Minutes of the Healthy Staffordshire Select Committee Meeting held on 21 September 2015

Present: Kath Perry (Chairman)

Attendance

Michael Greatorex (Vice-Chairman)	David Smith
Charlotte Atkins	Conor Wileman
Chris Cooke	Ann Edgeller
Philip Jones	Brian Gamble
Ian Lawson	Barbara Hughes
David Loades	Janet Johnson
Shelagh McKiernan	David Leytham
Christine Mitchell	Stephen Smith
Trish Rowlands	

PART ONE

103. Apologies

Apologies were received from Councillors Colin Eastwood, Andrew James and Dianne Todd.

104. Declarations of Interest

There were none received.

105. Minutes of the last meetings

Resolved: That the minutes of the meetings held on the 5 August 2015 and the 10 August 2015 be signed by the Chair.

106. Minor Injuries Unit at Sir Robert Peel Hospital, Tamworth and Samuel Johnson Hospital, Lichfield

Andrew Donald, Accountable Officer South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group (CCG) introduced Dr James Ward, Locality Clinical Director and Ruth Paulin, Head of Strategic Projects, South East Staffordshire and Seisdon Peninsula CCG.

Dr Ward reminded the Committee that the NHS was in the middle of a ten year programme of unprecedented financial challenge, at a time where patients were getting older, there was population growth both locally and nationally and medical care was becoming increasing complex and expensive. Health service inflation ran above the normal rate of inflation and health service spend had been increased by just over

inflation for the last five years. The majority of savings over the last five years had been achieved by controlling staff pay and staff costs but something different was required and the rate and scale of change would be significant. The CCG had a statutory duty to make a balanced budget but had a £16 million overspend last year. There was a recovery plan to address this but over £6.5 million of savings had to be delivered this financial year which equated to approximately three percent of the CCG's budget, with NHS productivity running at about one and half percent. The massive scale of change was emphasised and that inefficient care needed to be eliminated. The prescribing budget in the area was around £20 million per year and the running costs of the two Minor Injuries around £2.5 million per year. Minor Injuries Unit attendance cost on average around £58 which was similar to an Accident and Emergency Department attendance.

The CCGs proposals were around the urgent care system with the principle objective being to encourage more self-care. Dr James highlighted that there was a need to help people with urgent care needs to get the right advice, in the right place, first time. Unfortunately this did not always happen. There was a need to provide highly responsive urgent care services outside of hospital so people no longer chose to queue in A&E and that those with more serious or life threatening emergency needs received treatment in centres with the right facilities and with the expertise to maximise chances of survival and a good recovery. The urgent care system was complex and there was a long list of providers of urgent medical and social care, with overlap of provision. Practice members and patients had been consulted on the proposals and support had been received from all the GP practices in Burntwood, Lichfield and Tamworth. The proposals had also been discussed with the Patient Council. There had been wider engagement with patients regarding the issues that they thought were important for the CCG to focus on. Key patient messages included good communication which had been the number one priority as patients felt isolated and frustrated as they had moved between services. Patients had wanted better co-ordination of care and to look after themselves. Patients who understood their condition did much better than those patients who did not. Patients disapproved of waste in public services particularly when they could see the pressure on frontline staff.

It was explained that the Choose Well Campaign was trying to help people identify where to go when they needed help. The NHS 111 service was intended to prevent people attending an A&E department inappropriately and use much better and more efficient services. NHS 111 was a triage service to help signpost people to the most appropriate care. The main activity at Minor Injuries Units took place during the day and reduced significantly after 9pm. The x-ray facility was not available consistently and was restricted to office hours at the Lichfield and Tamworth sites which limited the number of people that could be treated first time at the Units. In addition the Units did not have access to the diagnostics that would be considered standard in a modern practice, for example there was no way blood test results could be fed back quickly. Detailed analysis of patients who presented at the Minor Injuries Units had showed that over half of patients presented when there was no x-ray facility available. Fifty percent of attendances did not require any diagnostic investigation or treatment and patients were seen by a nurse, had a wound dressing and had not required any follow up care. Sixty percent of attendances were suitable for General Practice and primary care, for example, wound dressings or minor illness, nineteen percent of attendance were for follow up treatment and twenty five percent of people seen at night had moved onto an

alternative service provider which meant that there was double the expenditure and the patient did not get the appropriate treatment immediately.

The CCG was proposing that the Units opening hours should change to 8am – 9pm. The proposals had been based on a strategy which diverted the patient and encouraged them to seek help before attending. The out of hours service had been delivered on the same site as the Minor Injuries Units. The main justification was that the proposed changes would reduce waste. On average nurses had been seeing one patient every two hours at the sites which was not efficient care. The proposal was clinically sound, there were low volumes of patients and the proposals would not put people at risk. The proposal would not affect outcomes for patients with more serious conditions.

The public consultation would start over the next four weeks and Members comments were invited. The case for change would be presented to all scrutiny bodies and decision would be made on how the CCG should proceed.

A Member sought a copy of the consultation material and queried why the Committee had not had sight of it before the meeting. Ruth Paulin confirmed that the consultation had begun that day and the information would be available on the CCG's website and a copy provided to Members after the meeting. Approval was sought for a four week consultation. It was commented that the case for change document had been previously shared with the Committee in confidence and a document that had been devised with the Patient Council would now be much more widely available. On further questioning Ruth Paulin confirmed that the document included a description of the available services, including the GP out of hours service, community hospitals and other services and at the end of the consultation process, if it was decided to make changes, the CCG would be actively promoting any changes made and publicising the alternatives.

Andrew Donald referred to the work required to make sure that people knew about the alternatives to the Minor Injuries Units. In relation to GPs there was work to be undertaken to consider what needed to be done differently. It was acknowledged that access to GPs was one issue that was often raised. Getting a GP appointment could be difficult. Changes to the Minor Injuries Unit in Cannock had resulted in one thousand more GP appointments being made available in the area. The CCG was working with GPs to consider how they could manage extra demand, for example wound dressings, so that they could do this work.

A Member commented that the need for change was obvious but it was important that the primary care service was in place and understood before any changes were made. Andrew Donald acknowledged that this was important and that this would be part of the work being undertaken.

Dr Ward referred to wound dressing clinics that had been set up by the community provider and that all GP practices were aware that they would need to take referrals from Minor Injuries Units. GPs from Tamworth and Lichfield attended the Units to review patients and close working arrangements were already in place. Absorbing the five or six patients per night that used the Sir Robert Peel Minor Injuries Unit would not be too difficult but the CCG did not want to be complacent about this.

It was queried why the consultation period would be for only four weeks as it would be significant change to local service delivery. Andrew Donald referred to the verbal advice received by the Scrutiny and Support Manager. The changes proposed were significantly less than the proposals relating to the Cannock Minor Injuries.

It was queried how the CCG would be engaging with patients and patient groups when there had been no questions circulated to the Committee and how patients and primary care services would know about the alternatives on offer.

Ruth Paulin explained that if, at the end of the consultation period, a decision was made to change provision, there would be an implementation phase separate to the proposed four week consultation period which would be focussed on educating patients on any changes to be made. For the consultation phase there were a number of public events planned in the localities, an online survey and a questionnaire to be distributed. Some engagement work had already taken place with District Councillors and patient groups. If the requirement was to extend the consultation then this would be undertaken. There would be a significant period of engagement subsequent to the decision as well as during the consultation. A number of events would be publicised.

Andrew Donald emphasised that significant pre-consultation had been undertaken. There had been a series of events entitled 'Lets talk about health' which had asked about general CCG challenges. There had been work in the Districts and the Patient Council.

Concerns were raised by Members that the outcome of the consultation had already been decided as the implementation period indicated the outcome was known.

Andrew Donald explained that as part of the consultation process community groups would be used to access patients. Two local MPs had been informed about the developments and Burton Hospitals would be used to gather information from patient groups that used the services. The numbers who used the services were very small. It was important to share the alternatives. The pre-consultation period had resulted in questions about what alternatives were available at night if the Minor Injuries Unit was not available and a list has been put together. A report would be put together for the Governing Body which would include all the information gathered for the Body to make a final decision on whether it supported the proposals for the reduction of opening hours overnight. The CCG reached into groups and connected with others which was a model for other CCGs. Andrew Donald had confidence that information had already been gathered from the public and further information was being collated. He stated that it was important to manage the resources the CCG had whilst also retaining clinical services. This was the least worst option in trying to manage a minus £17.994 million budget. It was one of the ways of making the most of the money that the CCG had and to bring the budget back into balance. MPs had questioned the proposals and made alternative suggestions.

It was commented by a Member that the CCG was running a business and queried why the Committee was only now being asked about closing a service that people had not used between 9pm and the early hours of the morning. The average cost per visit at night when people were not attending was highlighted. Concerns were raised that if people were to access services elsewhere the cost would move to another budget. It

was suggested that as there was another major service locally, provision could come together and operate more efficiently. It was commented that the questionnaire on the proposals should ask about the service rather than people's personal details.

Andrew Donald explained that healthcare costs had increased by four percent each year and that the NHS budget had not kept up with this. The NHS was keeping more people alive for longer but not healthier for longer. Infrastructure issues had not been addressed previously. Difficult decisions now had to be made. When services were taken away, members of the public were disappointed, but best patient care had to be provided within the resources available. In relation to integration four things could be done to manage the NHS better. These included stopping doing things which were controversial, substituting one thing for another which was better clinically, running faster to save money which was not sustainable going forward and integrating services. Many services and organisations operated in silos and did not connect together. The challenge for commissioners was to get services more connected and get organisations to work across boundaries for the benefit of patients, centred on patient's needs.

Ruth Paulin referred to the questionnaire. She explained that it was very simple, was one element of the consultation plan and had just four questions. The language had to be patient facing and it had been developed with the Patient Council. It would provide the information required but was not intrusive. It was confirmed that the questionnaire would be available following the meeting subject to the agreement of the Committee.

Members queried the impact on A&E services. It was commented by a Member that the number of Cannock Chase GP appointments had been increased temporarily until March but to her knowledge this was not a permanent arrangement.

Dr Ward explained that work was required with local providers to ensure that there was not a significant impact, however he reiterated that numbers of patients were low and one in four were already been diverted to an alternative service. The NHS share of spend for Primary Care services had reduced year on year and was now below six and half percent, a reduction from approximately ten percent five years ago. NHS England co-ordinated primary care services. There was a lot of work to be done to integrate services locally. The number of practices in Lichfield had reduced from eleven to eight and numbers could continue to decline. This created options for dealing with urgent care more effectively in the future. Each GP Practice received lots of calls for patients between 8am and 8:30am and if this was centralised for example, with a more direct booking service, there would be better outcomes for patients. The proposal put forward was a small part of the urgent care strategy. There was no variation between the number of patients attending the Minor Injuries Units during weekdays and the weekend which suggested there was a cohort of patients that were just using the Minor Injuries Units rather than GPs which was not necessarily a good thing as they would be receiving nurse appointments rather than GP appointments and could have missed out on health promotion and screening programmes offered by the GP.

Ruth Paulin referred to the more radical options considered by the CCG. The numbers of patients attending at night was very low and if a person needed to see a doctor the out of hours patient service was located at both of the hospitals where the Minor Injuries Units were based. If a person rang the out of hours service they would still be able to see a doctor at either of those hospitals if required.

Andrew Donald referred to the importance of doing more work in primary care to avoid people going elsewhere and to ensure that more money could support prevention. GPs could do more with populations that needed it, for example the elderly may require more than a ten minute appointment. The issue was how GPs in Tamworth and Lichfield could work differently together to create the space and time to do what Cannock GPs were doing in keeping people away from hospital. It was important to discuss how GP services could be provided in the future. An options appraisal had been requested to consider how the two hospitals could be used most effectively in the future. This was to ensure a proper debate about how the facilities could be used rather than just stopping or increasing parts of the service.

It was queried by a Member if centres of excellence would lead to fewer units.

It was clarified by Andrew Donald that it could not be presumed that if one CCG took a decision others would follow, however there was a national strategy around urgent care and a document produced by Sir Bruce Keogh suggested that there should be specialist hospitals, a next level down to A&E and primary care urgent care which linked back to general practice. Nationally there was a wide range of services as every time the NHS had had a problem in the past another access point was opened. This had created confusion over where patients should go. Services needed to be streamlined. This could be the start of this process but there was more work to be undertaken.

It was reported by a Committee Member that Tamworth Borough Health Scrutiny Committee had received a presentation on the matter. The issues concerning the Tamworth Committee had been raised by the Healthy Staffordshire Select Committee also. The Chairman of the Tamworth Committee was not at the meeting but it was reported that the Tamworth Committee would be calling a special meeting to consider its formal response to the consultation. Concern had been expressed by Tamworth Members about communication and the suggestion of an options appraisal was welcomed by the Member in attendance. In terms of Members understanding of the position, it was remarked that there had been no indication of the savings that could be made if the decision was taken. Members had also queried if other services would go from the community hospitals and raised concerns about the long term future of the hospitals. It was commented that the outcome from the engagement with the Patient Council had not been shared and more information was requested regarding the engagement events and the documentation in support of the proposals.

Andrew Donald referred to the savings that could be made and explained that the CCG paid for Minor Injuries Unit attendances so the logic was that if patients did not go to the Units, savings would be made, however there was no guarantee that patients would not go to Units elsewhere. Burton Hospitals NHS Foundation Trust which ran the Units would potentially make savings to their infrastructure costs if the changes were agreed. Discussions with the Trust to date indicated that the CCG would also get some benefit. The amount of benefit overall was however very small. The big issue was about changing provision when provision was already available. Information from the Patient Council would be shared with the Committee. Nine events called ‘Let’s talk about patient health’, had been held and had discussed the challenges that the CCG faced and the types of changes that had to be made in the future. Representatives of the public, voluntary agencies and statutory agencies had been involved. The events going forward

would be focussed solely on the consultation. The CCG needed to be credible in the information that it shared. Even if the CCG did not make savings and Burton NHS Foundation Trust did, then this would be a saving to the health economy and the system needed to work as a whole rather than in individual parts.

Ruth Paulin added that the AGM would take place on the 29 September and drop in events would take place across Lichfield and Tamworth. At the end of the period of consultation all information would be collated and presented to the Select Committee and the Governing Body. The Committee would have the opportunity to say whether the consultation has been adequate.

A Member suggested more engagement was required. Concerns were raised that some people would still need to been seen during the night locally and that they would end up seeing a doctor which would cost more money than if they had seen a nurse or health visitor.

Andrew Donald explained that an out of hours and 111 contract was already in place so there would be no extra cost as these services would undertake the work they are required to do. The hospital would remain open and the out of hours service should cover the individual patients.

Dr Ward explained that it could be counter productive to go to Minor Injuries Units when quick triage was required and appropriate care could be assessed quickly through consulting with 111 or using the out of hours doctor service.

Andrew Donald confirmed that the contract for the out of hours service meant that no matter how many patients were seen the price would remain the same. The CCG was going to use the existing services available and there had to be education on what was available and what to do.

A Member referred to the need for Tamworth residents to travel to hospitals outside of the area and use of the Minor Injuries Unit. It was commented that the frontline was being cut and reducing the footfall to the local hospitals would make the hospitals not viable and people had concerns they would therefore be shut down. It was queried if GPs and hospital A&Es would receive payment for the additional patients seen who would have previously gone to a Minor Injuries Units.

Andrew Donald referred to the different views on Community Hospitals and suggested that what was required was a proper options appraisal, with Burton Hospitals NHS Foundation Trust on what should be done with the hospitals, subject to a discussion across the GP membership and the Governing Body about where the hospitals were going in the future. This was about streamlining the system. It reflected the national picture where there were multiple services and a lack of clarity on what was available. When the County Hospital A&E closed, people self-managed and did not access services elsewhere. People made intelligent decisions about how they used services if they have the right information. If there were appropriate care plans in place for children for example, it was not the case that they would need to be admitted overnight to hospital. GPs had general medical services contracts, within this they must see patients and patient slots had to be used and maximised. GPs would be asked to do work not within the contract and this has to be funded from elsewhere but this would be a very

small amount. Six patients was not a large amount of additional people to be seen by GPs. There could not be duplication of services as this wasted money.

A Member made reference to the small change that the proposals would bring considering the scale of the changes required and asked if budgets were just been moved about. It was queried if in five years' time small cuts would still be brought to the Committee for consideration.

Andrew Donald explained that in 2010 the new Government implemented the Health and Social Care Act. CCGs in Staffordshire had been in place since 2013 and now had significant deficits. It was the job of CCGs and GPs to make changes to reduce costs and maintain sustainability. The system was consuming too much of the things that were not required and this had to be stopped. Although the proposal was a small change it was very symbolic as the public needed to understand that the CCG was trying to make best use of the resources that it had. Money could not be spent on duplicating services where there was no money. South East Staffordshire and Seisdon CCG needed to achieve a minus £18 million deficit. This deficit was not sustainable in the long term. Clinicians had to explain why they were making changes to the things that people valued. South East Staffordshire and Seisdon CCG was a level one CCG and therefore did not have a primary care budget but it was working with GPs to achieve co-commissioning which would give access to the primary care budget to make changes.

RESOLVED:

- That a copy of the consultation document be shared with the Committee.
- That details of the feedback from patient groups and the Patient Council be shared with the Committee
- That the Committee recommend a 6 week consultation period be adopted.
- That the Committee further consider the matter once the consultation concludes.

107. Hearing aid commissioning policy for the South Staffordshire Clinical Commissioning Groups

Andrew Donald, in his capacity as Chief Officer, Stafford and Surround CCG, introduced Dr. Marianne Holmes, Clinical Lead, Stafford and Surrounds CCG and Jane Chapman, CCG Engagement Lead, Stafford and Surrounds CCG.

The Chair reminded the Committee that new proposals were put forward to the Committee and that concerns had been shared with the Committee regarding the proposals.

Dr Holmes explained that there was a similar group under Primary Care Trusts to the Clinical Priorities Advisory Group (CPAG). These Groups looked at services and treatments to see if they were best use of NHS money and whether new services were right to introduce locally. There were two prioritisation groups in Staffordshire one in the North and one in the South, with close working between them. Approximately seven years ago a joint policy was developed between the two groups to enable them both to use one another's scores. The South Group's process had been taken from the North Group's process and a modified Portsmouth score was used. There were individual scoring programmes in the North and South however scoring outcomes had been very

similar. The North Group had looked at hearing aids for mild, moderate and severe hearing loss and the South Group had accepted the North Group's scores and also looked at the provision. The scoring system took multiple things into account, including if evidence was robust, for example whether it took information from randomised trials or case studies. It looked at the health impact on the person, the cost impact and for example whether one group was affected more than another. The different areas were not weighted differently. There were different scores in relation to hearing aids dependent on whether hearing loss was mild, moderate or severe due to the impact that this would have on a person's life.

Jane Chapman explained that the CPAG had established that the service currently provided did not meet the threshold for commissioning. Normally this would have resulted in the decommissioning of a service, however the CCG knew from the engagement undertaken by North Staffordshire CCG that this had attracted strong negative feedback from stakeholder and specialist groups. The CCG therefore did not want to ask whether to decommission hearing aids for mild to moderate hearing loss as this would result in a similar response and cause unnecessary distress. The CCG was however looking to build on the engagement undertaken in North Staffordshire and consult on what it would mean if Stafford and Surrounds CCG implemented the thresholds that had been approved in North Staffordshire. The introduction of an eligibility criteria for mild to moderate hearing loss would impact on a small number of patients currently eligible, which was estimated to be around fifteen percent of patients. Stoke CCG were following a similar process and had asked that the timescales for consultation were aligned*. The consultation was planned to start on the 27 September and finish on the 20 December 2015. This would be a twelve week process following advice from the Committee. Questions were being refined so that the same questions could be asked by all CCGs as hearing aids were commissioned jointly and this would reduce duplication and support working across CCGs. Once the CCG consultation programme was completed it would be shared with the Committee. The consultation process would involve local meetings open to the public, including hearing providers and Action on Hearing Loss and other local specialists.

Andrew Donald reiterated that North Staffordshire CCG's process had collected evidence that the CCG would use but a further three month consultation across South Staffordshire and Stoke was being proposed to gather more information. The proposal was to change the thresholds by which someone could access a hearing aid and not to decommission a service. This would allow individuals, where they felt they had a special case, to put a claim through their consultants to be considered even if routinely they would not have access. Changing the threshold was a more appropriate way of managing this process rather than decommissioning.

A Member referred to the lack of consultation by North Staffordshire CCG and the flawed engagement exercise. The CCGs plans to properly consult were queried. Given the number of people possibly affected in South Staffordshire compared to the numbers in the North of the County, it was queried how the CCG would ensure that the proposals would be designed to meet the needs of those in the population that the CCG served, and not those in the North of the County.

Jane Chapman referred to the different ways of working in the South of the County compared to in the North. The consultation would ask about the South Staffordshire

commissioning policy. The work to date showed a small proportion of people with mild to moderate hearing loss that would be affected, approximately fifteen percent. The way hearing loss was assessed was dependent on the impact it had on a person's life rather than just the measurable hearing loss.

A Member asked if fifteen percent of those with mild hearing loss would not qualify for hearing aids compared to those that presently had one and how people could prove the impact of hearing loss on their lives.

Dr Holmes explained that the scoring system was universal and that the CCG had used a threshold of a score of one hundred on whether or not to commission hearing aids. The score of the provision of hearing aids for mild and moderate was under a score of one hundred. The evidence did not support the commissioning of hearing aids for mild and moderate hearing loss, but clinicians would take into account the impact on life.

Andrew Donald explained that it was a commissioning policy and not decommissioning. Routinely people with mild to moderate hearing loss would not be able to access a hearing aid but there were some safeguards in place so that people who had other circumstances, which meant that it might be reasonable for them to have access to a hearing aid, could do so. The same framework was being used as in North Staffordshire but it was being applied differently in South Staffordshire.

A Member sought clarification that if someone had mild to moderate hearing loss then they would not get a hearing aid unless they could articulate that it would impact on their everyday life using the questionnaire in the paperwork. How it would be proved that the questions had been answered truthfully was queried and how clinicians could be sure that the questionnaire reflected everyday life, as people with a disability underestimated the impact of the disability on their everyday life or could be having a good day when they filled in the questionnaire, was questioned.

Andrew Donald explained that clinicians needed to be trusted to make a proper judgement as they worked with patients.

Dr Holmes explained that the audiologist would do the scoring and that the default was to believe what the patient was saying. This approach was used a lot for example in sleep apnoea. It was not about proving or disproving what the person was saying. Hearing aids impacted on sound generally and a lot of people with mild hearing loss did not tolerate them. In mild hearing loss a person could hear conversation but hearing aids increased background noise which made it difficult for those with mild hearing loss to hear so they stopped wearing the hearing aids and only started wearing them again when hearing loss got worse.

It was queried what the chances were that someone with severe hearing loss would adapt to using a hearing aid if they had never used one previously.

Dr Holmes clarified that from an evidence point of view this was not known but that people typically started using hearing aids when they were experiencing moderate hearing loss.

Andrew Donald explained that sometimes a line had to be drawn and evidence available had to be used to make decisions.

Dr Holmes explained that the scoring considered if people were able to hear speech so people still had time to adapt.

It was commented that reference to investment in the report was curious as people had paid their taxes and should feel worthy of investment. It was stated that hearing aids were an investment and could transform people's lives. The cost difference between an NHS and private hearing aid was raised.

Andrew Donald explained that there was not the money available to provide everything that everyone wanted. In reality mild to moderate hearing loss did not meet the threshold. It was challenging for commissioners to provide what everyone wanted and this could not always be done.

A Member asked what would happen across Staffordshire regarding the provision of hearing aids. It was suggested that a professional should explain to the Committee about hearing loss as the Committee needed to understand the effects of hearing loss. Concerns were raised whether the right decision was being taken.

A workshop with the Select Committee was suggested to bring in clinical advice. North Staffordshire information was being used but it was important to talk to and consult the CCG's own population.

A Member sought clarification on whether or not hearing aid provision in Staffordshire would be provided individually by hospitals in the County or if the service would be eventually centralised.

Andrew Donald explained that the Staffordshire Transformation Programme had to ensure services were clinically and financially sustainable. Virtually all organisations in Staffordshire were in deficit so there was pressure to address this. Debate on a far larger scale was required about the provision of healthcare to ensure a clinically and financially sustainable situation.

A Member referred to the poor consultation undertaken by North Staffordshire CCG. It was queried what the CPAG score was and if it had gone to the CPAG group on more than one occasion.

Dr Holmes did not have this information available but explained that it had been scored by the North CPAG but not by the South CPAG. Both CPAGs had however used each others scores as both scored the same issues similarly.

A Member sought clarification if hearing aid provision had been considered at the CPAG twice. It was commented that the evidence could not have been strong as there had been no evidence available from this country. It was suggested that the Committee should find out more and listen to campaigners to get a better understanding.

Andrew Donald explained that clinical evidence changed all the time, and commissioners tried to use the most up to date information as possible. A judgement

had to be made on what money should be spent on and there had to be a way of giving people what they clinically needed within the resources available. The challenge was how to do more with the money that the CCG had.

A Member asked what the position was in East Staffordshire.

Andrew Donald confirmed that the Accountable Officer for East Staffordshire CCG had confirmed that the CCG wanted to be part of the process. It was commented that Stafford and Surrounds CCG had appointed a lay member from Action on Hearing Loss to ensure full debate.

A Member suggested that the Committee see the Portsmouth Score and how it had been arrived at and a comparison with scoring on other areas. It was queried if there was any evidence for treating mild to moderate hearing loss with hearing aids.

Dr Holmes explained that there was no evidence from within the UK and evidence from overseas had therefore been considered. An example of the scoring could be shared at the workshop. The score took into account several factors and if little evidence was available the score would be low. Finance accounted for two of the nine questions. East Staffordshire CCG had nominated doctors onto the CPAG. An example was provided of plurax catheters, used at the end stage of cancer treatment to prevent the fluid build-up in the stomach. This scored highly even though it was expensive, as it benefitted the patient and family by stopping them having to go into hospital. Diabetes education also scored highly.

A Member suggested that people should be asked about the impact of hearing aids on their lives. The report should consider what people were asking for rather than what the CCG was able to provide. It was highlighted that hearing aids cost the NHS approximately £90 per pair but if the NHS reduced its service and buying power the price could go up. It was commented that commercial alternatives were not always suitable. Withdrawing services would mean people would have to access services through the open market. It was commented that the questionnaire within the report was very patronising.

Andrew Donald thanked the Committee Member for the helpful points and explained that a debate with the public regarding what was wanted and needed was required. People consumed healthcare because they wanted it but not because they always needed it. An Any Qualified Provider Contract awarded contracts to numerous organisations, and optometrists offered hearing tests. The NHS was not allowed to offer co-payment. During the consultation the debate needed to be turned around to get different evidence about what the public was saying. The public would make intelligent choices. The point about patronising comments was taken on board and it was acknowledged that it was important to make sure that the document was not presented like that.

A Member asked why there was no age factor considered on the priorities as this appeared to go against the Age Well priority. Concerns were raised regarding loneliness and the effects that hearing loss had on people. It was suggested that the CCG ask Shropshire CCG what they were doing.

Andrew Donald explained that for clear commissioning decisions, people had to be involved in the design, implementation and evaluation. The question of age may be something to be taken significant account of. The whole issue was about how the resources available could be used to best effect for the population's benefit. £31 million more was being spent than the CCGs were allocated and there had to be a way found to manage the resources more effectively. The three month consultation was key.

A Member questioned why the CCG could not wait until an impact assessment on the changes made in North Staffordshire had been completed before putting the proposals forward. It was commented that the wording of the patient functional test had made it appear that it was directed towards the elderly and it was not clear if younger people affected by hearing loss could undertake the test. The Member reminded the Committee that the CCGs spent £185 million on prescribing in Staffordshire, this had increased more than the rate of inflation. The indication was that £40-50 million more than it should be was being spent on prescribing and that this imperilled health and social care.

Andrew Donald explained that following a twelve week consultation any proposals the CCG wished to implement would not be put in place until April 2016. The CCG would be doing its own impact assessment. The CCGs were tackling prescribing and the QIPP plans were clear that prescribing costs should be reduced. There were issues however as patients needed to understand for example when they did not need antibiotics.

In response to further questions referring to the NICE paper on prescribing, Dr Holmes referred to the GP Members Board discussions on the issue. Pharmacists had discussed with GPs how they could reduce prescribing. She suggested that the public also needed to take on some responsibility. Prescribing costs had increased as there was more medicine available and new drugs were more expensive.

A Member referred to the Business Case and asked what savings were estimated. The prematurity of the proposals was remarked on as the North Staffordshire scheme did not start until 1 October 2015. It was also commented that South Staffordshire had an older population than in North Staffordshire and this should be considered.

Jane Chapman explained that possible savings equated to approximately £30-40,000 per year but this has not been the primary driver of the proposals. The difference in populations was recognised and each CCG would have to go through an independent process and each CCG Governing Board would need to make a local decision on any proposals put forward.

Andrew Donald clarified that by the time the consultation had finished there would be six months of evidence from North Staffordshire and this would be taken account of.

The Chair thanked Members for their questions and for the responses received. It was agreed that a workshop would be undertaken to incorporate professionals, action groups and interested parties views. A Member suggested that this workshop session should be held in public due to the public interest in the issue. This would enable people to engage in the debate which was important as the proposals may be copied in other parts of the country.

It was confirmed by the Chair that the workshop meeting would be webcast.

**Note from Clerk – Following the meeting it was confirmed that Stoke on Trent CCG did not wish to introduce the eligibility criteria.*

Resolved;

- That a public workshop be held to consider the views of professionals, action groups and interested parties and to enable the Committee to make valid comment back to the CCG on the proposals.

108. Proposed changes to the provision of specialist inpatient haematolgy services at the County Hospital

Jonathan Belcher, Director of Strategy. Cannock and Staffordshire CCGs introduced the item. He explained that the proposal was about permanent change to the haematology services at County hospital and was in addition to the TSA work. The proposal before the Committee was for inpatient haematology services provided at County Hospital to be moved to the speciality haematology wards at the Royal Stoke University Hospital and New Cross Hospital, Wolverhampton. The proposal was considered to be the only technically viable option. The recommendations of the TSA had had a consequential impact on County Hospital but there had been no specific TSA recommendation regarding inpatient haematology so consultation needed to take place. The consultation was focussed on specialist inpatient haematology, this affected a small number of beds, eight in total at the County Hospital site. The impact at a patient level had been mapped and presented to the Committee.

Total inpatient activity at the County Hospital over a twelve month period equated to one hundred and eighteen cases or eighty three patients that had been through an inpatient ward. There was no changes proposed to outpatient or day case activity. It was important to recognise that as a result of the TSA model, patient flow had started to change and approximately forty percent of activity that would have previously gone to County Hospital had now moved towards Cannock Hospital and New Cross Hospitals. National evidence had been considered and additional expertise sought. The CCG had sought advice from specialists including Professor Charles Craddock, Director of the Blood and Marrow Transplant Unit at the Queen Elizabeth Hospital, Birmingham and Professor of Haemato-oncology at the University of Birmingham, and the West Midlands Haematology Network to consider other options. They had concurred that the proposal would be the most appropriate move for services. The current provision, how this has been assessed and the proposed future reconfiguration of services had been included in the Committee papers.

University Hospitals of North Midlands NHS Trust services at the County Hospital site were provided at level 2b service, with eight inpatient beds on two floors divided by gastroenterology. These beds were not fit for purpose given the future arrangements for haematology and the infrastructure required around it. The proposal was for the inpatient beds to move which would leave a 2a service at the County Hospital site, enabling outpatient and day care services to remain. There would also be two step down beds put onto the wards to allow repatriation of patients back to County Hospital. At Royal Stoke University Hospital there would be an additional five beds to match the reduction at County Hospital and to maintain the level 3 status of the hospital. The Cannock Hospital provided no services but through the redevelopment of the site there

would be a chemotherapy suite of twenty day case chairs, confirmation was awaited on when the suite would open, putting 2a service in place. An additional three beds would be provided at New Cross Hospital keeping the service at a level 2b. Level 2b and 3 services were the same except for the ability to provide bone marrow transplantation. In the North this would be provided by Royal Stoke University Hospital and in the South by University Hospitals Birmingham.

In undertaking the consultation a Health Equality Impact Assessment was completed under the TSA process however this was not sufficient for the haematology proposals so an additional Health Equality Impact Assessment was being undertaken. A clear timeline of events, as part of the previously agreed six week consultation process, was presented within the Committee papers. There were two options, to do nothing or to move services. Using the TSA evaluation criteria, the self assessment had added to the reason and rationale for the scoring of the two options. The TSA required the model to be clinically and financially sustainable and reasonable in terms of access and deliverability. The current provision was reasonable but not clinically sustainable and not financially sustainable as it was supported by in excess of £660,000 per year to keep the staffing base in place. The model was deliverable until 7 September 2015 when there was a decision by the Sustaining Services Board that for clinical and safety reasons the provision would not remain at the County Hospital site and a temporary service transfer was put in place. The questions being asked in the consultation included what other options could be considered, and whether the TSA evaluation principles had been applied appropriately. The communication and engagement plan and the technical aspects for change were also included in the Committee papers.

Dr. Gavin Russell, Associate Medical Director, University Hospitals North Midlands NHS Trust, commented that the proposals related to a small number of very sick patients. For those involved in the TSA model it was already understood that specialist services would move from County Hospital. This was not however under the framework of haematology. Cancer services were not removed from the County Hospital site. There was £3 million investment in a new chemotherapy unit at County Hospital and there was investment at Cannock Hospital for local patients to access chemotherapy. The proposal was in relation to patients who were extremely unwell, for example a young person with acute leukaemia undergoing treatment who was extremely at risk. The patient was prone to sepsis and therefore needed to be in the right environment to access facilities such as pressure rooms, ITU facilities and acute renal failure facilities. These facilities were not available at County Hospital. To treat very sick patients, effective numbers of consultants and middle grade doctors were required. There had been four consultants at County Hospital however, one had left and one had retired, so there was only two substantive posts at County Hospital. Recruitment to the County Hospital site was not successful as consultants wished to be part of a haematology team of eight to ten people in specialist centres. There were plans to develop more specialist haematology outpatient services at the County Hospital site as some patients had had to travel to Stoke anyway to access treatment.

A Member queried how seven day working could be managed and clarity was sought on why recruitment to the specialism had not been prioritised and whether reputational problems had impacted on this. Whether rotas could be shared and networking could take place between hospital sites was questioned.

Dr Russell explained that the number of haematology patients at County Hospital was small and the recruitment of nurses and a consultant haematologist could not therefore take place, unless they were part of a wider haematology team. Two rotas could not run at the same time or for such a small number of patients. People wanted to work at large centres as they needed to be part of a wider team and required colleagues for peer review. The County Hospital Consultants going to work at the Royal Stoke University Hospital would be part of the rota and would continue to work locally. Day surgery was continuing to increase at County Hospital and more outpatient and care of long term conditions was taking place.

In response to issues regarding seven day working it was confirmed that there was recruitment at the Royal Stoke University Hospital and there was no problems in envisaged in recruitment going forward.

A Member referred to the move of renal treatment to the Royal Stoke University Hospital. It was clarified by Dr Russell that a £3 million satellite renal facility was being built at Stafford which would have twelve stations. There were eighteen stations at Leighton Hospital and at the Royal Stoke University Hospital there were approximately fifty stations.

It was queried what the need of an inpatient was. Dr Russell referred to patients that received chemotherapy and were very prone to infection or getting infections and becoming very sick. Some of the lines used for putting in chemotherapy had to be done by imaging, which required an interventionist Radiologist of which there were few at County Hospital. At the Royal Stoke University Hospital the line could be put in very quickly. The facilities at the Royal Stoke University Hospital managed very unwell patients. For patients with less severe illness there may be opportunities for step down at County Hospital and day case treatment for patients at County Hospital would be evolved.

It was suggested that the consultation questionnaire should not ask personal questions and only ask questions relative to the proposal.

Jonathan Belcher confirmed that there was a duty under the Equality Act to ask such questions and an exercise had been undertaken to reduce the number of questions asked. It was confirmed that information provided in relation to the consultation would be considered even if not all of the questions had been answered.

Dr Russell stated that it was important to get the views of patients and their relatives and ask what could be done to make things better for them if services were moved. For example how they could be helped and supported through illness, had to be considered.

A Member referred to families' needs and what could be done to help people.

Jonathan Belcher explained that there was a two step process. The Trust would confirm overnight parking exceptions and through the Trust there would be engagement with patients to find out what else could be done to support them. An open day at both Units if the move was supported had been suggested.

The Chair thanked all for the questions and responses received.

Resolved:

• That the Committee agree the rationale supporting the recommendation that inpatient haematology services currently provided at the County Hospital be moved into the specialist wards at the Royal Stoke University Hospital and New Cross Hospital.

109. 'Living My Life My Way' - Strategy for Disabled People

Resolved:

- That this item be deferred to a future Committee meeting to ensure appropriate time for scrutiny of the item.
- That the Cabinet Member be asked to consider re-writing the report in response to feedback from Members at the meeting.

110. District and Borough Scrutiny Report Updates

It was commented that the Committee Chairman and Officers supporting the District and Borough Select Committees be contacted regarding the content of the report as in some cases the information submitted was too limited.

Resolved:

- That the Scrutiny and Support Manager contact the relevant Officers for more details regarding the work of the District and Borough Committees for inclusion in future updates to the Committee.

111. Healthy Staffordshire Select Committee Work Programme September 2015

The Chair of the Committee confirmed that following the Committee's discussions at the meeting, a workshop would be programmed to consider South Staffordshire Clinical Commissioning Groups proposals regarding hearing aid policy and consultation, in more detail. In addition agenda Item 7, ' Living My Life My Way' – Strategy for Disabled People would be brought to a future Committee meeting.

A Member referred to the item under 'Special meetings to be arranged' on the Work Programme, on the distressed health economy. It was suggested that as the conversation at the meeting had referred to the difficult financial position that CCGs faced, a session should take place on the outcome of the KPMG report which was over a year old. It was commented that the Committee needed to know what the outcome of joint working was and required more information about the deficits of the Staffordshire CCGs and NHS Trusts. The Committee requested more information on which organisations were successfully working within their budgets, what the common issues were across organisations, including over-prescribing for example, more information on issues such as joint working and on the County Council's financial position. This meeting needed to take place promptly as this information underpinned all of the Committee's current work.

A Member requested that the update from Healthwatch Staffordshire should be provided to the Committee as a priority.

Resolved:

- That a workshop for the Committee to consider the proposed hearing aid policy and consultation for the South Staffordshire Clinical Commissioning Groups be arranged.
- That the deferred item on 'Living My Life My Way' – Strategy for Disabled People be included on the Committee Work Programme.
- That the item on the work programme on the Distressed Health Economy be programmed to come to the Committee as a priority.
- That the update from Healthwatch Staffordshire be timetabled to come to a Committee meeting as a priority.

Chairman