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STAFFORDSHIRE moorlands DISTRICT COUNCIL

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Chief Executive

HEALTH OVERVIEW & SCRUTINY PANEL SUPPLEMENT AGENDA

Date: **Wednesday, 11 September 2019**

Time: **2.00 pm**

Venue: **The Council Chamber, Moorlands House, Stockwell Street, Leek**

Please find below an additional report which wasn't included when the agenda was published.

PART 1

4. Minutes of the Last Meeting of the Healthy Staffordshire Select Committee. **(Pages 3 - 10)**

SIMON BAKER
CHIEF EXECUTIVE

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Minutes of the Healthy Staffordshire Select Committee Meeting held on 15 July 2019

Present: Johnny McMahon (Chairman)

Attendance	
Charlotte Atkins	Dave Jones
Tina Clements	Paul Northcott (Vice-Chairman)
Janet Eagland	Jeremy Pert
Maureen Freeman	Bernard Peters
Phil Hewitt	Carolyn Trowbridge
Barbara Hughes	Victoria Wilson
Janet Johnson	

Apologies: Ann Edgeller, Richard Ford, Kath Perry and Ian Wilkes

PART ONE

14. Declarations of Interest

The Chairman declared an interest in item 4 'Single Strategic Commissioning Organisation' as he had previously Chaired a Clinical Commissioning Group board.

15. Single Strategic Commissioning Organisation

Sally Young, Director of Corporate Governance, Communications and Engagement and Anna Collins, Associate Director of Communication & Engagement attended the meeting to present the report and answer questions.

The Committee were being asked by the Staffordshire Clinical Commissioning Groups (CCG's) to provide feedback on the proposal to become a single Strategic Commissioning Group. All stakeholder consultation feedback would be reported to the CCGs GP membership during their consideration. The GP recommendation would then be conveyed to the CCG's governing body. Any application to merge would then have to be made to NHS England with a view for it to commence in April 2020.

The consultation had started in May and would conclude in July 2019. A number of public meetings had been held and the CCG website had links to the documents.

15 other groupings of CCG's in the Country were also going through this process at the same time.

The potential benefits of merging were outlined as:

To the public

- Local delivery, through Divisions, working to keep patients at the centre of all they do.
- Help reduce variations in patient outcomes and improve patient experiences.
- Stronger patient engagement (e.g. focussing on services and improving outcomes).
- Reduced duplication - doing things once, not multiple times (as envisaged by the Long Term Plan).
- Help deliver care closer to home by strengthening community services.
- Strengthen providers and commissioners working together.

To GPs

- Stronger primary care voice with providers within the Divisions.
- Enable GPs to do things once.
- Free up time for staff to deliver once rather six times.
- Clarity in decision making processes.
- A focus on Divisions deciding how they will implement a single strategy.
- Support GPs working together.

To Commissioners

- Focus on outcomes by strengthening our Divisions and giving delegated responsibility for local decision making to Divisional Committees.
- Quicker and simpler decision making.
- Better relationships with providers.
- Higher quality strategy.
- More efficiencies which can reduce costs and our deficit.

To Providers

- Better relationships and integrated working.
- Quicker and simpler decision making.
- More control over the design of services and also about working together as a system.

An overall advantage was that one single CCG would to align with the Sustainability and Transformation Partnership (STP).

Currently the options available were:

1. Keep the current arrangements of six separate CCGs under a single leadership team
2. Develop a new, single CCG

If NHS England were not in favour of option 2, the CCGs could relook at alternatives next year.

With regard to the recent NHS England's CCG assessments, Members asked if five of the six CCG's rated as "inadequate" would reduce the number of "inadequate" CCGs to one and was this a national motivator to encourage mergers. The Committee was informed that there were 5 different domains covered in the assessment process. However, if the financial domain is viewed as inadequate the overall rating would always reflect this, regardless of the findings in the other areas.

There was concern that the move was financially led and one consideration that hadn't been mentioned was commissioning policies. A question was asked on if the merger took place, would all commissioning policies align, for example hearing aids or would the local areas have the ability to continue to commission based on local need. In response, it was confirmed that a single CCG would align policies, and this had already commenced and discussed at a previous Committee meeting.

The Committee were concerned that the North and South of the County had very different population needs, and it was felt that local differences should be recognised.

A Member of the Committee felt that the Staffordshire NHS system was challenging, and little transformational change had happened in recent years to make the patient pathways sustainably viable and clinically more effective. It was asked how one CCG was going to address this. An example of a benefit was given as commissioners and suppliers meeting weekly to work together and draw up plans for an intelligence fixed price system which would move towards a more block contract approach where an agreed amount is paid and anything above that is agreed.

It was acknowledged that one CCG would change the way services were financed but not necessarily change the system for the patients benefit. It was asked how this was going to make the system transformative. In response, the Committee were informed that bringing all parties together would help but local knowledge would still be needed for local decisions.

There was concern around hard to reach groups and how they would access the consultation. On a wider issue, the Committee asked how many consultations were taking place at the current time across the county and could this lead to consultation overload especially as the documents were quite long and sometimes complicated. In response, it was informed that there were quite a few significant consultations taking place, but the CCG had an obligation to consult and public feedback and comments were needed in order to inform service design and decision making. It was acknowledged that there were also a number of Local Authority and Police and Crime Commissioner consultations all competing for attention. Summary documents were available and social media was used whenever possible.

In response to a question on what the STP thought about the proposed merger, the Committee were informed that a response had not yet been received. University Hospital North Midlands (UHNM) had indicated their support and a summary of all responses would be available at the end of the consultation.

It was felt that cultural change was needed more than changing the structures.

RESOLVED: That the Committees concerns, as listed below be fed into the consultation:

a) There was concern that the move was financially led and that commissioning policies hadn't been mentioned. The Committee were concerned that the North and South had a very different population need and local need should be recognised. There was a concern that commissioning policies would be changed to the detriment of the public.

b) It was felt that cultural change was needed more than changing the structures.

16. George Bryan Centre Engagement Plans

Lisa Agell, Head of Mental Health Services, Midlands Partnership NHS Foundation Trust and Nicola Harkness, Managing Director, South East Staffordshire CCG's, attended the meeting to present a report in relation to the engagement plans for the George Bryan Centre.

A fire at the Centre earlier in the year had led to the transfer of patients to St Georges Hospital, Stafford. It had since been decided to close the East Wing and the West Wing closed temporarily pending consultation about the future service provision for South Staffordshire.

The Committee was informed that the facility was a short stay service with an average stay was 21 days. The current capacity at St Georges was 12 short stay beds. Following the fire, patients were moved to St Georges, but no patient was discharged early or without a discharge plan.

The consultation process was described.

Security to the building was being provided until discussions with local partners were held to decide if there was a temporary use for the buildings. There were proposals to house the Community Mental Health services which is currently located in the Sir Robert Peel building. There were also discussions taking place over the Milford Ward which is normally used to support hospital winter pressures and the affect this would have on reducing capacity.

Members expressed concern that patients and families had to make a 60 mile round trip from Tamworth to Stafford and this was not acceptable, they felt that the need was in Tamworth and patients needed to be treated in their own communities.

A question was asked on the current location of the "Place of Safety" This was a facility where people who are at risk to themselves are placed but for a temporary measure until assessed. The facility can only be assessed by the Police. In the South of the County there were three assessment rooms and one in the North. There was no national guidance on the amount of facilities needed, it depended on local demand.

Following a question on the capacity of the ward prior to the fire, the Committee was informed that the George Bryan Centre was never 100% full.

RESOLVED:

a) That the CCGs and Midlands Partnership Group be informed that the Committee felt that the 12 bed based facility, should remain in Tamworth.
b) That following the consultation, the CCG should bring detailed proposals to the Committee for consideration.

17. East Staffordshire CCG Community Services Procurement

Nicola Harkness, Managing Director South East Staffordshire CCG's, attended the Committee to explain the commencement of the procurement process to secure a provider to deliver community services, following the termination of the Improving Lives contract by Virgin Healthcare Services Limited in April 2019.

Following a question on funding for the contract, it was explained that the CCG had carried out a benchmarking exercise with other CCGs and there was confidence that there was sufficient funding to commission community services.

A Member felt that this was a window of opportunity to address some of the cross boundary issues in South Staffordshire, with different systems between primary and community care. Members questioned how the whole community hospital relationship process would be made more seamless. It was explained that the procurement process was underway and the potential bidders would be known in November 2019. One of the key areas of inquiry as part of the bidding process would to understand how each bidder would aim to better integrate services as this was a key part of the NHS Long Term Plan.

The Committee were informed that the reasons for the termination of the contract had been explored and any learning from this information would be used to inform the development of the procurement process.

RESOLVED: That the report be received.

18. Integrated Urgent Care (GP Out of House and NHS 111 services)

Redecca Scullion, Deputy Director of Commissioning and Operations for Staffordshire and Stoke on Trent CCG's and Ashley Shatford, Urgent Care Strategic and Operations lead for the six CCG's attended the meeting to present the report and answer questions.

The Committee was informed of the plans to deliver the new national service specification for Integrated Urgent Care which included the integration of GP Out of Hours and NHS111 services. The service would be more aligned to a single point of access. The procurement process and timetable were explained. The new service would be operational from 1 October 2020.

It was explained that the current service was made up of a number of services which were difficult to navigate for patients. This confusion and lack of access to urgent care appointments often lead to an over reliance on A&E services. During the development of the specification, small pilots had been in operation in order to test the impact on patients and services.

A Member expressed concern that if the procurement was due to the mandate of a national specification and also a realignment with the STP model, would it fully integrate with all partners such as the West Midlands Ambulance Service (WMAS) and Mental Health Services, as full integration of both services and information was needed. It was also asked if there had been any analysis of the failures of the current services to access and if patients were in the wrong service and which partner had referred them. It was felt that this would highlight the problem areas, which could be addressed without the need for re-procurement.

It was explained that services such as WMAS and Mental Health were part of the Integrated Urgent Care and overall delivery and as part of the procurement process they would be consulted to see how they could support the integration of the 111 service in order to provide a system integration.

The current system was operated on a binary process and any future service needed to see a more clinical judgement. This should be possible through access to patient information records which could lead to better alternatives found in the community.

A Member asked, if integration was vital what was being procured and wouldn't it make more sense to procure a facilitator organisation to bring together the services. In response, it was explained that due to the European procurement rules, the contracts were due to expire so the services listed below had to go through a procurement exercise:

- 111 service.
- Call handling.
- Clinical validation of the calls and clinical support
- GP Out of Hours for Staffordshire with the except of Seisdon area which is under the Wolverhampton CCG.
- Urgent Care Centre at Royal Stoke A&E.
- Out of Hours prison service.
- Systems response and how it is all pulled together through the Urgent Care Board and the aligning in it with the Primary Care Board.

A Member felt that it appeared that this was an exercise to reduce A&E attendance by using different care pathways. If this was the case, how successful would it be and how will it be measured. In response, it was explained that it was greater than just reducing the number of people accessing A&E and more to do with getting people to the right place with less contact rather than being bounced around the system. Work was taking place with all partners in form of mini pilots, but the service needs to be delivered at an STP level as this will bring greater benefits.

NHS 111 works on clinical algorithms which were very defensive and often resulted in referring patients to A&E. The Committee were informed that the algorithms were national, but the CCG was looking at the Clinician completing the process by checking the responses and making the decision based on patient history and information. The algorithms will have to remain, but the new working method would stop it making a clinical decision.

The new service would also allow access to direct booking in primary care through the new GP contract.

When asked how other parts of the Country were addressing this, Members were informed that some areas were going through this is part but not in full. The Chairman suggested looking at the "Celtic fringe" as these tended to be ahead of England.

Concern was expressed over the transfer of patients to Primary care and Community care which were services that were also overburdened, and it was felt that more emphasis needed to be on patient behaviour changes and preventative care.

RESOLVED: That the Committee be kept informed of the outcome of the procurement process.

Chairman

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