Committee and Date	Appendix
Joint Health Overview and Scrutiny Committee 23rd August 2011 at 5.00 p.m.	**3** Public

MINUTES OF THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE MEETING HELD ON 16 JUNE, 2011 IN THE SHREWSBURY ROOM, SHIREHALL 1.30 PM – 3.00 PM

Responsible Officer Dianne Dorrell
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Present

Members of the Joint Committee

Shropshire Council:
Gerald Dakin (Chairman), and Co-opted Member David Beechey

Telford and Wrekin Council:
Veronica Fletcher, John Minor, Derek White and Co-opted Member Richard Shaw

Also Present

Adam Cairns, Chief Executive, Shrewsbury & Telford NHS Hospital Trust (SaTH)
Debbie Vogler, Director of Strategy (SaTH)
Kate Shaw, Programme Manager (SaTH)
Dr Leigh Griffin, Managing Director, Primary Care Trusts - NHS Telford & Wrekin and Shropshire County (PCT)
Barry McKinnon, Area Manager, Shropshire, West Midlands Ambulance Service (WMAS)
Valerie Beint, Corporate Director for Health and Care, Shropshire Council
Stephanie Jones, Scrutiny Officer, Telford & Wrekin Council
Dianne Dorrell, Scrutiny Officer, Shropshire Council
Fiona Howe, Scrutiny Officer, Shropshire Council

The Chairman welcomed guests and new and Co-opted Members; from Telford & Wrekin Council, Councillors Derek White, John Minor and Co-opted Member Richard Shaw (representing the Senior Citizens' Forum); and from Shropshire Council, Co-opted Member David Beechey (representing Community Involvement in Health & Care (CInCH)). Introductions followed. Changes in Scrutiny Support Officers were announced and both, Mrs Bottrill (TWC) who was away on maternity leave, and Mrs Dorrell, who was leaving Shropshire Council, were thanked for the support they had provided to the Joint Committee.

1. Apologies for Absence

1.1 Apologies for absence were received from Karen Calder, Tracey Huffer and Co-opted members, TWC – Dilys Davis and Jean Gulliver.

2. Declarations of Interest

2.1 No declarations of interest were received.

3. Minutes

3.1 The minutes of the meeting held on 24 March 2011 were confirmed as a correct record.

4. Future Reconfiguration of Hospital Services

4.1 The Chairman invited Barry McKinnon, Area Manager for WMAS Shropshire, to respond on point 29 set out in the Work Programme with regard to recruitment and training of paramedics to support transport between the two hospital sites. There

was currently a 62% skill mix of paramedics in Shropshire and more would be transferred in over the next 12 months. Work was ongoing by the Performance Unit on staffing profiles to be factored into the new 'Make Ready' system based on the 'hub' model used at Stafford. Reconfiguration to the 'Make Ready' system was taking place in Hereford with one central hub and Shropshire was one of the areas earmarked for the next 12 months, pending the acquisition of a suitable site.

4.2 The Chairman suggested WMAS engage with the public to keep them informed on plans to roll out 'Make Ready', with at least one public meeting in Shrewsbury and one in Telford. Barry McKinnon responded that he would pass on these comments and Members' concerns about having just one hub in Shropshire and about its location to the 'Make Ready' Project Team.

4.3 Debbie Vogler added that as part of SaTH's post consultation work, a Transfers and Transportation Group had been set up which had met on 27 May with a focus on cross border working between WMAS and the Welsh Ambulance Service (WAS) to mitigate the impact of increased journey times for patients as a result of the hospital reconfiguration. The Group were close to signing off an agreement to enhance cover and improve response times which was a significant issue in rural communities.

4.4 In response to a question about the involvement of Air Ambulance in transporting patients to the Princess Royal Hospital (PRH), Barry McKinnon explained that Air Ambulance response was based upon, and assessed against, a number of factors.

5. Progress in Developing the Outline Business Case (OBC)

5.1 The Chairman welcomed Adam Cairns, who presented an update on progress since the last meeting in March, focussing on four dimensions:-

- Capacity planning
- Service Models
- Staffing and developing workforce planning
- Financial analysis

5.2 Good progress was being made, working with partners such as the WMAS, Welsh Ambulance Services (WAS) and politicians to address the issues. The Trust was engaging with the Strategic Health Authority (SHA) and the Primary Care Trusts (PCTs) and had passed through a series of 'gateway' checks with the Office of Government Commerce.

5.3 Ten clinical working groups involving clinical staff and healthcare planners were working on pathways around:-

- Surgery, including urology and vascular
- Head and Neck
- Maternity, gynaecology and neonatology
- Children's services, with guidance from the Royal College of Paediatrics and Child Health (RCPCH)

Groups had met with support services and had reached agreement on high level service briefs. Progress had been made on developing appraisal options, workforce planning and financial analysis. A refresh of estates had taken place and emerging clinical consensus indicated there were some clear important adjacencies and agreement on clinical separations. The Midwife Led Unit (MLU) at the PRH would be sited away from the Consultant Led Unit, recognising the specialist midwifery services should not become 'medicalised'. Site plans were

displayed on the emerging preferred option which indicated a separate antenatal unit outside of the main hospital building and a new Childs Oncology Unit on the Ground floor with its own entrance and access to an outdoor area. A commitment had been made to families who had been involved in fundraising for the Rainbow Unit at RSH that the new paediatric oncology service at PRH would be at least as good as, if not better than, that at Shrewsbury. Paediatric oncology outpatients would be separate from other outpatients to reduce the risk of cross-infection, and the aim was also to separate in-patient adolescents from babies and younger children. In a light touch alteration to level 2, there would be space to accommodate children staying in overnight and families. A new obstetric unit would be built linking into the top floor.

5.4 Other progress was around the training of a new band of Paediatric Advanced Nurse Practitioners offering a much broader range of skills.

5.5 The process now was to keep capital costs in line with limits agreed by the SHA and to take a wider look at running costs and revenue implications. The SHA had agreed some minor changes to the draft OBC, the OGC gateway review was supportive, and the joint Primary Care Trust was also supportive. The next stage was to send the first draft OBC to the SHA by the end of June followed by a meeting of the Trust Board on 7 July. The aim then was to meet again with the Joint HOSC prior to the penultimate draft to the Board on 28 July. Following a further meeting with the PCT in August, the OBC would be submitted to the SHA, with any comments from the PCT, for final decision on 27 September.

5.6 Responding for the Joint Primary Care Trusts, Dr Leigh Griffin reported that both PCTs were working closely with SaTH and gave assurance that affordability had been challenged. The PCTs were very positive about progress and that the Joint HOSC's concerns were being addressed. Discussions were taking place at formal executive level and the PCTs would have the opportunity in August to confirm its support to the OBC.

5.7 The Chair thanked Mr Cairns and Dr Griffin for the information and referred to the importance of keeping the public informed, commending the newsletter 'Looking to the Future' which provided an update on work to secure the future of hospital services in Shrewsbury and Telford. Copies of the newsletter had been circulated. A number of questions were then put to Mr Cairns.

5.8 Expanding on plans for a 24 hour Paediatric Assessment Unit at the PRH and for a 13 hour per day unit at the RSH, 98% of children attending A&E between midnight and 9 am are dealt with by A&E teams and are sent home, equating to less than 3% per day across both sites. Those likely to require admittance are transferred to either Birmingham or Alder Hey as is current practice. Others at the RSH, likely to require an overnight stay are assessed in A&E, stabilised and triaged straight to the PRH. When the PAU at the RSH is closed, ambulances and GP admissions are routed to the PRH. It was not in the interests of patient safety to provide too much complex information for the public as the very small numbers presenting out of hours at the RSH would be adequately seen and assessed by A&E. It was also noted that if the situation required it, Ambulance crews may also take a child out of hours to A&E at the RSH if A&E support was needed before the crew could take a child on to the PRH.

5.9 It was noted there were no immediate plans to move abdominal surgery. Whilst there were still some concerns, there were more robust mechanisms now in place at the PRH, and there was a need to consider whether such a move would place other units under more pressure, such as the Intensive Care Unit at the RSH which was already under great pressure.

5.10 Thrombolysis was now undertaken 24/7 at both sites with support from Stoke and Stafford and steps to secure Abdominal Aortic Aneurism Screening remained active. The PCT were involved in discussions relating to the balance of risk and were assured by SaTH's progress in undertaking risk assessments.

5.11 With regard to affordability, the Trust Board would take this into account as a separate issue from other financial challenges faced by SaTH. Mr Griffin added that the joint executives were examining the reconfiguration in terms of quality and sustainability, believing it to be revenue neutral, notwithstanding that the next 3 – 4 years would be tough, with reconfiguration playing a pivotal part in sustaining affordable hospital services for Shropshire. In terms of foundation trust status, there was a need for financial sustainability also.

5.12 On other matters, questions were asked about work towards reducing time in hospital for those needing to be transferred to care homes and work with other agencies to provide care packages. It was noted that at a recent meeting, the PCT had discussed delayed hospital transfers as a key issue. The Corporate Director for Health and Care added that partners were working together with the best interests of the patient at the centre to ensure the right length of care in the right place.

5.13 The Chairman thanked those attending, noting progress towards developing the Outline Business Plan and expressing support for work going forward.

6. Children's Heart Surgery

6.1 The Scrutiny Manager presented a report on a national consultation to change the way that services are delivered on Paediatric Cardiac Surgery. Papers were circulated indicating the 4 options upon which Safe and Sustainable, Children's Congenital Heart Services in England was consulting. All four options included retaining services at Liverpool Alder Hey, Great Ormond Street and Birmingham Children's Hospital where currently children from Shropshire were sent for treatment. However, each option proposed the closure of Leicester hospital which could mean up to 50% additional pressure in Birmingham which was already stretched. It was noted that HOSCs have until 5 October to make submissions.

6.2 It was suggested that both Joint Chairmen attend the forthcoming meeting of the Regional Health Scrutiny Chair's on 29 June where the review would be discussed in detail and report back to Members and this was agreed.

7. Chairman's Update

7.1 The Chairman reported on a briefing held on 25 March to review progress in the implementation of **Improving Outcomes Guidance for Gynaecological Cancer Services**, following proposals last year to change this specialist cancer surgery from SaTH to a nationally compliant hospital (North Staffordshire or Wolverhampton). Notes of the meeting had been circulated and the Chairman invited Councillor Mrs Fletcher who had attended the briefing to comment.

7.2 Councillor Mrs Fletcher reported that there were a number of important recommendations and there was still concern around communications, both with patients and with staff and GP's. Information for patients and their treatment as well as patient notes were also of concern. The Joint HOSC still needed to be assured following the Audit review due in September but would maintain a monitoring role with any issues being brought back to the attention of the Chairmen at any time. It was suggested that Vicky Morris, Director of Quality and Safety/Chief Nurse (SaTH) be invited to report back.

7.3 The Chairman reported that there had been a number of new developments in the **National Institute of Clinical Guidance (NICE)** around quality standards, NICE Pathways, NHS evidence and QIPP collection. NICE were offering free of charge to

Scrutiny Committees, development sessions lasting around 40 minutes. The sessions would summarise NICE's responsibilities in health and social care, the value of evidence and the resources that are available from NICE which could support scrutiny and the relevant NICE Guidance. It was agreed that the Scrutiny Officer, Shropshire Council make appropriate arrangements for the session which was likely to be in July.

Chairman: ______________________________

Date: ______________________________