Buckinghamshire County Council

Select Committee

Health and Adult Social Care

Minutes

URGENT CARE WORKING GROUP

MINUTES OF THE HEALTH AND ADULT SOCIAL CARE - URGENT CARE WORKING GROUP HELD ON TUESDAY 28 JANUARY 2014, IN MEZZANINE ROOM 2, COUNTY HALL, AYLESBURY, COMMENCING AT 1.03 PM AND CONCLUDING AT 3.35 PM.

MEMBERS PRESENT

Buckinghamshire County Council

Lin Hazell (In the Chair)
Mr B Adams, Mrs M Aston, Mr M Shaw, Julia Wassell and Mr D Carroll

District Councils

Mr A Green	Wycombe District Council
Ms S Adoh	Local HealthWatch

Others in Attendance

Mrs E Wheaton, Democratic Services Officer
Mr J Povey, Overview and Scrutiny Policy Officer

1 APOLOGIES FOR ABSENCE / CHANGES IN MEMBERSHIP

Apologies were received from Carl Etholen, David Martin and Jean Teesdale.

Andy Huxley has replaced Darren Hayday on the Health and Adult Social Care Select Committee. The Chairman welcomed Mr Huxley to the meeting.

2 DECLARATIONS OF INTEREST

There were no declarations of interest.

3 URGENT CARE INQUIRY SCOPE

The Chairman started by explaining that the background to the meeting today is an extension of the 2013 work that the Health and Adult Social Care (HASC) Committee commenced in response to the Keogh Report into the quality of care and treatment at Buckinghamshire Healthcare NHS Trust. She made the following points.

- Whilst the Keogh team reported on the quality of services, the HASC is mindful of continued strong feeling concerning local urgent care services. This is evident from feedback received by committee members from the public, local media coverage and petitions submitted to the Council.

- In responding to these concerns this committee has tried to separate concerns over quality, from those concerning the design of the urgent care pathway and where people go for care.

- The HASC's earlier report, which was published in October, in response to the Keogh review of the Trust was concerned with issues of quality, and the HASC will continue to monitor quality improvements at the Trust, with items at the February and April committee meetings coming up.

- Other quality concerns around aspects of the urgent care pathway or particular providers could be looked at by the HASC in future.

- Todays' meeting is focussed on the Urgent care pathway design locally - basically where people go when they need urgent healthcare advice or treatment, and the public understanding of the pathways in place.

4 CLINICAL COMMISSIONING GROUP NOVEMBER RESPONSE TO SELECT COMMITTEE QUESTIONS

The Chairman welcomed Lou Patten (Aylesbury Vale Clinical Commissioning Group), Annet Gamell (Chiltern Clinical Commissioning Group), Neil Dardis (Buckinghamshire Healthcare NHS Trust) and Steve West (South Central Ambulance Service).

The Chairman explained that a number of public questions have been received in advance of the meeting and these will be read out by Committee Members. The names of the members of the public have been kept confidential.

Ms Patten took Members through the presentation which set both the national and local scene and she made the following main points.

- A model for transforming urgent and emergency care services has been developed by Sir Bruce Keogh and Professor Willet and it suggests that a new urgent and emergency care system needs to shift more people from the acute hospital setting to care as close to home as possible.

- Over 1 million emergency admissions in 2012/13 were considered avoidable.
- 50% of 999 ambulance calls could be managed at the scene.
- 40% of patients who attend A&E are discharged having needed no treatment at all.
- 20% of GP consultations relate to minor aliments which could largely be dealt with by self-care and support from the community pharmacy.
- Sir Bruce Keogh recognises that it is a 3-5year transformation process.
- NHS 111 telephone service – the right call to make to get to the right place first time for treatment. The service is headed by trained call handlers and clinicians. They have a local directory of services so they know what is open and where to direct the patient. It is a standalone service. SCAS are the providers of the 111 service.
- Minor injury and illness services must be local but not necessarily connected to a hospital.
- Serious injury and illness (A&E type services) – these services must be alongside other hospital services, e.g. Intensive care, Orthopaedics.
- Regional specialists – for example, Cardiac and Stroke services. These services must be alongside other specialist services, e.g. vascular, neuro-surgery. There are two specialist units at Wycombe Hospital for cardiac and stroke patients.

During discussion, Members read out the public questions as well as asking their own questions.

Section A – Current A&E and Urgent Care Pathway design

Public Question from Kate in High Wycombe who was drawing on her own ambulance trip to A&E following an asthma attack: "I want to know why the local hospital does not treat anything worthy of hospitalisation….I want every event that lead to the hospital being little more than a bandage dispenser investigated and the reasons behind each of these events made public". [Similar questions around concern over the diminished service provision at Wycombe Hospital have also been received].

In the interest of public understanding, do you think there is a need for a definitive explanation to be published and made available on the CCG's and BHT's websites to outline where people need to go for different levels of care and what services are available across the county – a" one-stop" shop? Dr Gamell agreed that public understanding and communication is very important. The move to where the current services are now located was a clinically-based decision. People do not seek urgent care on a regular basis so it's about reinforcing the messages – the 111 number is the key as it is the gateway to all services. If urgent but not life-threatening, then the message is for people to call 111. If a minor injury, use Wycombe MIIU and the service is available for all residents of Buckinghamshire. If it is a life threatening situation, call 999. Dr Gamell agreed that it is a complicated message but a lot has already been done to publicise the different numbers but she agreed that the numbers need to be continually promoted. She stated that people do not "rehearse" the numbers and the likelihood is that people will not need to use the service from one year to the next.

A Member went on to express concern about local residents being confused about the different numbers and also their ability to access websites in a time of distress. Dr Gamell agreed that it is not only about websites, it is about getting the message out there that 111 and 999 work alongside each other. Unfortunately there was supposed to be a national launch of the 111 number last October but it did not happen so a local campaign has been devised to promote the number and she acknowledged that more needs to be done. Mr West went on to say that because SCAS provides both 111 and 999 the systems are being standardised between the two so regardless of which number a person calls, its' the same

service but just two numbers. The same clinical assessment will be undertaken – it's simple, easy access. We would prefer people to call 111 so as not to overload the 999 system but we will still route people to the right care.

A Member stated that she was one of the instigators of a petition of around 16,000 signatures to keep an A&E department at Wycombe Hospital. She said that the people of Wycombe do not accept the loss of the A&E service and local people would prefer to go to Wycombe rather than to Stoke Mandeville. She went on to say that she represents a lot of vulnerable people and she asked for the policy decision to be reversed. She ended by saying that on behalf of the people of Wycombe, could the A&E service be reinstated at Wycombe Hospital.

The Chairman went on to say that people would like to understand why Stoke Mandeville Hospital was chosen as the site for an A&E and not Wycombe and also the reasons why an A&E department cannot be at both sites. She asked the representatives from the CCG's to explain the rationale behind both decisions.

Dr Gamell responded by saying that the rationale was clinically based and it is around what services are needed to provide a certain level of care. A&E is a speciality and if people are admitted after they have been to A&E, there needs to be the infrastructure behind the A&E department to provide the specialist services, such as respiratory. There needs to be a certain number of patients going through to the specialist services in order to maintain the skill levels of the medical staff. The models of care show that this would be based on a population of around half a million. In order to provide the specialist services at Wycombe Hospital, the medical teams would be servicing around half that number. If the Trust were to start with a blank canvass, they would look at having one main Hospital for the people of Buckinghamshire. The clinical model has been networked across the three Hospitals (Stoke Mandeville, Wycombe and Amersham).

A Member went on to say that there will always be the movement of people from one Hospital to another depending on their needs and level of care but felt that it made more sense to treat people locally in the first instance. He suggested that this would be better use of the ambulance service as it would reduce the number of transfers between Hospitals.

Dr Gamell explained that when Wycombe had the EMC, it did have the specialist services to support it - orthopaedics, trauma and surgical had moved but the rest of the services were available there. Mr Dardis went on to say that it is about staffing levels and deliverability and that the Trust wants patients to be seen by the most senior consultants in the right place. The Trust is investing heavily in having senior consultants there until 10pm at night and over the weekends and concentrating the skills so that patients have access to them at the right place. The Royal College of Emergency Medicine publishes guidance to say that for the size of population of Buckinghamshire, the Trust should have 8-10 consultants.

The Chairman went on to ask why Stoke Mandeville Hospital was identified as the preferred site for the A&E department and not Wycombe. Dr Gamell started by saying that some of the decisions were made some time ago. She went on to say that as she has already mentioned, A&E requires the infrastructure behind it in terms of specialist services so there is a practical decision around building space. There is a lack of ground space at the Wycombe site to build and expand. Wexham Park A&E is close to Wycombe and it's about having regional sites and looking at the whole strategic picture.

A Member asked if the criteria for having an A&E changed from around 500,000 population to 250,000 people, would it be feasible to suggest that Wycombe would be viable for an A&E department? Dr Gamell explained that when the number of patients

attending the EMC at Wycombe were analysed, it showed that 42,000 were going to EMC over a period of a year. Of those 42,000, about 32,000 could have been dealt with by an MIIU. So the bulk of work historically undertaken at the EMC is now being carried out by the MIIU.

A Member expressed concern about the 10,000 people who are not satisfied. Ms Patten said that the services of the MIIU do need to be emphasised and publicised more. She went on to say that the majority of people who were concerned about the EMC closing can now be treated by the MIIU. The CCGs are constantly looking at ways of promoting the services to the members of the public Communication is key because peoples' interpretation of what services are being offered can be very different.

A Member felt that the lack of communication at the time of changing the EMC to MIIU was paramount to adding to peoples' confusion about what is available at Wycombe now. The Chairman said that local Members need to explain the changes to their electorates and to help them through the system.

A Member commented that there are still a lot of outstanding issues around communication and also transport as the people of Wycombe cannot easily get back from Stoke Mandeville. The Chairman said that a number of people experience transport issues unless they live close to a Hospital. Ms Patten stressed that transport is a whole system problem. The Chairman suggested that transport will be put on a list of issues to be explored further in the future.

The Health and Adult Social Select Committee compiled a topic paper on BHT Acute Service Configuration evidence. This cites evidence from the College of Emergency Medicine that centralisation is not a universal remedy and the risk that increased transport times in rural areas could negate benefits of centralisation. In the HASC's October report on the Keogh inquiry into BHT, the Committee included a section on how future reporting on BHiB benefits should be improved. This included requesting data to give assurance that longer journey times were not negating benefits of acute service centralisation locally. Do you agree that there is a need to provide this assurance and will you support efforts to provide this?

This links to a question received from Steve Baker MP concerning how many people had died en route to A&E who otherwise may have survived if Wycombe still handled emergency cases.

Mr West responded by saying that he was not aware of any adverse incidences recorded by SCAS where patients have died en route to Hospital. He said that SCAS has seen an average increase in task time in the Wycombe area of around 5 minutes and for the whole of Buckinghamshire, around 3 minutes. He went on to say that it is we know that getting patients to a specialist unit produces a better outcome for the patient. SCAS do not anticipate any issues about getting patients to the right place and they do not perceive it as a major risk in terms of transport into the unit. There is a full adverse incident reporting system so any patient who lost their life on the way to Hospital would be reported and fully investigated. The Chairman asked whether this data could be made available at the next meeting which is attended by SCAS.

Action: Mr West

A Member asked about the part-time ambulance station at Amersham and will that cause delays in people being taken to A&E by ambulance. Mr West explained that there is a routine patient transport base in Amersham which is the service provided for out-patients

and day use attendance. The emergency services are stationed out of Wycombe and Stoke Mandeville so that clinician time is maximised out with the patients and there are standby locations across the county. There have been no changes in Amersham.

Public Question from DR – "Why is the minor injuries unit located in the same place as the A&E Department at Stoke Mandeville? I went to this as I didn't have a GP after recently moving house, but when I was seen I was lectured by the registrar that my injury was minor and not for an A&E department. Mr Dardis explained that all A&E departments can deal with both minor and major injuries. He said that he was unaware of the specific circumstances around this particular case and could only apologise if it was not handled correctly. All patients can be managed and treated if they attend the A&E Department. Ms Patten said that this demonstrates that the person went to the wrong place.

A Member went on to say that the new system relies on people self-diagnosing and decide where they should go. She expressed concern about the most dependent and vulnerable people who cannot always successfully self-diagnose otherwise there will always be mistakes between the 111 number and 999, MIIU and A&E. It will never be an exact science until there is a bigger "funnel".

A Member asked whether there was an issue with medical staff being overworked as a consequence of the new A&E arrangements. Mr Dardis said that the feedback from the teams around consolidating the services on one site has been very positive and particularly for the junior doctor who see more of their senior consultants so they feel much better supported. Consolidating services has also enabled consultants to work more appropriate rotas.

A Member felt that a number of people are not registered with a GP and are using A&E as their "GP" surgery. The Chairman said that when the Committee were looking at Better Healthcare in Bucks, a large number of people had not registered with a GP and this is obviously an issue which needs to be addressed.

Public Question from Steve Baker MP – "How many people from the Wycombe constituency have presented for acute care in Bucks but have not been treated as their case was considered to be insufficiently serious?" - we appreciate you may not have such figures readily available, but it would be helpful if you could clarify how many cases are handled at A&E, if the Hospital staff consider the patients case is not very serious and they should have gone elsewhere (GP, self-care or pharmacy, etc). Are they turned away? Dr Gamell responded by saying that patients are assessed before a decision about what treatment to give and the patient would be notified if they had presented in the wrong place. MIIU records those patients who are not treated. Ms Patten went on to say that 40% of people who attend A&E receive no treatment at all – that's a national figure. Generally speaking, around 110 people attend MIIU every day and the split between illness and injury is around 50% to each. Around 17-20% of people are sent home without any treatment or for self-care and are advised on the most appropriate place for them to receive what they need (ie. their GP, a pharmacist). People are also given help with registering with a GP if they are not registered.

The Chairman mentioned that some people will decide to go to A&E because they cannot get an appointment with their GP. Access to GPs may well need to be revisited again to try and resolve this issue.

Public Question from DB which relates to concerns around the case of an elderly person in the Chalfonts who had to wait 1hr and 45 mins for an ambulance to arrive, after she had fallen on the pavement and incurred a serious head injury. Police and a

young doctor provided first aid while they waited. The Police advised they have increasingly of late had to attend accidents when an ambulance had taken a great time to arrive. As commissioners of the service, do you monitor the instances of excessive ambulance waits and do you investigate such instances? Should an excessive wait like this be considered an ambulance equivalent of a hospital 'never event' and be similarly reported and investigated? Ms Patten responded by saying that the CCGs review and monitor the ambulance targets as commissioners of the service. Category A response times are monitored closely and any delays would be reported to us and it would be fully investigated and dealt with. Mr West went on to say that SCAS has faced a challenging 12 months with a 20% increase in activity from where we were 18 months ago with all the changes in the services which SCAS has had to respond to. The 8 minute response time is as good as it has ever been and SCAS has a 70% response rate which is very good. SCAS grade calls in the same way as the police and will access the response time accordingly. Patients who do not require a life-threatening response, will receive a managed response time which can be up to 4 hours. For life-threatening situations, SCAS will respond within 8 minutes.

If SCAS receives a compliant, then an Investigating Manager would be assigned to look into it and if there were any lessons were identified and areas to improve on then these would be fed through the organisation. SCAS looks at breaches to response times so any response time over 30 minutes for a life threatening situation would be fully investigated. These situations are very rare and would be reported back to the Commissioners.

The Chairman asked whether SCAS would go back to the individual concerned to speak to them even if they had not submitted a formal complaint but their response time was very long. Mr West explained that SCAS would not routinely go back but if the individual put a formal complaint in, then SCAS would deal with this as part of the complaints process.

Public Question from Wycombe Labour Party which is not about the urgent care pathway but on how hospital discharge delays impact on A&E pressures. They are concerned County Council social care services may be delaying discharges and causing an A&E log jam. Please can you explain the extent to which the Councils service is contributing to this problem, and how to monitor and work with the council on avoiding discharge delays? The Chairman added that the Committee will be looking at Hospital discharge as a separate piece of work. Dr Gamell said that a lot of work is being done across the system on integrated care and it has been recognised that there is a gap with discharge planning so this is being looked into. Delayed discharges of care are quite low in Buckinghamshire. The CCGs are working closely with the County Council in terms of supported discharge (a package including both health and social care services). Ms Patten went on to say that there is a resilience telephone call every day across the system which looks at the number of people who need to be admitted and the number of people who are being discharged so that the number of beds can be identified.

How many patients are then readmitted because they are discharged too early? Ms Patten said that she did not have this information available for this but this is monitored very closely. Mr Dardis went on to say that the re-admittance rates are very low and we have been able to provide patients with a planned return so they can see the right specialist rather than joining the queue again.

A Member felt that the success of this joint working should be celebrated and the teams congratulated on their partnership working.

Public Question received from LB on the GP registration process. The lady who submitted the question explained that she needed to see a GP concerning a painful

eye infection. Having just moved house, she did not have a utility bill in her name, only her husbands, and the GP surgery refused to register and see her. A chemist directed her to an opticians but none were open locally, so she ended up at a Slough walk in clinic. Is the GP registration process unnecessarily inflexible and adding to the pressure on Urgent Care Centres and A&E? Dr Gamell responded by saying that she was unable to comment on the specific details of this but she said that a GP can see people in emergency situations as a temporary resident. GPs have catchment areas and she said that most GPs would see patients appropriately. A lot of the process around GP registration has become nationally driven by statutory requirements. She urged everyone to register with a GP in a timely way to avoid any problems in an emergency situation.

Public Question from PR on Wexham Park A&E who queries why a GP cannot refer a patient direct to a specialist at the Hospital rather than to A&E to join the queue. The example they used was when someone made a repeat visit to the GP concerning an upset stomach and diarrhoea. Can you explain if, and how, GP referral into Wexham Park could be improved and is this an issue common to Buckinghamshire Healthcare Trust as well? Dr Gamell explained that a GP would not necessarily refer patients to A&E – they would refer a patient to a specialist team. The new Buckinghamshire Healthcare NHS Trust surgical and medical units should mean that people do not have to go to A&E if they have been referred to a specialist team by their GP. The same set-up is evolving at Wexham Park. People should not be referred to A&E by their GP to have to start at the back of the queue at A&E.

The Chairman asked Committee Members and members of the public to submit any further questions on current A&E and urgent care pathway design to James Povey, policy officer (jpovey@buckscc.gov.uk)

Action: Committee Members

Section B – Information to the Public on Urgent Care Pathway options

Public Question received from Steve Baker MP – "What feedback has been received from patients on their understanding about how to access acute hospital services? What more needs to be done to ensure patients are confident in presenting at the correct place for treatment?" Dr Gamell explained that both CCGs have received a lot of feedback from their localities meetings and the top feedback issue is communication. The message is that we are trying to do this – 111 is the key number and first port of call. Some people have said we did not know there was an MIIU was there and others knew it was there but did not know what services were available there. One of things which is being developed is a video showing what services are available and we should be able to share this with you soon.

Helen Peggs (communications team from BHT) went on to say that it has been recognised that communication is the biggest issue but it has also been recognised that urgent care only affects people every 3-4 years so it is difficult to keep everyone up-to-date therefore it is important to remember the 111 number. A communications group has been set-up which includes representatives from Steve Baker's office and Healthwatch and some really productive meetings have taken place. A video on MIIU will be launched soon and will be rolled out to GP waiting rooms and council offices. She stressed that it is everybody's responsibility to get the messages out there. It is a community problem. Mr Dardis said that following the Keogh report, BHT was asked to review the transfer between sites and the feedback received from patients was very positive but the one complaint that was made was around transferring from Wycombe to Stoke Mandeville and having to join the end of the A&E queue. This resulted in the setting up of the surgical and medical units so that patients

transfer directing to those units do not have to go through A&E.

Is it good enough to urge people to call 111 for signposting in all cases, or should there be a clearer explanation/diagram of the options in various parts of the county published? Ms Patten responded by saying that the 111 number is the correct route for people to take if they are not sure where to go. In December, 13,200 people called the 111 service – the highest volume of calls to date. Around 9,000-11,000 people call the 111 per month. She went on to say that it is about different ways of communicating with people. Nationally, there is recognition that there is ongoing confusion about what services are called. The second phase of the Keogh report is due in Spring time so there may be some clarity around what services are called. Dr Gamell said that a local directory of services sits behind the 111 number so that the call handlers can provide local advice to people who use the number (for example, opening times of pharmacists and where they are located).

A member commented that with an ageing population, the CCGs should be concentrating on centres where older people tend to populate so that key messages can be promoted through these channels.

What information is being distributed to people who live in the South of the County who would use Slough and Wexham Park? Dr Gamell explained that there was a leaflet that went out in November time explaining where to go for certain services. Ms Peggs then went on to say that adverts were placed in various local newspapers and leaflets were made available in libraries and GP surgeries in South Bucks.

Public Question from Wycombe Labour Party - Linked with this could a version of this diagram or alternative summary of the urgent care services including, who commissions the services, who provides it, what it costs, what is delivered, performance data, who monitors the providers performance, what penalties are there for performance failure and who is responsible for all the providers work effectively together? Ms Patten said that it is available in the public domain but it is probably not all collated in one place. She said that she could respond with an information pack. The BBC news website is also a good place to find further information on urgent care services. The Chairman suggested that this information could be linked in with the County Council's website and this could be one of the recommendations.

Action: James Povey for report

With various elements of the urgent care pathway being commissioned by different agencies, who is taking ownership for the monitoring and delivery of efforts to shift people away from acute services?

Who is driving change locally and is there adequate understanding of demand, activity and capacity? Dr Gamell explained that it is the whole system working together – acute care, the two CCGs, mental health. Urgent Care System Working Group has all members of the whole system who are addressing all the issues around delivering care which reports to the Urgent Care Executive team.

The Keogh report also recommends stronger links between Community and GP healthcare settings, serving patients with long term conditions and acute hospitals so that access to specialist care should not be limited to the acute hospital setting. What barriers locally are there to this and what should be prioritised in delivering acute healthcare services closer to the community? Dr Gamell started by saying once again it's about communication and specifically, in this case, it is about IT communication and the sharing of information. As a system, it has recently employed a joint Director of integration,

one of the first posts in the country to bring together these points about bringing all the services together. Nationally, there is a health system which is Hospital focussed but it needs to move towards a more Community based system where care is provided closer to home. Hospitals are seen as a place of safety.

The Chairman asked whether the CCGs are measuring the 111 number in terms of its effectiveness against the national picture. Ms Patten said that around 7% of those people who call 111 are transferred to 999 whilst the national average is 10% so that is a good measure of understanding. The 111 call resulting in the patient going to A&E is around 4-5% locally, which is slightly below the national average. Around 40% of people who call it are using it for out-of-hours assistance. The abandonment rate locally is 0.7% - this is significantly low and this is because there are a high number of call handlers so people do not tend to "give up and put the phone down". Overall, it is a very encouraging picture. The 111 number performs well against the national average figures so there are some good indicators for Buckinghamshire.

A Member commented that more and more pharmacists are encouraging patients to go directly to them. There is also a new pharmacy opening in Aylesbury which is good news for local people.

[Andy Huxley and Brian Adams left the meeting at 2.55pm]

A Member felt that the move away from the Hospital setting to the community relies heavily on the GPs being embedded in their local services. The member said that in their area, the GPs do not really engage with their local communities.

What support do you give to the GPs to help them to engage with the local community? Dr Gamell said that the CCGs are broken down into localities – 4 localities in Chilterns and 3 in Aylesbury. The local GPs are assigned to a locality. A multi-agency group within surgeries has been established, for example, mental health services, social care services, etc. There are lots of different pieces of work going on in the communities/localities.

<u>Section C – Future Shape of Local Urgent Care Provision (draw on National Audit Office and Keogh Urgent Care Review Reports)</u>

Can you clarify based on your understanding of the Keogh/NHS England Urgent Care Review, what the local A&E designations (Emergency Centre, Major Emergency Centre and Urgent Care Centre) would be in the future? Ms Patten responded by saying that this will become clearer in the second phase of the Keogh report. The CCG feels confident that the services it has developed locally are in-line with the Keogh recommendations currently and in the future – ie. urgent care provision through the MIIU and the network across the whole acute setting. It is generally believed that Buckinghamshire is ahead of the game in terms of the reconfiguration of its services.

A member expressed concern about the titles keep changing of what things are called – different levels of A&E which confuses people. It is an on-going battle to get people to understand the different names. Ms Patten said that they are reluctant to rename things just yet until the second phase of the report has been published.

Public Question from Wycombe Labour Party – Can you reassure Wycombe residents that the MIIU at Wycombe Hospital will stay open for the foreseeable future and such a service would fit with the Keogh Urgent Care Review vision? Dr Gamell confirmed that this will be the case.

The Chairman said that is the service likely to remain a 24/7 service. Dr Gamell said that the figures last year of 32,500 using MIIU showed that 4.1 were using it per day during the night. The out-of-hours provision is now co-located with the MIIU. Clearly there is a need for an MIIU service overnight but the demand is less so it may be that the 4.1 people would be best placed getting an appointment to then go down to the unit to see the out-of-hours doctor.

A member said that some people are going to Stoke Mandeville during the night because they do not realise they can be treated at Wycombe. Dr Gamell said that this is probably the case but the MIIU will remain 24/7 for the timebeing.

A member asked where the place of safety is in Wycombe under the Mental Health Act? The Chairman said that representatives from the mental health services will be attending the meeting in March so she suggested this question should be asked at this meeting.

Ms Patten said that the message to members of the public is that if they did urgent care during the night then they should call 111 to make sure they are directed to the right place first time.

What do you expect the impact of the merger between Heatherwood & Wexham Park Trust and Frimley Park (which could happen in the coming months) will be on A&E and urgent care services received by residents in South Bucks long term? Dr Gamell said that the full details of how the proposed merger will impact on the two Hospitals but there is a need for an A&E provision in Slough so there are no plans to move this to Frimley Park. The Chairman said that she attends the Slough Scrutiny meetings and her understanding is that at this point in time Wexham Park will stay the same in terms of the services it delivers but it would be under a different management. The aim of the merger is about maximising the benefit for the patients.

Dr Gamell said that a quarter of the population of the Chiltern Clinical Commissioning Group attend Wexham Park Hospital so it is very important for the CCCG to work closely with them.

Beyond A&E designations, what else would need to change, or be enhanced locally to deliver the 3-5 year vision outlined in the Keogh report? What work is already happening on this and what should the priorities be? Ms Patten said that she believes that the infrastructure is right and the telephone structure is right but as mentioned during the meeting, communications needs to improve. The CCGs do a lot of analysis on who uses the different services and the type of people who might use A&E now and in the future. The CCG has a lot of knowledge and data which helps them to plan and target the key areas with its key messages.

Based on concerns from MC, who feels we need to reopen Wycombe A&E as Stoke Mandeville is too busy and will only get worse with the proposed new housing developments in the area……Who is taking a lead on negotiating NHS contributions from developers to fund capacity improvements at Stoke Mandeville Hospital, and is it likely that if the Vale does end up accommodating 10-20,000 new dwellings in the next 20 years, the Hospital will need significant expansion? The Chairman added that if Wycombe and Aylesbury continue to expand at their current levels, can the A&E at Stoke Mandeville cope with the additional pressures? Ms Patten said that the basis for an A&E is about what other services and specialist services need to be co-located with it. The unit would be more likely to expand rather than split into two. In terms of negotiating NHS contributions from developers (Section 106 payment), the CCGs will look at the council's 15 year plans for potential housing developments and will work alongside them to try and meet the health needs of the growing population. Currently there is a S106 payment

that is being undertaken in Lacey Hill, Buckingham which the CCG fully supports for the new GP practice which is going there.

The Chairman said that an A&E department should be provided per 500,000 of population and a 10% "wriggle room" margin is built into this so any housing development will take the number outside of the criteria. Dr Gamell explained that the 500,000 population is the minimum criteria. If the numbers needing A&E increases, then it can cope with the increased demand through expansion. Ms Patten explained that around 50% of those brought in by ambulance can be treated at the scene so there is still a lot of work to be done on the whole system.

A member went on to say that in 20 years' time, 25% more people will be living in Buckinghamshire. There will be an increase in stroke patients and people needing more specialist services. The road between Wycombe and Aylesbury is not good at the moment with lots more houses being built around the area and no money for improved road services, this is going to have an effect on the ambulance service. Logic says that it would be better to disperse the services in other areas – ie. would it not be better to have a satellite A&E at Wycombe? The member felt that things will only get worse. Ms Patten said that if pushed on this issue, it is more likely that there would be more urgent care centres rather than an A&E department.

Public Question from DR – The Hampden Fields development has proposed to close part of the Walton Gyratory System to mitigate the impact of the traffic it will generate, which is likely to have a detrimental impact on emergency services response times. How concerned are you by this and will you be pressing the developer and the County Council to devise alternative solutions? Ms Patten said that as a commissioner and provider of services, we have an ongoing dialogue about the roads in the area. If this is going to happen, then SCAS would have been made aware of this. Through our resilience planning, SCAS put in place alternative plans – the ambulances are put in different places. Mr West went on to say that the ambulances would be re-deployed to other places to accommodate any road closures. He said that if HS2 goes ahead there will be huge implications on SCAS and response time.

The Chairman said that she was made aware that the NHS is moving towards being paperless in 2018 – how are you preparing for this? Mr Dardis said that BHT is attempting to move towards a paperless organisation and patient records are being scanned but the key is integrated patient records across the system, especially those with long-term conditions. SCAS is in the process of introducing electronic records for patients and having them available on an electronic tablet. This is due to go live over the next 6 months.

A member asked what happens to people who opt-out of sharing their information. Dr Gamell said that it is a summary of their record and confidentiality would be respected. It is important to have systems that will talk to each other.

The Chairman thanked all the presenters for their contributions. The Committee will now reflect on what it has heard today and the areas to look at in the report will include the following:

- Communications
- Expand on the services and pathways
- Signposting
- Promoting use of 111 number
- More work on Hospital transport – essential piece of work

- Linking with the Audit websites.

5 SERVICE CONFIGURATION TOPIC PAPER

The Chairman asked Members to note the service configuration topic paper which was included in the agenda pack.

6 DATE AND TIME OF NEXT MEETING

The draft report will be presented to the Health and Adult Social Care Select Committee meeting in March.

CHAIRMAN