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
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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: .....