HEALTH AND CARE OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health and Care Overview and Scrutiny Committee held on Tuesday 13 November 2018 at the Council Chamber - Shire Hall, Gloucester.

Present:

Cllr Stephen Andrews	Cllr Steve Lydon
Cllr Iain Dobie	Cllr Carole Allaway Martin
Cllr Collette Finnegan	Cllr Helen Molyneux
Cllr Terry Hale	Cllr Nigel Robbins OBE
Cllr Colin Hay	Cllr Pam Tracey MBE
Cllr Stephen Hirst	Cllr Robert Vines
Cllr Martin Horwood	Cllr Eva Ward

Substitutes: Cllr Ron Allen (in place of Cllr Janet Day)

Gloucestershire Clinical Commissioning Group (GCCG)

Mary Hutton – Accountable Officer
Becky Parish – Associate Director Patient and Public Engagement
Dr Hein Le Roux, Deputy Clinical Chair and Clinical Commissioning Lead

Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT)
Deborah Lee – Chief Executive
Peter Lachecki – Chair
Simon Lanceley – Director of Strategy and Transformation

Gloucestershire County Council
Mark Branton – Deputy Director: Adult Social Care
Sarah Scott – Director of Public Health
Cllr Roger Wilson – Cabinet Member Adult Social Care Commissioning
Cllr Tim Harman – Cabinet Member Public Health and Communities
Sarah Jasper - Acting Head of Safeguarding Adults

Gloucestershire Care Services NHS Trust/2Gether NHS Foundation Trust
Ingrid Barker - Chair
Jane Melton - Director of Engagement and Integration
Candace Plouffe – Chief Operating Officer

Apologies: Cllr Janet Day

52. DECLARATIONS OF INTEREST

Cllr Stephen Hirst declared a personal interest as Chair of Tetbury Hospital.

Cllr Stephen Andrews declared a personal interest as he is a Community First Responder with the South Western Ambulance Service NHS Foundation Trust.

Cllr Carole Allaway Martin declared a personal interest as she is a member of the Royal College of Nursing and as the council appointed Governor to the 2Gether NHS Foundation Trust.

Cllr Martin Horwood declared a personal interest as a family member works for the NHS.

53. MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on Tuesday 11 September 2018 were agreed as a correct record and signed by the Chairman.

54. GLOUCESTERSHIRE SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2017/18

54.1 The Acting Head of Adult Safeguarding presented the main areas of activity undertaken by the GSAB in the period 2017 to 2018. Using case studies she also drew member's attention to safeguarding adults reviews undertaken during this time period. These cases illustrated the impact of adverse childhood experiences (ACEs) on the individual and their longer term effect.

54.2 The committee was pleased to note that the GSAB was already working closely with the Gloucestershire Children's Safeguarding Board (GSCB) as it was clear that there is learning across the lifecycle.

54.3 It was agreed that Housing had a significant role in safeguarding matters; housing officers have powers that safeguarding officers do not, eg. the right to enter their property, and were well placed to spot concerns and report them. The committee noted that housing providers were active members of the GSAB.

54.4 The committee was concerned with regard to those people placed out of area, both by this council and by other local authorities placing people in Gloucestershire. People placed out of area were more vulnerable to abuse as they were at distance from family and friends and a case study described in the Annual Report deftly demonstrated this. A particular concern related to people placed in Gloucestershire by other local authorities. An important factor was that the placing authority should (continue to) ensure that placements were suitable and that the individual was safe. However the committee heard that this does not always happen and this council has no powers to enforce this duty. It is also of concern that providers did not always inform this council when a person from out of the area was placed with them, despite there being a clear expectation from GCC Commissioning. There was ongoing work in this area to address this.

Committee members agreed that this area would benefit from better regulation and agreed that it would write to the Secretary of State for Health and Care with its concerns.
ACTION Andrea Clarke

54.5 In response to a question it was explained that the Multi Agency Safeguarding Hub (MASH) which was now located in Shire Hall, currently focused on children. The longer term ambition expressed by the Assistant Chief Constable was to make this an all age group. Members indicated that they would like to visit the MASH.
ACTION Andrea Clarke

54.6 It was explained that if a member of the public reported a concern it was difficult to let them know what action had been taken as the consent of the individual concerned was required.

54.7 Members questioned what was being done to identify young adults who were at risk and what support was available. In response it was explained that this would be a specific focus for the GSAB this year. It was stated that recent research talked of children "walking off the cliff edge at the age of 18" in terms of services available to them; it was important to understand how these gaps could be filled. In response it was explained that this would be a specific focus for the GSAB this year. It was stated that recent research talked of children walking off the cliff edge at the age of 18; it was important to understand how these gaps could be filled and what we could do to help people overcome what they faced in childhood; this was about a trauma informed approach (Adverse Childhood Experiences (ACEs)).

55. QUARTER 2 PUBLIC HEALTH PERFORMANCE REPORT

55.1 The Director of Public Health (DPH) presented the report. The committee had shared concerns with regard to drug and alcohol performance against target at previous committees. The DPH indicated that she had included additional information on this matter in her report to committee later on the agenda to inform on the wider context. The committee remained concerned and would need to discuss at its next work planning meeting whether this matter would be better addressed through a workshop.
ACTION Andrea Clarke

55.2 It was stated that the data for Cheltenham relating to disadvantaged children and the effect of this on their life chances was stark, and it was questioned how the Gloucestershire Health and Wellbeing Board (GHWB) was addressing this issue. It was explained that the GHWB was in the process of refreshing the Joint Health and Wellbeing Strategy (JHWBS) and this matter was being included in the GHWB discussion around priorities. The GHWB was also leading on the Adverse Childhood Experiences (ACEs) work (please see www.actionaces.org); the council was leading on a restorative practice programme; and the council also lead on the Children's Partnership Framework in Gloucestershire.

55.3 The DPH also explained that the public health team were working on population health dashboard and this would be shared with the committee in due course.

56. QUARTER 2 ADULT SOCIAL CARE PERFORMANCE REPORT

56.1 The committee continued to be concerned with regard to performance against reassessments. This concern was exacerbated by the lack of detail in the comments section about what was being done to address this situation; the committee has asked for this to be improved. The committee acknowledged that this was a complex area with various recording issues adding to the complexity, but does feel that it was time that there was a positive shift in performance against these targets.

57. GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP PERFORMANCE REPORT

57.1 The committee agreed that having previously expressed concerns with regard to the performance of the South Western Ambulance NHS Foundation Trust (SWASFT) against category 1 calls, it was only right to congratulate the Trust for now achieving this target. However, it was acknowledged that this would become more challenging as winter pressures built.

57.2 Some members continued to express concern at the difference in performance against the 4 hour A and E target across the two acute hospitals. However the committee was reminded that at the overall Trust level (which was the national reporting requirement) the 90%target has been consistently met in every quarter in 2018/19. These members questioned why performance at Gloucestershire Royal Hospital (GRH) was not at the same level as at Cheltenham General Hospital. It was explained that there were particular pressures on the GRH site, particularly related to the level of activity and acuity of patients. The Chief Executive, Gloucestershire Hospitals Trust NHS Foundation Trust (GHNHSFT), informed the committee that it was important to place this within the wider context of how does the GHNHSFT maintain resilience across available resources; matching resources to the demand.. She also added that excessive demand was primarily a daytime issue.

57.3 It was commented that it was disappointing that the committee was not receiving the most up to date data on Children and Young People Services (CYPS) delivered by the 2Gether NHS Foundation Trust (2G). It was explained that this was a timing issue. It was also explained that 2G and the GCCG were still waiting to hear whether the bid to become a trailblazer pilot to reduce waiting times has been successful.

57.4 It was explained that a significant factor in those areas where performance targets were not being met related to the available workforce. It was clarified that this was not about finance but about workforce shortages at the national

level. A particular concern related to the two week wait and 62 day cancer targets which have been consistently not achieving target. The committee was informed that the GHNHSFT has just appointed two urology consultants and it was expected that the impact of these appointments would soon be seen in the performance reporting.

57.5 In response to concerns with regard to cross border factors relating to continuing health care the committee it was agreed that the committee would receive a written briefing from the GCCG.
ACTION: Becky Parish

58. ONE GLOUCESTERSHIRE ICS LEAD REPORT

58.1 The committee was particularly interested in the structure and membership of the Integrated Locality Boards particularly with regard to whether/how they would engage with local government.

58.2 The committee noted the report.

59. GENERAL SURGERY

59.1 To try to set the context for the debate on this matter the committee's role in this process was explained. Unlike substantial/significant service change proposals the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 were silent on proposals for pilot schemes. The committee's role therefore was that of critical friend. If the committee agreed that the pilot was not something that it could support this would not prevent the GHNHSFT from proceeding to plan for the pilot. If the committee was so minded it could decide to write to the Secretary of State for Health and Care with its concerns, but this also would not prevent the GHNHSFT from proceeding, unless he chose to intervene. (It was important to set the wider context to this issue in that the first that the committee knew of this proposal was following a leaked internal staff memo by a GHNHSFT staff member two days after the committee's 11 September 2018 meeting. This was followed by 57 GHNHSFT consultants writing to all members of the GHNHSFT Board expressing views on the preferred model of care, and which was subsequently the basis for articles in the local media.)

59.2 The Chief Executive, GHNHSFT, assured members that this was a pilot and that no irreversible steps would be taken during the pilot's timeline. She expected a robust debate with members of the committee today. She explained the timing for the different communications, noting that the approach for this proposal was identical for that previously taken for orthopaedics and gastroenterology and noted the timing of the Trust meeting and the HCSOC was unfortunate.

59.3 The Director of Strategy and Transformation at the Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) gave a detailed presentation on this proposal highlighting the benefits that were expected to be achieved, and the

metrics that would be used in the evaluation of this pilot. Two consultant surgeons from GHNHSFT also explained to the committee what an average day in general surgery looked and felt like. (The presentation slides were uploaded to the council website and included in the minute book.)

59.4 In the discussion that followed, it was stated by members that this was just another step in the downgrading of Cheltenham General Hospital (CGH); that this meant that access to emergency surgery was not safe and quoted an anonymous consultant who had spoken on local radio that this proposal was not safe for patients.

59.5 Some members felt that the fact that this number of consultants (57) had written this letter and that to them this signified a high degree of concern; and also suggested that there was a culture of fear at the GHNHSFT whereby consultants were afraid to raise their concerns publicly. In response it was commented that as they had signed the letter this did not seem to indicate that they were afraid to raise their voice.

59.6 The Chief Executive, GHNHSFT, drew members attention to the wording of the letter which in fact set out support for the proposed direction of travel and did not raise concerns for safety. She stated that it was clear that there was clinical consensus on the proposals related to emergency surgery, and that this was confirmed by the consultant letter; where there was some dissonance related to the proposed model for the elective pathway. She stated that whilst the views of the 57 consultants were important and added value to the discussion it was necessary to place them in context and understand that they represented a minority of the overall number of consultants at the GHNHSFT (400). She also reminded the committee that similar letters had been received with regard to the trauma and orthopaedic pilot but that this has been a success and none of the articulated fears had ultimately been realised.

59.7 The Chief Executive further stated that she wanted to be clear that this proposal was in no way linked to the provision of A & E at Cheltenham General Hospital; of the 130 attendances per day at CGH A&E only around 5 related to general surgery in Gloucestershire. Furthermore, she did not recognise the view that there would be a deterioration in access to general surgery, access and quality would in all likelihood be improved by this change.

59.8 In response to criticism that the GHNHSFT had not brought this matter to committee earlier it was explained that the GHNNSFT were required to take any proposals through its clinical governance process and senior leadership team. The senior leadership team had signed off the proposal in principle on 13 September 2018 (two days after the committee meeting). This information was then shared with staff via an internal email. The email had been shared outside of the Trust by a member of staff which placed the GHNHSFT in the position of having to share information publicly earlier than it would have wished to given that much of the planning and preparation was still in

process. The GHNHSFT would have shared this proposal with the committee in due course as it had with the trauma and orthopaedic and Gastroenterology pilot proposals.

59.9 In response to a question it was explained that whilst the service was safe now, the long term sustainability of the service was at risk and there was evidence that the current service was falling behind others and local patients were not receiving care in line with national standards. This proposal was also part of wider considerations linked to the system's vision for the development of centres of excellence (CoE). One of the aims associated with the CoE proposals was the potential to bring back to Gloucestershire several areas of service where significant numbers of patients currently travel out of county for more specialist care. CoE were also expected to improve the training experience for clinicians and improve recruitment and retention in medical, nursing and other specialist areas of workforce.

59.10 Cllr Flo Clucas, Cabinet Member Healthy Lifestyles Cheltenham Borough Council, had asked to speak to the committee on this matter. At the discretion of the Chair this was allowed. Cllr Clucas reiterated other members concerns regarding the letter from the consultants, access to general surgery in an emergency situation, and that there was a culture of fear at the Trust. She also stated that she felt that all options should have been presented to this committee for consideration; she felt that the committee should have another meeting to discuss this matter.

59.11 The Chief Executive, GHNHSFT, the Director of Strategy and Transformation and the Chair of GHNHSFT, and the two consultants present informed the committee that they did not recognise this description of the Trust. It was reiterated that this was not an anonymous letter; the consultants had felt able to sign their names to it. All signatories to the letter had received a response from the Chief Executive, and this had been discussed openly at a GHNHSFT Board meeting. It was also stated that the letter indicated support for the proposed CoE model, including the centralisation of emergency care and dedicated elective centres.

59.12 Other members were of the view that this was an excellent proposal; that it was good to have specialist teams in place; and that sometimes pilots were the only way to identify the way forward. It would be important to be clear as to what the process would follow the completion of the pilot.

59.13 The Deputy Accountable Officer, GCCG, explained that the GCCG supported the pilot, that the report was clear on the work that has already been done to identify how this pilot would be measured, and that the GCCG and GHNHSFT were committed to a full evaluation.
ACTION Andrea Clarke

59.14 It was agreed that the committee would write to the GHNHSFT and GCCG Boards outlining its concerns. The committee would also hold an additional meeting to discuss this proposal to gain a better understanding of the detail

of the proposal particularly the benefits for both staff and patients, what the implementation planning timeline looks like, including the decision points, and the frequency of updates to the committee.

59.15 The Chief Executive GHNHSFT indicated that she would support the committee's proposed work on this matter; she would prefer to be in a position where the majority of members were supportive of the proposal. However her paramount concern was addressing the safety and sustainability of emergency general surgery. She was clear that the GHNHSFT would continue with its planning for this pilot; she was also clear that this was a pilot and should it become clear that it was not generating the expected outcomes this was reversible. It was reiterated that the proposal was addressing significant issues within the service and had been developed through a panel of external experts, chaired by the national lead for general surgery. She stated that she fully accepted the need for HCOSC support should the Trust propose a permanent change.

60. INTERVENTIONAL AND COMMUNITY RADIOLOGY

60.1 This item related to the need to implement a temporary service change. It was important to note that changes could be made temporarily under regulation 23(2) of the s.244 Regulations (National Health Service Act 2006) because of a risk to safety or welfare of patients or staff and that in these circumstances it might not be possible to undertake any public involvement or consultation with the Local Authority.

60.2 The Director of Strategy and Transformation, GHNHSFT, and the Chief Operating Officer, Gloucestershire Care Services NHS Trust (GCSNHST) gave a detailed presentation of the reasons for the service change which were attributable to severe shortages in staffing which were jeopardising the GHNHSFT's ability to provide acute radiology services safely. It was noted that this was the first time that the NHS in Gloucestershire has had to take this type of action.

60.3 Members were concerned regarding the impact on those people who would usually visit the community hospitals most affected by this change. They asserted that it would be important that there was clear communication on what services were available and when, otherwise there was the potential for the acute hospitals to be adversely affected by an increased footfall.

60.4 In response to members concerns regarding the reduction in hours it was explained that this was the minimum level of commitment. This service operated on a six week rota and with the goodwill of staff it might be possible to provide an additional day in Tewkesbury and the North Cotswolds. It was also explained that most of the referrals to the service were routine referrals from GPs and not related to emergency care.

60.5 The reasons for the service change related to the workforce; this was a national issue, and had recently been reported in the national media but the

position in Gloucestershire was even more challenged with a 24% vacancy rate in radiographers. The committee would be regularly informed on progress but it was recognised that in the current circumstances GCSNHST and GHNHSFT were not able to specify when this service would be fully restored as it relied on the Trust's ability to recruit new and retain existing staff.

61. DIRECTOR OF PUBLIC HEALTH REPORT

61.1 The committee noted the report.

62. DIRECTOR OF ADULT SOCIAL SERVICES REPORT

62.1 The committee noted the report.

63. GCCG CLINICAL CHAIR/ACCOUNTABLE OFFICER REPORT

63.1 A member raised anecdotal information which related to the issue of a specific thyroid medication being withdrawn, and asked for an explanation as to why this had been undertaken. She questioned whether the GCCG review panel was overriding a government ruling relating to prescription entitlement.

63.2 The Deputy Accountable Officer, GCCG, informed the committee that the GCCG was not overriding national guidance but rather was responding to it. The evidence related to this drug (in that it delivered better outcomes than alternatives) was limited. Individual cases should be reviewed by a consultant endocrinologist; and there were some exceptions. In Gloucestershire a Review Panel, which included clinicians and lay representation, had reviewed cases and letters regarding the review and the Review Panel's decision. Due to data protection requirements, it was then for the GP to communicate the information to the patient.

63.4 The Deputy Accountable Officer informed members that the GCCG had a duty to regularly review financial resources. The Deputy Clinical Chair, GCCG, explained that the evidence was not there to support routinely prescribing this medication. He also informed the committee that this approach was supported by the British Thyroid Society.

CHAIRMAN

Meeting concluded at 2.12 pm