Appendix A

NOTES

Health OSC Steering Group
Friday 4 April 2014 – Scrutiny Chairs Room (B14a)
2.00pm

Present:

- County Councillor Steve Holgate
- County Councillor Mohammed Iqbal
- County Councillor Margaret Brindle
- County Councillor Fabian Craig-Wilson

Notes of last meeting
The notes of the Steering Group meeting held on 14 March were agreed as correct.

Care Closer to Home
Janice Horrocks (Consultant working with Southport & Ormskirk Hospital Trust and West Lancs CCG) attended Steering Group to provide members with an overview of the Care Closer to Home Programme.

The Care Closer to Home programme outline – April 2014

Care Closer to Home (CCtH) is a partnership of health and social care organisations across North Sefton and West Lancashire, who are working together to transform health and care delivery to improve the health and wellbeing of our communities.

The CCtH vision statement:

This programme is about allowing everyone to live fulfilling, independent lives, which are supported by safe, quality, patient centred, accessible and seamless services. This will be delivered by a skilled, committed, satisfied and integrated workforce, who together with the public and colleagues across the health, social care and voluntary sectors, take pride in providing quality care. We will achieve this by being innovative and having the vision and courage to do the right thing, building trust and co-ownership with care providers, partners and patients through effective two way communication and listening to experiences of care.

The aim of the CCtH programme is to make significant improvements, by ensuring services work better together across the local NHS – hospital, community and general practice – social care and the independent and voluntary, community and faith sectors. CCtH is focused on providing better, more seamless care for people with long term conditions and those at greatest risk of needing urgent hospital treatment. CCtH aims are summarised as follows:

- Empower patients to take control of and responsibility for their own health and wellbeing through self-care and management programmes.

- Ensure that primary care services are accessible and of high quality in order to reduce demand on hospital services.

- Improve the co-ordination of care for patients living with long term conditions in order to reduce their need for urgent care services.

- Ensure that health and social care services are commissioned and delivered in a collaborative way in order that as many people as possible can be cared for out of hospital and to facilitate peoples' discharge from secondary care more effectively than it is currently.

- Establish services to deliver as much as possible of peoples' urgent care needs out of hospital if they do not need the expertise of hospital clinicians.

A number of **strategic objectives for the CCtH programme** are set out below:

- To design an urgent care system that delivers integrated services outside of hospital for people whose need for urgent care might be for responsive advice, support and treatment.

- To ensure that the existing commissioned health, social care and voluntary services that make a contribution to urgent care delivery are optimized.

- To better plan and deliver care and support to people with long term conditions in order to minimise their need for hospital based urgent care.

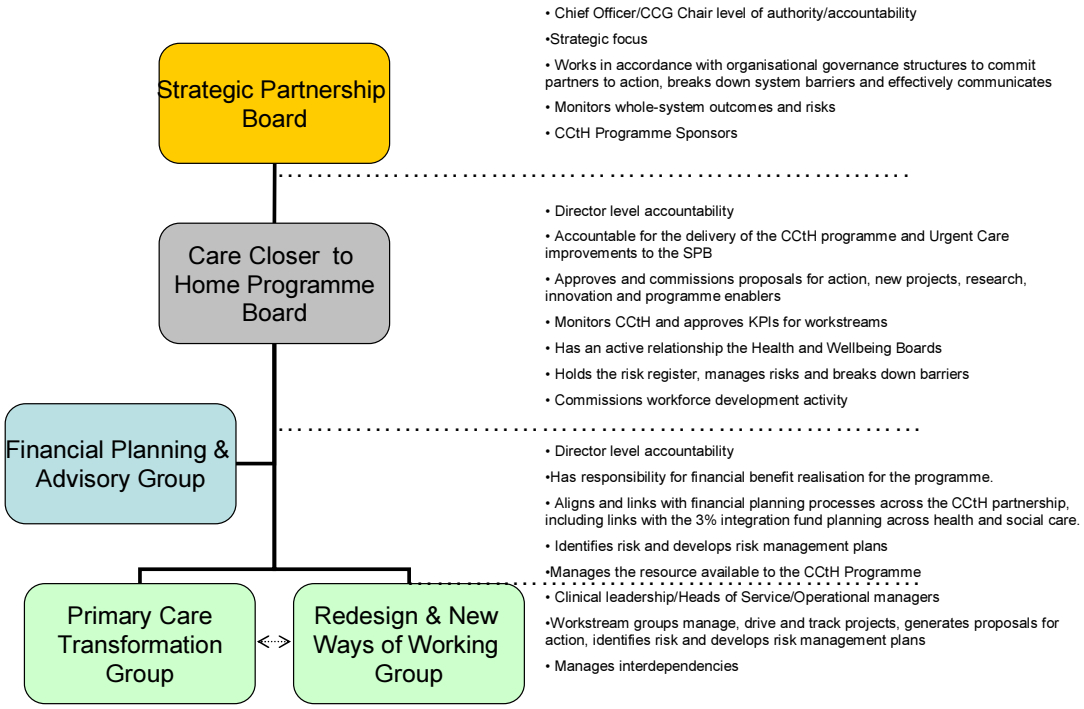
- To ensure that end to end pathways in and out of hospital run smoothly ensuring a good patient experience.

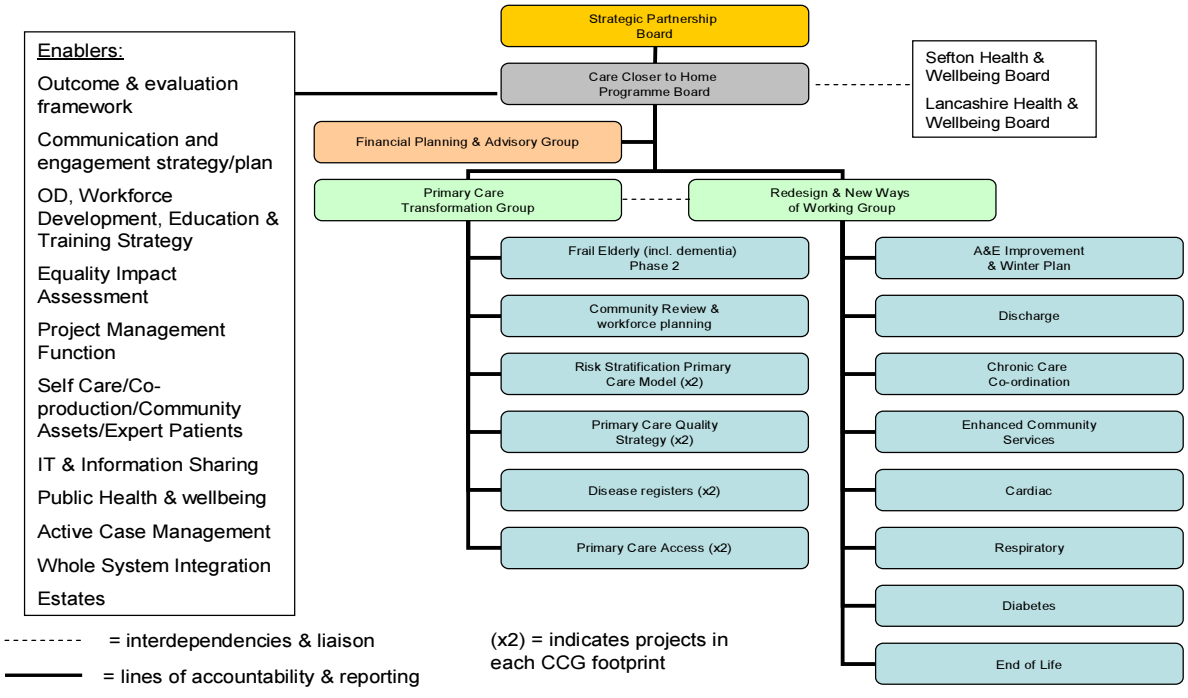
- To improve local population awareness of alternatives to A&E attendance to address its urgent care need.

The CCtH programme is designed to deliver better health outcomes and people will see more services provided effectively and safely closer to home, making it easier and more convenient for patients. CCtH will support patients to better manage their long term conditions, and make it easier for people to get the most appropriate care in the most suitable location at the time they need it. The success of the CCtH programme will be measured by health outcomes, patient experience and reduced demand for urgent care.

Appendix A

The CCtH programme governance and architecture





A general discussion took place and the main points were:

- Brings all partners together, nursing homes, 3rd sector, inc CVS, dementia groups etc, LA's (Sefton, LCC, West Lancs DC), CCGs,
- About shifting care out of acute settings and into the community – growing elderly population, twice as many care homes in the Southport area than the rest of the country.
- Developing intermediate care (step up/step down) – CCGs doing this
- SOHT working with CCGs as part of Better Care Fund to increase the step down beds – need more. – working in the Sefton area but still need to agree funding with LCC.
- The winter intermediate care plan has worked – system is right but just have a capacity issue.
- The improvements that's happened over the last year has worked and reduced acute activity – but it's an issue when activity gets too low in terms of sustainability/safety.
- This is the only way of dealing with the older population needs without increasing investment.
- Needing to quantify and prove what's already been done and that's its working – big difference has been made in terms of A&E – massive reduction in waiting ambulances.
- Slighter fewer beds - 98 to 93% occupancy.
- Re funding for activity – is there more activity now due to shorter length of stay. Would like to slightly reduce bed capacity to enable a better way of working, want to be just slightly less than capacity so have free space to work.
- Frail/elderly ward – created this winter this is different to intermediate care which doesn't always require a hospital stay. Have funded beds in nursing homes. This method is more cost effective than keeping someone in hospital but just has a nursing need (i.e. not specialist medical need)
- This unit now works differently – remit is to try to discharge people within 5 days. Already have OT, physio, social work team on site to work together swiftly – multi disciplinary team focused on rehab - Trust worked hard to create this ward with very short timescales
- Readmission rates reduced – Community emergency response team – provide intensive support on discharge up to 6 wks (longer if needed) then hand over to whoever will provide the ongoing support – e.g. community matron, nursing home etc.
- Overall – the current system was 'overheating' so the new ways of working has produced a level that is safer to manage. (By reduction in occupancy).
- Beyond the community investment it's also an acute trust – steadily improved over last few years, smaller trust than neighbours. Trust Development Agency (TDA) is beginning to produce national reporting for every trust and the website shows level of improvement over the last year.
- Working with patients waiting longer than 18 weeks – rather than just hitting the target for the majority – lots of quality and finance standards that they need to adhere to. Need to be sustainable systems in place. TDA have forwarded them for inspection in October – part of the process of becoming a trust.
- Main A&E is in Southport, Paediatric A&E in Ormskirk, walk in centre in Skem and another in Ormskirk which is a partnership arrangement with local GPs and the trust.

- Difference in standards in walk in centres due to who manages it. Ormskirk one is steadily growing and its felt because this is the preferable service to sitting in A&E.
- GPs are starting to improve where they refer patients – but some GPs will do what they want
- WLCCGs – acute visiting scheme, employ 2 GPs and working with NWAS, if ambulance team determine that a GP can deal with it then this is arranged and a GP visits the home rather than take someone to A&E. – testing and piloting this system
- Genuine partnership and all partners are at the table – everyone is owning the process.

Southport & Ormskirk Hospital Trust - Pathology

Damien Reed, Deputy CEO/Finance Director attended Steering Group to update members on the partnership arrangement with St Helens & Knowsley NHS Trust for pathology services.

The Trust is proposing to agree a partnership arrangement with St Helens & Knowsley NHS Trust.

Although the move will save money, the main driver is quality. Southport & Ormskirk's pathology directorate is simply too small to be viable on its own. We have long-standing consultant vacancies in both cellular pathology and biochemistry that have proved impossible to fill, and we are also struggling to maintain scientific staffing levels in the blood science department. As well as economies of scale, a larger laboratory will allow greater subspecialisation and also bring the professional benefits of a larger pool of colleagues.

Currently, it is expected that the microbiology and cellular pathology departments at Southport & Ormskirk Hospital NHS Trust (SOHT) will physically move to Whiston Hospital some time during 2014-15. The blood sciences department (biochemistry, blood transfusion and laboratory haematology) and the mortuary and bereavement service will remain physically based at SOHT.

There should be no impact on services received by primary care or consultants within the Trust

A discussion took place and the main points were:

- Damien explained the new approach to providing this service – no impact on patients as the service will still be provided from the hospital, the changes are who the staff are that are doing the service.
- Janice happy to meet with members whenever they want – Steve explained about the new ways we're trying to deliver scrutiny and information to members.
- Other point Steve wanted to ask/make is about the amount of administrators and spin doctors – do they feel that the amount of admin money spent is reflective of the work required. Damien replied that their Communications team is 2 people and they have a full and necessary workload. – Obviously this is key when wanting to deliver a new concept and new ways of working.
- Janice replied – works with 3 comms leads and she still struggles to get their assistance as they are very busy and no capacity to take up new work

streams. Have to invest in engagement and ask communities involved in the discussions and decisions.

- Part of the reason why they need to work closer with health and well being (PH colleagues) – early days and lots of room for improvement. Are providers involved enough in the design and delivery of services.
- Some of what will happen in the future is down to national direction – BCF is more about services working together.
- FCW expressed concerns around best practice models in that duplications need to be weeded out and patient info should follow them through a pathway so they don't have to go through the same process more than once.
- One of the biggest challenges is the integration of IT systems – will enable all partners to access and share info more easily
- Working with GPs is easier – as the trust has agreed to work with their systems, podiatry and diabetes and community matrons – possibly take over in 12 months
- Sharing between hospitals is more tricky as don't always delivery pathways in the same way.
- FCW feels that the info should be with the patient and not the hospital to get round this issue – Damien agreed that more work is needed on this
- This is a solution that can only be done centrally – systems and protocols
- Info governance is an issue for GPs and CCGs – they no longer have direct access to patient info and the CSU anonymise the info instead so it's of no use.
- Why not use NI no or pin number to enable access to records.
- The trust has a vast quantity of manual records that need to be electronically recorded. – some GPs are very resistant to doing things differently.
- Project starting looking at electronic discharge - the Trusts discipline about how it communicates with GPs etc. CCG has included this as a quality incentive within the contract. This should have a positive effect on the readmission issues.
- The financial pressure on acute trusts are increasing significantly – issue for the future as this is not sustainable
- No longer have the financial safety net within the local health economy.

Dates of future meetings

- 2 May – Mark Hindle, Chief Exec, Calderstones
- 23 May – ELCCG re proposals for Health Access Centre in Hyndburn – change this date as it's the day of the local election count.