JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

Minutes of a meeting of the Joint Health Overview & Scrutiny Committee held on Thursday, 15 April 2021 at 2.00 pm in Remote Meeting

Present: Councillors K Calder (Co-Chair (Shropshire Council)), H Kidd (Shropshire Council), M Shinetone (Shropshire Council), S J Reynolds and D R W White (Co-Chair).
Co-optees: H Knight, J O'Loughlin and D Saunders

In Attendance: A Holyoak (Committee Officer (Shropshire Council)), J Galkowski (Democracy Officer (Scrutiny) (Telford & Wrekin Council)), T Jones (Deputy Director Partnerships, Shropshire, Telford & Wrekin CCG), Nicky O'Connor (STP Programme Director, Shropshire Telford & Wrekin STP), K Robinson (Democracy Officer (Scrutiny) (Telford & Wrekin Council)), R Robinson (Director of Public Health (Shropshire Council)), J Rowe (Executive Director: Adult Social Care ,Health Integration and Wellbeing (Telford & Wrekin Council)), D Webb (Overview and Scrutiny Officer (Shropshire Council))

Apologies: Councillor D Beechey (Shropshire Council)

JHOSC1 Declarations of Interest

None.

JHOSC2 Minutes of the Previous Meeting

RESOLVED - that the minutes of the meeting held on 22 October 2020 be approved.

RESOLVED - that the minutes of the meeting held on 24 November 2020 be approved.

JHOSC3 End of Life Care Update

Members received the update report of the Deputy Director: Partnerships, Shropshire, Telford & Wrekin CCG.

The Committee were informed that the report was an update on a previous report received by the Committee and that it covered the achievements of the review of end of life care to date and the next steps of the review.

The Deputy Director provided Members with an overview of the report. The first section of the report covered the background to the review. In the second section, the methodology of the review was laid out. The original idea had been to shortlist focus areas from data but there had been a decision to open up one of the focus areas to influence from the feedback received from those with lived experience. There was a desire to include symptom control as a

focus. Section 3 of the report covered the four areas that formed the key areas of focus, while Section 4 set out the regional focus on palliative and end of life care. Section 5 focussed on next steps, in which working groups would seek to deliver change. Finally, Section 6 summarised where the review was.

Following the presentation, a discussion followed. Members asked a number of questions:
Who sat on the Community and Place Board?
Representatives from the main health providers, HealthWatch, and social care colleagues. The hospice was not involved but a representative was the Chair of the End of Life Group, so the hospice was involved.

Did the hospice contribute as an individual stakeholder?
It did.

Why had a generalist approach been favoured in the report to a specialist one?
Generalists needed support in end of life care as it was not something they usually dealt with. This would improve end of life care more broadly.

Could the term generalist be defined?
Generalists were staff that did not work in a specialist end of life care role.

Where was the CCG at with the Advanced Care Plan (ACP)?
This was outside of the area of expertise; however, the work was being led by the hospice in conjunction with oncologists from SATH. It was looking at producing an ACP.

Was the review of end of life care underpinned by a holistic approach?
The report was the result of engagement, holistic was not a term used in the report but the review was being approached holistically.

How close to fruition were information systems that shared data to avoid repetition of questioning patients?
Shared care records were not a part of the review, however, that work was progressing at pace.
For those who wished to die at home, there was an issue around support from GPs and district nurses. Was there anything in the report around supporting that choice?
In terms of the reviews, this was a routine end of life commissioning question. In those instances where individuals were unable to access the necessary equipment it was necessary to speak to service providers to find out why as equipment was commissioned. This was not an area fed back by service users as a particular issue.

Would Phase 2 of the review be able to influence equipment provision and the delivery and recovery of equipment from a patient's home?
In each of the four key areas there would be a task and finish group established, COVID had enabled rapid change across a wide area as clinicians came together to examine the problem and had found active ways

of solving it. Equipment could feature in a number of the task and finish groups' conversations, looking at a solution focussed approach. Separately, issues around commissioned services, such as equipment, had to be reported and actioned as individual cases. Where people did not receive the equipment needed, they should report this to the CCG.

Who would be taking part in the task and finish groups?
For each area, there would be a lead clinician and a lead manager, membership would then be opened up; looking at healthcare providers, people with lived experience, HealthWatch members, and non-statutory areas involved in the specific area. It would depend on the area being looked at but a broad membership would be pursued.

Occupational therapists appeared to be in short supply but appointments with them were necessary prior to receiving equipment. Would occupational therapists be a part of the review?
The review and its outcomes would depend on the collective discussions about the questions posed. The therapy base in Telford & Wrekin was being assessed by the Telford & Wrekin Integrated Place Partnership. The review looked at how to improve experience but other pieces of work were looking at those other issues Members had raised such as the availability of therapists and the rapid response team.

Post-COVID with the build-up of waiting lists, staff shortages, and major financial problems in the health economy, were there any fears about the impact of these challenges on the end of life care process?
There had been concerns, but continued work on the paper had been secured at the Community and Place-Based Board in spite of those challenges.

Regarding Generalists, would they be able to identify gaps in the review? How would they feed that in? How long would the grace period for identifying gaps in service be?
The working group looking at that issue would generate the answer to that question.

Members expressed their intention to invite Professor Derek Willis to the Committee at the next stage of the process.

Members recommended revisiting this matter in September.

Resolved that –

i. The completion of Phase One of the Review and the collaborative identification of the 4 areas of focus be noted.

ii. The change of CCG leadership of the End of Life Review as it entered Phase Two and the continued commitment of system partners to engage in the improvement workstreams to address the four key areas, including clinical leadership for all four key areas be noted.

iii. The regional NHSEI requirements regarding local system PEoLC group whose membership would include representatives from the voluntary sector and people with lived experience be noted.

iiii, The agreement that this refreshed PEoLC would act as the programme board for the four key improvement projects and report into the Community and Place based Board which in turn would report directly to the shadow ICS Board, thus ensuring prominent line of sight on the progress of the 4 working groups be noted.

iiiii. The JHOSC would receive a report on the EOL task and finish group progress in September 2021.

JHOSC4 Shropshire, Telford & Wrekin Integrated Care System

The Committee received the presentation of the STP Programme Director from Shropshire, Telford & Wrekin STP.

It was expected that the legislation would begin the parliamentary process in May 2021 with integrated care systems (ICS) becoming statutory bodies from April 2022. The proposal would be that there would be two bodies forming the ICS – a statutory body made up of the existing NHS bodies and local authorities and another, broader, partnership bringing together partners from across the system. The second body would likely be focussed on population health.

There were four purposes of an integrated care system:

1. Improving health outcomes in the general population
2. Tackling inequalities in outcomes, experience, and access
3. Enhancing productivity and value for money
4. Helping the NHS to support broader social and economic development

System pledges had been drafted as an integrated care system on areas to improve. There was the potential to work together with the Committee to improve things. In terms of place based working, people had worked together locally to generate ideas on how to improve. A commitment had been made to tackle ill health and health inequalities as well as to improve mental health services.

Commitments had been made with local government on working together on climate change and to regenerate economies.

The sense was that the legislation intended for work to be undertaken locally as much as possible.

Members posed a number of questions:
Concern was expressed at the creation of a two tier integrated care system in which democratic bodies, such as the Joint Health Overview & Scrutiny Committee, formed the lower tier.

The primary body would be the partnership board, the one including the democratically elected; it would then be for the statutory body to take the nucleus of what they asked for into action.

There was an engagement and accountability plan due in March 2021, where could that be found?
This had been delayed; it was expected in May 2021. However, the individual responsible would likely be interested in consulting with the Committee on how to pull that report together.

In terms of integrated care systems, would you agree that the system should be simple, local, and evolutionary?
Yes.

Does the workforce stream look at all workforce (including nursing staff, care staff) or just within the NHS?
This may be something to consider in a specific session, as a standalone item. Conversations on the issue were ongoing; workforce strategy covered all of the health and care workforce.

Given the challenges faced by the local health economy, are you confident that you can move forward in the way presented?
The pledges aimed to address these challenges; working together presented an opportunity to achieve goals.

Was there an agreed understanding of what health inequalities were within Shropshire, Telford & Wrekin?
In the next steps for place-based working, health inequalities were central. They were categorised in three ways, what could be done at a civic level? What intervention could be made in communities? And what could be done around services to improve them?

When would the ICS meet in public?
Board meetings would be held in public but work was being done on how they would be held. Initial plans were for an annual general meeting in September 2021.

How did you ensure that departments all speak to one another?
There was a long way to go on this issue, people needed to be enabled to work closer. Digital working was key. A digital work stream was in place, but pump priming was needed. Sharing of information was critical to success.

What was being done to help primary care be a part of this?
Primary care had a mandated seat on the board, but they needed to be enabled to engage and attend. It was critical that primary care were at place based boards, which they were, as this was where they could have most impact on what was happening on the ground. The place-based boards would be where real change could be made, not the ICS. The ICS would be policy and strategy focussed.

Did place based boards meet in public?
No.

Was there an opportunity to take part in the place-based boards for members of the public and elected Members?
They developed from local health and care staff working together and were chaired by senior individuals. They were ultimately, where pathways of care would be determined, informed by what was happening in primary care networks and the health and care issues in specific communities. HealthWatch and the voluntary sector were involved.

Where did scrutiny fit in? How could scrutiny play a part?
There were officers on the board from both authorities, as well as Councillors and they had served to link the board up to date.

Could the Committee see the board minutes?
Yes, this could be arranged.

How would SEND sit within ICS?
An outline governance schematic was within the presentation, that would evolve, but there was a children's and young people's delivery board proposed. SEND would be central to that.

On wider determinants of health, education and housing for example, was there a platform for those areas and professions to be involved?
There was.

Members made clear that they believed scrutiny's role in the new system had to be clearly identified and enhanced.

There was a consultation document out for review on the accountability of the ICSs; it was felt that local authorities should assess and respond to the document.

Members thanked the STP Programme Director for their attendance.

RESOLVED that –

- **The Committee request both local authorities draft a response to the Government consultation document.**
- **The Committee write to the LGA to ask for their response to the consultation.**

JHOSC5 Co-Chair's Update

Councillor White thanked the Committee's Co-Chair, Councillor Calder, for their work on the Committee.

The meeting ended at 4.00 pm

Chairman: _____

Date: Date Not Specified