Shropshire Council	Joint Health Overview and Scrutiny Committee 15 April 2021 2.00 pm	Item Public

MINUTES OF THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE MEETING HELD ON 22 OCTOBER 2020
2.00 PM – 3.55 PM

Responsible Officer: Amanda Holyoak
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Present
Councillor Karen Calder (Co-Chair), Councillor Heather Kidd, Councillor Derek White (Co-Chair), Councillor Stephen Burrell, Councillor Stephen Reynolds, Hilary Knight, Ian Hulme

1 Apologies for Absence

Apologies were received from Councillor Madge Shineton. David Beechey, Dag Saunders and Janet O Louglin were unable to access the meeting due to technical difficulties.

2 Disposable Pecuniary Interests

Members were reminded that they must not participate in any items in which they had a disclosable pecuniary interest.

3 Minutes of the Previous Meeting

The minutes of the meeting held on 6 August 2020 were confirmed as a correct record.

4 System Winter Planning 2020 - 2021

Sam Tilley, Director of Planning, Shropshire and Telford and Wrekin Clinical Commissioning Groups, and Nigel Lee, Chief Operating Officer, Shrewsbury and Telford Hospital Trust, were in attendance to present the report before members and answer questions. The report explained that the usual winter planning arrangements were set within a wider Restoration and Recovery Programme for the NHS as a result of the covid19 pandemic. It also explained the requirements set out in the most recent “Phase 3 letter” (12 August 2020) including the acceleration of return to near normal levels of non-covid19 health services and preparation for winter demand pressures alongside vigilance for covid19 spikes locally.

The report explained the differences in planning arrangements for this year and how the benefits to be realised from Covid19 specific learning were being taken on board by the system into the next phase. Planning has been undertaken on the basis of five key themes: Discharge, Hospital Front Door, Community, Primary Care and Acute Services

with the overall focus on demand management. Following a rigorous multi-agency process, 30 winter capacity schemes would be utilised in the winter plan across a range of system partners these would start coming on stream from November and there would be close oversight of implementation and impact through the Urgent and Emergency Care Delivery Group and Board and Gold Command. Examples of schemes related to attendance, admission avoidance and discharge to help preserve capacity in the acute trust over the winter months were provided.

The winter plan would be an iterative process and would be monitored and refined as real time data came through. It was also reiterated that the NHS was not closed and as much elective activity as possible was underway and this would be supported through the addition of an additional CT imaging unit and two mobile MRI scanners. Delivery of the vaccination programme would be a huge piece of work from December onwards.

Members asked a number of questions and received responses as follows:

What risk and challenges were there around staff resilience – in a system where this had already been an issue pre-covid?

It was acknowledged that the challenges already in the system had been exacerbated by covid 19. There was no easy answer, pressures were immense and staff were tired and stressed already. A System People Group was in place so that partners could manage the next few months and also the longer term. A Memorandum of Understanding had been agreed across key partners in order to redeploy staff to the areas of greatest need.

Support for care homes had been provided in relation to infection control and PPE training was available. As the first wave had arrived later in Shropshire than other parts of the country there had been the opportunity to utilise lessons learnt in relation to discharge into care homes and there was a very strict process of swabbing in place.

There had been an active bring back staff programme and although overseas recruitment had been held up due to covid travel restrictions, workforce recruits from India were now starting to arrive. Additional staff from private companies were being utilised, eg radiography staff for imaging.

Are more beds needed – how will this be achieved within the limitations of buildings? Is the community bed capacity required available?

Nigel Lee, Chief Operating Officer, SATH said that Future Fit had brought additional capital in order to deliver capacity fit for purpose. The Ambulatory space linked to A&E front door was reducing the need for admissions. The move of the Midwifery Led Unit at PRH alongside the Consultant Led Unit had also provided an increase in capacity but concerns remained. Optimisation of discharge work on a daily basis was a priority and the Trust supported the national agenda of ringing 111 for guidance first. The Director of Planning confirmed that capacity in Community Hospitals was currently good but that 'home first' remained the priority with care wrapped around patients as necessary.

What was being done to speed up discharges which were delayed due to waits for medication? Could external pharmacies be used?

This was an issue that SATH had been trying to tackle for a while. Wards were very busy and rounds were led by a consultant, delays stemmed from a wait for discharge summaries and approval for medications. It was intended that wherever possible one or two junior doctors could produce discharge summaries and order medications the day before discharge wherever possible. This remained a challenge as the right level of authority was required to access the medication software. Some improvement had been made but there was still a way to go. A balance between safety and timely discharge was needed. The Chief Operating Officer said he would have to check whether it would be possible to use external pharmacies via using local agreements - there would need to be appropriate stocks and processes in place as there were at the hospital pharmacy.

Discharge – were there delays discharging patients over weekends, (an example was cited of a recent case of a delay in discharge)

Many services were active over weekends although not necessarily on both days or at both sites. Pharmacy, medical staff and additional discharge consultants were on duty every weekend at both sites to facilitate weekend discharge.

At a recent LGA meeting it had been identified that hospitals were very full – not just with covid patients but with others needing critical care. What was the position locally?

Mr Lee reported that SaTH had not stopped urgent cancer surgery during the pandemic. He confirmed that the hospitals were extremely busy and that critical care covered both covid patients and those with other conditions. The challenge of managing pathways and separating patients with covid or potentially with covid was significant.

A critical care surge plan was in place involving use of two operating theatres along with additional equipment. Formal collaboration arrangements were in place with University Hospital North Midlands at Stoke. The Adult Critical Care Network was also active and SATH had recently received some patients from Walsall, as part of providing mutual aid across the network. Active dialogue was maintained across the local, neighbouring and regional system. It would be a continued challenge across the Winter

Is there a dashboard picture showing take up of beds by covid patients/other acute conditions?

This changed on a daily basis – as of now there were covid cases in the mid 20s out of a bed base of about 680. Around a third of critical care capacity was taken up with covid/potential covid cases. Some of the additional capacity planned would not be in place until closer to Christmas. Mr Lee suggested that if the Joint HOSC wanted more information that he discuss specific requirements with the Chair outside of the meeting.

The report referred to 'what had not worked well with previous winter planning arrangements but must this year'. What more being done to ensure that what not gone well previously would deliver this year?

Whereas lack of flexibility across organisational boundaries and staffing issues had been a feature of the past, covid had helped to move that agenda forward quite significantly. Multi-agency arrangements for sharing staff across the system were now in place and strides forward had been made in working as a system with shared priorities with a default setting of problem solving.

What more was being done to address ambulance handover issues?

Investment and capacity at the front door were essential to addressing this issue, RSH in particular had a small A&E and peaks in demand were harder to manage than they would be in a larger organisation. The investment which would come on line at Christmas involving an ambulatory environment would help provide a better pathway for some patients. Some patients could be supported, treated and discharged the same day with appropriate support at home.

Why are patients coming to A&E if this is not the right place for them?

Work on establishing the right pathways for patients was underway – with a number of these pathways and options being available and evident to primary care, 111 colleagues and also users directly to help avoid admissions.

The Chair thanked Sam Tilley and Nigel Lee for attending the meeting and answering questions. The Committee requested a similar report again in a year's time with more detail so that members could understand what high level actions would actually look like on the ground. This would help to assure members as lay people. Sam Tilley welcomed this guidance.

5 Sustainability and Transformation Partnership (STP) End of Life Review Update

Tracy Jones, Deputy Director Integrated Care, CCG and Alison Massey, Senior Project Manager End of Life Review were welcomed to the meeting.

Alison Massey took Members through a short presentation outlining the proposed scope and approach of the review – this would not be taking a traditional approach, rather one that involved using information already held - using a collaborative approach across organisational boundaries to design solutions. The expected timescale was six months and the purpose of the review was not to develop a strategy, rather to review how to make an impactful change on individual experiences.

Phase 1 of the review had just commenced and all stakeholders had been asked to review information they held and to identify themes and feedback to pose some questions and inform the work going forward.

Members asked a number of questions and received the following responses:

The report stated that a strategy was not the expected outcome but referred to 'aspirations' and appendix 1 was labelled as a strategy. What status did the document at appendix 1 have – who did it apply to, who had signed up to it and how was it co-ordinated

throughout the system? What influence would this piece of work have across the whole system once completed?

Tracey Jones reported that the proposed methodology for the review had been shared with the groups across the system identified in section 1 of the report, and each had signed up to it. These included the organisations containing lead end of life clinicians.

The End of Life Review Group had been established as a sub section of the STP Community and Place Based Cluster which reported into the ICS Shadow Board. Phase 1 involved each organisation collating the information it held already to identify areas for action. Part 2 involved implementing that action through four key areas. Each area would have a system working group which would be made up of front line clinicians, managers and Healthwatch amongst others - key to developing solutions to the questions.

Some changes could be made by clinicians throughout the duration of the review to see if they could be made to work. This was an STP priority area and where any areas of difference or difficulty were identified, these would be escalated up to system leaders to identify how to remove barriers.

What quantity and kind of data has been collected - the Joint HOSC had experienced difficulties previously in seeking such data and information.

Each individual stakeholder had been asked to review information they already held to produce four questions. They had been asked to consider issues which were not to do with a single organisation but a pathway of care which was not connecting across the system.

Tracy Jones reported that the level of detail in PALS reports alone would be supplemented by individual one to one in depth interviews. If any JHOSC members knew of anyone willing to contribute to the review and share their experiences this would be welcome.

How many people would be interviewed as part of the review? The Joint HOSC felt that qualitative data was particularly valuable in this area

Tracey Jones stated that that feedback would be sought from as many individuals as were willing to give it within the timeframe.

The Chair observed that the proposals sounded excellent but was aware of a person who was about to disengage with the process of giving feedback and hoped that any trauma experienced by others would not be exacerbated by participation.

Tracy Jones provided reassurance that she would be speaking to people individually to ascertain their willingness and readiness to participate in the review and would outline boundaries and expectations around contribution. She would be very supportive of anyone coming forward to share their story.

The Co-Chair referred to action proposed in the past to address end of life issues, which had not been successful. It was good to hear that a new approach was to be taken. He had heard of cases where do not resuscitate instructions had been applied without permission and it was essential that families be involved and treated in a respectful way.

It was acknowledged that the old approach had not delivered the changes needed and all organisations involved had accepted this new methodology. Consistency of approach would be very important. The whole end of life pathway was vast but the four areas would be identified collectively by stakeholders. The Joint HOSC were asked to identify if it felt that any stakeholders were missing from section 7 of the report

The Co-Chair felt that the PALS system should be replaced by one organisation that applied across the whole of the system to enable a full picture when things went wrong.

Tracey Jones suggested that wider issues relating to PALS be raised with the Chief Officer of the CCGs.

How would the four areas to take forward be identified and agreed collectively?

All stakeholders should have an input in taking the long list into short list. The methodology used would depend on how many and how apart the areas identified were when responses came back from all stakeholders

Can you provide the Joint HOSC with assurance that the stakeholders participating in the review will be of sufficient seniority to make the commitments needed in progressing this work?

The system had made a commitment to the work and lead clinicians in end of life care from each organisation were involved. There had also been a commitment made that the thoughts of front line staff be supported.

How will you measure impact of the work?

Measuring patient experience was difficult and comparing like with like was not possible. One reason there would be a focus on questions was to provide a basis for measurement – 'how do you know that things have improved'. Participants in the review would be asked 'how will we know if we make the change that we've got it right'. This might involve staff surveys and looking at both quantitative and qualitative data.

The timescale appears to be ambitious, particularly with activity planned over the coming weeks

The timescales in the report provided an indication of the process but there would be a flexible approach if needed.

Would the Leads for the four areas be able to provide the time needed to the Review?

Key individuals leading on end of life in different organisations would provide the leads for each area. If there were any issues with availability then this could be escalated through the Cluster Board. The working day of individuals involved in the project involved end of life as their day job and contributing to service, system and patient improvements was part of their roles.

Lynne Cawley, Chief Officer Healthwatch Shropshire, emphasised the importance when talking to people of establishing when the event had happened, as some people could take a very long time to feel able to talk about experiences. She also suggested contact

be established with the bereavement team at SATH where there might be an opportunity to ask questions that fit into the review.

It was also reported that Gordon Kochane and Jo Robins, Public Health at Shropshire Council had been working on bereavement support and may be useful contacts.

Tracey Jones welcomed these suggestions and said she would follow these up after the meeting.

The Committee thanked Tracey Jones and Alison Massey for attending the meeting and it was agreed that an update would be provided to the Committee at its 11 March 2021 meeting.

6 **Co-Chair's Update**

An additional meeting of the Committee will be arranged in November focusing on children's mental health.

The Chair encouraged any members of the committee or members of the public to make contact if they had any observations, comments or questions related to the Committee's work.

Signed …… (Chairman)

Date: