018, 9.30am in The Quaker Room, Meeting Point House, Telford Town Centre TF3 4HS

Members Present:
Telford and Wrekin Councillors: Andy Burford (Co-Chair), Hilda Rhodes
Shropshire Councillors: Heather Kidd, Madge Shineton
Telford and Wrekin Co-optees: Carolyn Henniker, Hilary Knight and Dag Saunders,
Shropshire Co-optees: Ian Hulme, Mandy Thorn

Also Present:
Tom Dodds, Statutory Scrutiny Officer, Shropshire Council
David Evans, Chief Officer Telford & Wrekin CCG; Senior Responsible Officer, Future Fit
Simon Freeman, Chief Officer Shropshire CCG
Amanda Holyoak, Committee Officer, Shropshire Council
Jessica Tangye, Senior Democratic and Scrutiny Services Officer, Telford & Wrekin Council (minutes)
Simon Wright, Chief Executive, Shrewsbury and Telford Hospital Trust

1. Apologies for Absence

Apologies were received from Telford Councillor Stephen Burrell and Shropshire Councillor and Joint HOSC Co-Chair Karen Calder. Shropshire Co-optees David Beechey.

2. Disclosable Pecuniary Interests

It was noted that Shropshire Co-optee Mandy Thorn was a provider of residential and domiciliary care services in Shropshire and Telford & Wrekin.

3. Minutes

The minutes of the meeting of the Joint Health Overview and Scrutiny Committee held on 5 December 2017 were agreed as an accurate record.

4.

The Co-chair, Cllr Andy Burford introduced the meeting and stated that this was a meeting held in public and not a public meeting therefore there would be no opportunity for the public to ask questions at this meeting. The Co-chair noted that in future meetings, the aim would be to involve the public, as many scrutiny committees did so but this had not yet been confirmed.

5. Sustainability and Safety of Clinical Services provided by Shrewsbury and Telford Hospitals NHS Trust

The Co-chair welcomed the Chief Executive of SaTH and asked him to outline the current situation at the hospitals, not just A&E but other services too. He asked for an update on the implementation of the contingency plan, what this would mean for services. An update was also requested on the Winter Resilience plan, how it had worked and in conjunction with the plans and activity of other services over the winter period, such as West Midlands Ambulance Service (WMAS) and Primary Care.

The Chief Executive reported that for Accident and Emergency (A&E), the Trust was in dialogue with one individual who they were hoping would transfer across to SaTH to join the substantive consultant group to replace the outgoing consultant. It was hoped that this would conclude in April 2018.

There was an ongoing need for the Trust to provide the A&E service for both communities of Shropshire and Telford & Wrekin. A series of adjustments had been made to support services including the appointment of three paramedics and three nurses to manage minor flows and with the aim of releasing junior doctors to work in trauma area/ majors and resus in both A&Es. The Trust was further investing in 30 junior doctors at both sites to support the clinical decision making across the wards as decision making was currently slow.
The Trust was in dialogue with the University Hospital North Midlands regarding a joint appointment to attract consultants to 'be part of something new and exciting'.
Advertisement included blogs and different products to try to attract consultant interest in the new clinical decision unit and on the basis of £1.6m for the new urgent care centre opening in June 2018. By increasing the number of substantive consultants to five, it meant that the service could continue. The Trust was looking for help from NHS Improvement to secure a further two posts for winter 2018-19 as five consultants on the rota would still mean there was some frailty in the service as locum consultants could resign with one week's notice.

Members asked about service level at A&E and the reason for a drop in service in January 2018:-
It was noted that in January there was 107% bed occupancy, 105 inpatients more than beds available presented at A&E. Measures had already been taken by the Trust in advance of winter; opening bed bases, working with partners on spot purchases and with the local authorities working on discharge. The hospitals had simply been overwhelmed.
Members asked whether there was a level of unnecessary attendance. It was highlighted that the rate of admission as a system as well as a hospital was low in Shropshire, Telford & Wrekin. Patients were not admitted unless there was good reason, there was no indication that the hospitals were admitting inappropriately. The flu had meant bed bases had doubled compared with last year; from 15-20 beds to 40 beds. There had also been a shift in the time that patients, specifically elderly patients were presenting at A&E. Evening arrival of elderly patients had increased significantly during the hours 7.00-10.00pm when less medical cover was available.

Members asked how well the primary care streaming approach was working:-

It was reported that the impact was modest; 20-25 patients on average were going through streaming. The Trust was planning to open up the model to more patients; the new Urgent Care Unit in Telford would be working towards this improved model, which would help with minor streaming of patients. Otherwise, the CCG Officers agreed that GP streaming was unlikely to have a major effect on admissions as the rate of admissions was not a problem in the county. The CCGs were more concerned with inadequate services in the community to care for severely ill people which meant that when people were admitted they were generally much more ill and stayed for longer.

A concern was raised about reliability of older equipment which was in the process of slowly being replaced. It was emphasised that where equipment had broken down, the patient should routinely be transferred to the site with working equipment.

David Evans highlighted that the CCGs were looking to provide better access to GP services; with 100 % pre-bookable on the day appointments by 2019. Members questioned whether this was realistic, when the general impression of primary care was that it was increasingly under strain. David Evans stated that it was aspirational but achievable. GP services were under pressure, some were under more pressure than others but signposting still needed to be clearer for people to make the choice to utilise services other than GPs, such as community pharmacy. In Telford, 10-20% of people routinely did not need to see a GP but education of the public to use right service at the right time was needed. It was suggested that Neighbourhood working, across sectors, would make a difference. Simon Freeman stated that a one size fits all approach was not viable in the community, particularly in rural Shropshire, for example GP opening hours of 8am -8pm worked in some places but the demand was not the same across the county.

Members raised the issue of community nursing and reduced hours:-
A much better community support service that was health based and not social work based was needed, especially for older people presenting late in the day. The feeling was that community based services were needed more than ever, particularly as places in the care sector were not available/ diminishing and robust work was being undertaken to improve hospital discharge. It was agreed that there needed to be a better understanding around what support in the community looked like; often people needed to access services seven days before they presented at hospital.

There was a challenge around discharge, Simon Wright emphasised the intentional kindness of the physicians at the hospital in not releasing frail elderly people without being assured that there was support available in the community. Increasingly junior doctors would support earlier discharges. However, notwithstanding this the Trust's hospital discharge was in the best quarter of NHS but improvement was still needed, which would introduce a further cost pressure of £1.8m. Discharge could take longer due to the lack of support for consultant registrars, who often had to step down to do the registrars job. It was acknowledged that even a slight delay could lead to deterioration in a patient and that timely and quick action was needed to prevent deterioration. When so many patients were presenting, the medical and nursing teams just extended the hours that they worked – 14 hours a days for 2 months. The Committee agreed with the Trust that it was necessary to provide more resource to support medical and nursing teams. If the range of services could be extended in the community, it would help.

Members asked why discharge could be held up by the hospital and yet social care was making progress in reducing delayed discharge documented. The response was that it could sometimes be lack of pharmacist/ doctors getting round to discharge – there were figures on all of these. A new approach was being piloted which involved a 4pm huddle with all appropriate staff before discharge however with the majority of patients presenting in evening a greater part of the problem was that lack of bed space. It was agreed that the Committee would receive figures on delayed discharge and an update on how well the new approach pilot was working.

Members were concerned about rural pharmacies in terms of access/ reduced hours. Pharmacists were often the first point of contact in a rural location but they were few and far between – there was only one pharmacy for whole south west Shropshire in Bishops Castle. Something was being done about increasing the numbers of pharmacists and increasing opening hours.

In terms of contingencies, the Trust was continuing to explore alternatives as there was no desire or intention to reduce or close part of the A&Es before a planned strategic solution for emergency pressures was found. For patients remaining over 6 days in hospital, twice daily reports were being produced on every patient detailing what needed to be done to get them home. An integrated discharge approach with all providers was being developed, some related to hospital, some process related and some staffing. The constraints on discharge were being looked into, and being evidenced.

It was acknowledged that adult social care was working as effectively as it could in Telford & Wrekin and Shropshire Councils; improvement and performance in terms of DTOC had been immeasurable.

Members questioned the numbers of patients being transferred from care homes to A&E and whether more could be done to prevent admissions:-
Telford CCG had employed an additional pharmacist within medicines management team to work with care homes to ensure interactions were identified and to make sure drugs were available. It was taking time to roll out across all care homes. Broadly, there were good relationship between care home sector, the Local Authority and other agencies to ensure residents received the right care and were not admitted inappropriately.

Members suggested that hospital discharges were more effective if good nursing services were accessible in the community and asked whether there had been a reduction in commissioning of community nursing by CCGs. It was reported that there were rapid response teams as opposed to traditional community nursing but how they operated was different. The Commissioners noted that the Community Trust could have reduced numbers but this was not as a result of commissioning decisions. The CCGs wanted to see an increase in funding but within this financial envelope it was difficult.

One of the challenges as a system that the Commissioners were trying to work through was not just staffing numbers but also the workload and skill levels. The CCGs were working with the Community Trust to do this. It was only recently that the Community Trust had started to use an electronic system – to date it had been a paper based system that made it hard to collate information on service delivery. Currently, measuring and costing a community nurse visit was impossible whereas in the hospitals a framework in place. The

CCGs had generally worked on block contracts and in Shropshire contract notices had been issued to gather this evidence.

The Committee expressed concerns about the lack of joined up working with the Community Trust, particularly in the context of the national move towards integrated care services and systems but the CCGs were confident that there was a joint solution. The model of care for the future was a smaller acute sector and far more care being delivered at home, which was why the CCGs were looking at localities and neighbourhoods, increasing support in rural areas and joining up the work.

The Co-Chair summarised that the position was slightly more optimistic than the media reported, in terms of the hospitals' contingency plans, particularly with the drive to appointed two additional consultants before next Winter 2018/19. The prime focus in the hospitals was on mitigating actions to reduce demand on acute services. The Joint HOSC had reinforced many time that the community and primary sector needed investment and resource to bolster provision and confidence. Simon Freeman confirmed that there hadn't been dis- investment but the fact that there was no way of quantifying current community provision or demand was worrying. The Committee felt that resources were paltry compared to need and in some areas there was no way of estimating what the need would be. The Chair noted that the NHS was not expected to do the impossible but the Committee did expect transparency about the blockages in the system in order to ask relevant questions and provide challenge. Detail around hospital discharge was requested from the Trust, in order for the Committee to track progress.

In relation to A&E staffing, Simon Wright clarified that the additional resource secured was in the form of an existing doctor converting into a consultant post. This would ensure extra resilience, not extra capacity. Even with all the steps that the Trust had taken, the emergency service was still fragile. He wanted to be clear that there was a series of steps being taken to build resilience and continue to allow the hospitals to maintain services – there were regular visits and quality checks, reports by CQC – which was reassuring even though there were delays in departments. In terms of the winter resilience, Simon Wright stated that winter 2017/18 had been a watershed and very different to previous winter periods. He stated that SaTH could not go into the next winter period in the same staffing position and that it had proved difficult to recruit. Conversations were ongoing with NHS Improvement at the moment about what they could do to transfer individuals into the Trust whilst the issues were being worked through.

David Evans suggested that a presentation on neighbourhood and localities work may be valuable for the committee. The Co-chair agreed, but that it would also need to describe the limitations of the work as well as the good initiatives. It would need to evidence the impact of the projects in neighbourhoods and localities, highlight where the difficulties were and the resources needed. David Evans explained that next year the CCG wanted to save £8,000 on emergency admissions – which equated to a reduction of three admissions per week in each of the Neighbourhoods in Telford. This target had been set for 2018-19 and it was for GP's to sign up to this and find appropriate schemes for reducing emergency admissions.

The Committee asked about the impact of the nation-wide cancellation of procedures for the Trust and what needed to happen to get back up to speed. Simon Wright explained that 350 operations had been cancelled and that he had asked for more support from the Department of Health. The Trust expected to catch up and recover in three months subject

to the final months of the winter period. A planned reduction in surgery had been instigated earlier in the year in order to accommodate the winter period, so some reduction had been anticipated.
The Co –chair requested further detail on overnight closure at PRH, such as which services would have to go out of county for the overnight period. Simon Wright clarified that initially, the Trust would look to secure locum services although this was an unsatisfactory way of providing a core service. Questions about unplanned closure could not be answered because it would depend on the patients' needs at the time. Although this was not a satisfactory answer for the Committee, it was a recognised model enacted by the NHS when there were unexpected issues. The consultant post continued to be a challenge but the Trust was improving their recruitment offer as described earlier. Work was also being done with NHSI and NHSE but the best solution was the strategic solution - Future Fit.

Simon Wright stated that the position of the Trust was well understand by Department of Health in terms of risk in workforce and the teams upholding the service. It was clear that maintaining safety of patients over this winter period had been the most difficult in 25 years. It was acknowledged that the strategic solution in Future Fit was key, but delays continued in terms of the availability of funding. Events like the collapse of Carillion had not helped and had stalled the process.

The Committee asked about telehealth within the hospitals and Simon Wright confirmed that it was in place with the hospital in Stoke but it needed improvement, there were links with Birmingham neuro-science and allowing information exchange between sites. This sort of investment was needed, which provided decision makers with information but in certain circumstances there were no alternative to a senior doctor. Technology did not address the risks in A&E, for example, a deteriorating child in the middle of the night required a consultant to be available within 30 minutes to conduct a visual and physical assessment. It was suggested that this was an area where the Joint HOSC could provide some value in looking at the potential service improvement. It was noted that the NHS IT development fund was underspent, even though SaTH had tried to access this pot of money, it was going to organisations that were in an accelerated state. It was noted that Shropshire Partners in Care was involved in the digital transformation of social care.

The Chair introduced the item on other system Issues – West Midlands Ambulance Service; the Trust had seen increased demand over the winter period and this was the picture across West Midlands. Locally, ambulances had been turning up in very short bursts, causing difficulties for the Trust particular between 7.00- 10.00pm. A significant proportion of hospital services did not operate after hours which meant it was more likely that people would be admitted to A&E. This was being taken up by the A&E Delivery Board.

The Committee raised a concern about the impact of the switch- over to NHS 111; it was noted that an extra 8% of the population was expected to present at A&E. Simon Wright confirmed that it was necessary to understand where the surges in demand were coming from, currently it looked like calls were being grouped together which would inevitably mean ambulances arrived at A&E all within a short time frame. The hospitals could cope with normal demand, GPs making the call for an ambulance in a planned way, so that the ambulance had a slot at the hospital but current surges were overwhelming the A&Es. Simon Wright had asked for evidence to establish what was really happening. Activity growth in Telford had been analysed and it was noted that many patients were arriving at

A&E by other means, not just by ambulance, individuals were electing to go to A&E rather than use other services. The Committee agreed to return to this as a future agenda item.

The Committee asked about the Better Care Fund and whether it was achieving as expected. In Telford the extra funding through BCF had been positive in relation to enabling social care to continue to function at a level that it may not have been able to. In Shropshire, a positive impact had also been seen by the local Scrutiny Committee, further integration of services and closer links with Primary Care were planned.

There was a brief update on some of the clinical services that had been reported at previous scrutiny meetings where there had been fragility and suspension in services.

> In Ophthalmology, the service had been completely transformed; eight of the nine posts had been appointed to including to paediatric. The back log issues had been addressed. A final piece of capital was due to be approved to include a new theatre that would allow operations to increase from 30 per week to 100 week reducing use of private sector completely.
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> The Walton Centre partnership, three additional neurologists had been secured which was closer to national requirement. Specialist nursing services had been increased and the Trust was now in a position to deliver an outstanding neurology service with local access – consultants were coming into the county to deliver services for patients.
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> In dermatology the Trust was looking to conclude the contract with local Shropshire skin clinic. Other NHS organisation were supporting the service, resources were in place including five dermatologists and it was mostly nurse-led.
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> Spinal services – sign off for the partnership with Robert Jones Agnes Hunt was being finalised for the new financial year.

Chairs Update

The Committee agreed to look back at how the winter plan had operated in 2017/18 once analysis had been completed and the winter period had come to an end. Performance blockages in the hospitals would be looked into and detail would be provided by the Trust on delayed discharge. Telehealth would be considered by the Committee and a decision would be made on how this could be reviewed. Future agenda items would include the Ambulance services/ NHS 111; Neighbourhood presentation; community nursing (possibly an in-depth look into this as it was a wide area and could include a range of nursing).

The meeting ended at 11.21am

Chair: …… Date: ……..