MINUTES

HEALTH IN DACORUM

13 DECEMBER 2017

Present:

Councillors:

Councillor Birnie
Councillor England
Councillor Guest (Chairman)
Councillor Hicks
Councillor Maddern
Councillor Taylor (Vice Chair)
Councillor Timmis
Councillor W Wyatt-Lowe

Outside Representatives:

Helen Brown	Deputy Chief Executive & Director of Strategy, West Hertfordshire Hospital NHS Trust (WHHT)
Freddie Banks for	Consultant Urologist, Associate Medical Director Clinical Strategy, WHHT
Esther Moors	Acute Redevelopment Programme Director, WHHT
Louise Halfpenny	Director of Communications, WHHT
David Evans	Programme Director. NHS Herts Valleys Clinical Commissioning Group (HVCCG)
Ian Armitage	Programme Director – Urgent Care, HVCCG
Kevin Minier	Chair, Dacorum Patients Group
DBC Officers:	Ben Russell, Community Partnerships Officer R Twidle, Member Support Officer (Minutes)

The Meeting commenced at 7:30pm. (Cllr Taylor (Vice Chair) began the meeting; he took the opportunity to thank all the outside Health professionals for attending the Committee, and asked all attendees to introduce themselves; Cllr Guest arrived shortly after at 7:33pm, and continued the meeting as Chairman).

55 MINUTES

The minutes of the meeting from 13 September and 31 October 2017 were agreed by the Members present and signed by the Chairman.

56 APOLOGIES FOR ABSENCE

Apologies for absence were submitted on behalf of Cllrs Brown and Timmis, as well as E Glatter.

57 DECLARATIONS OF INTEREST

Cllr England declared an interest, noting he was part of a steering group for group called the 'Herts Valley Hospital'. He said that the aim of this group was to bring a new hospital to a greenfield site in the Herts Valley; this site had yet to be agreed. Cllr W Wyatt-Lowe also declared that he was a Trustee with Age UK Dacorum.

58 PUBLIC PARTICIPATION

Cllr Taylor noted that the Committee members had received a response from E Glatter on behalf of Dacorum Hospital Action Group (DHAG) in relation to the Dacorum Local Plan consultation. H Brown confirmed that she had not seen this response; Cllr Taylor confirmed that he would email a copy to H Brown, via Member Support. Cllr Guest re-iterated and confirmed that the Committee had noted the response of DHAG

59 ACTION POINTS

The Committee noted that the outstanding action point in respect of Iain MacBeath and DToC's. Cllr Taylor asked that this item be chased for the next meeting. R Twidle confirmed this, and also highlighted that I MacBeath was due to attend the next meeting of 7 March 2018.

Action Point: R Twidle to contact I MacBeath regarding DToC'S Action Point.

Cllr Guest highlighted the letter from M Graver, contained within the agenda pack, inviting the Committee to tour the new Marlowes Health & Well Being centre, which was due to open in May 2018. Within his letter, M Graver had invited the Committee to visit the centre before the next Committee of 7 March 2018. After discussion, the Committee agreed that a visit of the centre would be most beneficial when it was 'up and running', rather than before it had opened. The Committee considered that this would give staff and visitors the opportunity to get used to their new surroundings, and so would be a more accurate picture of the service it was providing to the community. Cllr Guest asked R Twidle to return to M Graver confirming this,

Action Point: R Twidle to advise M Graver that, instead of a pre -opening tour in March 2018, the Committee would like to visit The Marlowes Health & Well Being Centre once it has opened for a period of time.

60 WARD ISSUES FROM OTHER COUNCILLORS

Cllr Guest introduced the item; she asked the committee members if they had any issues, or wished to highlight any issues on behalf of other Councillors.

Cllr Hicks did not wish to add anything aside from highlighting that the doctor's surgery in Tring, which he had previously expressed concerns about, was to remain open for at least three years, possibly five.

Cllr Birnie noted that it was likely that the Community Centre in Bennett's End would be getting a defibrillator. Cllr Guest and Cllr W Wyatt-Lowe also noted this was also in addition to the defibrillators at Warner's End and Adeyfield Community Centre's.

61 GET, SET, GO DACORUM

Cllr Guest introduced B Russell, the Dacorum project manager on the item. B Russell then gave a presentation to the Committee, based on the information contained within pg 16 of the agenda pack. He said that the three year project had been a fantastic success, and highlighted that 90% of the activities launched as part of the project remained self-sustainable. He confirmed that in view of this success, DBC intended to apply for a further grant from Sport England, as well as working with other local authorities. He also noted that the project was awarded 'Community Project of the Year 2016' at the Herts Sports Partnership Awards, as well as silver award for the national marketing campaign.

Following on from this, B Russell introduced the Sports and Physical Activity Strategy; the purpose of this was to demonstrate DBC's commitment to delivering high quality sporting provision to all. Again, he provided a presentation based on the key information set out in pg 17 of the agenda pack. B Russell invited questions from the Committee.

Cllr Birnie asked about the decision not to award Sportspace the leisure centre contract; what would be the impact upon this strategy? B Russell said that it would have no impact as DBC would be working with the leisure operator as a key partner, irrespective of who it was. Cllr Hicks highlighted that Sportspace still administered the XC and Little Hay Golf Course, therefore they would still remain a stakeholder. B Russell agreed with this point.

Cllr England asked about the cycle paths, in particular the gaps in the network. B Russell that this would be considered as part of the action plan with members of the project board which would include members of Hertfordshire County Council (HCC). He acknowledged that Dacorum's cycle infrastructure was relatively poor, but noted that Dacorum had a number of very wide pathways, which presented an opportunity to amend these to cycle paths.

Cllr England also asked about the consultation with stakeholders; how wide would this go? B Russell said they conducted focus groups with residents, as well as a more in depth consultation with key partners such as hospital, Sport England, Public Health, HCC as well as sporting clubs. Cllr Guest confirmed that it would be helpful for the Committee to receive feedback via email regarding the strategy. Cllr Guest also added her personal support of the strategy, endorsing the significant positive effects of exercise.

Following Cllr Birnie's question, B Russell confirmed a numbers of ways this project had been communicated, including flyers, social media, on the screens in Hemel town centre as well as Community Centre's. In addition to this, Cllr Birnie also suggested Radio Dacorum as another way of publicising activities.

Cllr Guest highlighted that 2018 was the year of Physical Activity; she said she would email B Russell, Cllr Neil Harden (PH Holder for Residents and Corporate Services) and County Cllr Richard Roberts (Executive Member for Public Health & Protection) to discuss the best way to promote this.

Cllr Guest thanked B Russell for the presentation, and for answering the Committee's questions.

62 HERTS VALLEYS CLINICAL COMMISSIONING GROUP & WEST HERTFORDSHIRE STRATEGIC REVIEW OF HEALTH UPDATE

H Brown and D Evans confirmed that the item would be a combined update; this was because of the amount of interplay and overplay between the work of both stakeholders.

H Brown confirmed that the presentation would focus on the following matters:

- Hemel Hempstead and Dacorum Project Group – Strategic Outline Case (SOC) for redevelopment of Hemel Hempstead General Hospital (HHGH). (H Brown)
- Main acute redevelopment strategic outline case (E Moors & F Banks)
- Urgent Care Strategy, opening hours for Hemel UTC and West Herts Medical Centre contract (I Armitage & D Evans)

H Brown, E Moors & F Banks provided the Committee with a detailed presentation based on the information set out in pg 2 – 7 of the presentation slides (Appendix A). D Evans also gave the perspective on slide 7 of presentation from the HVCCG's point of view.

Cllr Taylor asked H Brown and D Evans for clarification regarding the presentation pack, in particular, what they would like DBC to do with this information; did they wanted the packs handed back, or were they content for it to be shared with the public? H Brown said that while she was not unhappy for it to be shared, it should be made clear that this was very much a 'work in progress" and so should be treated in this spirit. Cllr Guest re-iterated this point to K Minier, saying that he should treat this document as such when sharing with the other members of DHAG. She also noted that this document should be recorded as 'draft' within the minutes.

Cllr Birnie observed that the proposals sounded very useful, particular the cross-working between specialisms and sites; however he thought that the IT would need to be improved in order to facilitate this. E Moors agreed, saying that the way the Trust wished to deliver care in the future was very reliant on it. She said that technology had significantly moved on, and was able to support care in the community. Cllr Birnie re-iterated his point, saying that IT would need to support Specialist with emails, accessing patient records, etc.

Cllr Birnie also noted the comments about specialism on different sites; he asked whether investment in one site could leave others under-resourced. Cllr Birnie cited the example of the MRI scanner being moved from HHGH to St Albans City Hospital (SACH). F Banks accepted that this may be a possibility, but emphasised that that in the case of the MRI scanner, it would be located where it was most needed for diagnosis. H Brown added that MRI was expensive equipment, that was difficult to staff. It could not be sustained on three sites, and was absolutely necessary to be placed at SACH, in order to support the planned surgical model for the cancer services. However, H Brown added that a local MRI would still be available to Dacorum residents (albeit not a same day service), through different routes. She emphasised the need to think of HHGH and SACH as complimentary services. F Banks added that this model would mean that SACH would be a consultant-led site, delivering excellent service to the area.

Cllr Hicks clarified that 'maternity services' referred to midwife appointments and support, rather than delivery/labour wards. He also asked for further clarification regarding the flexi care housing; he asked if it would be temporary accommodation. D Evans said that it would not be temporary; instead it would be for individuals requiring extra care. Cllr Hicks asked about where this fitted in relation to the removal of step-down beds following their removal at Gossoms End, and future removal at HHGH. D Evans that this was also being taken into consideration within the planning for flexi care. There was a discussion on how this plan could look, however D Evans emphasised that this was a plan still in the process of being developed. Finally, Cllr Hicks noted that a huge amount of housing was currently being built in Dacorum, as well as Aylesbury; given that a significant number of Dacorum's residents accessed healthcare provided by Bucks, he questioned the impact of the new housing and residents on the healthcare services. He asked what forward planning had taken place. H Brown confirmed that strategic planning took into account predications for both growth in population and housing.

Cllr Maddern noted the proposal to develop SACH into a cancer specialist site; she observed that it was building on what had developed for the breast clinic, and described this as a "fantastic" facility. She wanted to clarify that the proposal was for the biopsy and diagnosis to take place on the same day. F Banks confirmed this, and said this was the standard being aimed for. Cllr Maddern praised this as a model.

Cllr Maddern also asked when a decision about the new hospital on a greenfield site was due to be made. H Brown was unable to confirm this. She said this was being debated at national level. She said that West Herts was recognised as a priority.

Cllr Birnie asked where the post-operative cancer care would take place. F Banks confirmed this was still being developed. Cllr Birnie also asked the impact of the Trust's finances, given he understood that its accumulated deficit was approximately £100million, upon this project. H Brown acknowledged it was a very challenging environment; she also highlighted that all Healthcare providers were managing deficits. However, she said, there needed to be investment within the infrastructure, otherwise it would be almost impossible to reduce one's deficit.

Cllr England asked if the stakeholders recognised that Dacorum had the largest population as an identifiable area, and would continue grow over the coming years. H Brown acknowledged that the Trust served a significant population, along with Three Rivers and Watford, however also highlighted that there were two other hospitals, Luton & Dunstable and Stoke Mandeville nearby. This meant it was not as simple as developing a hospital in Dacorum because of its population. Cllr England said while he understood the proposals, he was concerned that residents would not feel they had a 'proper' hospital. H Brown highlighted that HHGH would provide local services, urgent care and diagnostics, as well as a special focus on long term conditions. She also emphasised that the respiratory services, which were previously located in Harefield and provided specialist care, were now located at HHGH. F Banks added that this was an opportunity to provide top quality integrated care to West Herts residents. He believed there was a need to focus on West Herts, rather than Dacorum, St Albans, etc.

Cllr Birnie asked that the flexi care proposal be added to a future work programme. Cllr Guest agreed. H Brown suggested that this item be added to the March 2018 committee meeting, (if the plans had been developed by this time) as it would fit in

with I MacBeath's item regarding delayed transfers. Cllr Guest suggested that H Brown liaise with I MacBeath and R Twidle about developing this item.

Action Point: H Brown to provide a presentation on flexi care/wrap around housing at a future Committee meeting.

H Brown also said that she would welcome a view from the Committee on the Strategic Outline Case. She said that it was hoped to be approved in April 2018, it should be available at the next Committee meeting following this. Cllr Guest asked H Brown to liaise with R Twidle as to when this could be brought to the Committee.

Cllr Taylor also took the opportunity to again offer his sincere thanks to all of the stakeholders for attending the Committee, and presenting their plans to their Committee. He emphasised how meaningful it was for DBC representatives to engage so readily and easily with the Health professionals. He said that the Committee would welcome any plans that they wishes to bring and discuss with the Committee. Cllr Guest echoed these comments.

Cllr England asked about the current situation regarding the greenfield site/new hospital proposal; there was a subsequent discussion with H Brown about the various possibilities regarding the site as well as the time scales of the decision. Cllr Guest asked that when WHHT receive notice from NHS improvements with regard to the greenfield site/new hospital proposal, that H Brown inform the Committee, via R Twidle. H Brown agreed.

I Armitage & D Evans then provided the Committee with a further presentation based on the information set out in pg 8 – 16 of the presentation slides (Appendix A).

Cllr Birnie said that this proposal appeared to be relying heavily on 111. He also noted that between the closure of the overnight service and the implementation of the proposals contained in the SOC, it would be nearly two years.

Cllr Hicks said that although the proposals looked impressive, there was a certain amount of trust to be regained in the '111' service following various negative press. He also asked about people on Dacorum's boundaries; how would they be treated by the service? D Evans said patients may be booked (via 111) into a GP's surgery for urgent care, rather than travelling to HHGH. H Brown said that '111' had access to a national directory; this enabled them to book patients into a range of urgent care options.

Cllr England highlighted that HHGH was very accessible by public transport; he was concerned that by removing this as an overnight option, patients without access to transport may be unable to access some of the urgent care options. H Brown noted Cllr England's comments, however highlighted the significant costs involved in keeping HHGH open overnight, which would inevitably be at the cost of other services. She also said that realistically, if patients needed to be seen in the middle of the night, this would indicate a need to be treated by A&E. D Evans further commented on this point that it was his role as HVCCG commissioner is to spend the resource in the best, most effective way to achieve the best outcomes to the population. He said one of the purpose of consulting was to make clear in an open and transparent way, the consequences of spending, and explain that one service may then be at the cost of another.

Following questions by Cllr Birnie and Cllr Hicks about the process surrounding how a '111' call would be identified as a '999' emergency, H Brown confirmed that there was a clear protocol with calls to '111' and '999'. They were assessed very early on if the caller needed to be escalated/de-escalated to the other service.

Cllr Guest invited any further questions; when none were forthcoming, she thanked the stakeholders for attending.

63 PUBLIC HEALTH & PREVENTION

Cllr Guest introduced Cllr W Wyatt-Lowe, the Committee representative on this item. He provided an overview of this item, and confirmed that he would submit a more report to the Committee regarding the item (see Appendix B).

64 HERTFORDSHIRE COUNTY COUNCIL HEALTH SCRUTINY

Cllr Guest introduced Cllr Birnie, the Committee representative on this item. He provided a detailed update to the Committee regarding the item. He also confirmed that he would provide this update as a report to the Committee (see Appendix C).

K Minier asked if the forthcoming CQC inspectorate report was discussed; Cllr Birnie essentially said that very little had been said, given that it had yet to be published.

As the matter of street triage had also been raised within Cllr W Wyatt-Lowe's update, he & Cllr Birnie discussed the impact that this had had within the community, particularly on supporting those with mental health needs.

65 HERTFORDSHIRE COUNTY COUNCIL ADULT CARE SERVICES

As representative of the item, Cllr Guest introduced the detailed report (contained in item 12 of the agenda pack) to the Committee regarding this matter.

66 WORK PROGRAMME - 2017/2018

Cllr Guest requested that The Marlowes Health & Well-Being item be deferred from the March 2018 meeting to a future meeting.

The date of the next meeting is on 7 March 2018.

The meeting ended at 10:33pm

Herts Valleys Clinical Commissioning Group

West Hertfordshire Hospitals NHS Trust

Health in Dacorum update

December 2017

DRAFT - PLEASE NOTE THAT THESE DOCUMENTS OUTLINE AN ONGOING PROJECT- IT IS A 'WORK IN PROGRESS'

WHHT & HVCCG joint updates on:

- Hemel Hempstead and Dacorum Project Group – strategic outline case for redevelopment of HHGH.
- Main acute redevelopment strategic outline case
- Urgent Care Strategy, opening hours for Hemel UTC and West Herts Medical Centre contract

Hemel Hempstead Hospital SOC

- Proposed (draft) clinical / service model has been developed and shared with the stakeholder group.
- Builds on YCYF and Trust transformation strategies – we are continually changing the way we deliver care (e.g. virtual fracture clinic, tele-dermatology, hot clinics) so future services will look and feel different, facilitated by technological transformation.
- WHHT have looked at Hemel and SACH together – complimentary services.
  - SACH focus on planned care, cancer and surgery.
  - Hemel focus on long term conditions and medical specialties.
  - Emergency and specialised care and local services for 'south' of catchment at WGH.
- Three categories:
  - Current services expected to remain
  - New services / service developments would like to explore further
  - Current services proposed to potentially relocate to St Albans
- HCT community and HPFT mental health services at the Marlowes – will review option to incorporate in to the redevelopment or retain at the Marlowes. Opportunities to flex services between the two sites if the Marlowes is retained.
- Preliminary discussions with Hertfordshire County Council re opportunities for joint working.

Acute Provider - Potential Clinical Model Options:

Services Likely to be Retained:

Unscheduled Care:
- Urgent Care Centre

Medical / Long-term Conditions Outpatients:
- Dermatology
- Cardiology
- Haematology
- Diabetes & Endocrinology
- Neurology
- Respiratory
- Gastroenterology

Surgical Outpatients:
- Musculoskeletal / Ortho
- Pain
- *Ophthalmology (provided by Bucks)*
- *Ear, Nose & Throat / Audiology*
- *General Surgery*

Womens & Childrens Outpatients:
- Paediatrics
- Gynaecology
- Maternity

Clinical Support Services:
- Outpatient therapies
- Pharmacy
- X-Ray & Ultrasound
- *CT – tbc, dependent on clinical model*

Potential Changes to Service Model:

Hemel Clinical Model Development:

Unscheduled Care:
- Urgent Treatment Centre

Long-term Conditions:
- Long-term Condition (including frailty) Centre
- Planned Medical Care
- Dermatology Centre

Surgical Outpatients:
- No additional specialties planned

Womens & Childrens Outpatients:
- Paediatrics Integrated Care
- Focus on CAMH / Families

Clinical Support Services:
- Increase point of care testing (supports UTC). NB: pathology plans across WHHT currently being reviewed.

Hemel Model Changes:

Cancer & 1-stop Services:
Cancer service focus at SACH, so potential clinical benefits in reconfiguring:
- Urology
- Endoscopy

Surgical Outpatients:
- Potential clinical benefits of focusing sub-specialist surgical expertise.
- Clinical benefits of sub-specialist orthopaedics & fracture clinic at SACH due to extent of subspecialisation in this service.

Clinical Support Services:
- MRI & CT needed to support elective surgical care & cancer services at SACH.

Other Providers –

Further Potential Same Site Clinical Model Options:

Bedded / Flexible Care Facility for Older People

Consolidate Services from the Marlowes

Primary Care Facility

Others? Eg Collaboration with Voluntary Sector?

NB: This document is intended to summarise discussion to date across a range of groups. It is expected that thinking will develop, *particularly for those services shown in italics, for which further work is needed and/or commissioning changes anticipated*. Further detail will be added over the coming months and some of the above plans change, as part of the business case development process and whilst seeking wider engagement in planning.

Site options / financials

- Clinical model will translate across into space requirement / m2.
- Reviewing options for locations – new build / new site, new build HHGH site, refurbishment of existing buildings on HHGH site. This is a requirement at SOC stage.
- Estimated capital costs expected to be between £30m and £50m dependent on the option. Land sale could contribute between £10-15m. Will need to raise c £20-40m additional funding.
- Want to be in a position to bid for new NHS capital announced in the budget – important to complete and approve SOC asap.

Next steps

- Aim to finalise SOC for Board approval in April 2018.
- SOC sets broad direction of travel and preferred way forward.
- Outline business case (OBC) provides more detail and finalises the service model and preferred estates solution.
- Full engagement on the clinical model to take place as the first step in developing the OBC. (So SOC approval would be contingent on finalising the clinical model and the outcome of the engagement process).

Main acute redevelopment SOC

- SOC submitted to NHS I for formal review in August 2017 – review underway
- NHS I have received representations re 'greenfield' option and will make a recommendation as to whether to carry forward a greenfield option or to proceed on the basis set out in the SOC (ie WGH & SACH, with local hospital at HHGH)
- If proceed with Greenfield option this is potentially a game changer for HHGH redevelopment.
- Bid submitted for STP funding – need to secure funding to do the significant detailed work required at OBC (c £10m)
- Will let stakeholders know as soon as hear anything.

Urgent Care – Strategic Approach

- **Local access to urgent care needs**
  - NHS 111 acting as the pivotal point of access
  - Urgent treatment approach across all west Herts localities
    - Urgent treatment centres strategically positioned in the area, managed by GP's and provided by multi-disciplinary team
    - Urgent treatment access via GP based provision
- **Principles:**
  - Developing the 5 Year Forward View – National strategy for urgent care
  - Establishing a coordinated approach across all service providers
  - Providing 'urgent care' closer to home
  - Reducing pressures in A&E allowing them to manage real emergencies
  - Joined-up approach to standardised system response to urgent care needs

Purpose: *Why do we need an Urgent Care Strategy?*

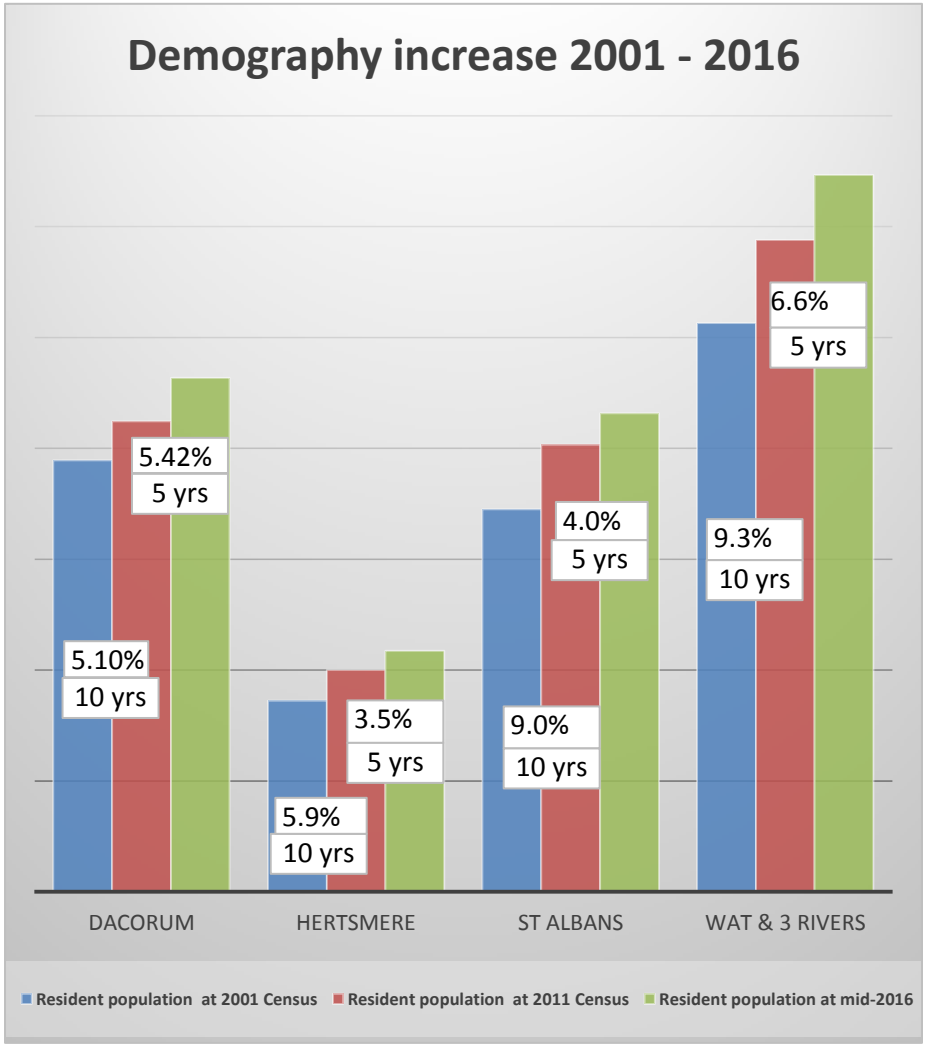
20% **increase in A&E attendances** in the past five years. A&E is expected to grow by a further 5% year on year

48% of patients in acute hospital beds during a 2013 study could have been cared for elsewhere

9,785 alcohol-related hospital admissions in 2011/12. **This number is increasing year-on-year**

Nearly 1 in 10 ambulance call outs in 2012 were accounted for by people with long term conditions

10 years longer the average life expectancy in Chorleywood West compared to Borehamwood



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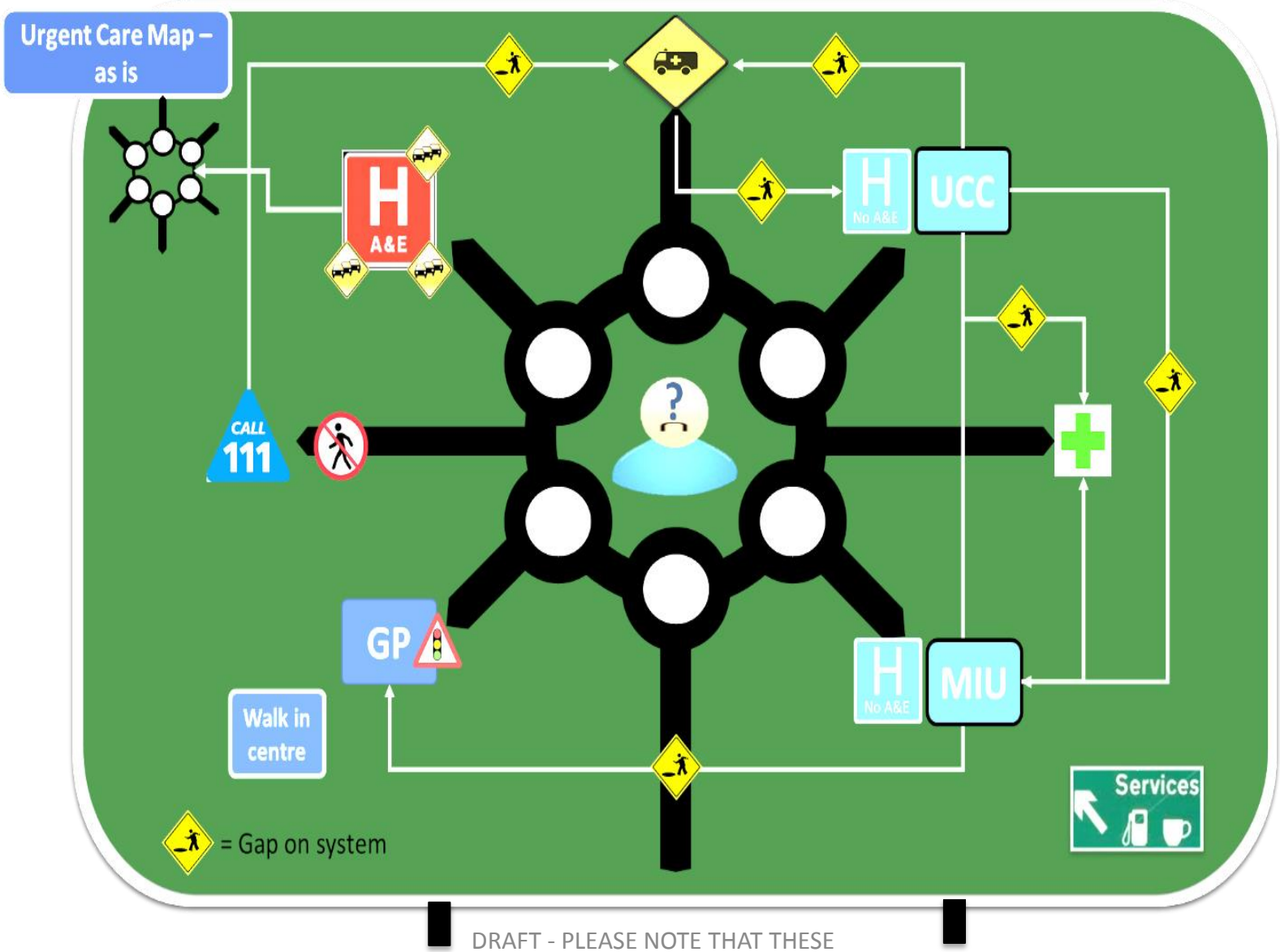
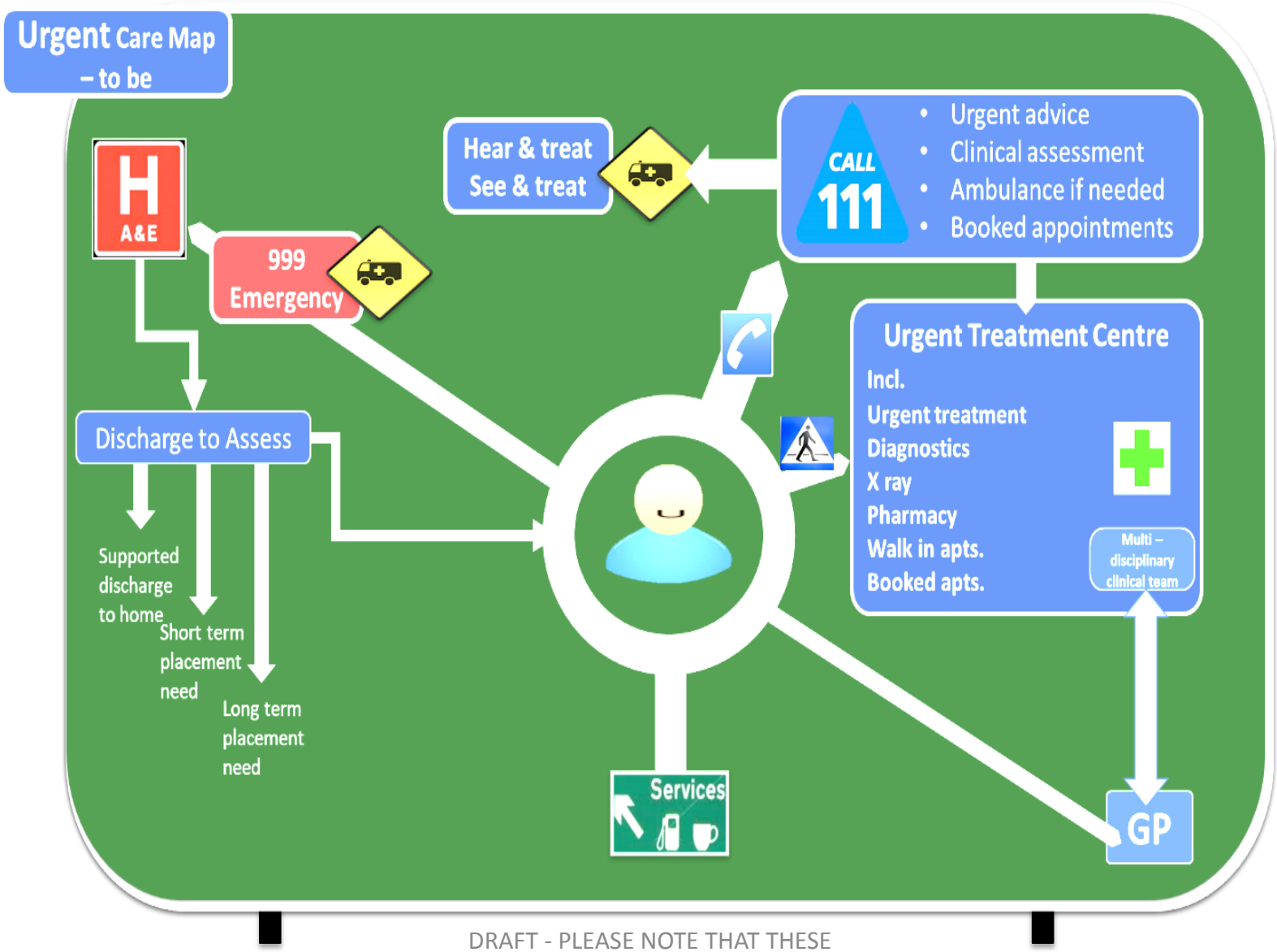
Reducing confusion

Current model



Reducing confusion

Future model



A joined-up approach to service delivery

- An NHS 111 service providing advice for self care / community services, clinical advice and booked appointments
- Urgent Treatment Access points, locality based providing booked appts and walk-in access for diagnostics, and urgent care treatment
- An Ambulance service which provides clinical assessment, see & treat and access to local Urgent Treatment options
- A GP service that provides access to urgent care treatment OOH and /or via booked appointments.
- National GP Forward View - the introduction of extended access to GP appointments evenings and weekends (from 6.30pm -8pm Mon – Fri & circa 8am-8pm Saturdays and Sundays) to enable 50% to have extended access by March 2018 and 100% by March 2019.
- An urgent care system which shares joint protocols for access and service delivery, preventing attendance at A&E departments, providing a more effective response to urgent care needs closer to home

UCC to UTC

What's the difference?

There are probably only a few key differences for the Hemel UCC, but they are significant: -

Near-patient or Point of Care testing – A variety of test equipment which provide same day results and most within minutes, allowing the clinicians to make more accurate diagnosis on the spot. For example;

- *Lactate testing:* an essential test in the assessment of sepsis
- *D-dimer testing:* can be used to help diagnose blood clotting abnormalities such as thrombosis

There are several others we hope to introduce including full blood count tests.

Booked appointments through NHS 111 – If your clinical assessment leads to an appointment to see someone, this can now be done through the NHS111 service. It is currently done via a phone message to the UTC, but will shortly be done as a direct booking through the computer systems in use.

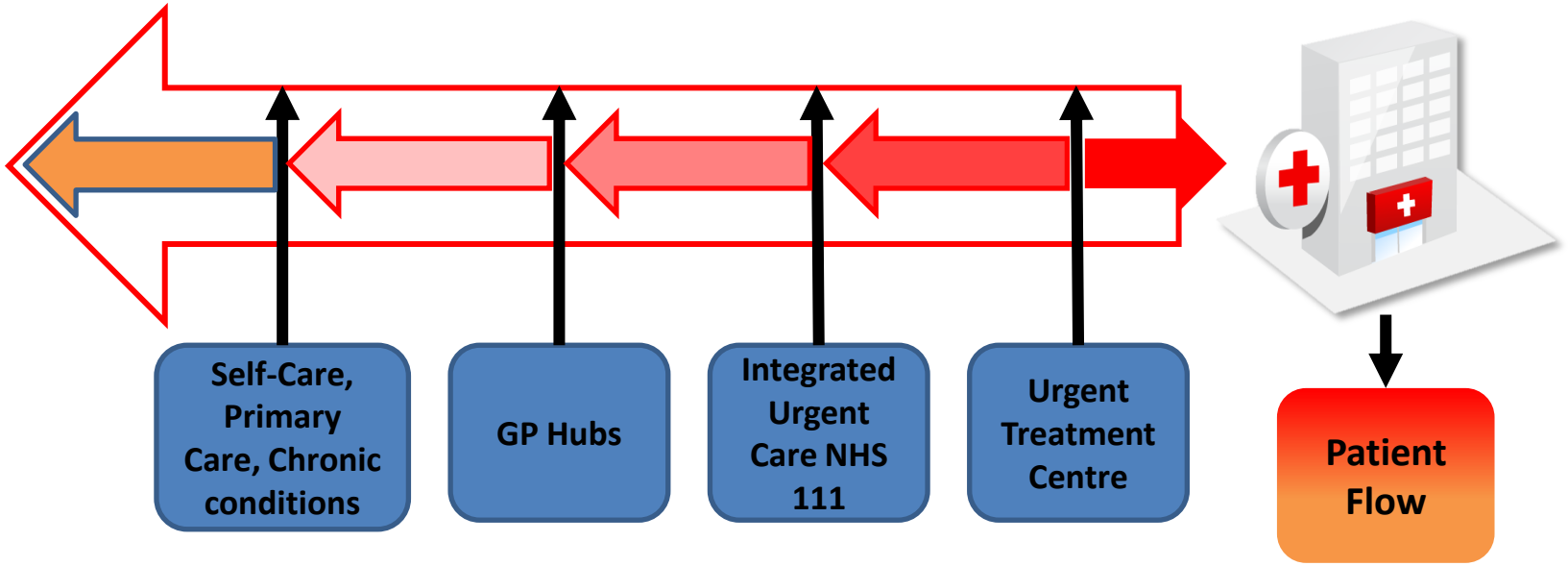
Shared Protocols – We have started a simple agreement with the Ambulance service , NHS111, GP's, UTC and the Acute trust to standardise responses to certain conditions which will reduce the need for people to attend or be taken to A&E

Strategic Outline:

Urgent Care closer to home

Strategic overview

Demand & Capacity planning → System Development → Channel Shift



Developing services to deliver strategic aims

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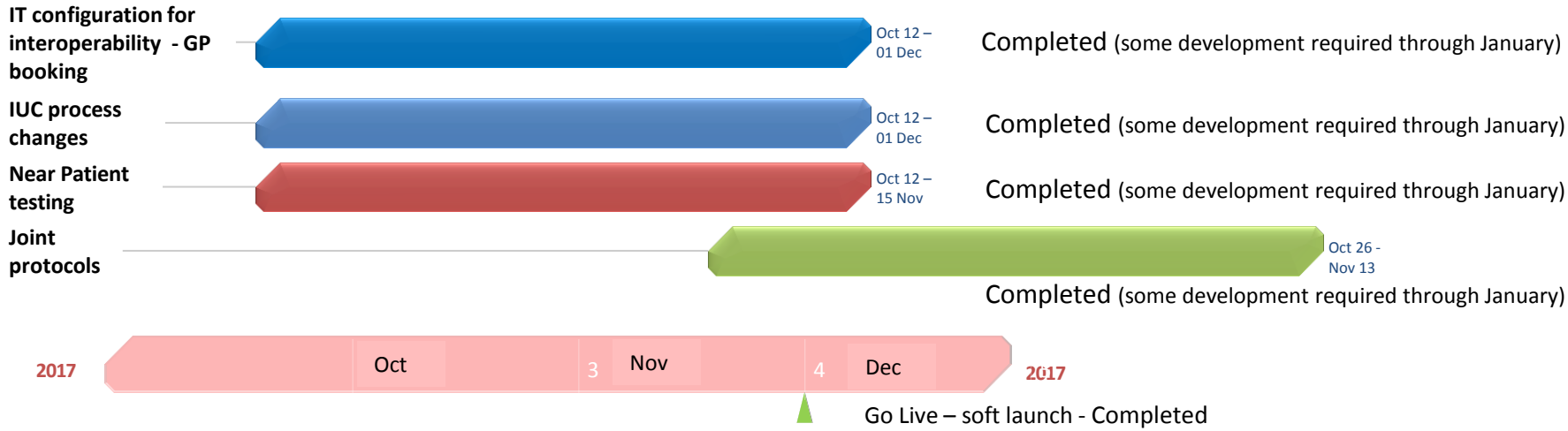
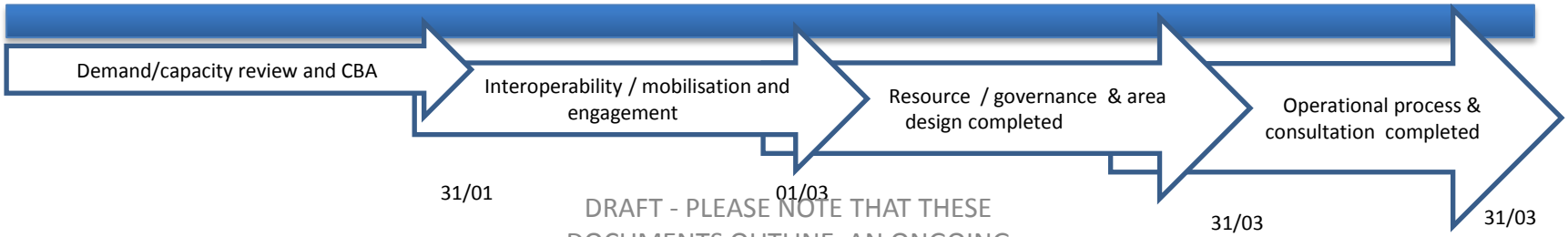
Phase 1 – Hemel – implementation actions

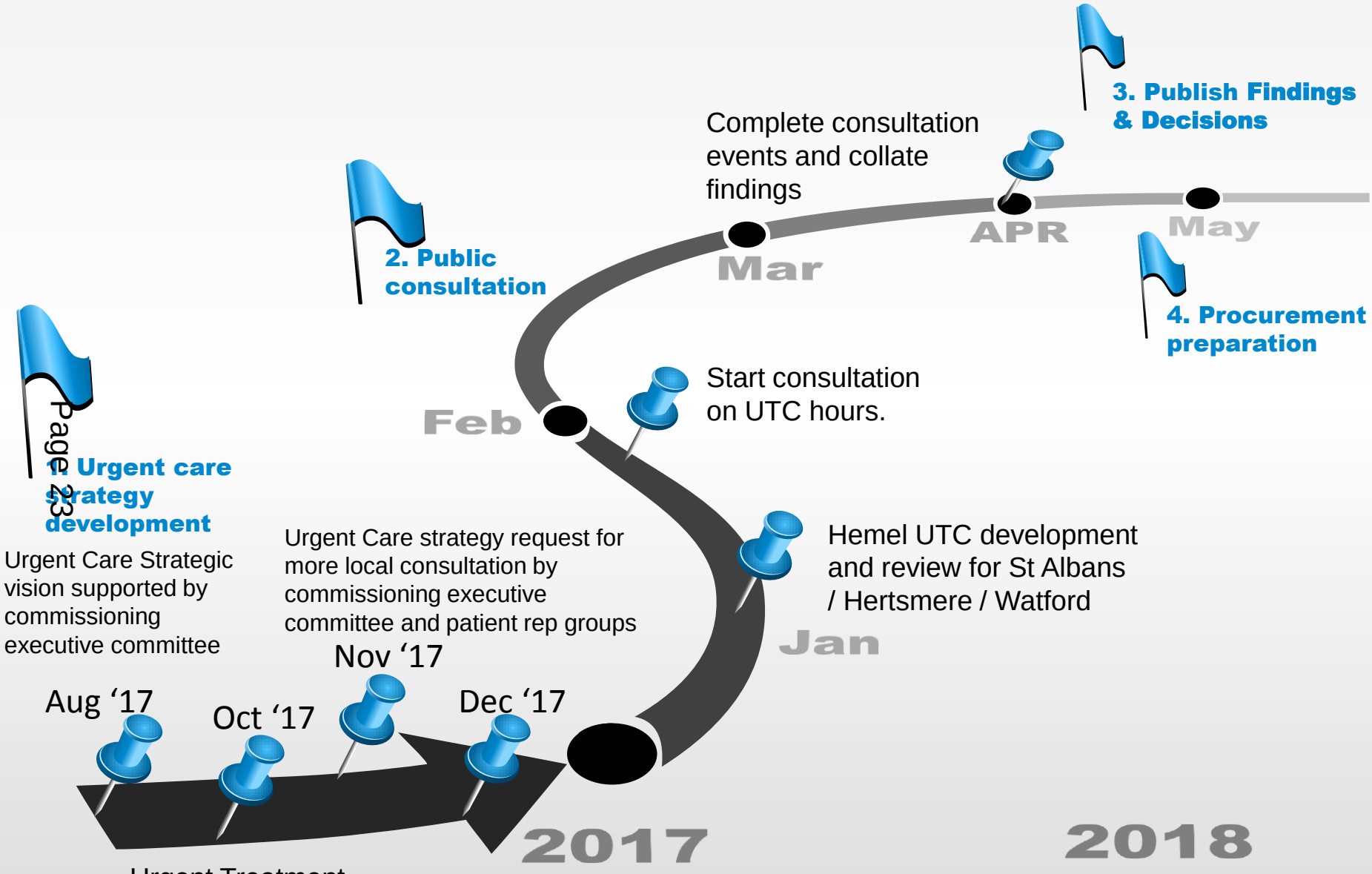


Phase 2 – St Albans / Watford / Hertsmere – Revised plan

Estimated Timeline		
Urgent Treatment Approach – review (all areas)	01-Dec	31 - Mar
Resolve IT and interoperability / booked apts	01 - Dec	01 - Feb
Model for each area agreed		01-Mar
Implementation plan in place for each area		31-Mar
Implementation Watford General as (2nd UTC)		30-Apr

Supporting activity





PUBLIC HEALTH & PREVENTION UPDATE – Appendix B

Public Health panel on 10th November
The agenda can be found at
https://cmis.hertfordshire.gov.uk/hertfordshire/Calendarofcouncilmeetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/752/Committee/86/SelectedTab/Documents/Default.aspx

Herts Stop Smoking Services.

We received the service's annual report. Tobacco is still the leading cause of preventable illness / death in the UK, accounting for approx 1,500 per annum in Herts.
In 2016 the Hertfordshire smoking rate was 13.5% versus 15.5% in England.
Current priority areas are:-
Routine / manual workers, areas of greatest deprivation, prisoners, and people with MH issues.
The Service's current project areas are:-
Improving accessibility of services to young people, non-British, and pregnant mums.
Looking at behaviour change models rather than always using 1:1 interviews.
Improving conversion rates.
Getting harm reduction advice to those unable to stop (such as e-cigarettes).
Disseminating messages such as 'shisha' being more harmful than cigarettes, and cannabis smoking being as harmful as cigarettes.

Our stats have Herts better than the EoE (East of England) on 28 day quits, and quit ratios. It is worth noting that 30% of quitters came from 20% most deprived areas. However 28.9% of routine / manual workers smoke in Herts vs 26.5% in England. Smoking in pregnancy has fallen from 9.2% to 6.7% in 2 years. "Love your Bump" has won 2 national awards. Our cost per quit is better than all our statistical neighbours. We endorse e-Cigarettes and provide support to all NHS organisations willing to accept.

The full Annual report contains 40 pages of data and references – yet irritatingly failed to show OOC (Out of County) Trusts in the table of referrals made from each Acute site – an emphasis I aim to change.

Public Health Peer Review Initial Report

The review was held on 18-20 October, and was generally favourable, citing wide-ranging well-developed projects, but possibly a lack of co-ordinated planning. Members will be offered Prevention training early in new year. Our DPH (Director of Public Health) likes to summarise Prevention as "it is really about avoiding the need for public services".
Other suggestions made were for best practice workshops, sharing innovation, rapid evaluation and adaption. We also need to "talk up" Self-Management, to conduct a charm offensive with GPs, and to encourage "Active Giants of Prevention".
Members developed an interesting discussion of ME (myalgic encephalopathy) as an example of varying degrees of knowledge and attitude between CCGs around the country. Sadly only 30% of CCGs seem to know anything about the subject. Members were encouraged to see the film "Unrest".

Complaints and compliments review of HCC performance overall

There has been a significant drop in the number of complaints received by HCC as a whole over the last. Annual totals for the last 3 years are:-

2014/5 = 1,184 : 2015/6 = 1,279 : 2016/7 = 1,059. Childrens Services was the best performer. The report also included the Social Care Ombudsman's Annual Letter, informing us of the 121 complaints / enquiries they received.

HCC Audit Committee on the 1st December

The agenda paper for this report can be found in Item 7 of the address below

https://cmis.hertfordshire.gov.uk/hertfordshire/Calendarofcouncilmeetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/707/Committee/3/SelectedTab/Documents/Default.aspx

The committee had previously requested a "Deep Dive" report into a serious risk to the Health system in Hertfordshire – concerning the recruitment and retention of an adequate homecare workforce. A detailed paper was brought to the committee, examining the increasing risk of a reduction in our ability to provide safe and appropriate care in peoples' own homes, thereby impacting on the health and wellbeing of our residents.

52% of local authorities are, like us, reporting difficulties in this area. The 85+ age band is expected to more than double in next 12 years, causing increasing demand. The many pressures include an ageing workforce, families that are increasingly spread out geographically, high employment in the County, proximity to London, the high cost of accommodation for workers, a poor media image, self-funders attracting providers preferentially, and possibe Brexit effects, to name but a few.

Our homecare providers employ around 10,500 staff, and the turnover rate is in the 40%+ region. The 3 main reasons given for high turnover are Pay Rates, Inadequate travel compensation, Attraction of other Sectors. It is currently estimated that 15,000 staff will be needed by 2030, but the figure will be higher if more support is provided at home (at the expense of residential care). As of 1st October 165 people were awaiting care packages in Herts (indicating a need for approximately 200 extra staff). Incidentally, it is worth noting that the waiting figures in Herts Valleys are twice as bad as E&N Herts – possibly correlated the DToCs figures which can be anywhere from 1.6 to 10 times as high at Watford as they are at the Lister.

HCC is supporting providers out of the "improved BCF", which allowed us to give a 71p hourly rate increase (rising to 90p by April). Average hourly rates in Herts are currently £17.88 compared with a minimum recommended by UK Home Care Providers association of £17.19. Only 10% pay over 17.19.

HCC works with providers to move to guaranteed shift work (where wanted), to support the Herts Care Standard, to influence recruiting policy, and workforce retention, and to offer its Rewards program to the whole sector. Additional iBCF money of £450K pa has been committed to upskilling and training the workforce. The commissioned4 Lead provider commissions include all these provisions, spot providers will follow whenever contracts are renewed. Note that the Care Act imposes a duty to ensure a sustainable and vibrant care market. There has been a strong move (from 14% to 75%) in favour of local providers, not least because of several Serious Concerns investigations with national providers. Complaints are down by 50% since 2014.

There is a Herts Good Care campaign promoting working in the sector, using social media in particular, but also encouraging the over 55s and retirees to join the workforce. So far the campaign has resulted in 165 placements. The Good Care recruitment team is helping young people with careers advice, CV writing, interview advice, etc.

A copy of the Hertfordshire Care Standard, and a case study of a care provider's recruitment campaign are included as items 7b and 7c in the agenda papers.

Health and Well-being board December 13th.

The Meeting Papers can be found at
http://cmis.hertfordshire.gov.uk/hertfordshire/Calendarofcouncilmeetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/699/Committee/13/Default.aspx

Perhaps the most worrying statistic given by our Director of Public Health is that DALYs (Disability Affected Life Years) are increasing, while expected Life Years may be stabilising – or even reducing (as in the USA).

STP (Sustainability and Transformation Partnership) (item 3)
We heard a lengthy report from the STP (Peter Cutler) on all the various work streams that they are running. There seemed to be a significant omission of reference to all the similar work done by HCC and the 10 district authorities over the last 4 years, such as social prescribing, community navigators, prevention, etc. The emphasis was also on issues faced by the 3 acute trusts inside the STP area (ignoring the 15% of our residents who use acute services outside the county). A lot was said about standardising clinical planned pathways (however only 3 pathways were mentioned, which is a lot less than at least one neighbouring STP (NW Central London). Since the last report one clinical lead from each CCG has joined the management board. I did not hear anything about representation or consultation involving the community, or wider potential partners such as Police / Fire or the Voluntary sector. Is this yet another top-down NHS reorganisation which will just tell us what they have decided?
A list of the projects they are covering identified 7 clinical work streams and 9 enabling work streams. For the detailed list, and expansion of activities, please see the working papers, pages 1-2.
It is well worth reading Section 4.1 on Urgent care / A&E (page 3) to realise how the current thinking reflects the same ideas as were being trailed in the early days of the CCGs.
Section 4.3 reflects further work on what was originally called the Falls project in Adult Care – with amalgamation of scores of different "Frailty" care plans being reduced into a single standard approach across the STP.
Section 4.9 illustrates the Prevention agenda from the STP's viewpoint, with CVD (Cardio-Vascular disease) as first target, followed by the promotion of Self-management and Social Prescribing. Also featured is a Medicines Optimisation project which has already saved £9m with £4m more to come soon. This project was to be presented to a parliamentary on the afternoon of the same day (Dec 13).

BCF (item 4)
We heard about the 4 NHSE target measures for our use of the BCF.
Better than target:-
Admissions to Residential / Nursing care (388 against 575 target – though some late data is normal)
Effective Reablement % @ home 31 days from the start of the reablement (87% v 85% target)
Worse than target:-
Non-elective admissions (27,427 vs 27,401 target but only 0.1% adrift)
DToCs per 100K population (1,299 vs target 1228).
However, we are making Year on Year inroads into DToCs, while many other Local Authorities are not doing.

Street Triage (item 5)
The PCC has commissioned a report to evaluate the scheme (which currently operates 3 cars, each containing one or two Police officers and a Mental health paramedic. The consultancy who conducted the evaluation presented the report – the slides have not yet been distributed – I will circulate them if I can. Essentially, however, it was equivocal on the value of the scheme, as it depends on a subjective view of how to define the benefits. It raised the issues of whether it should be Health or Police or Both funded, but made no recommendations.

PH Peer Challenge (item 6)
This was a repeat presentation of what came to the Public Health panel – see page 1 of this report.

CQC Review of CAMHS (item 7)
The Prime Minister announced a thematic review of CAMHS in January 2017. The CQC + Ofsted have been sharpening their teeth on 10 H&WB areas, including Herts. This will lead into a new Green paper on children and young people's mental health. Aim is to ensure that C YP + families have timely access to high quality mental health care, with a target of 28 days to **access** not to assessment. The presentation powerpoint is included in the agenda.

HERTS COUNTY COUNCIL HEALTH SCRUTINY UPDATE – Appendix C

Report to Health in Dacorum Committee
County Council Health Scrutiny Committee 12/12/2017

Introduction

The purpose of the meeting was to scrutinise the finances of 6 NHS Trusts, 3 of which are of interest to Dacorum; namely, West Herts Hospital (WHHT), Herts Partners University Foundation (HPFT) and East of England Ambulance Service (EEAS). Two of these are financially in good health but WHHT is not.

EEAS

1. Services are provided across Herts, Beds, Essex, Cambs, Suffolk and Norfolk.
2. The Ambulance Response Programme deals with 999 emergencies from 3 call centres each staffed by approximately 110 staff, mostly medically qualified.
    a. Each caller undergoes a triage set of questions by clinicians at senior paramedic/district nurse and or GP level.
    b. A decision is then made on appropriate treatment, response time and vehicle. The patient may be dealt with at home by a medic or social services and only as a last resort in A&E. As a result, across the service area only 50% of patients are now taken to A&E, representing a fall of 100K admissions p.a. (for which the Trust receives no extra income from their CCG's).
3. The Trust currently breaks even, but there is pressure on the capital budget because ambulances (approx. cost £150K each) need constant upgrading and replacement.
4. The only way that the Trust can increase income is by securing contract(s) for non urgent patient transfers and it is currently bidding for the Herts contract.

HPFT

1. This Trust provides mental health and learning disabilities inpatient care as well as treatment in the community. The Integrated Marlowes Health and Wellbeing Centre is at the centre of its operations,
2. Wherever possible treatment is provided in the home and even in-patients are encouraged to spend weekends or longer breaks at home. This allows for maximum usage of available beds.
3. A street triage system has been developed in conjunction with the police and EEAS services, with the aim of obviating patients going to A&E and/or into custody.
4. A vital part of the Trust's work is the Child & Adolescent Mental Health Service and it has managed to reduce delayed referrals from 40% to 5%.
5. The Trust had a surplus of £1million at the end of the last financial year and expects to duplicate this in the current period.

WHHT

Governance seems better than in former years but;

1. The anticipated deficit at the end of the financial year is c£42million.
2. Anticipated refurbishment and development estate costs for the next 2 years are c£80million.
3. Cashflow problems have been caused by disputes with the CCG over payments e.g.
    a. E.o.y billings.
    b. Invoices for months 1-3.
    c. Medical procedures no longer funded by the CCG that the Trust claims had already been performed prior to the new embargo.
4. Financial shortfalls have been routinely funded by borrowing, leading to an accumulated debt in excess of £100million. (The Trust has applied to NHS England to write this debt off, but so have 15 other Trusts nationally, who are in a similar position).
5. Ambulances from North London have started "dumping" their patients at Watford General.

6. A&E is under pressure with 85-95% ward occupancy. This leads to delayed transfers that the Trust estimates to cost £16.5million p.a.
7. There is a high staff turnover, particularly of nurses who often go to large London Trusts where the training is believed to be better. Even though many return after training, the immediate result is high agency staff costs.
8. Owing to the financial pressure, there is no money to upgrade the aged ICT system and the Trust is trying to outsource some of this to neighbouring Trusts.
9. Compliance with CQINS is best described as optimistic and the Trust admits that it has no chance of meeting its CIT target "without a fundamental change to the environment that the Trust operates within." (It is not clear whether this includes the location of Watford General).

Pressures on all Trusts

1. A growing and ageing population, leading to greater demands on services.
2. Unsatisfactory relations with, sometimes capricious, CCG's. (The Scrutiny Committee resolved to add CCG's to its work programme.)
3. Poor staff retention and resultant high staff agency costs.
4. Meeting capital requirements when operations budgets are under extreme pressure.

The good news

Even under extreme pressure, no Trust allows financial problems to impact upon patient care.