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 12 February 2015 in The Council Chamber, Shirehall, Shrewsbury from 2.10 pm – 4.20 pm

PRESENT – Councillor D White (TWC Health Scrutiny Chair) (Chairman), Councillor G Dakin (SC Health Scrutiny Chair), Mr D Beechey (SC co-optee), Ms D Davis (TWC Health Co-optee), Mrs V Fletcher, Mr I Hulme (SC Co-optee), Cllr S Jones (SC), Mr J Minor (TW), Mr B Parnaby (TW Co-optee) Mrs M Thorn (SC Co-optee).

Also Present –

F Bottrill (Scrutiny Group Specialist, TWC)
S Chandler (Director Adult Social Care, SC)
L Chapman (Portfolio Holder, Adult Social Care, Shropshire Council)
K Calder (Portfolio Holder Health, Shropshire Council)
J Ditheridge (Chief Executive, Community Health Trust)
A England (Cabinet Member for Adult Social Care, Telford & Wrekin Council)
D Evans, (Accountable Officer, Telford & Wrekin CCG)
A Holyoak (Committee Officer, Shropshire Council)
M Innes (Chair, Telford & Wrekin CCG)
C Morton (Accountable Officer, Shropshire CCG)
A Osborne (Communications Director, SATH)
M Sharon (Future Fit Programme Director)
P Taylor (Director of Health, Wellbeing and Care, Telford & Wrekin Council)
R Thomson, (Director of Public Health, Shropshire Council)
I Winstanley (Chief Executive ShropDoc/GP Federation)

The Chairman informed those present of the recent death of two co-opted Members of the Committee, Mr Richard Shaw, from the Senior Citizen's Forum, Telford and Wrekin and Mr Martin Withnall, from Telford and Wrekin Healthwatch. It was agreed that a letter be sent from the Committee expressing condolences to their families and expressing gratitude for their valued contribution to its work.

JHOSC-10 APOLOGIES FOR ABSENCE

Apologies were received from Cllr Tracey Huffer (SC)

Mr Barry Parnaby, Telford & Wrekin Healthwatch, was welcomed to the meeting as a co-optee of Telford and Wrekin Council.

JHOSC-11 DISCLOSABLE PECUNIARY INTERESTS

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.

JHOSC-12 MINUTES

RESOLVED – that the minutes of meeting of the Joint Health Overview and Scrutiny Committee held on 29 September 2014 be confirmed as a correct record and signed by the Chairman, subject to the addition of Mr I Hulme and Mrs V Fletcher being added to the list of attendees

JHOSC-13 FUTURE FIT

The Chairman reminded those present of the role of the Joint Health Overview and Scrutiny Committee relating to proposals for substantial developments in service. He also referred to the important role of Overview and Scrutiny Committees in looking at safety and quality issues affecting their community.

The Future Fit Programme Director gave a brief presentation on the Programme which covered: what the Programme wished to achieve; progress to date; details of the recommended shortlist; details of the women's and children's variants; proposals for developing urgent care centres, and next steps, including the proposals for two strands relating to community offer. A copy of the presentation is attached to the signed minutes.

The Committee then went on to ask questions of NHS and Local Authority Representatives regarding the Future Fit Programme.

1 How are organisations working together to address the challenged services at the Acute Trust, for example, Accident and Emergency, and ensure they are safe until changes are made.

The Accountable Officer, Shropshire CCG, explained that the CCG and provider organisations worked together to ensure services were safe, through a Strategic Resilience Group, chaired by herself. Representatives from Shrewsbury and Telford Hospital Trust (SATH), West Midlands Ambulance Service (WMAS) and Shropdoc sat on this Group.

2 How will you work together to resolve the wider capacity issues and reduce the number of patients fit for discharge at SATH? How will you work together to identify the extent of this problem and the underlying issues?

Those present acknowledged the well known recent difficulties related to patients who were medically fit for discharge. All were working towards the

target set which had been set by the NHS Trust Development Authority (TDA) and NHS England.

3 *If there is a problem to address and Integrated Community Service (ICS) is not the answer, does the Acute Trust have any other suggestions? What are the other pressure points in freeing up beds?*

It was felt that the Integrated Community Service was a significant part of the answer but it was acknowledged that this was not the only solution. The level of discharges from the Acute Trust were higher during week days and lower at weekends and work was underway to investigate how to obtain a more even distribution across the week. Weekend activity often resulted in a difficult Monday which could lead to 12 hour trolley breaches.

The Communications Director, Shrewsbury and Telford Hospital NHS Trust (SATH), reported on a 'discharge to assess' pilot currently underway and the need for expansion in availability of domicillary care. A package of support to the voluntary sector had been made available through the British Red Cross and SATH was looking to support this to facilitate more of a 7 day process. A lot of good work was underway but there was more to do.

4 How will SaTH's financial position affect the viability of the Future Fit Programme.

The Communications Director, SaTH, referred to the drivers of quality, outcome and safety which needed to be addressed through Future Fit but needed to be affordable. Ending duplication at two sites of costs, services, equipment and infrastructure would allow improvement of viability. The financial assessment of all options would be critical. A new offer with care closer to home would be more affordable and better for patients.

The Co-Chairman referred to staff shortages, difficulties in recruiting and reliance on agency nurses and the Communications Director confirmed that one of the big drivers for Future Fit was challenges around recruitment. These were challenges that were faced nationally and there was a need to attract the brightest and best otherwise agency costs would continue to increase.

5 How many Urgent Care Centres/Local planned care facilities / Community Units / Health Hubs and diagnostic and Treatment Centres will there be as part of the Future Fit programme and where will they be located?

The Future Fit Programme Director explained that the development of a rural urgent care centre offer was underway. At this stage it was not possible to say how many rural urgent care centres there would be. It was confirmed that there would be a minimum level of care and opening times offered from urgent care centres which would help address the current challenge of people not knowing where to go.

6 How affordable is the Future Fit Programme? How is the programme taking into account utilising existing buildings, facilities and equipment and including the costs of the maintenance backlog at RSH? (We understand that only co-location with paediatrics is a must)

The Future Fit Programme Director explained that the assumptions in the feasibility study aligned with College of Emergency Medicine Guidance regarding the 'seven key specialities': Critical Care, Acute Medicine, Imaging, Laboratories, paediatrics, orthopaedics and general surgery.

Existing buildings would be utilised to the greatest extent possible. If an Emergency Centre and Diagnostic and Treatment Centre were to be located on a Greenfield site, the existing estate would be used less. An Urgent Care Centre offer was likely to start with utilising existing community facilities. The Programme would be clearer about affordability in around May or June.

7 What is the outcome of the Care Quality Commission (CQC) inspection? Does this affect the Future Fit Programme?

The Communications Director, SATH, reported that the overall CQC inspection rating had been 'requires improvement'. The report had recognised staff care as good and it was felt by the Trust to be a fair and balanced report which had not contained anything unexpected. A big theme of the report had been challenges around speciality care. An action plan was being drawn up by the Trust Board.

8 What is the clinical view on the co-location of A&E with Women's and Children's Services?

The Committee was referred to the 'Acute Services' template completed by SATH clinicians for the Evaluation Panel (copy attached to signed minutes) which summarised the clinical quality and safety advantages and disadvantages of co-locating consultant led obstetrics and neonatal care with emergency care.

9 How will you work together to reach a realistic consensus on the number of beds needed in the acute sector? How does this affect the affordability of the Future Fit Programme and what are the long term consequences for the sustainability of services.

The Accountable Officer, Shropshire CCG, said the Project Management Office had been set up to focus on delivery. Part of the work was to consider bed capacity in the acute and community sectors and Future Fit modelling. However expensive an acute bed was, it was very expensive to do things twice and it was essential to ensure that a patient would reach the right bed at the right time.

A Member referred to a public consultation event she had attended in relation to Future Fit where it had been stated that financial aspects had not yet been taken into account.

The Chairman of Telford and Wrekin CCG explained the Future Fit response to the Call to Action in November 2013 had been designed to address the population needs of Shropshire. There had been agreement that these should be driven from a truly clinical point of view designed from the bottom up, not top down. Costing the options and managing capital and recurring costs would be part of that process.

Other Members queried financial viability issues as the two cheapest options on paper were not included on the short list and that which was highest in cost was. Members asked what would happen if funding was not obtainable for a greenfield site, and if that was discounted, whether the long list would then be re-visited for a more affordable option.

The Accountable Officer, Shropshire CCG, emphasised that clinical care was the central focus and nationally more investment was needed for prevention. Money spent on buildings could not be spent elsewhere and the evaluation panel members had weighed up the evaluation criteria quality and safety, access and delivery. A solution needed to be found which balanced with financial viability.

The Programme Director stated that the final option would need to be affordable to both commissioners and providers. If some options on the short list were removed because they were not viable, it would be possible to re-visit other options.

In response to further questions from Members, it was confirmed that the preferred option would have to be determined as affordable before consultation began.

Members also raised issues around investment in primary and community care and the need to know who should be making this investment and leading on this.

10 How are you ensuring that the current services are delivered with care, compassion, competence, communication, courage and commitment while planning and delivering the Future Fit Programme?

The Communications Director, SATH, said the CQC rating of caring in current services at SATH had been very reassuring. All were thankful to public service colleagues for doing a good job under difficult circumstances.

11 How are transfers between hospitals being managed? What are the performance measures for the current contract and how is the provider performing?

A member of the Committee had heard that there had been some inappropriate use of West Midlands Ambulance Service ambulances on occasions for transfer of patients between hospitals. The Committee heard

that there had been problems with inter-site transfer previously but a new contract was now in place.

12 What arrangements have been put in place to build on the success of the GP service at the A&E at PRH?

Members heard that there was strong clinical evidence both nationally and from local schemes and pilot studies that co-location of general practice within A&E provided better patient outcomes, and also helped avoid admissions and overcrowding. The walk in service had now located at Royal Shrewsbury Hospital and the Pilot Study at the PRH was being evaluated.

13 How well is the Welsh Ambulance Service engaging in the Future Fit Programme and working to resolve the cross border pressures on the WMAS?

It was confirmed that Welsh Ambulance Service was represented on the Programme Board and had attended the evaluation panel. They had been asked to enter into the data sharing agreement.

14 How well has Future Fit communicated the current provision of services at PRH and RSH? e.g. that patients with some acute illnesses / injuries are currently treated out of county?

It was acknowledged that there was always more that could be done in terms of communication. Members commented that the public did not generally realise that the regional trauma centre was Stafford or Stoke, rather than Shrewsbury or Telford. They were informed that this would be addressed as progress was made in the next Future Fit phase, from May onwards.

PRIMARY AND COMMUNITY CARE

15 How are you working together to develop the capacity and model of care in Primary and Community Services (Future Fit 2)? How will you ensure that this work takes place alongside the current Future Fit Programme? What is the timetable for Future Fit 2 and do you have the capacity to deliver on this in time? What is the risk that resources will be directed towards increasing capacity at SaTH at the expense of primary and community services?

The Accountable Officer, Shropshire CCG reported on willingness from GP surgeries, the Community Health Trust, voluntary organisations and Shropshire Partners in Care (SPIC) to start shaping work. Change would involve developing new integrated ways of working.

16 What are the local plans for 7 day working in primary care? How can this be used to encourage integration of primary and community health services and are doctors and the GP Federation engaged?

Members heard about work underway in Shropshire with some practices already offering weekend working. However the current capacity of General

Practice was limited and the solution was likely to incorporate Nurse Practitioners, Pharmacies and clusters of practices across weekends.

The Chief Executive of the GP Federation explained that the number of GPs would fall short of demand for several years yet. However, he reported that the GP Federation was fully engaged and a visionary event was planned for 24th February to develop 'Future Fit 2' – the community offering.

Reference was also made to planned development of 'Team around the Practice' Schemes.

A Member of the Committee referred to a scheme in Telford and Wrekin involving Pharmacies which had been designed to divert patients where appropriate from making a GP appointment. He commented that it had been inconsistently promoted by chemists and the scheme had not appeared to have been well monitored. It was agreed that consistency of offer was extremely important so that people knew how to navigate themselves to the appropriate point.

The Accountable Officer, Telford and Wrekin CCG pointed out that both CCGs now had delegated commissioning responsibility for GPs which would give them more influence.

17 How many Urgent Care Centres / Local planned care facilities/ Community units /Health hubs and Diagnostic and Treatment Centres will there be as part of the Future Fit programme and where will they be located?

The Committee had already heard that this was a work in progress.

18 How will GPs be supported to work together / federate? How will this be managed particularly in rural areas? What is the role of the Community Health Trust to support this?

Other discussion during the meeting addressed these points.

19 How will you ensure that GPs are fully engaged in Future Fit? It is recognised that there are several channels to do this through the CCG, GP Federation and Shrop DoC. How will this work be co-ordinated to recognise the role of GPs as commissioners and providers? How will you enable GPs to develop a clear vision for how their sector relates to the wider NHS and care services?

Other discussion during the meeting addressed these points.

20 Is there an enhanced role of the GP Federation to work with GPs to develop new services and business models? How robust is the current model of primary care and how is the shortage of GPs being addressed?

The Chief Executive of the GP Forum referred to earlier responses and reiterated that Primary Care was keen to play a role in finding solutions. All GP Forum meetings were extremely well attended.

21 How will you ensure that the Future Fit Programme and the Better Care Fund work is co-ordinated?

All emphasised that the Better Care Fund would be a very important means to drive change and the Future Fit solution.

22 What is the future of the Community Health Trust?

The Chief Executive of the Community Health Trust said Shropshire needed an organisation to manage a wide range of community services. The future was bright, and it had been agreed with the TDA that the Trust would aim to become a Foundation Trust.

23 How are you ensuring that the current services are delivered with compassion, competence, communication, courage and commitment while managing change?

The Chief Executive of the Community Health Trust emphasised that the primary purpose for any NHS organisation was to create an environment to deliver high quality care to people within the service. It was essential to establish sound values and culture and engage well with staff. Staff were caring about patients and felt they could speak up when something was not right, or if something went wrong. When any change was introduced, the reason it would make a difference for patients was always emphasised. External scrutiny included audits and peer reviews.

24 What are the financial implications of the installation and running costs of diagnostic equipment in primary and community care locations?

Members were informed that there were costs to installing diagnostic equipment in community locations, but that this was not the biggest issue which was one of recruiting a flexible workforce to operate it. If this could be addressed, there was enormous potential to improve the quality of customer service closer to home and avoid unnecessary A&E visits.

25 What is meant by the term 'prevention' - is this preventing people getting ill or preventing ill people going to hospital or both?

Members heard that early intervention in lifestyle, health and education and preventing ill health in the first place was a key concern of Future Fit.
The Director of Public Health, Shropshire Council, commented on three key areas – keeping well, getting better and helping patients with long term conditions to cope, eg with diabetes. He also referred to efforts in addressing smoking cessation and obesity, and in increasing uptake of healthcheck screening programmes. He reported on variations in uptake of these across sections of the population. He also referred to making healthcare in rural

areas as accessible as possible, citing examples of use of telecare in Australia, Finland and Canada.

27 How can the different health and social care systems and regulators be aligned to deliver the Future Fit Programme?
28 How far is integration between health and social care a joint programme? What capacity is there within the local authorities to jointly lead this work?
29 How can you jointly manage and share the risk of the perverse incentives that the payment by result system creates?

Members asked if the Community Health Trust experienced any issues working with the Acute Trust and Social Care services and how issues were communicated if there were any problems. Practitioners on the ground worked closely together to solve problems and when problems were part of a larger pathway issue these were addressed together. Time had been released to allow opportunities for people to talk to each other.

The Chief Executive of the Community Health Trust commented that issues did exist but that these should be easy to address, for example, people changing care locations having to undergo multiple assessments.

The Director of Health, Wellbeing and Care, Telford and Wrekin Council, and Director of Adult Social Care, Shropshire Council, confirmed Social Care engagement in the Future Fit process and membership of the Programme Board. The need for the Health and Wellbeing Boards to demonstrate leadership was emphasised, particularly for Future Fit 2, discharge pathways and admission avoidance. The Care Act further cemented requirements and intervention.

Seven day working would have implications for social care and purchasing from the independent sector and social care was wedded to these principles. An integrated way of working was needed throughout Shropshire and Telford and Wrekin. However, in Local Government, finances were being reduced year by year until at least until 2018 and this would be very challenging.

The Director of Adult Social Care, Shropshire Council emphasised that prevention was very important and there was more that communities could do to keep themselves healthy and well, and more that could be done to support this.

He said that Social Care would need to step forward and contribute to Future Fit 2 but was concerned that it sounded like a follow on to Future Fit, when Future Fit itself needed to look across the whole system

Members were informed that NHS tariffs encouraged activity that did not assist the whole system and created perverse incentives. The Director commented on a professional, positive and constructively challenging relationship between social care and the NHS, both before and during Future Fit. Enhancements would only be made by communities, the NHS, volunteers and social services working together.

The Accountable Officer, Telford and Wrekin CCG said the working assumption was that CCG cash allocation would be as expected over the next 3 – 4 years. He commented on the social care budget pressures and the need to work with providers to establish a system that worked. He was comforted by the commitment of all organisations in trying to address this.

30 How well are Welsh commissioners and providers of health and social care engaging in the Future Fit Programme? If the Welsh commissioning arrangements change so Welsh patients are treated at Welsh hospitals what are the implications for the Future Fit programme?

It was reported that Powys Local Health Board was an integral partner in the Future Fit Programme with Clinical and Managerial Colleagues sitting on the Programme Board, along with the Welsh Ambulance Service. It was not expected that commissioning intentions in Wales would change and there was not enough capacity in the North Wales system to treat all patients.

31 How will the change to co-commissioning affect the decisions about the Future Fit programme?

The Accountable Officer, Telford and Wrekin CCG said that both CCGs saw the change to co-commissioning as an opportunity which could help develop solutions, for example, federations between groups of practices.

The Chief Executive of the GP Forum said it should help ultimately in moving some primary care into times when people could access it more freely, and also help with sharing of practice sites and records.

PUBLIC EXPECTATIONS

32 How are patient and political expectations being managed?

The Programme aimed to be both transparent and to create a clear dialogue with politicians and the public. The forthcoming election period would however mean reduction in levels of communication activity. Members emphasised the need to present clear, simple and jargon free messages to the public.

33 How can people be helped to understand that when seeking primary care you do not always have to see a GP often primary care clinician would be sufficient?

The Chair of Telford and Wrekin CCG said that this would emerge through Future Fit Communications. There was clear evidence that people needed as early an appointment as possible and a quick explanation of how they could get their needs addressed and at the right level, not necessarily a GP. This was both for planned care and urgent care.

34 How can patients be supported to understand that they do not always need continuity of care from the same GP?

This would eventually be achieved through patient experience and the sharing of records and information would be essential to this. However, continuity of care would remain important in some cases although not necessarily from a GP.

35 How can patients be supported to manage their own health more effectively? ie Smoking and obesity – are these measureable and being tracked?

Question addressed in previous discussions.

A Member of the Committee emphasised the need for a different way of supporting people in the community and the incredible pressure on Adult Social Care budgets. She highlighted the lack of discussion around a joined up approach to workforce development and felt that training was needed for a new kind of worker able to support people in their own home.

The Better Care Fund was seen as the right vehicle for this and the Accountable Officer, Telford and Wrekin CCG said there was potential for CCGs to put commissioning budgets into the Better Care Fund. This would need careful governance to limit risk and ensure that providers were not being put at risk.

It was also reported that Health Education England was involved in clinical design and reconfiguration of workforce challenges, and discussion was ongoing. The Accountable Officer, Telford and Wrekin CCG reported that he was a Board Member of the National Skills Academy for Health and would be taking this suggestion forward.

The Chairman thanked all those in attendance for their time and for responding to the Committee's questions.

The meeting closed at 4.30 pm.

Chairman……

Date……