Health Scrutiny Committee
Meeting to be held on Tuesday, 4 February 2020

Electoral Division affected: (All Divisions);

Report of the Health Scrutiny Steering Group

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Executive Summary

Overview of matters presented and considered by the Health Scrutiny Steering Group at its meetings held on 20 November 2019 and 18 December 2019.

Recommendation

The Health Scrutiny Committee is asked to receive the report of its Steering Group.

Background and Advice

The Steering Group is made up of the Chair and Deputy Chair of the Health Scrutiny Committee plus two additional members, one each nominated by the Conservative and Labour Groups.

The main purpose of the Steering Group is to manage the workload of the Committee more effectively in the light of increasing number of changes to health services which are considered to be substantial. The main functions of the Steering Group are listed below:

1. To act as a preparatory body on behalf of the Committee to develop the following aspects in relation to planned topics/reviews scheduled on the Committee's work plan:
    - Reasons/focus, objectives and outcomes for scrutiny review;
    - Develop key lines of enquiry;
    - Request evidence, data and/or information for the report to the Committee;
    - Determine who to invite to the Committee;

2. To act as the first point of contact between Scrutiny and the Health Service Trusts and Clinical Commissioning Groups;

3. To liaise, on behalf of the Committee, with Health Service Trusts and Clinical Commissioning Groups;

4. To make proposals to the Committee on whether they consider NHS service changes to be 'substantial' thereby instigating further consultation with scrutiny;

5. To act as mediator when agreement cannot be reached on NHS service changes by the Committee. The conclusions of any disagreements including referral to Secretary of State will rest with the Committee;

6. To invite any local Councillor(s) whose ward(s) as well as any County Councillor(s) whose division(s) are/will be affected to sit on the Group for the duration of the topic to be considered;

7. To develop and maintain its own work programme for the Committee to consider and allocate topics accordingly.

It is important to note that the Steering Group is not a formal decision making body and that it will report its activities and any aspect of its work to the Committee for consideration and agreement.

Meeting held on 20 November 2019

- **North West Ambulance Service: Rota Review - Lancashire Area Consultations**

Peter Mulcahy, Head of Service Cumbria and Lancashire Area, North West Ambulance NHS Trust presented a report providing an update regarding the recent review of staffing levels and shift patterns affecting all frontline staff at the Trust.

The following points were highlighted:

- The new Ambulance Response Programme now required ambulance services to reach 100% of life threatening cases within seven minutes. In order that this be met it had been necessary to review clinical resources to ensure they were sufficient to meet demand. The review had resulted in an increase of ambulance cover of 519 hours per week in Lancashire (689 including south Cumbria who supported north Lancashire), supported by funding of £8.3 million. These hours were for double crewed ambulances of one driver and one technician in Lancashire only.

- The Trust would be subject to a £1 million fine by the commissioner if the required changes to enable targets to be met were not made. In addition the Trust would be held accountable for any inappropriate referrals to hospital.

- It had been identified that some delayed responses were as a result of staffing levels and additional recruitment had been undertaken to address this. Paramedic roles now required a three year degree course plus a year of mentorship. It was noted that there was a national shortage of paramedics, however the Trust had a good reputation as an employer.

- The Trust had commissioned a management consultancy company to carry out a demand analysis of attendance data over last three years. They had identified

projections taking into account changes to the local demographic and had established a suitable model of delivery to meet anticipated needs.

- The changes required to meet the delivery model included a review of the traditional 12 hour shift patterns. Staff had been consulted on preferred shift patterns and this would be accommodated where choices met legislative requirements and demand. All staff would be given the opportunity to vote on the proposed shift pattern during a six month consultation and implementation was planned from April 2020.

- Other measures employed to meet demand included: the conversion of a number of rapid response cars to fully equipped ambulances and staff responsible for low acuity vehicles (used for admissions discharges and transfers) had been given the opportunity to attend fast track training to technician level.

In response to questions from members the following information was clarified:

- The additional hours would be fulfilled by a mix of new shift patterns and new ambulances. Currently 90% of vehicles were in use for 24 hours 7 days a week on two 12 hour shifts, however demand was not spread equally over that time. There was a nationwide commonality of demand over a day, whereby need was high in a morning, followed by a significant surge early afternoon, during GP opening times, and in the evening. The service adapted to demands and known patterns of need. The Trust maintained a pool of spare vehicles and all were maintained to a higher specification than manufacturer recommendation. Pre-planned maintenance was scheduled every six weeks.

- The volunteers mentioned in the report, referred to paid staff who were part of the collaborative working parties liaising with staff to agree the new way of working. However the Trust did buy in services from the voluntary sector and actively encouraged volunteers to apply for jobs.

- In terms of waiting times for an ambulance, once an emergency call had been received the first step was to identify the priority of the call and the most suitable level of support required. For some types of calls the standard agreed time was a three hour response. Calls where there was a protracted delay in arriving were monitored and if any harm resulted from that delay, an investigation would be undertaken and patients would be contacted under the duty of candour. The Trust continued to raise awareness on the 'hear and treat' (resolved on the phone) and 'see and treat' (resolved on site, no admission to hospital required) initiatives. Recent data was shared where over a quarter of incidents were dealt with without admission to hospital. This programme was supported by employing nurse and paramedic skills in the call centre to ensure that the vast majority admitted to hospital were on the correct pathway.

- Busy periods over the year were identified and planned for by reducing leave, budgeting and making additional ambulances available.

Resolved: That the report detailing the recent review of staffing levels and shift patterns affecting all frontline staff at the Trust be noted.

❖ **Terms of Reference for the proposed Joint Health Scrutiny Committee for the Lancashire and South Cumbria Integrated Care System (ICS)**

The steering group discussed the request from the Health Scrutiny Committee to amend the terms of reference for the proposed Joint Health Scrutiny Committee for the Lancashire and South Cumbria Integrated Care System (ICS). It was highlighted that the request to have three Lancashire district council members with voting rights would be constitutionally inconsistent for Lancashire as district council members on the Lancashire Health Scrutiny Committee were non-voting.

Early indication from the other local authorities involved was that they would agree to the additional seats but only as non-voting. The group in considering this point further recommended that the membership of the terms of reference should be revised as follows:

1. Amendment: Each local authority to appoint on the basis of two members from the administration and one opposition member.
2. Addition: Up to three non-voting district council members from the Lancashire County Council Health Scrutiny Committee.

Resolved: That the Chair of the Health Scrutiny Committee writes to the relevant local authorities to seek formal responses to the Committee's requests and the Steering Group's suggestion.

❖ **Suicide Prevention in Lancashire Progress Report**

Lancashire County Council officers: Dr Sakthi Karunanithi, Director of Public Health and Chris Lee, Public Health Specialist for Behaviour Change presented an update on the initiatives undertaken to prevent suicide in Lancashire.

The following points were highlighted:

- The report detailed the substantial work programme in place from December 2017 when the Healthier Lancashire and South Cumbria Integrated Care Strategy (ICS) received funding to reduce suicide rates in the area. Although the numbers in the ICS had fallen, a spike in 2018 and improved rates in other areas had moved the ICS from fourth to third for highest number of deaths by suicide in England for both sexes.

- A Lancashire wide suicide prevention and self-harm partnership had been established which enhanced information sharing and learning and was well attended. It was initially anticipated that this would be driven locally once embedded, however that was yet to take place.

- There was now a focus on real time surveillance, capturing raw data of suspected suicides or drug related death, via the police form completed for the coroner. This allowed for targeted data analysis allowing for more precise tracking of specific places of death. This enabled cluster evaluation, including trends of methodology, age and areas, which would drive prevention work. For example 'hardening' high risk target areas for suicide by installing barriers and signposts for such services as the Samaritans and using technology to alert services for identified high risk individuals. It was explained that last minute interventions to engage the person, such as a text or prompt to reach out could effectively pause suicidal thoughts or actions.

- Training had been commissioned by the county council including Mental Health First Aid, Safe Talk and ASIST (Applied Suicide Intervention Skills Training). The ICS national funding was short term so this was in preparation for when this concluded. Training had also been made available for county councillors and the Public Health team were looking to target district members to raise awareness and secure champions for the agenda. The campaign across the ICS, involving people who had been at risk was highlighted.

- Other initiatives included: bereavement support for families affected by suicide; emergent work for young people at risk of suicide and the subsequent risk of clustering; funding allocated to small organisations to promote an innovative approach to prevention work at a local level; campaigns to promote workplace health and wellbeing and work in schools and colleges for both students and staff.

In response to questions the following information was clarified:

- Bereavement support was specific for suicide and was not extended to bereavements connected with deaths generally.

- The team was aware of the core drivers for suicide and the impact of local weather had not been considered. Deprivation was a key factor as was age, however incidents occurred across all ages and in all areas.

- The team was hoping to review the depression care pathway to address reported difficulties of accessing mental health services.

- The innovative preventative groups listed in the report did not include those groups already providing support. It was acknowledged that sports initiatives such as those delivered by Active Lancashire were valuable for promoting good mental health.

Resolved: That an update regarding suicide rates for the Lancashire and South Cumbria Integrated Care Strategy and the impact of prevention initiatives and real time data analysis be presented to the Health Scrutiny Committee Steering Group in November 2020.

❖ **Committee Work Programme**

Gary Halsall, Senior Democratic Services Officer, Democratic Services advised the steering group that the item deferred from the November Health Scrutiny Committee meeting and the items from the cancelled 3 December 2019 meeting would need to be rescheduled on the work 2019/20 programme. In addition there was a request for a report on Disabled Facilities Grants to be scheduled in accordingly.

Resolved: That the work programme be adjusted to accommodate the agenda items from the cancelled 3 December 2019 Health Scrutiny meeting, keeping to a maximum of two main items per meeting.

Meeting held on 18 December 2019

❖ Review of Primary Care Networks and Neighbourhoods Across Lancashire Consultations

The following points were highlighted and discussed:

- The development of the Primary Care Networks and Neighbourhoods was within the context of NHS Long Term Plan's proposals to deliver local services. The terms Primary Care Networks and Neighbourhoods were often used interchangeably, however there were subtle differences. The overarching concept was to bring GPs together to allow them to work together at scale.

  In response to a request for further clarification it was explained that GPs were becoming increasingly isolated, and this was a way of sharing some areas of work between groups. For example, administrative functions, sharing staff and other resources. This could mean merging practices, working together in a federation, or collaborating to share best practice.

  Those practices that were already working together as Neighbourhoods became Primary Care Networks. Other practices came together for the first time from 1 July 2019, by comparison to other Primary Care Networks that had been established as much as three or four years ago. The new way of working in Primary Care Networks presented new challenges and significant variability regarding leadership.

- Members queried the 'significant ambitions' of NHS England and it was clarified that the expectations were that in the first year the networks would be established with a minimum of at least one social prescribing link worker and one clinical pharmacist. The five national service specifications target for April 2020 were: the introduction of structured medication reviews, enhanced health in care homes, anticipatory care (with community services), personalised care and supporting early cancer diagnosis. The remaining two objectives for 2021 were: cardiovascular disease case-finding and locally agreed action to tackle inequalities. The Integrated Care Partnerships already had some services in place for care homes and that would be developed further by looking at national best practice. Work was underway with regard to cancer diagnosis models, again comparing to national best practice and implementation was anticipated in February 2020. The others would not be in place by April 2020.

- The implementation of some wider staffing roles within GP surgeries, e.g. paramedics employed in response to the shortage of GPs, had been successful across the Fylde and Wyre areas. The embedding of other nationally identified and funded roles that would support the agenda was underway, however the workforce was not readily available and more training and time was needed to shape the roles to meet both the expectations of agenda, and the needs of the service users. There were currently not enough trained staff in the required wider roles.

  In response to a question it was confirmed that funding was available for the training, provided by Health Education England.

- It was confirmed that although they were currently separate, it was a requirement for primary community health care teams such as community mental health providers to integrate into Primary Care Networks.

- Collaborative work with Lancashire County Council colleagues regarding the population health management approach was underway. This was a key feature that would drive Primary Care Networks forward to support a change in structure and provision.

- It was explained that the networks were a vehicle for provision of services and were not commissioners. The networks would interface with the Integrated Care Partnership and this may be done differently for each one. The Clinical Directors were under pressure to deliver the objectives for the Primary Care Networks and it would be necessary to manage the expectations of NHS England, as most were at the start of their journey. The contract for delivery was five years and it was confirmed that it would take that and longer for networks to develop. Each network was at a different stage on the maturity journey and the aim was to move each one to the same level.

- There were 220 GP practices in Lancashire and South Cumbria with 41 Primary Care Networks. To date, three practices from West Lancashire had not joined a network, as their location sat across multiple networks.

  In response to a question it was confirmed that it was hoped that this situation could be resolved, as being part of a network was a benefit to patients.

  NHS England expected between 30,000 to 50,000 service users per network, however five were lower than 30,000. For example, practices in Fleetwood had already been working together as a community for five years so it would not be practical to move them to a network outside their natural geographies and so a case was made to NHS England not to change their current arrangement. In areas of dense conurbation like Blackpool, networks were arranged in their natural communities.

Dr John Miles, the Clinical Director for the Wyre and Fylde Rural Extended Primary Care Network updated the steering group on the network's progress to date and next steps.

The following points were highlighted and discussed:

- Each network had a Clinical Director, for which the sole responsibility was to the practices within it. Since inception, the emphasis had been on building relationships with the practices, understanding the range of population challenges and looking at ways to address shared practice based challenges.

- The Fylde Coast Integrated Care Partnership consisted of eight Primary Care Networks. Examples of the work underway with the networks was shared, such as population health management. For example, using health based and community data to interpret local population issues such as the physical condition of housing and isolation as having a direct impact on health and wellbeing. This

related to the work of the Social Prescribing Link worker as a gateway to link population identified needs with what appropriate support was available in the community. There would not be a single solution that was suitable for the Primary Care Networks' needs, however there would be common elements.

- Fleetwood was already a mature collaboration, who had been engaging with the community on a very broad large scale for several years. Examples of developing links and initiatives in place that have proven successful, were shared with the group.

- The aim was to establish Neighbourhood Care Teams, which put the patient at the centre and allowed access to a range of care providers to meet their health and wellbeing needs. It was noted that this model worked well when all services in the team worked together and was currently a success in Garstang. The goal was to implement this across all Primary Care Networks over the next 2-3 years.

  In response to a question it was clarified that the challenge was to build relationships between the services in the Neighbourhood Care Team and to ensure that the most relevant person was in the collaboration. Each service would have different processes and needs, and the model would need to be adaptable. There were also practical considerations such as aligning computer records. In other networks, the mental health and social care relationships in the team needed more work, this relationship was in place in the Garstang Primary Care Network but not in others. The model would need to fit in with the needs of the area.

Members made the following challenges:

- There was a lack of political involvement, councillors had a good insight into community needs and issues and it was clear that there was a lack of public knowledge regarding the work and development of the networks.

  Members were advised that a Citizens Enquiry had been held in Blackpool, when the public were interviewed to gain a greater insight into their needs and understanding of services.
  The Primary Care Network details, including the Clinical Director information, would be shared with councillors, so they could be aware of what services were set up within their constituency.

- There were issues for some rural residents of Lancashire having access to Health Centres and this impacted on emergency services at hospitals. This emphasised the lack of understanding by the public regarding what was available. It was suggested that integrated service provision worked best when teams were co-located and supported by suitable estate. Preston and South Ribble estate needed more investment.

  It was confirmed that Integrated Care Partnerships had been tasked to improve access for patients, including providing extended hours and services tailored to the local population based on their specific challenges.

In response to further comments it was agreed that services needed to work more closely with authorities and businesses. It was noted that funding was available to support the voluntary, community and faith sector going forward that would facilitate this. However consistency with funding was a risk for the sector.

- In response to a question it was confirmed that the Clinical Director role included: improving access to general practice, integration of services, workforce development and developing relationships with the community and district councils. However each Clinical Director role would be different and there was no set model for the networks.

- Members asked how duplication of work was avoided and how best practice was shared between networks, as some services would be the same for all demographics.

  It was confirmed that each Integrated Care Partnership had a monthly networking meeting and a three monthly meeting was held for all 41 Primary Care Networks in the Integrated Care Strategy. There was a digital platform available to share good practice, and development funding of £1.3 million was available for Lancashire and South Cumbria to support networks in their engagement with communities and building leadership.

- In response to a query regarding using community venues and pharmacists to provide easier access to services, it was confirmed that the development of the networks was an opportunity to take an innovative and pragmatic approach to make changes and improve service delivery.

- It was clarified that Primary Care Networks were a group of GPs working together, whereas Neighbourhoods described GPs working with all community providers.

Resolved: That the Steering Group receive an overview on the work currently being undertaken by the County Council's Public Health team on Primary Care Networks and Neighbourhoods at its meeting scheduled for 19 February 2020.

Implications:

This item has the following implications, as indicated:

Risk management

This report has no significant risk implications.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Tel
None		

Reason for inclusion in Part II: N/A