MINUTES of the meeting of the **WELLBEING AND HEALTH SCRUTINY BOARD** held at 10.30 am on 12 November 2015 at Ashcombe, County Hall, Kingston upon Thames, KT1 2DN.

These minutes are subject to confirmation by the Committee at its meeting on Thursday, 7 January 2016.

Elected Members:

	Mr W D Barker OBE
*	Mr Ben Carasco (Vice-Chairman)
*	Mr Bill Chapman (Chairman)
	Mr Graham Ellwood
*	Mr Bob Gardner
*	Mr Tim Hall
*	Mr Peter Hickman
*	Rachael I. Lake
*	Mrs Tina Mountain
*	Mr Chris Pitt
*	Mrs Pauline Searle
*	Mrs Helena Windsor
*	District Councillor Lucy Botting
*	Borough Councillor Karen Randolph
*	Borough Councillor Mrs Rachel Turner

Ex officio Members:

Mrs Sally Ann B Marks, Chairman of the County Council
Mr Nick Skellett CBE, Vice-Chairman of the County Council

21 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS [Item 1]

Apologies were received from Bill Barker and Graham Ellwood

22 MINUTES OF THE PREVIOUS MEETING: 16 SEPTEMBER 2015 [Item 2]

The minutes were agreed as a true record of the meeting.

23 DECLARATIONS OF INTEREST [Item 3]

None received

24 QUESTIONS AND PETITIONS [Item 4]

Question received from Bess Harding MBE, on 28 October 2015

The Board agreed to take this question under item 7

NHS response at annexe 1

Question received from Mrs Helena Windsor on 6 November 2015

Awaiting response

25 CHAIRMAN'S ORAL REPORT [Item 5]

Management Problems at South East Coast Ambulance Service (SECAmb)

The Chief Executive of South East Coast Ambulance Service NHS Foundation Trust has admitted that, during last winter's period of heavy load, the Trust introduced additional delays to the dispatch of help to some categories of call. It is understood that this fact came to light through the action of a whistle-blower.

The CEO has accepted the findings of an investigation by Monitor and has begun to implement changes that Monitor requires.

I will be inviting the CEO of SECAmb to 7 January 16 meeting of this Board to explain matters, and on 18January I will be meeting Chairmen of other HOSCs in the South East to compare impressions.

Patient Transport Service

The re-commissioning of this non-urgent service is in its Prequalification Questionnaire stage with Invitations to Tender and responses to take place between January and March 2016.

October Newsletter

We published our first Wellbeing and Health Scrutiny Board Newsletter in October. Please provide any feedback or suggestions to Ross or me.

Since our last meeting I have attended the Annual General Meetings of Surrey Heath CCG, NE Hants & Farnham CCG and Surrey and Sussex Hospital. All three achieved excellent involvement for the many members of the public who attended.

Children and Adolescent Mental Health Service (CAMHS)

Margaret Hicks and I received a briefing on the joint work by the County Council and the CCGs to re-commission the CAMH Service. The documentation will be released in mid-November. The subject will be brought to this Board at our 7 January meeting.

Mental Health Crisis Concordat

I represented the Wellbeing and Health Scrutiny Board at the most recent meeting of the Social Care Services Board at which the Agenda include an update on 'Mental Health Concordat and Mental Health Code of Practice'. The main points that I took from Item were:

- The Safe Haven Café in Aldershot is credited with reducing by 30% the number of people in crises attending A&E. Each Surrey CCG is introducing its own safe Haven Café.
- Mental Health staff are providing a 7 night support service to Surrey Police. In a single year Surrey Police and Surrey and Border Partnership Trust (SABP) have reduced the number of people in crises that are held Police custody by a factor of 3 down to 6%
- A plan has been agreed to develop an integrated communication and pathway between 111 and SABP, known as the 'single point of contact'
- An out-of-hours assessment and respite service for young people in mental health crises is planned.

Musculoskeletal (MSK) Services in North West Surrey

North West Surrey CCG had intended to re-commission its MSK Services from a single supplier in order to facilitate improvement to the patients' pathway. A suitable supplier did not step forward and so that line has been abandoned for the time being at least.

Re-commissioning of Community Services

The 6 Surrey CCGs and Surrey County Council have begun recommissioning of Community Services with some new contracts expected to come into operation in April 2017.

Review of Personal Medical Services (PMS) Contracts

Today, under Item 6 at Section 2.2.1 we will be hearing about work being undertaken by NHS England to review the PMS Contracts of GPs

across Surrey. NHS England have written to me to state that they will write again in January to report on their analysis. At that point we can decide whether we need to schedule any item in the March or May Board Meetings.

Air Pollution

Members may recall that the 2013/14 Annual Report by the Surrey Director of Public Health, Helen Atkinson, made the point that, across England, air pollution is second only to smoking as a contributor to ill-health. Road traffic is a major contributor to air pollution in Surrey, especially in the more urban areas.

There is evidence that fuel consumption and the generation of air pollution is highest during vehicle acceleration and increases with vehicle speed. The instantaneous fuel consumption meters fitted in many vehicles readily show that. The Highways Agency has recognised this evidence when planning how to limit air pollution from the managed motorway (SMART) being developed on the M3.

I believe that there is more to be done to limit air pollution on our Surrey roads, in particular by setting appropriate speed limits and in the design of road alterations.

Licensing of the Sale of Alcohol

The Surrey Director of Public Health's Report pointed to excessive alcohol consumption as the third most significant determinant of ill-health. The Public Health Prevention Plans address this point and Members will have noted that the advice to limit alcohol consumption is being put across in GP's surgeries, Hospitals, Pharmacies and generally across the media.

Educated individual personal choice will get the best results. However, there may be a role for the Borough and Districts' Licensing function. Health professionals have held the view that some help could be forthcoming from Licensing Committees and Public Health is now one of the authorities that must be consulted on any application for the sale of alcohol.

Unfortunately, in my view, this is not a realistic expectation under the current Licensing Law in England (Licensing Act 2003). This Law is based on a presumption to grant a Licence unless certain Licensing Objectives are not satisfied, but these Objectives do not include anything to do with health. The Scottish Parliament has added a 5th Licensing Objective: 'Protecting and Improving Public Health'.It would seem to be worthwhile to examine what has been the experience in Scotland with their tighter alcohol Licensing Laws

26 ACCESS TO PRIMARY CARE [Item 6]

Declarations of interest:

None

Witnesses:

Dr David Eyre-Brooke, Clinical Chair, NHS Guildford & Waverley CCG

Dr Claire Fuller, Acting Clinical Chief Officer, NHS Surrey Downs CCG

Rose Hopkins, Head of Primary Care, NHS Surrey Heath CCG

Matthew Parris, Engagement and Insight Manager, Health watch Surrey

Key points raised during the discussion:

1. The Clinical Chair of Guildford & Waverley CCG stated the main issues related to access to primary care in Surrey. Principally, caring for the frail/ elderly was said to be one of the main financial costs as patients were getting older and had higher expectations. The Board queried the likelihood of NHS England recruiting 5,000 new GPs they were advised the probability of achieving this was quite low. Surrey's recruitment problem was deemed to be less severe than elsewhere in the country allowing the NHS to learn from others experiences. Instead, the challenge was to offer services in a new way for example, urgent care was being integrated across hospitals and general practices.

2. The Head of Primary Care informed the Board that general practices in Surrey Heath had extended opening hours to 8am-8pm to increase GP appointment availability. This would reduce the number of patients going straight to A&E. Patients would be able to call up on the day and make an appointment for the same day. Surgeries will stay closed on weekend and patients will be urged to use the out of hour's system. It was expressed that by working together, practices could control wasted appointments.

3. It was highlighted by the Board that communication is a key aspect of making the system work to its best ability. There was agreement that the public could be better informed of the extended surgery opening hours and accessible walk-in centres. It was noted that the main funding was also spent on extendable hours being applied to Nurses and Health care assistants, as well as GPs. The Board were given the

example in this area of the Community Assessment and Diagnostics Unit on the Epsom Hospital site which had received good feedback from patients had prompted a meeting with the local press to publicise the services more broadly across the Mole Valley district.

4. It was reported that Healthwatch Surrey's understanding of current patient experience of general practice is one of deterioration. It was suggested that part of the solution would require partners working together to agree and communicate what patients can expect when accessing their GP. It was stated that some GP practices are very successful in managing appointments in a way which suits patient's needs, whilst others are not. This remains a priority for Healthwatch Surrey and it will be undertaking further work in this area. It was agreed by the Board that communication is vital when looking at ways to strengthen GP services in Surrey.

5. The Board asked what could be done by CCGs, by working together with the NHS and general practices to create a new model sharing practices in federations and by developing the NHS workforce. The Board were advised that the traditional list system and consistent, personal contact can be diluted by a more federated system but for G&W CCG this was a tolerable change. CCGs do have levers they can use to influence primary care in Surrey for example, they can encourage federation and the new capital funding available for practices required CCG sanction to approve plans.

6. Further to these points, the numbers of doctors in hospitals have been increasing while the numbers of GPs have been declining so there is a role for the Royal Colleges in addressing this. CCGs are working with Health Education England to develop a Community Geriatrician role – merging GP and Geriatrician roles. The Board asked about an increase role for Pharmacists in the future and were advised that there is a national surplus of Pharmacists with the Government supporting moves into General Practice beginning in areas of highest need first.

7. The Board asked about the lack of equality in funding in different practices in Surrey. The Acting Clinical Chief Officer stated that she was very well aware of the inadequate funding of different practices and were currently coming up with ways to solve this issue, including integration of two practices. The CCG leaders discussed the limitation of the Carr-Hill resource allocation formula which is based on deprivation. For example, Surrey Downs CCG is the second most affluent area in England so their funding is affected despite an elderly population and high prevalence of learning disabilities. However, caution was added when it was suggested this was raised with NHS England as it would be a tough sell for Surrey CCGs when their

situation was compared with an area of high deprivation such as NHS Tower Hamlets.

Recommendations:

- The Board recognises the need for effective communications with patients and the public and recommends that the Surrey Health and Wellbeing Board works with the NHS England Communications Team to explore publicity relating to expectation of delivery of primary care services.

- The Scrutiny Board will schedule further scrutiny on new models of local delivery of primary care.

27 NORTH EAST HAMPSHIRE AND FARNHAM CCG COMMUNITY BED REVIEW [Item 7]

Declarations of interest:

None

Witnesses:

Charlotte Keeble, Associate Director of Integrated and Urgent Care, NHS North East Hampshire and Farnham CCG

Key Points raised during the discussions:

1. The Board were advised that this project forms part of the CCG's Vanguard programme which aims to reduce the number of people who are admitted to hospital. The main aim for the community bed review was said to be to ensure improvements of people's experiences and to make sure the use of beds and facilities was meeting local needs.

2. The Board inquired about the scale of the review and the development of future options. They were advised the project was about admission avoidance – who could be cared for at a lower level. The CCG reviewed anonymised patient notes. There were flexible timescales attached to the project due to complexity and engagement has been extensive including working with the Wessex Clinical Senate.

3. A number of issues were identified by the review including the scale of the community portion of the health system and understanding the impact these services have on acute activity. The CCG had to deal with complex geography with different access criteria operating under different providers in different areas of the patch. For example,

Farnham Hospital is a shared resource across neighbouring CCGs so there is a difficulty in controlling patient flows. Community bed stock needs to be seen alongside Integrated Care Teams – Frimley Outreach and Southern Health are merging services to transform Out of Hospital Care – to reduce admissions.

4. The Board inquired about the use of 'step down beds' - patients who are discharged from acute hospitals for specialist help or care - and whether this was hampered by delayed transfers of care. The Associate Director of Integrated and Urgent Care advised that this was not necessarily the case and that step down care did not always mean community beds and advised that Farnham hospital was underutilised as patients are inclined to travel longer distances to use their local services.

5. The Board were informed that Farnham Community Hospital had opened another ward for the overflow of winter with 22 new beds. A strict criterion had been introduced for patients admitted onto this ward (14-17 days use for those reabling) but these were closed at the end of March 2015 and were now under evaluation and engagement with the community and partners would continue over upcoming months to consider further options.

6. The Associate Director of Integrated and Urgent Care commented that local health and social care services would make the most impact, following this report and the development of new options, by giving people the right care at the right place.

Recommendations:

The Board welcomed the Vanguard work on community beds and the simplifying/standardising the pathways across geographies and providers.

The Board recommended that:

- A request on an update in the second quarter of 2016 in order to help publicise the results across Surrey.
- An update on the broader Primary and Acute Care System (PACS) Vanguard programme.

28 SURREY STROKE SERVICES REVIEW UPDATE [Item 8]

Declarations of interest:

None

Witnesses:

Dr Claire Fuller, Acting Clinical Chief Officer, Surrey Downs CCG

Suzi Shettle, Head of Communications and Engagement, Surrey Downs CCG

Key points raised during the discussion:

1. A public question was received by Bess Harding (see item 4) about funding for consultants at Epsom General Hospital complementing the work done by the community to raise funds for equipment. The Acting Clinical Chief Officer answered the question by stating that the management for the stroke unit has improved and that they are recruiting a specialist stroke doctor to deal with the shortage issue. It was explained that this review aims to improve outcomes for Epsom and Surrey patients as a whole; it is not about individual services.

2. Witnesses felt that there was misinformation about treating stroke; in that it is not simply about the number of consultants there are, there is challenge because of a regional shortage of Speech and Language Therapists. Work to re-shape geriatrician roles may help but Health Education England have a role to play to improve quality, improve attractiveness and retain staff in this area.

3. The Clinical Chair also explained that strokes are more common among people with an irregular heart beat and that identifying this condition (known as Atrial Fibrillation) is important to help prevent strokes. It was stated that 70% of Atrial Fibrillation (AF) strokes are preventable, if all cases of AF were idenitifed and all patients correctly treated with anticoagulation. National campaigns such as 'FAST' have helped to raise awareness about the signs of stroke and what to do if someone witnesses someone having a stroke. The Board queried whether there should be a Surrey wide campaign for stroke recognition and the precursor to a stroke: Transient Ischaemic Attacks (TIA).

4. There was an overall agreement with the Board that stroke services were not acceptable, as it was stated that if you had a stroke in Surrey you are more likely to die than if you had a stroke and were living in London. It was decided by the Board that a more creative solution

needs to be thought of to increase standards within Surrey hospitals by allowing everybody to access the right care.

5. The Board was advised that the Commissioners do not want to replicate London's models but they do want to achieve their outcomes. This would require hyper specialist acute units in Surrey with the whole pathway under consideration – community provision; discharge capacity needs to improve especially in the east of the county around SASH.

6. The Board was concerned by the lack of access to Stoke Units in Surrey and what the workforce challenges were. They inquired when they will start to see progress and were informed that there will be a sustainable solution for Surrey, including Epsom, with six potential new consultants and recruitment opportunities for speech and language therapists.

7. A question was asked regarding the data presented to the Board including differences between Epsom & St Helier hospitals and other Hospitals in Surrey, declining outcomes at Frimley Health as the Trust now includes the previously challenged hospitals of Heatherwood and Wexham Park. Additionally, Members felt that comparison of Epsom and SASH required further investigation. They also asked whether mortality rates cross-referenced with those held by the Coroner. The Acting Clinical Chief Officer agreed to provide further information on these points outside the meeting.

8. The Commissioners were working hard to pin down the outcomes they want to get from the system of providers. Three units across five acutes were proposed. This model was checked by the Clinical Senate and in the East Surrey and Epsom cases – data showed that a system response was required to improve outcomes. Furthermore, Capgemini modelled all the options and found that even two out of five would be enough for Surrey but three units offers capacity.

Recommendations:

The Board thanks the witnesses and requests a further update on the delivery of the proposed service specification at its May 2016 meeting.

29 RECOMMENDATIONS TRACKER AND FORWARD WORK PROGRAMME [Item 9]

Key points raised during the discussion

None

30 DATE OF NEXT MEETING [Item 10]

The Board noted its next meeting will be held at 10.30 am on Thursday 7 January 2016.

Meeting ended at 12.55 pm.

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Chairman

Annexe 1

PUBLIC QUESTION RECEIVED BY THE WELLBEING AND HEALTH SCRUTINY BOARD

Question received from Bess Harding, on 28 October 2015

Will we have an acute stroke unit at Epsom, what is the plan if we don't? Epsom also has a good rehab unit it is quiet and nurses answer bells quickly.

The alternative is a journey of 45 minutes to East Surrey Hospital. Ambulances and crews cost money – return journey will probably be 3 hours. Ambulances will be returning stroke patients within 72 hours to their home hospital – may not be acute ambulance but it still costs money. Families who do not have transport will be faced with 2 hour bus journeys in each direction. Taxis are £30 each way minimum. How many people can afford that for 3 or more days?

Why can't this money be used to employ 1.5 or even 2 more extra consultants at Epsom and then it would comply with consultant ward rounds at weekends?

Answer received from North West Surrey CCG

On behalf of the Surrey Stroke Review:
The purpose of the Surrey Stroke Review is to see how we can make sure Surrey residents have access to the very best services for stroke, at all stages of their care, so anyone suffering a stroke has the best possible chances of recovery.

At the moment, no decisions about future services have been made and this includes any decisions about the level of stroke services that might be provided in the future at Epsom Hospital. We recognise the concerns expressed by local people about hospital services, particularly around accessibility, and these points are being fed back into the review.

Clinical evidence clearly demonstrates that having access to the most specialist hospital services immediately after a stroke gives people the best possible chances of recovery and helps to reduce the devastating consequences of stroke. We need to make sure people across Surrey, no matter where they live, have access to this specialist care when they need it. However, Surrey doesn't have a big enough population or enough specialist professionals and equipment to have this at every hospital. Even with unlimited funding there aren't enough specialist stroke clinicians available to do this.

Over the next few months we will be working with health service providers - including colleagues from Epsom - to plan the best ways to

improve outcomes, address the feedback we have heard during our engagement with national and local experts and the public, and to develop proposals. At the same time a compilation of all the feedback received as part of the review will be released to help guide planning. This ensures that clinicians and local people's views continue to drive service planning in Surrey. Transport, accessibility, local people's feedback, clinical evidence and workforce issues will all be key parts of the evidence that health systems, including Epsom, are asked to consider.

Member Question to Wellbeing and Health Scrutiny Board – 12 November 2015

Received from Mrs Helena Windsor

Child Safeguarding

In October 2015 Surrey parents, Karissa Cox and Richard Carter were cleared of child abuse as the observations that had led medical staff to suspect abuse were shown to be due to a genetic blood clotting disorder and infantile rickets. This process took three years, during which time the child was placed for adoption.

It is acknowledged that medical staff face difficult decisions when paediatric patients present with injuries or symptoms which could indicate abuse and must be supported in taking the appropriate precautions. However, it should be noted that, firstly - this should not distract staff from following through with medical investigations as, where there is a medical condition, delayed diagnosis means delayed treatment and, secondly, there should also be a duty of care to innocent parents, who will already be facing the distress of a sick, injured or dead child.

What protocols have Royal Surrey County Hospital and our other hospitals put in place to ensure that, when a child presents with symptoms that may be indicative of abuse, the relevant diagnostic tests for medical conditions which may present with similar symptoms are carried out promptly?

Response

Requested, to be tabled at a future meeting

Chairman – Wellbeing and Health Scrutiny Board