HEALTH AND CARE OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health and Care Overview and Scrutiny Committee held on Wednesday 20 February 2019 at the Council Chamber - Shire Hall, Gloucester.

PRESENT:

Cllr Carole Allaway Martin
Cllr Iain Dobie
Cllr Brian Oosthuysen
Cllr Nigel Robbins
Cllr Colette Finnegan
Cllr Stephen Andrews
Cllr Pam Tracey
Cllr Helen Molyneux
Cllr Stephen Hirst
Cllr Rob Vines
Cllr Martin Horwood
Cllr Terry Hale
Cllr Suzanne Williams

Substitutes: Cllr Ron Allen for Cllr Janet Day

Officers in attendance:

Gloucestershire Clinical Commissioning Group (GCCG)
Mary Hutton – Accountable Officer
Becky Parish – Associate Director Patient and Public Engagement
Maria Metherall – Senior Commissioning Manager: Urgent Care
Caroline Smith – Senior Manager Engagement and Inclusion
Mark Wilkingshaw – Accountable Officer and Director of Commissioning
Ellen Rule – Director of Transformation and Service Redesign

Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT)
Peter Lachecki – Chair
Simon Lanceley – Director of Strategy and Transformation
Simon Dwerryhouse – Service Line Director
Claire Fowler – Urology, Breast & Vascular Service Line Director
Mark Vipond – Upper GI Consultant
Tim Cook – Colorectal Consultant

HealthWatch
Alan Thomas, Healthwatch

Gloucestershire Care Services NHS Trust/2Gether NHS Foundation Trust

Paul Roberts, Chief Executive

Apologies:

Cllr Steve Lydon

1. DECLARATIONS OF INTEREST

No additional declarations.

2. MOTION 825 – PROTECTING GLOUCESTERSHIRE HOSPITALS' WALK-IN-SERVICES

2.1 The Committee noted the motion that had been referred from full Council and welcomed a presentation from the Senior Commissioning Manager for Urgent Care on developing the Gloucestershire model of care for Urgent Treatment Centres. It was explained that she was unable to confirm any details of Urgent Treatment Centres at this stage as further work and engagement was planned. Following engagement in the Spring and Summer a review would be undertaken and a more formal process of consultation would take place in Autumn/ Winter.

2.3 Members noted the national requirements including the March 2017: 'Next steps of the NHS Five Year Forward View) and the July 2017 NHSE' Principles and Standards. The NHS Long Term Plan stated the implementation of the Urgent Treatment Centre model by Autumn 2020. It was explained that the overarching principle of establishing Urgent Treatment Centres was to remove confusion and provide consistency of service offer to the people of Gloucestershire.

2.4 In terms of outlining the need for change it was explained that the systems were confusing with fragmented pathways with multiple hand-offs, as well as staffing/ workforce constraint. Making the change would improve the quality of the patient experience, Urgent care was to become more planned in order to address system 'surge'. It was explained that urgent care activity was very predictable but did create known demand surges that created pressures.

2.5 The national guidance had been reviewed and there had been a mapping of current services, reviewing patient experience feedback. Workshops were held involving clinical, managerial, Healthwatch and patient and public representatives. Draft service specifications had been prepared. There was still more to be done and there was encouragement for everyone to get involved.

2.6 Members were informed about what the Urgent Treatment Centre model would provide and how it would be less confusing for public, patients and staff and that it would provide a largely bookable service to allow it to be more planned. All services needed to be aligned so there was a less fragmented approach that provided the best use of staff skills. This would ensure the Emergency Department was preserved largely for people with 'life and limb' threatening conditions.

2.7 It was explained that the system was undertaking a number of test and learn initiatives via a 'Plan, Do, Study, Act' approach to test assumptions and new ways of working.

2.8 Some members felt that there was confusion around the details of Urgent Treatment Centres (UTC) and asked for confirmation that there would be no downgrading of Cheltenham A & E to a UTC. In response it was explained that there was still a significant amount of engagement with the public and so no details could be confirmed.

2.9 In response to a question, it was clarified that it was a minimum 12 hours open time for UTCs and that where need arose this could be extended. It was also confirmed that there would be full integration with the out of hour's services.

2.10 Some members spoke positively about UTCs and emphasised the importance of ensuring the best outcomes for patients. It was suggested that in many instances UTCs represented an upgrade for patients.

2.11 One member emphasised the rurality of the county and asked whether the changes would satisfy rural communities. In response, it was explained that there was a clear commitment around travel times and that modelling had been carried out to look at how to address the challenges presented in rural areas.

2.12 In response to a question, it was suggested that more could be done to enhance the overnight offer at Cheltenham General Emergency Department and that the service currently provided was not replicating an urgent treatment centre model. Further work would be carried out to integrate Cheltenham's overnight emergency service and the out of hour's service, testing new ways of working.

2.13 Members agreed that they were in favour of steps to reduce confusion and ensure the services were more joined up. Alan Thomas from HealthWatch emphasised the importance of enhancement of patient experience and warned against confusing the NHS Long Term Plan with the steps being taken in Gloucestershire.

2.14 It was clarified that GPs in Gloucestershire provided support and care for people who were ill. Injury was not included in the current contract and so people should call the 111 service in future if they are injured.

2.15 Members requested that a letter be put together from the Committee drawing their attention to motion 825 as well as providing information in relation to ensuring a focus on outcomes for patients and the need for clear communication of plans. This letter would go to the CCG and include a request that Cheltenham General Hospital not be downgraded.

ACTION Cllr Carole Allaway Martin/ Democratic Services

2.16 The Committee requested that they receive a timetable for engagement and clarity of what stage they could encourage people to fully engage. They would have a separate agenda item at future committee meetings to monitor progress.

ACTION **Cllr Carole Allaway Martin**

3. GENERAL SURGERY RECONFIGURATION PILOT

3.1 At the Health and Care Scrutiny Committee on 13 November 2018, members agreed to hold an additional meeting to discuss the proposal around the General Surgery Reconfiguration Pilot. Members had requested more detail particularly around the benefits for both staff and patients, what the implementation planning timeline looked like, including decision points and the frequency of the updates to the committee going forward. Members were informed that the Committee had the role of a critical friend and could express views and concerns but that they did not have the power to refer to the Secretary of State as this was a pilot.

3.2 Cheltenham Borough Council had been in contact, asking for the Health and Care Scrutiny Committee to examine the proposals in detail and to allow an opportunity for the 57 consultants who had signed a letter raising their concerns to be able to address the meeting. The Committee had not received any contact from the signatories to attend the meeting. The Overview and Scrutiny Committee at Cheltenham Borough Council had considered the issue and heard from a representative and the draft minutes of that meeting had been circulated to members.

3.3 Peter Lachecki took the opportunity to update members on confirmation that the Trust had been graded by CQC as good a couple of weeks previously. There were many areas of outstanding practice identified in the report including an embedded systematic approach to quality improvement.

3.4 Members received a presentation from Sion Lanceley and consultants who were core members of the task and finish group that had worked up the options related to the model of emergency general surgery. It was explained that the current model of emergency general surgery did not meet national standards. It was important that there was a model of ensuring specialist teams were free to review new patients, that there was provision for ambulatory care services and consultant ward rounds. The current model allowed for patients to be admitted unnecessarily and to stay longer. It was recognised that 14 general surgeons agreed ‘do nothing’ was not an option and that all fourteen supported the centralisation of emergency general surgery to Gloucestershire Royal.

3.5 There was a majority clinical support for the proposed model of planned care, which it was explained was the only option which could be implemented in the short term. The pilot would be evaluated and, by its nature, was temporary; any substantive and permanent change would be subject to public consultation.

3.6 It was explained that general surgery comprises two abdominal specialities. It was broken down for the committee what emergency work included and what elective work included. 70% of emergency patients did not require an operation. It was

explained that most of the work was completely independent; the first point of call if patients became unwell would be the team they were being looked after by. It was suggested that having surgery patients co-located made a lot of sense.

3.7 Members were informed centralising emergency general surgery would improve patient outcomes. Patients often waited to be reviewed by the surgical team and patients saw the right specialist less than 50% of the time. As part of the pilot, all patients would see a sub-specialist surgeon and patients referred by GP or ambulance would go directly to GRH. CGH walk in patients that need to be reviewed by the surgical team would be transferred directly to the GRH surgical assessment unit – they would not need to go via GRH Emergency Department. . If a patient was too ill to transfer, a GRH surgeon would go to CGH.

3.8 There was information around how changes to elective care would reduce cancellations as those with planned short-stay and daycase general surgery would be moved to Cheltenham General. As part of the pilot, three times the number of patients would have their operation at CGH.

3.9 Members noted the benefits for emergency care and planned care as detailed in the slide included two surgical teams being on duty providing 24/7 specialist colorectal and upper GI consultant cover and standardised care pathways and improved patient experience.

3.10 Since 2011there had been no clinical consensus around the reconfiguration of general surgery and so a task and finish process was established to deliver recommendations. All options were designed by clinical teams and all options included the centralisation of emergency general surgery at Gloucestershire Royal Hospital.

3.11 Referring to the letter signed by 57 colleagues, members were informed of the areas of support for centres of excellence and centralisation of emergency general surgery at GRH and long term strategy to centralise short stay surgical services at Cheltenham. The difference in opinion was on the preferred location of complex planned elective general surgery.

3.12 The Trust was in the implementation planning mode at the moment, but members were shown some of the pilot evaluation criteria as part of the presentation.

3.13 In March 2019 John Abercrombie would return to GHFT to look at how things had changed and give his view. The pilot would go live in September. There would be a 12 month monitoring programme in order to address seasonality. Updates would be shared with HOSC every three months.

3.14 Cllr Iain Dobie was invited to provide further feedback from the Cheltenham Borough Council meeting. The issue was considered at the Council meeting on 21 January 2019 and at Scrutiny on 11 February 2019. Concerns had been expressed that once the pilot had been implemented some of the changes would be irreversible, that not all the options for change had been properly assessed (with particular reference to Option 4 not being fully examined), and the potential

aggravation of bed shortage issues at Gloucestershire Royal Hospital. A representative of the consultants who had signed the letter had suggested to the scrutiny committee that this was not a pilot but a major reconfiguration of services and emphasised the concerns already expressed. In addition the point was raised that where patients needed to be moved between sites this would compromise their recovery.

3.15 Responding to points raised by members, and noting the concerns from Cheltenham Borough Council, Simon Lanceley explained that it was not within the Trust's gift to permanently enact change without public consultation. It was further explained that there would be a criteria to assess the pilot and to develop further. Option 4 was a full emergency and elective split but that could not have been implemented in the timescale. It was suggested that John Abercrombie had stated that this was 2-3 years away due to the staff numbers and workforce skillset required. On the perception of bed shortages, recently 12 gastroenterology beds had moved to Cheltenham General and a new Acute Medical Initial Assessment (AMIA) model implemented to reduce unnecessary admissions. The Trusts long term clinical strategy would address variation in bed occupancy between the two sites. By improving the access for patients to senior decision makers it would allow for quick decisions and rapid assessment that could reduce the requirements for beds.

3.16 Some members raised concerns about the potential impact of the Oncology Centre of excellence and how its reputation could be damaged. The example was given of consultants working together and how a splitting of teams could impact on that timely level of support. In response it was explained that under the pilot there would continue to be availability of emergency consultants to provide this support with one free to go and assess individuals. Most procedures as joint cases were planned operations and so the appropriate people would be on hand. Consultants emphasised that the reputation of the Oncology Unit would not be affected, with further detailed provided around the level of care provided which was in place pre and post surgery.

3.17 A specific concern was raised regarding the time it would take a surgeon to travel between Gloucester and Cheltenham if they were required. Members were informed that currently if a general surgeon was in surgery then there might be a 3 to 4 hour wait anyway. It was suggested that the pilot actually freed up surgeons to provide greater availability.

3.18 One member raised his dissatisfaction at the level of information provided. He had requested detail around the questions and points raised against each of the options considered, including the final outcome document. In addition he would have welcomed further information on the operation capacity at Gloucestershire Royal Hospital. He explained that national standards were not being met with regards to emergency surgery in Gloucester but that for complex elective surgery in Cheltenham, those standards were being met. He reiterated previous concerns regarding the bed base at Gloucester and on the concerns expressed regarding oncology, he suggested that Cheltenham's reputation for safe complex surgery could be lost.

3.19 It was emphasised that Option 4 was not off the table with more detail to be produced with John Abercrombie in March. One member suggested that this had been a late consideration and asked whether if this was the long term direction, would the current pilot be a retrograde step in achieving that goal? In response, it was explained that there were advantages and disadvantages associated with all the options and that Option 2 was the one that could be implemented. It was emphasised that there would be no additional patient risk and that future planning, potentially around Option 4, would be informed by the pilot.

3.20 There was further discussion around the potential impact on the Oncology unit with one member suggesting that the assurances provided to members was disputed by other surgeons that had been in contact. It was suggested by some members that the changes would be a fundamental error and undermine the service. In particular there were questions regarding adequate consultant and junior doctor cover. In response to concerns it was clarified that there were continual interactions between staff across Gloucester and Cheltenham with a one hospital approach in place and . Cheltenham General would continue to have registrar cover at night.

3.21 In response to a question it was stated that as part of an upgraded level of care SWAST ambulance would transfer patients between sites when required.

3.22 Members welcomed the opportunity to discuss the detail of the pilot and thanked all officers for their presentation and their responses to questions. Members felt that the most appropriate forum to explore the remainder of their questions and to best scrutinise the pilot would be through a scrutiny task group. A one page strategy would be developed setting out the aims, ambitions and timescale for the work and this would be circulated to members for comment.

ACTION Cllr Carole Allaway Martin/ Democratic Services

3.23 The Committee agreed to write a letter to the Secretary of State outlining their concerns around a lack of clarity on the role of Health Scrutiny in regards to a reconfiguration pilot.

ACTION Cllr Carole Allaway Martin/ Democratic

CHAIRMAN

Meeting concluded at 12:30pm