Herefordshire Council

Minutes of the meeting of Adults and wellbeing scrutiny committee held at The Council Chamber - The Shire Hall, St. Peter's Square, Hereford, HR1 2HX on Thursday 16 November 2017 at 10.00 am

Present: **Councillor PA Andrews (Chairman)**
Councillor J Stone (Vice-Chairman)

Councillors: MJK Cooper, PE Crockett and A Seldon

In attendance: **Councillors WLS Bowen and TM James**

Officers: **Herefordshire Council: J Coleman, M Samuels**
NHS Herefordshire Clinical Commissioning Group: H Braund, J Brooks, S Hairsnape
Wye Valley NHS Trust: D Farnsworth, J Ives
West Midlands Ambulance Service NHS Foundation Trust: L Parkes, P Wall
NHS Sandwell and West Birmingham Clinical Commissioning Group: R Ellis
2gether NHS Foundation Trust: F Martin
Healthwatch Herefordshire: C Price

17. APOLOGIES FOR ABSENCE

Apologies were received from Cllr CA Gandy, Cllr RL Mayo and Cllr D Summers.

18. NAMED SUBSTITUTES (IF ANY)

Cllr A Seldon substituted for Cllr D Summers.

19. DECLARATIONS OF INTEREST

There were no declarations of interest.

20. MINUTES

RESOLVED:

That the minutes of the meeting held on 21 September 2017 be confirmed as a correct record and signed by the chairman.

21. QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions from members of the public.

22. QUESTIONS FROM COUNCILLORS

There were no questions from councillors.

23. PERFORMANCE OF WEST MIDLANDS AMBULANCE SERVICE NHS FOUNDATION TRUST

Officers from West Midlands Ambulance Service gave a presentation to provide an overview of the key issues for the service including:

- Activity in Herefordshire for the year to date: this had risen by around 3%, broadly consistent with overall activity for the region.
- Non-conveyance: although the approach was to try and keep people at home, non-conveyance of patients was below the regional average. This was due to a tendency to address risk and ensure that patients' ongoing health needs were met and appropriate pathway were followed.
- Ambulance usage per head of population: across the 22 commissioning groups for the region, Herefordshire did not have the highest level of use in comparison.
- Response Programme trial: the service had taken part in this national trial designed to ensure that response standards were being met and this had informed national standards that were now in place. In Herefordshire a key challenge was to meet the 7-minute response time, and this was now measured as an average figure in recognition of the rurality of the county.
- Response categories: changes had been made by NHS England, including differing response times for each category.
- Performance for Herefordshire: this was improving; category 1 responses remained a challenge, although the response programme trial had led to improved performance for every category.
- Nature of calls: referred to as 'chief complaints', in Herefordshire, these were predominantly under the 'medical / generally ill' classification.
- Service achievements: the trust was the highest performing ambulance service. Estates rationalisation to develop operational hubs had led to better facilities to support response times and efficient working, and the service was working with commissioners to address demand management to ensure that calls were not being 'stacked'.

Members responded with a number of questions and comments.

Commending the service for the achievement of a paramedic on every shift, a member asked about how this had been possible. It was explained that a graduate training scheme had brought paramedics through and their deployment supported each vehicle to be autonomous to make clinical decisions, supported by a clinical network for wider decision making.

Regarding a question on the impact of the national standard for responses to category 1 calls on staff morale, officers described that expectations were communicated to staff who were encouraged to make suggestions and provide feedback.

A member asked how the impact of moving the call centre from Worcester to the base in Dudley had been addressed as regards local knowledge and directing vehicles to calls. Officers explained that there was a despatch team working with the area to become familiar with it. There were good communications with the call centres and a dedicated Herefordshire desk to provide local focus which had improved integrated urgent care. The clinical hub was working to provide better care to make the most of care pathways.
The commissioner from Sandwell and West Birmingham Clinical Commissioning Group added that in order to support patients to access the most appropriate care there were links with the local hub and the GP out of hours service to enable close working to achieve the right level of response.

Referring to the figures provided in the presentation, a member noted an increase in activity in May 2017. Officers clarified that this was for the whole region, although there

was no apparent reason for the increase. However, the service did seek to reduce demand for anticipated peaks.

A member commented on the categorisation of diabetes-related calls being in category 3, and wondered about the opportunity to link this to the national diabetes framework and instead move it to category 2 in recognition of wider health implications. Officers explained they were governed by the nationally-defined categories but clarified that category 3 related to people who were well with their diabetes, but if someone with diabetes were unconscious, for example, this would be a category 1 call.

The vice-chairman welcomed the service's achievements and thanked officers for the recent opportunity for committee members to visit the ambulance hub in Hereford.
Referring to the use of defibrillators in public places, he asked about the training availability and its effectiveness for users in the community. Officers described the arrangements for a dedicated trainer who was going out to groups which included community first responders. However, the defibrillators were technologically advanced and designed for use by someone with no training, although they could be supported by the call handler who could talk them through what to do.

The vice-chairman commented on the rurality of Herefordshire and the 7-minute response time standard for category 1 calls, which, in the context of roads and conditions differing from urban areas, was a lot to expect of crew to achieve in the county. He asked about the impact on morale for crew if unable to get to a call within the standard. Officers responded that staff would strive towards the 7 minutes as a target and do their best, focusing on outcomes. The chairman noted the siting of ambulances around the area in order to be better-placed to get to calls more quickly.

A member asked whether it was the case that first responders were required to fund some of their equipment. Officers confirmed that some first responders were self-funded or charity status although the details needed confirming.

Members asked about modes of transport used by the service, such as motorcycles and 4-wheel drives, in meeting the response times. It was confirmed that there were a couple of motorcycles in Birmingham where it was deemed they would be more effective and that double-crewed ambulances achieved better outcomes against the response standards in Herefordshire. There were vehicles with 4-wheel drive capability based at the Hereford hub. Officers also gave reassurance that there was technology in place to ensure that mobile communications networks were protected to ensure coverage in remote areas.

In response to a question from the chairman about the impact of the closure of the walk-in centre on the volume of 999 calls, there had been no identified correlation.

Commenting on the impact of publicity in raising public awareness, the chairman asked about how the coverage by the recent BBC documentary series had affected recruitment. It was reported that the service had received around 3000 applications for student paramedics.
Responding to a further question, officers added that violence towards staff had increased nationally but was not as significant in Herefordshire, where there had been two incidents in the past 6 months.

RESOLVED
That:

(a) the performance and service developments of WMAS be commended;

(b) performance targets to be defined so as to be specific, measurable, achievable, relevant and time-bound (or 'SMART') as a presentable format for members to consider;
(c) handover times at accident and emergency be monitored; and
(d) a performance update be included in the committee's work programme for 2018 – 19.

24. LIVING WELL AT HOME - TRANSFORMING COMMUNITY SERVICES

The director of operations, NHS Herefordshire Clinical Commissioning Group (CCG) introduced her report and reminded members that the CCG presented information on the engagement approach around developing community services to the committee on 23 August 2017. The approach had been adapted in response to the committee's recommendations. Healthwatch had contributed to the work, by running some of the events and attending the public meetings.
A lot of information had been provided for the meeting, although it was structured for officers to guide through.

The deputy director of operations presented the report, drawing attention to the following:

- the process of engagement commenced at the start of July, and ran through to the end of October.
- There had been inter-agency involvement between 2gether NHS Foundation Trust, Wye Valley NHS Trust and Herefordshire Council in facilitating the discussions.
- The approach to engagement recognised the diversity and rurality of the county and sought to get to the depth of conversations at various locations including doctors' surgeries and supermarkets. It was intended to hear from people who did not tend to come to public events so social media were used. All types of care experiences were heard and the process explored what healthcare looked like. Parish and town council were attended and an ongoing dialogue was established.

The findings from the engagement exercise and locality information were shown in appendices 2 and 3 and all information had been shared with participants. The key areas of interest were summarised as:

- barriers to accessing services, such as transport, and perceived barriers such as not wanting to be a burden on system.
- overwhelming feedback for services not to rely on the internet. There was too much information so it was hard for people to filter out unhelpful information, and other people wanted to speak to someone to check their problem out.
- prevention was a key activity and it was important to recognise that the NHS was not a finite resource.
- Addressing rurality and how to identify issues regarding frailty and mental health was part of the community resilience approach.

The chairman noted that the 803 members of the public who participated amounted to 0.5% of population and represented a statistically limited representation of the county's demographic. She particularly noted the deficit in responses from younger people and commented that the choice of venues was not user friendly. It was acknowledged that this was a small number over a 3 month period, and experience showed that it was difficult to engage with the diversity of people who did not think the subject was relevant to them. A range of venues were visited, including children's centres and maternity clinics as well as making use of social media.

A member commented that the flaw in the exercise was that people who were not users would not engage, and wondered where this approach originated from if it were a waste of time. He commented further that some of the issues were not being taken seriously enough, such as population growth in near future anticipated with the university

development, and that there was insufficient information to inform this. The member expressed reservations about the approach that had been taken and commented on a need to look at the model for information gathering and how to achieve better representation.

The CCG accountable officer responded that it was recognised that the demographic was changing and it was necessary to plan for the future. He added that the NHS worked to a centralised planning process which did not always work. In this engagement exercise, the intention was to be open and transparent about the position and supporting choices about people's healthcare. In terms of whether the engagement had taken the right approach, it was agreed that the percentage level of response was small, but the quality of the engagement with those people was good. It was difficult to engage people unless they were using services, but the data collected was rich and would influence how health services would be designed for the future.

The Healthwatch representative commented that the level of engagement was good as it was about the breadth of opinion and the views that were given. It was difficult to engage with people in Herefordshire, but the approach yielded a decent amount of engagement.

The member responded that the point of the exercise was to gather information, and that it seemed the public had not been given the information they could relate to in order to obtain a level of meaningful engagement.

Responding to the comment, the accountable officer explained that the informing piece was the national NHS strategy led by the 5 year forward view which set out the broad strategic direction disseminated to the 44 sustainability and transformation partnerships. The Herefordshire and Worcestershire plan was about getting the NHS fit for the future and to manage resources, and there had been extensive engagement around this. The recent engagement was intended to establish what this meant for families, carers and relatives, using a locality based approach to find local solutions for local problems.

The director for adults and wellbeing observed that there had been significant forward planning and analysis and the projected demographics over the next 15 years were understood, and the growing cohorts of older people and the university population would inform the planning. It was recognised that the current model was not sustainable and although NHS budgets were increasing in real terms this was not reflective of the projected growth in demand. The county had to be financially sustainable by 2020, so it was essential for the population to live healthier lifestyles with low level needs and reducing long-term reliance on the acute care sector. It was essential to talk to as many people as possible to gather views but there had to be a shift in the basic model so people were in their own homes and not demanding hospital services.

The director of operations explained that the CCG governing body supported the locality based dialogue on living well at home and self-care with the demand for more support for people to keep well. Referring to the clinical case for change summarised in appendix 6 of the papers, she described that the health and care system was working as one to support people to help themselves and be supported at home. She added that it was essential to have plans that were sustainable in the long term so the system worked together to produce a clinical case for change, which was endorsed by the West Midlands Clinical Senate which had tested the clinical viability and credibility. It was concluded that there were workforce development needs which were being addressed, along with the ongoing engagement. The senate supported the model with regard to choice and consistency with national strategy. Appendix 6 showed the facts and nature of Herefordshire such as transport, supporting people to access care and bringing it as close to them as possible. To further this plan, there was investment in additional care such as the home first service, and in community services teams and moving away from bed-based care.

The Wye Valley NHS Trust director of community services added that the work to support people in their own homes was an integrated approach through the home first team and it was intended from 1 December to deliver patient care to those whose care was best provided in the community. It was well known that people become less independent the longer they stay in hospital and it was possible to support people more quickly with plans in place in their own home.

Responding to the points raised, the chairman recognised the difficulties in maintaining consistent standards of home care and finding staff to care in rural areas. She pointed out that community hospitals pre-dated the NHS and were cherished by communities and so attempts to downgrade them would be a challenge without a convincing argument.

The director responded that there was no risk to the community hospitals as they were at the heart of the community and this was not about taking the resource away from communities. The engagement work would tell people that they are seen them as hubs for the future. The challenges around community care were recognised and work had identified that teams needed to feel they had wider support and a network, which would help teams to recruit and retain people.

A member in attendance commented that the plan was about the withdrawal of intermediate beds from market towns and observed that the engagement exercise was resource heavy with little response and low-key publicity, which did not find out what the public wanted. He suggested that whilst this was about meeting central requirements, the public would not engage in the removal of intermediate care and introducing potentially poor quality and costly home care. It was clear what the public wanted, which was a decent healthcare system and to be treated when they needed it. He added that there were issues regarding resources over winter and the impact of Brexit on the workforce.

The accountable officer reminded members that this was about reducing reliance on beds and increasing support for home care. The plan was designed to ensure this was a meaningful local strategy and ensure due process for engagement, which has gathered feedback to support a reduced reliance on beds and support people to be cared for at home. The plan made financial sense and reflected national strategy.

The director of operations identified the next steps; to move forward in using additional capacity and shifting how care was supported. It was proposed that the Hillside beds would be withdrawn by February 2018 with a period of transition for the workforce to adapt and to recognise the better ways of supporting people. The locality discussions would continue, being clear about the resources available.

A member expressed that the suggestion of Hillside being reduced or ended was appalling. She asked about the rationale, the data regarding occupancy and the views of staff regarding their redeployment. She also expressed concern about the timing as February presented issues for winter care needs and bed blocking. The member believed that this was an annexe that was greatly needed.

In response, the Wye Valley NHS Trust managing director explained that an audit of needs and evidence base that showed that people's care could be better provided at home and needs could be met. There had been consultation with staff on the changes.

The director of community services added that staff were aware of this meeting and had started to engage on their feelings, that they were proud of their service and recognised that the site presented challenges and did not provide for care of individuals. The aim was to retain as many as these staff as possible within teams in the community.

A member made the observation that last winter the services were well-used, suggesting that people would not receive that level of care within the community because staff would not have the same amount of time to spend with people. There was also the scenario of people being left unsupported in between visits.

The director of community services clarified that the intention was for those people who were medically stable to be supported to go home as soon as possible, rather than those with acute needs. The Hillside Centre saw 400 patients per year, and there was more than sufficient capacity to care for those people in the community who were best placed in their own home.

The CCG accountable officer added that it was necessary to make decisions without immediately available replacement services but as this was a necessary direction, the two provisions were working in tandem. It was envisaged that a settling in time would be needed ready for end of winter in February. He added that the new approach would more than provide what was required and although the Hillside Centre was the right facility 15 years ago it was not recognised that people needed to be supported at home. It was made clear by the CCG governing body that this was a clinical decision around quality of care.

The member replied that there remained a concern regarding bed reduction and an increase in delayed transfers of care.

The vice-chairman commented that the perceived threats to services were inflammatory because local community hospitals in market towns were hugely valued by the public, although it was recognised there was financial pressure and most people would prefer to be at home. He added that this, however, needed resources, and asked about the practicalities of deploying people locally to look after people at home.

The director of community services explained that it was possible to maximise support at locality level and the locality teams would include the voluntary and third sector although it was necessary to expand this to make the pathway clearer and deliverable.

A member asked whether it were possible to retain the Hillside building in case required in an emergency. The CCG accountable officer explained that the Hillside Centre building was owned by the council so it was for the council to determine its use.

The director of community services added that the wish was for the Hillside staff to be redeployed to community teams as a priority, or to other parts of the acute service.

A member in attendance commented that it was not sustainable or safe to rely on volunteers. The director of community services explained that the vision was for localities to work together to increase professional staff but also to recognise that there were people in communities who contributed.

A member in attendance referred back to the earlier point regarding the opening of the Hillside Centre as at the time assurance was given that the new facility would meet demand. The proposals suggested that the population forecasting was wrong at that time, and asked what assurance there was that it was right this time.

The accountable officer explained that the demographic changes such as an increased burden of supporting frailty and long term conditions that were shared by social and health care had not been fully taken into account.

RESOLVED
That:

(a) Improvements to the delivery of care at home be supported;
(b) The 'double-running' arrangement during the transition period into community provision be supported;
(c) That the principle of keeping services local be supported;
(d) NHS Herefordshire Clinical Commissioning Group provide an update to the committee at an appropriate time in 2018.

25. COMMITTEE WORK PROGRAMME 2018

Members reviewed that work programme and it was suggested that the workshop to be held in early 2018 be designed to cover themes relating to the sustainability and transformation partnership and NHS reconfiguration.

Attention was drawn to the proposed changes to the Spring 2018 dates, those being 27 March 2018 and 8 May 2018.

It was agreed that it would be arranged for members to visit the air ambulance hub.

RESOLVED
That the proposed amendments to the work programme and committee dates for 2018 be approved.

The meeting ended at 12.25 pm **Chairman**