BIRMINGHAM CITY COUNCIL AND SANDWELL MBC

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (BIRMINGHAM CITY COUNCIL AND SANDWELL METROPOLITAN BOROUGH COUNCIL) 5 JULY 2016

MINUTES OF A MEETING OF THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (BIRMINGHAM CITY COUNCIL AND SANDWELL METROPOLITAN BOROUGH COUNCIL) HELD ON TUESDAY 5 JULY 2016 AT 1400 HOURS IN COMMITTEE ROOM 6, COUNCIL HOUSE, BIRMINGHAM

PRESENT: - Councillor John Cotton (Chairperson); Councillors Deirdre Alden, Sue Anderson, Kath Hartley, Bob Piper and Paul Sandars.

IN ATTENDANCE:-

Tammy Davis – Nurse Manager, Sandwell and West Birmingham Hospitals NHS Trust
William Hodgetts – Healthwatch Sandwell
Paul Holden – Committee Manager, BCC
Toby Lewis – Chief Executive, Sandwell and West Birmingham Hospitals NHS Trust
Angela Poulton, RCRH Programme Director, Sandwell and West Birmingham Clinical Commissioning Group (CCG)
Gail Sadler – Research and Policy Officer, BCC
Jayne Salter-Scott – Head of Engagement, Sandwell and West Birmingham CCG
Sally Sandel – Senior Commissioning Manager, Sandwell and West Birmingham CCG
Sarah Sprung – Scrutiny Lead, Sandwell Metropolitan Borough Council
Dr Jane Upton – Healthwatch Birmingham

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NOTICE OF RECORDING

5/16 It was noted that the meeting was being webcast for live or subsequent broadcast via the Council's Internet site (www.birminghamnewsroom.com) and that members of the press/public may record and take photographs. The meeting would be filmed except where there were confidential or exempt items.

APOLOGIES

6/16 Apologies were submitted on behalf of Councillors Carole Griffiths and Ann Jarvis for their inability to attend the meeting.

DECLARATIONS OF INTERESTS

7/16 No interests were declared.

MINUTES OF PREVIOUS MEETING

8/16 The Minutes of the meeting held on 11 February, 2016 were confirmed.

RIGHT CARE RIGHT HERE – ITS EVOLUTION

9/16 Toby Lewis, Chief Executive, Sandwell and West Birmingham Hospitals NHS Trust together with Angela Poulton, RCRH Programme Director and Jayne Salter-Scott, Head of Engagement, Sandwell and West Birmingham Clinical Commissioning Group (CCG) were in attendance.

The following PowerPoint slides were presented to the Joint Health Scrutiny Committee:-

(See document No. 1)

During the discussion that ensued the following were amongst the issues raised and comments made further to questions:-

a) The Chief Executive advised the Joint Health Scrutiny Committee that the Trust had approaching 150 community-based beds - roughly double the number it had 3 years ago. The intention was that there would be 25 fewer acute beds when the new Midland Metropolitan Hospital opened.
b) Members were informed that the external review to be commissioned and report by June 2017 would confirm whether the Trust was on track to provide the right mix of acute/community-based beds and non-bedded community services when the Midland Metropolitan Hospital opened. It was highlighted that if required there was scope to bring into play 3 hospital wards (80 beds) at Sandwell Hospital or as a longer term measure provide another 3 wards at the new hospital.
c) The Head of Engagement indicated that the transition from the Right Care Right Here to the Sustainability and Transformation Plan (STP) was being presented to the public as the next step on a journey being taken together.
d) A Member voiced concern that no new primary care facilities had been provided in Wednesbury. He also referred to an organisation that had an exclusive primary care deal and in highlighting that he'd not seen any new-build facilities enquired as to the current position.
e) Further to d) above, the Head of Engagement advised the meeting that she understood there were plans for Wednesbury that were scheduled to go ahead and undertook to make enquiries . Furthermore, the Chief Executive pointed out that the Trust and Walsall Health Care, as secondary care providers, had an interest in ensuring that best use was made of existing community assets in the area if no new facilities were provided. In the wider context, the Head of Engagement highlighted that there was a lot taking place in relation to primary care services and that she could report to a future meeting on that as well as the STP, which was currently at a relatively

early stage of development. The Head of Engagement indicated that she did not know the current position regarding the organisation referred to but undertook to find out and respond.

f) The Chief Executive reported that after vacation by acute services, 3 intermediate step-down wards would be moved into Sandwell Hospital; flagged-up the risk of localisation producing duplication if undiagnosed patients were seen by consultants in General Practice, as patients could not be diagnosed in that situation and would have to be seen again at hospital; indicated that he considered that most long-term care patients could usually be followed-up locally; and felt that as the Accident and Emergency Department at Sandwell Hospital would be replaced by an Urgent Care Centre which was expected to see about 35,000 patients a year, this should provide some reassurance to service users.

g) Members were advised by the RCRH Programme Director that residents she'd met had felt more reassured after it was explained that most of the services they received would be available nearer to home at Sandwell Hospital and that patients would only have to go to the new hospital if really necessary.

h) A Member considered that Right Care Right Here was a model founded on the right principles and therefore needed to be replicated going forward. The Member indicated that she would welcome seeing a report on the successes, lessons learnt and how service arrangements would look when the new hospital was up and running.

i) In relation to standardising working arrangements with social care services for all hospital attending patients, the Chief Executive reported that a process would be embarked upon with staff to ascertain whether service provider variations had any clinical merit or were just historical discrepancies - in which case the Trust would seek to remove them. He pointed out that the new hospital would be sited near the Birmingham City Council and Sandwell Metropolitan Borough Council boundary.

j) The Chief Executive advised the meeting that there was a view that the historic care home model that had existed in the UK may not work going forward and that there was a need to look with the market at how a measure of consistency could be introduced in respect of the range of services provided. He considered for example that it would probably make sense if all the care homes that the Trust worked with could admit patients on Saturdays and Sundays. Furthermore, reference was made to areas that could be looked at with the social care services e.g. rather than assessments being carried out twice, acute services and social care carrying them out on each other's behalf and thereby saving a lot of time. He highlighted that the new hospital provided a useful cut-off time in respect of when new arrangements ought to be in place.

The Chair thanked the representatives for the detailed report and discussion on the issues. He proposed that they feedback to Birmingham and Sandwell separately where an issue was specific to a particular Local Authority and aim to have a wider general oversight at the Joint Health Scrutiny Committee in the autumn. Members concurred with this approach.

UPDATE ON SWB END OF LIFE CARE SERVICE

The following report was received:-

(See document No. 2)

Toby Lewis, Chief Executive and Tammy Davis, Nurse Manager, Sandwell and West Birmingham Hospitals NHS Trust were in attendance together with Sally Sandel, Senior Commissioning Manager and Jayne Salter-Scott, Head of Engagement, Sandwell and West Birmingham Clinical Commissioning Group (CCG).

The following PowerPoint slides were presented to the Joint Health Scrutiny Committee:-

(See document No. 3)

During the discussion that ensued the following were amongst the issues raised and comments made further to questions:-

a) A Member informed the meeting that he'd received a letter from an individual who considered that the Trust's preferred option of a Day Hospice (i.e. Rowley Regis Hospital) would not be an appropriate place to locate the service as there was a cemetery in close proximity. The Nurse Manager reported that this had not been raised at the stakeholder events but indicated that if this was an issue of concern it would be taken into account.
b) It was suggested to the representatives that as part of the process of consulting residents a map of the area which included local landmarks should be provided.
c) Members were advised by the Chief Executive that he considered that if the right type of Day Hospice services could be put in place at Rowley Regis Hospital this might outweigh any concerns of the nature referred to in a) above. Further to comments made, he also pointed out that the hospital did not immediately overlook a graveyard although there was one beyond the trees and gardens.
d) The Chief Executive reported that they had come to the view that it was not possible to provide a rounded service from the Bradbury House premises. Consequently, the only scenario in which the building could continue to be used was if people did not wish a wide range of Day Hospice services to be provided; however, feedback so far indicated that they did.
e) It was underlined by the Chief Executive that the 4 sites listed in the presentation were all possible options for locating the Day Hospice. Furthermore, he reported that it would be possible to provide an improved service from Leasowes. Nonetheless, he stressed that there would need to be discussions with citizens around trade-offs if Rowley Regis Hospital was not the public's preferred option.
f) The Nurse Manager underlined that Rowley Regis Hospital had become their preferred option for a Day Hospice as a consequence of feedback from patients at the stakeholder events and also talking to staff.
g) The Head of Engagement stressed that what they would not embark upon was a tokenistic consultation exercise. However, she considered that it would be wrong not to put forward their preferred location for a Day Hospice

when there was one. It was indicated that other possible options that could be explored included a hub and spoke model, providing satellite premises or building new facilities. The consultation would be genuine and no decisions had yet been taken on where the Day Hospice would be located.

h) A Member indicated that he had doubts whether Bradbury House was the right place to locate the Day Hospice if a rounded service was going to be provided. Furthermore, with a view to learning from what was already in place he referred to visiting other facilities e.g. St Giles in Lichfield. He felt that there was a need to be ambitious in terms of what could be achieved.

i) In referring to the forthcoming consultation, a representative of Healthwatch Sandwell had concerns that information could be presented in such a way that people went along with what an organisation wished to do. He did not believe that the approach being taken was the way to gain public confidence. He also highlighted that no telephone number for the Palliative Care Coordination Hub had been provided and sought clarification regarding the opening hours for the End of Life Care services.

j) Further to i) above, the Nurse Manager reported that it was intended that the Palliative Care Coordination Hub (currently operating from 8am to 8pm) would be open 24/7 when the Urgent Response Team was at full complement. The aim was that by September 2016 there would be a 24/7 service. She also undertook to provide the Healthwatch Sandwell representative with the telephone number for the Palliative Care Coordination Hub.

k) In referring to (i) above, the Head of Engagement stressed that the consultation would be open and transparent and that they had not sought in any way to disguise that there was a preferred option in respect of the location of the Day Hospice. In addition, she emphasised that, as commissioners, the CCG really did need to listen to what people had to say prior to engaging in the difficult conversations within the organisation on the best way to proceed and making a decision.

l) A representative of Healthwatch Birmingham in referring to the stakeholder events that had already taken place asked how it was proposed to increase the numbers of people involved in the consultation and involve those from ethnic groups and any other demographics of people who did not currently use services. Furthermore, she enquired what weight the data collected would have in the CCG's decision-making.

m) Further to l) above, the Head of Engagement indicated that they were looking to use their existing channels and relationships, such as the local Healthwatch organisations, and pointed out that the consultation process would be supported by an equality impact assessment. The CCG would work with the voluntary sector and faith-based organisations and leaders aimed at engaging and consulting with people from different communities and cultures. The representative pointed out that there were also issues around demographics in terms of the age profile and highlighted that the services were not only for older people and individuals who had cancer.

n) At this juncture, the Head of Engagement advised the meeting that once the draft Implementation Plan was populated this would be made available to the Members and organisations. The representative highlighted that she would welcome any feedback if any opportunities were being missed as they wished to make the consultation as robust as possible. The weight that would be given to data collected it was indicated would be looked at prior to commencement of the consultation exercise.

o) Further to concerns expressed by a Member, the Head of Engagement highlighted that because the preferred option / other locations constituted a substantial variation of service there would be a 12 week public consultation period.

p) The Head Nurse acknowledged that the provision of 6 Home from Home beds did not sound that many but highlighted that they were very much a last resort and that the majority of patients wished to stay in their own homes or usual place of residence; furthermore there was the flexibility to increase the number to 8 beds if required, though so far there had not been the demand. Hospice beds were also an option. She advised Members that a lot was being done to advertise the availability of the Home to Home beds and that the service would be monitored in case there was increased demand.

q) Members were informed that it was proposed to start the 12 weeks consultation period by 1 August 2016. However, it was difficult to say at this stage when the new service would come into effect as this would depend on the outcome of the consultation.

r) Further to (q) above, reference was made to many people being on holiday during August and a Member therefore suggested beginning the 12 weeks consultation period in September or beginning in July and running it over a 16 weeks period. The Chief Executive advised the meeting that he was fairly relaxed about whether the consultation period ran for 12 or 16 weeks but pointed out that the existing day hospice service was judged by the Care Quality Commission to be unacceptable in its current form. He therefore stressed the need for the consultation period to be followed by a rapid decision-making process and invited the Members to work with the representatives in that regard.

Further to comments made by the Chair, the Members agreed that the consultation should begin now in July and run for 16 weeks. He also highlighted to the representatives that the Members would wish to work closely with them on the development of proposals following the outcome of the consultation. The Chair thanked the representatives for reporting to the meeting.

10/16 **RESOLVED**:-

That approval be given to public consultation on future Day Hospice provision beginning now in July 2016 and taking place over a 16 weeks period.

DATE OF NEXT MEETING

11/16 Members indicated that they concurred with the Joint Chairs agreeing the date of the next meeting.

The meeting ended at 1556 hours.

CHAIRPERSON