HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview & Scrutiny Committee held on Tuesday 21 May 2019 at the Council Chamber - Shire Hall, Gloucester.

PRESENT:

Cllr Stephen Andrews	Cllr Carole Allaway Martin
Cllr Terry Hale	Cllr Brian Oosthuysen
Cllr Stephen Hirst	Cllr Nigel Robbins OBE
Cllr Paul Hodgkinson	Cllr Pam Tracey MBE
Cllr Martin Horwood	Cllr Robert Vines
Cllr Steve Lydon	Cllr Suzanne Williams

Substitutes:

Officers in attendance:

NHS Gloucestershire Clinical Commissioning Group (GCCG)
Mary Hutton – Accountable Officer, ICS Lead
Becky Parish – Associate Director Engagement and Experience
Dr Andy Seymour – Clinical Chair

Gloucestershire Hospitals NHS Foundation Trust
Deborah Lee – Chief Executive
Peter Lachecki - Chair
Simon Lanceley – Director of Strategy and Transformation
Dr Ian Shaw – Consultant Gastroenterologist
Dr Kate Hellier – Consultant Physician in Stroke and General & Old Age Medicine

Healthwatch Gloucestershire
Bob Lloyd Smith

Gloucestershire Care Services NHS Trust/ 2Gether NHS Foundation Trust
Paul Roberts – Chief Executive
Ingrid Barker – Chair
Candace Plouffe – Chief Operating Officer
Juliette Richardson – Matron at Vale Community Hospital
Angela Dodd – Clinical Lead Therapist at Gloucestershire Royal Hospital

Apologies: Cllr Collette Finnegan and Cllr Helen Molyneux

1. APOLOGIES FOR ABSENCE

As noted above.

2. DECLARATIONS OF INTEREST

No additional declarations made.

3. MINUTES OF THE PREVIOUS MEETINGS

3.1 The minutes of the Health and Care Scrutiny Committee meeting on 15 January 2019 were agreed as a correct record.

3.2 The minutes of the Health and Care Scrutiny Committee meeting on 20 February 2019 were agreed as a correct record.

3.3 Some district members of the committee expressed their concern with regards to the scrutiny review that had been carried out and led to the split of scrutiny of Health and Adult Social Care. The Health Scrutiny committee no longer had adult social care or public health within its remit and there was not district representation on the newly formed Adult Social Care and Communities Scrutiny Committee. One member stated that there should have been consultation with district councils as well as health colleagues. He asked that district members be invited to the Adult Social Care and Communities Scrutiny Committee. Another member stated that the split in the remit went against the direction of travel nationally of integration and suggested that this was a retrograde step.

3.4 Members noted that the General Surgery Reconfiguration pilot considered by the committee at its meeting on 20 February had now been halted as a result of legal challenge. One member asked for an update regarding this; he explained that following a visit from John Abercrombie and a promise to consider all options to put out for consultation, he was seeking reassurance that ‘option 4’ was being worked on and would be consulted on.

In response Deborah Lee outlined that the proposal as detailed in the pilot remained the preferred option for the immediate term. John Abercrombie had visited the Trust and worked with colleagues to develop ‘option 4’, but this was not an option that could be implemented in the short term. There were immediate and pressing issues and option 2 was considered the best option to meet those needs. General emergency surgery was currently in an unsustainable position. Engagement work would be carried out in the summer to explore options for General Surgery including ‘option 2’ and ‘option 4’. All feasible options would then be consulted on.

3.5 One member stated the need for a genuine understanding of the terminology being used, whether that be ‘consultation’ or the use of terms such as ‘temporary’ and ‘pilot’. He emphasised the importance of genuine consultation reflecting a willingness to listen to the public and be prepared to ‘change your mind’. In response it was explained that the Trust had held constructive discussions with the local authority to receive guidance in this case as the legislation was unhelpful regarding the interpretation of substantial variation of a temporary nature. Work would be carried out with Members to agree a local interpretation. With regards to consultation, this

was set out in statute and all NHS organisations were obliged to seek views and consult on options, these would be given full and careful consideration by boards and Governing Bodies.

3.6 Noting that the scrutiny task group on the General Surgery Pilot had been suspended due to the threat of legal action, one member asked that the task group reconvene in order to understand the options being considered by the Trust. In response the Chair noted that the task group work was in-complete but that the situation had changed and she would seek advice and consider the most appropriate action for the group moving forward.
ACTION Cllr Carole Allaway Martin/ Stephen Bace

4. STROKE REHABILITATION UPDATE

4.1 Paul Roberts introduced the presentation reminding members of the discussion in July 2018. The decision had been made by the CCG and Trusts in August 2018 and was established at the Vale Community Hospital and the unit had opened in February 2019. There was encouraging progress to report on. Candace Plouffe explained that the changes were in response to a review of the county's rehabilitation services which highlighted that a change was needed for the county to provide consistent and high quality rehabilitation to improve patient outcomes.

4.2 An engagement process was carried out with concerns identified around transport issues for visitors and insufficient beds in the locality for general needs. This was mitigated by sharing bed modelling process and outcome and reviewing and monitoring transport links. It was confirmed that there was ongoing provision for Musculo Skeletal physiotherapy at the Vale Community Hospital.

4.3 It was explained that at the Vale Community Hospital there was a high calibre team which had been able to begin a robust educational programme to develop specialist skills as well as forge strong links with the rest of the hospital. It was stated that the IT systems were also robust and the equipment was very good to help support the right group of patients.

4.4 The committee were provided with the expected benefits including a rehabilitation gym and social space for patients to come together. Therapy took place at any time within the unit seven days a week. Rooms were all single occupancies with en-suites. Previous issues had been regular access to enough therapy inputs per patient, the new unit had allowed an increase in this per patient, in particular extra speech and language therapy.

4.5 Members noted the statistics provided in the slides where it was reported that there had been 29 admissions since the opening in April 2019. Bed occupancy was now at 97% and a 100% improvement in patients 'Activity of Daily Living' score as determined using the Barthel measurement tool.

4.6 Members noted the experiences provided from clinicians which was very positive, in particular outlining how existing staff at the Vale Hospital had welcomed them and that skills and expertise overlapped and were shared.

4.7 The Committee was provided with details of the patient experience which also included feedback on the wider team, from the acute experience at Gloucestershire Royal Hopsital through to Early Supported Discharge to home and the extended stroke rehabilitation at the Vale Community Hospital. The feedback from patients had been very positive with details provided of the impact and improvement in outcomes from the treatment.

4.8 With regards to next steps, a formal service review would be carried out in September 2019with an analysis of SSNAP outcomes and the continuation of the review and transformation of Stroke care pathway. The Chair commented how the presentation seemed to demonstrate that an enhanced service had been delivered.

4.9 In response to a question it was explained that there were conversations daily with patients and it was about having the right patients in the right place at the right time to deliver the best outcomes.

4.10 One member asked for clarification regarding the threshold for admission and the criteria being used, as well as querying the impact of the location with regards to transport issues. In response it was explained that if a patient had complex needs such as a feeding tube then it may not be suitable to move them to the Vale Community Hospital. Everyone else would be eligible and it was important to ensure there was a flow of patients through the Vale Community Hospital. With regards to transport, when patients understood the benefits on offer they were often willing to travel and there was good free parking facilities. Public Transport availability was being monitored and this would be picked up in the review.

5. GASTROENTEROLOGY EVALUATION AND PILOT PROPOSALS

5.1 Simon Lanceley and Dr Ian Shaw updated members on the gastroenterology pilot, reminding members that the statistics provided covered December 2018 through to February 2019 and therefore included the busy winter period. The pilot ensured that patients were seen by the right speciality team and that junior doctors were available and waiting times reduced. This involved moving the service across to Cheltenham General with the exception of two acute beds which had been retained at Gloucestershire Royal..

5.2 The Committee received details of the nine metrics that were being tracked as part of the pilot. It was reflected that the data was coming from the winter period and it was pleasing to see a number of the indicators going green (positive).

5.3 Members noted the scenarios around patient experience which demonstrated the improvement in daily review provision and enhanced in-patient endoscopy service post pilot where patients were seen by the gastroenterology team on arrival. The patient feedback also showed the positive difference between the patient experience pre-move to post move. In response to a question it was clarified in some instances a junior doctor would make an initial assessment before the patient saw a member of the gastroenterology team but overall senior assessment was now happening more consistently and more quickly.

5.4 The staff experience highlighted the increased monitoring of trainees and emphasised that staff felt they were better supported and there was better provision of specialist skills and training.

5.5 The Committee was provided with detail on the pilot metrics. It was noted that initially there had been a reduction in length of stay but that had begun to rise. It was believed that this reflected a more complex group of patients going through the new designated specialist ward such as those with chronic liver conditions who tended to stay in hospital longer. It was emphasised that the figures still hadn't exceeded the historic length of stay. This was being monitored closely.

5.6 The Chair responded to the presentation by noting that this pilot and the stroke enhancement work showed the impact on the morale and the improved resilience of staff due to being adequately resourced in order to provide better outcomes for patients.

5.7 In response to questions, it was explained that both the gastroenterology pilot and the Trauma and Orthopaedic pilot which would be highlighted in the next presentation would be part of the 'One place' public consultation at the end of the year.

5.8 One member asked what could be done to help reduce discharge delays and was informed that discharge was looking to be streamlined and a system-wide discharge event was taking place on the 5th June. Where appropriate, a patient would not have to wait for a consultant or senior member of the team to be discharged through the introduction of a model called 'criteria led discharge' which enabled a nurse or therapist to discharge.

5.9 Members noted that the provision of advice and guidance to GPs was a good sign of joined up working and some members highlighted how they would welcome more detail of that joined up working between GPs and acute care. It was explained that advice and guidance in Gloucestershire was the third highest nationally across all specialisms and this had the potential to reduce out patient referrals.

6. TRAUMA AND ORTHOPAEDIC PILOT

6.1 Simon Lanceley provided the context for the pilot outlining the national support for its design and implementation. Since 2015, mortality from hip fracture had reduced from 10.5% to 4.8% with 31 patients lives saved every year due to changes to the pathway. 90% of patients received early pain relief and the patient experience metric was at 9.2 out of 10.

6.2 It was explained that the data in the slides in relation to this work included two winter periods and only one summer period and there was an expectation that the accumulated data would benefit from the summer period resulting in a reduction in average wait times.

6.3 One member raised concerns regarding the average wait times for one trauma procedure detailed in the presentation and provided anecdotal evidence on incidents that had led to patients needing further treatments. In response it was explained that concerns raised had been historical before the pilot and assurances had been provided to the National Body who had closed the issue. The member suggested there were a number of questions still to be asked regarding the pilot. It was suggested that the Committee could write to the Trust with any questions they had regarding this and ask for feedback.
ACTION Cllr Carole Allaway Martin

6.5 In response to a question, it was explained that the model of centres of excellence allowed expert triage and helped to improve the speed and quality of early decisions from more senior clinicians which in turn improved outcomes and experience for patients.

6.6 The Committee understood that time had been spent delivering education sessions in MIUs in order to help decision making regarding detection of fractures and interpretation of X-rays which was leading to fewer patients being referred to the two hospitals.

7. RADIOLOGY SERVICE - UPDATE

7.1 Paul Roberts provided members with context ahead of the discussion around the temporary change to X ray services. The decision had been made to set up a Diagnostic Programme Board to handle the significant numbers of challenges and opportunities around imaging services. It was felt that a full strategic approach was required in conjunction with the NHS long term plan, which placed an increased emphasis on the use of diagnostics. Members received details of the Diagnostics Programme Board with initial priorities around community x-ray, workforce, One Place programme, point of care testing and managed equipment programme. There was a service user group for pathology and looking to establish one for radiology.

7.2 The Diagnostics Programme Board was considering strategies around the issue of recruitment of diagnostics staff and how to take advantage of

developments in technology. It was explained that a large proportion of imaging equipment was in need of replacement which would take a large capital investment. Thanks for generous public fundraising activity was noted.

7.3 Since November 2018 there had been a reinstatement of an additional 44 hours of X-ray provision in community hospitals of the original reduction. Members were informed that 9.5 full time equivalent radiographers had been recruited to the county but that 11 had left in the same period. Agency workers and bank staff had been used successfully to fill the gaps in rotas. A range of initiatives were being put in place to improve recruitment including working with the University of Gloucestershire on an accredited course and having overseas and regional recruitment plans.

7.4 Waiting times for X-rays at every community hospital in the county had increased apart from in Cirencester. Members noted that the biggest waits were at the North Cotswold and Tewkesbury hospitals. One member expressed specific concerns about the waiting times in Tewkesbury. It was explained that some patients chose to wait to have an x-ray at a more convenient location when it was not urgent and patients who were clinically urgent would always be seen promptly and transport could be arranged if necessary.

7.5 Members noted that the temporary changes had been due to shortages in radiographers and that more immediate and longer term solutions were being worked on.

7.6 The Committee noted the petition discussed at a previous meeting regarding the waiting times in the North Cotswold and members sought clarification over the definition of a temporary change, asking if this was a pilot. It was explained that this was a temporary change in relation to staff shortages and this was not something that would have been desired or designed. Paul Roberts explained that in his view it was important to have a flexible approach. In some communities there would need to be an extension in the range of services provided and in others less to enable focus where the demand was expected. In response to a question it was explained that the default plan was to reinstate services when and where possible, but a more strategic plan for diagnostics across the county was being developed by the newly established Diagnostics Programme Board..

7.7 Further discussion was held around the use of the term ‘temporary’, Deborah Lee stated that in her view a pilot was something that was being tested with a view to future implementation. These arrangements were not being tested, they were changes that had been unavoidable due to safety concerns and would remain temporary until the Trust was able to reinstate the former arrangements or chose to consult on a different permanent solution.

7.8 There was some discussion around MIIUs and how referrals were being made for X-rays. In response to a question it was explained that there wasn’t

a wait time, if X- ray facilities were available locally then that would be carried out immediately or, if facilities not available on site at the site, the standard procedure would be to treat conservatively and either come back the next day or be sent to another site where X-ray facilities were available. It was explained that this was the standard procedure before the temporary change.

7.9 A brief update would be brought to the committee in July 2019.
ACTION Work Plan

7.10 In response to the discussion on the Committee's role in relation to temporary service change and pilots. A memorandum of understanding or 'check-list' would be drawn up that would clarify the terminology and provide a local interpretation of what constituted a substantial variation and how the Committee would act in relation to this.
ACTION Cllr Carole Allaway Martin/ Deborah Lee/ Mary Hutton

8. GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP PERFORMANCE REPORT

8.1 Mary Hutton provided details of the performance report which would be received by the Committee at each meeting going forward. It was noted that some information that the Committee received regularly were not available due to the date of the meeting and the change of the Committee remit to focus solely on health, but would be included in future reports.

8.2 One member raised concerns regarding ambulance response times in the Cotswolds, noting improvements in some districts against concerning performance elsewhere. In response it was explained that there were a number of actions underway to try to improve performance, while noting that the rural nature and geographical challenges within the Cotswolds made it difficult. Information was included in the report relating to actions to work with Rapid Response and care homes and working with First Responder Service.

8.3 In response to a question about waiting lists, and in particular a Gloucestershire Live article suggesting that Gloucestershire Hospitals waiting lists were the largest since records began, it was stated that this was an area of focus for the Trust following the return to reporting last month. Initially the focus had been to reduce the waiting time for first appointment for cancer patients (two weeks) which had been achieved. Now the focus had been turned towards routine patients with plans including mobilising new technology to help reduce waiting times and drive efficiencies. Members would consider an item on this at their work planning meeting.
ACTION Work Plan

8.4 One member further discussed the challenges around waiting times and highlighted his view that there needed to be a full A & E department at Cheltenham General Hopsital. In response it was explained that challenges

in this area were at a national level and that Gloucestershire was 31 out of 135 in the country (1 being best performance)and had maintained its position in the top quartile of Trusts nationally throughout last year. Further work would continue to respond to demand. One important thing was to ensure that patients who could be better cared for elsewhere in the system were being directed there as care was often quicker and more appropriate.

8.5 Concern was raised regarding the 62 day wait for referral to treatment for cancer. It was suggested that performance was moving in the wrong direction. The Trust responded by stating that this was an area they welcomed being identified. The focus on the two week initial appointment had been the right one but now the focus was on this target with a recovery trajectory for September 2019. A specific item would be brought to a future committee meeting.
ACTION Work Plan

9. ONE GLOUCESTERSHIRE ICS LEAD REPORT

9.1 One member asked for clarification of the ICS Executive as referred in the report. It was explained that this was a group of executives from the organisations involved in the plan who met regularly to develop the work.

9.2 In response to a question it was explained that Integrated Locality Partnerships were relatively new but that there had been a pilot in Cheltenham (and Stroud and Forest of Dean). There was an ambition to widen the scope of the Partnerships. It was suggested that members may benefit from a briefing regarding the newly established Integrated Locality Partnerships and Primary Care Networks..
ACTION Paul Roberts

10. GCCG CLINICAL CHAIR/ ACCOUNTABLE OFFICER REPORT

For Information.

CHAIRMAN

Meeting concluded at 12.30 pm