MINUTES OF THE MEETING OF THE GREATER MANCHESTER JOINT HEALTH SCRUTINY MEETING HELD ON WEDNESDAY 15 JANUARY 2020, AT BOARDROOM, GMCA OFFICES, CHURCHGATE HOUSE, OXFORD STREET, MANCHESTER M1 6EU

PRESENT:

Councillor John O'Brien (in the Chair)	Wigan Council
Councillor Linda Thomas	Bolton Council
Councillor Stella Smith	Bury Council
Councillor Eve Holt	Manchester City Council
Councillor Eddie Moores	Oldham Council
Councillor Ray Dutton	Rochdale Council
Councillor Margaret Morris	Salford City Council
Councillor Keith Holloway	Stockport MBC
Councillor Sophie Taylor	Trafford Council

OFFICERS IN ATTENDANCE:

Lindsay Dunn	GMCA
Joanne Heron	GMCA
Warren Heppolette	Executive Lead, Strategy and System Development, Greater Manchester Health and Social Care Partnership (GMHSCP)
Zoe O'Neill	Head of Engagement, GMHSCP
Christina Walters	Programme Director – Improving Specialist Care Programme, GMHSCP
Alison Wheelan	Communications Lead, Improving Specialist Care Programme, GMHSCP
Nadia Baig	Lead Commissioner, Oldham CCG
Dr Jenifer Hoyle	Consultant Respiratory Physician, Pennine Acute NHS FT
Cath Briggs	Clinical Chair Stockport CCG
Andrea Green	Accountable Officer Stockport CCG/Improving Specialist Care Accountable Officer Lead

APOLOGIES:

No apologies for absence were received.

JHSC/01/20 DECLARATIONS OF INTEREST

Councillor Holloway declared that his daughter was an employee of the Oldham Clinical Commissioning Group.

JHSC/02/20 MINUTES OF THE MEETING HELD ON 10 JULY 2019

Members were asked to consider the approval of the minutes of the last meeting held on 11 September 2019.

Resolved/-

That the minutes of the last meeting held on 11 September 2019 be approved as a correct record.

JHSC/03/20 IMPROVING SPECILAIST CARE – RESPIRATORY

The Committee considered a report from Nadia Baig (Director of Commissioning at Oldham CCG and Commissioning Lead for Improving Specialist Care – Respiratory) and Dr Jennifer Hoyle, (Consultant Respiratory Physician at Pennine Acute NHS FT and Clinical Lead for Improving Specialist Care – Respiratory), which provided a proposed approach to progress the transformation of Respiratory services to ensure rapid improvement to the clinical service and to provide an equitable service for all patients accessing Greater Manchester Respiratory services.

It was advised that an update was presented to the Greater Manchester Joint Commissioning Board Executive on 17 December 2019, which outlined the key areas of progress on the Model of Care and the intention to present the report to the Joint Health Scrutiny Committee for its consideration. This followed dialogue undertaken with NHS England which had identified that the model of care did not present a substantial service change to patients within acute sites where Respiratory care was delivered. It was highlighted that the improvements focused on streamlining pathways for patients with a Respiratory disease, ensuring a consistent approach utilising a more integrated workforce.

Nadia Baig introduced a presentation which outlined the main drivers for the case for change, current respiratory provision along with the main aims and priorities. Dr Jennifer Hoyle provided an overview of patient engagement, which included methods of engagement utilised and detailed the issues which patients considered important for future services and what they considered could be improved.

In summary, the clinical benefits, outcomes and experience for patients of the Respiratory Model of Care and next steps were provided. Members were invited to consider the principle that the scale of change to Respiratory services in Greater Manchester would not be a substantial variation given that patients would not be impacted negatively by location or delivery of services. Therefore, the Committee were requested to consider approval to progress to a Decision-Making Business Case.

Members welcomed the proposal and agreed that the Respiratory Model of Care would enhance patient experience and ensure a consistent, high quality approach across GM and approved the recommendation that there was not a need for wider public consultation.

It was noted that an enhanced primary and community service would be delivered and the methods to develop this were requested. It was confirmed that digital innovations as part of a combined offer would be required to provide seamless integration with community services, which would include patient/social partnerships.

It was suggested that a future update could provide reference to the impacts of pollution on respiratory disease and connections with the GM Clean Air Plan.
Members highlighted the impact and implications of the model on the Primary Care workforce and recommended that additional resources to upskill and increase the workforce would be

required. The timeline for the process and further engagement with local health scrutiny committees was requested.

An overview of the role of the blended workforce model which had been adopted in Liverpool which included the deployment of physician associates in community settings was provided. It was highlighted that this had reduced costs in acute and secondary care enabling additional resources in community and primary care settings.

It was anticipated that the decision making business case would be prepared by autumn 2020. Following that, work would be undertaken with each of the localities to identify what the requirements would be in terms of workforce and resources. It was recognised that there would be variations and localities would be required to develop individual business cases to meet their own requirements. It was considered appropriate to engage with local health scrutiny committees at the time of developing the individual business cases and bring elements together such as clean air and the links with long terms respiratory conditions.

It was highlighted that a key driver for respiratory problems was nicotine addiction and smoking. The Committee requested information on the links with the models of care and prevention.

It was confirmed that public health were engaged with Strategic Clinical Networks and the primary prevention aspects particularly with regards to the flu vaccination programme. It was highlighted that the NHS significantly contribute to air pollution causing harm to public health and the model encompassed elements of prevention including work to reduce travel to sites and the programme to replace inhalers which release greenhouse gases with dry powder inhalers. It was recognised that smoking cessation services across GM were variable and a single pathway and set of common standards needed to be developed.

The Committee asked how success would be quantified once implemented. An improvement in patient outcomes and quality of life was the principle aim, however it was recognised that this would be difficult to quantify. Therefore other measures such as a reduction in costs, improving mortality and reducing morbidity could be possible measures.

A Member requested further explanation and the reasons why some people are reluctant to receive the flu immunisation vaccination. It had been found that some people did not think flu immunisation was applicable to them despite suffering from some form of respiratory disease, such as asthma and others believed that the vaccination would make them feel unwell. It was therefore accepted that although there would be some barriers, better information and greater education was required in this area.

The Committee welcomed the work under taken to address the links between air pollution and respiratory diseases but highlighted the difficulties being experienced by some with regards to the new type of inhalers. It was explained that this was an area of continuous development and more environmentally friendly products were being made available, however more innovation was required.

In summary, the Chair thanked the Committee for their input and it was agreed that the scale of change to the Respiratory service was not a substantial variation given patients would not be impacted negatively by location or delivery of services. It was agreed that the revised Model of Care offered an improved, equitable and standardised service to all GM residents which

would meet the needs of patients and improve patient experience and outcomes. It was confirmed that the GM Joint Health Scrutiny Committee was satisfied that there was no requirement for wider public consultation.

Resolved/-

1. That it be agreed that the scale of change to the Respiratory service was not a substantial variation given patients would not be impacted negatively by location or delivery of services.
2. That it be noted that the revised Model of Care offered an improved, equitable and standardised service to all GM residents.
3. That it be noted that the new Model of Care was designed and developed in consultation with patients and their families and clinicians.
4. That it be agreed that the proposed new model of care would meet the needs of patients and improve patient experience and outcomes.
5. That the review of service and transformation to the new model of respiratory care be agreed and confirm GM Joint Health Scrutiny Committee was satisfied that there was no requirement for wider public consultation.
6. That it be agreed that the change in services were all "good practice changes" which involved a better integration and use of resources and a standardised set of protocols and programmes when treating patients.
7. That further engagement be undertaken with local health scrutiny committees at the time of developing individual business cases.

JHSC/04/20 HOMELESS HEALTHCARE IN GREATER MANCHESTER AND 'A BED EVERY NIGHT'

Dr Cath Briggs, Clinical Chair, Stockport CCG provided the Committee with an overview of work on homelessness and health overseen by GM Health and Social Care Partnership (GMHSCP), including the £2m investment from GM Joint Commissioning Board (JCB) and GMHSCP into the emergency rough sleeper programme 'A Bed Every Night' (ABEN).

Members were informed that homelessness was a Greater Manchester and Mayoral priority with a commitment to ending the need for rough sleeping and preventing homelessness. In 2017 GM Health and Social Care Partnership established a programme of work capturing the contribution of the health and care system towards delivering this goal. Sat within the broader Housing and Health programme, the work on homeless healthcare had focused on identifying areas of the health system where it could be ensured the right services were in place to support people experiencing homelessness. This had included;

- The 'right to register' with a GP for people with no fixed address.
- A GM Homeless Hospital Discharge Protocol.
- The sharing of successful models of outreach and supporting localities to develop and improve models where required.
- Providing advice and support to localities in improving, developing and commissioning new services for people experiencing homelessness.

In June 2019, GMHSCP and the JCB agreed to invest a collective £2m into the 12-month extension of emergency rough sleeper provision 'A Bed Every Night' (ABEN), acknowledging that homelessness and rough sleeping was a GM wide priority and as such required a cross system response.

Since its launch in November 2018, ABEN had accommodated over 2,600 people and supported almost 1,000 people to move on to more suitable accommodation. A second phase of ABEN started in July 19, funded through a variety of public sector partners and charitable contributions, acknowledging the need for all partners across the Greater Manchester system to contribute and respond to tackling the issue of rough sleeping.

Over winter 2019/20, ABEN had committed to providing over 400 beds across Greater Manchester, dependent on demand, the current figure was reported as 456 people accommodated. During the period that ABEN had been running, the rough sleeper figures for Greater Manchester had decreased substantially by 37%.

An overview of the work programme and the next phase of activity for the Homeless Health and Wellbeing Task and Finish Group was provided. Warren Heppolette, Executive Lead, Strategy and System Development, GMHSCP reflected on the considerable specialist expertise which was well connected across the system in GM and had enabled the immediate response in ABEN provision. It was recognised that a needs assessment and stock take of current services had identified comprehensive provision across all ten localities. However, further connections with other forms of social support, to provide more appropriate care for rough sleepers faced with more complex and challenging issues would be required. There was further recognition that the issue of homeless families would be explored in more detail in order to improve the understanding and make recommendations on appropriate models of support.

The Committee welcomed the helpful update and in discussion identified that a number of the homeless population were ex-veterans and questioned if the programme was connected to the veterans networks. It was confirmed that the current work in relation to healthcare considerations for those experiencing homelessness was connected to the Armed Forces Covenant in Greater Manchester and the wider work around military veteran support. However, it was proposed that there was further opportunity to connect with developed specilaised provision including mental health support.

Members recognised that homeless individuals were not likely to visit a GP practice and asked what methods were in place to ensure alternative access to healthcare was available. It was explained that staff from practices held drop in sessions at hostels on specific days, however it was accepted that people had health needs every day, therefore it was hoped that trusting relationships would be developed by establishing proactive engagement with GP Practices in close proximity to ABEN provision. It was suggested and agreed that details of existing homeless healthcare provision across GM localities be shared with the Committee.

In discussion, the Committee considered those families who were at risk of becoming homeless and asked how healthcare provision was being linked to housing provision. Furthermore, how signposting to access and awareness of services was being promoted.

It was recognised that there would be some new joint working relationships that would need to be established in order to provide a substantial response to prevention and supporting homeless families which could include schools and colleges.

Members provided examples of their homeless healthcare locality arrangements and asked if these would be replicated across GM. The outreach model utilised in Bolton was recognised

and it was proposed that a flexible approach which responded to need would be adopted across localities.

In discussion the Committee considered the broader issues of homeless families, including relationship breakdowns, housing stock and universal credit. It was confirmed that the main housing providers were connected with the programme and were in the process of refreshing the Memorandum of Understanding (MoU) with the GMCA and GMHSCP. However, it was acknowledged that private landlord regulation was an area which required greater connectivity.

Members asked for further clarity of how the statistics for homelessness were recorded. It was confirmed that the impact of ABEN, which measured the rough sleeper count, had reported a 37% reduction on last year's total. It was suggested that the more difficult measure to track would be those who are homeless but not rough sleeping or at risk of becoming homelessness. It was clarified that there was the option to record A&E attendances for those experiencing homelessness, however this was not being widely adopted although this had informed the GM Homeless Hospital Discharge Protocol.

Resolved/-

1. That the content of this report and the progress made through the Health and Wellbeing Task and Finish Group be noted.
2. That it be noted that a further discussion would take place at the February meeting of JCB to review any future investment arrangements and commitment from the health system to tackling homelessness.
3. That details of existing homeless healthcare provision across GM localities be shared with the Committee.

JHSC/05/20 WORK PROGRAMME

Consideration was given to the report of Joanne Heron, Statutory Scrutiny Officer, Governance and Scrutiny Team, GMCA.

The planned programme of work up to the March 2020 meeting was detailed to the Committee – the Statutory Scrutiny Officer asked that Members contact her if they would like to make any additions to the programme.

Resolved/-

That the work programme items be approved.

JHSC/06/20 DATE OF FUTURE MEETING

Members were reminded that the next meeting will take place between 10.00am – 12 noon on Wednesday 11 March 2020 at Parkway Business Centre Princess Road, Manchester, M14 7LU.