Committee and Date Joint Health Overview and Scrutiny Committee 15 March 2012 10.00	Item No **3** Public

MINUTES OF THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE MEETING HELD ON 19 DECEMBER 2011

Responsible Officer Fiona Howe
Email: Fiona.howe@shropshire.gov.uk Telephone: 01743 252876

Present

Shropshire Council:
Gerald Dakin (Chairman), Karen Calder, Tracey Huffer and Co-opted Members Mandy Thorn and David Beechey.

Telford and Wrekin Council:
Derek White and Co-opted Members Dilys Davis, Jean Gulliver and Richard Shaw.

In Attendance

Adam Cairnes, Chief Executive, Shrewsbury and Telford NHS Hospital Trust
Dr Ashley Fraser, Medical Director, Shrewsbury and Telford NHS Hospital Trust
Adrian Osbourne, Communications Director, Shrewsbury and Telford NHS Hospital Trust
Kate Shaw, Programme Manager, Shrewsbury and Telford NHS Hospital Trust
Debbie Vogler, Director of Strategy, Shrewsbury and Telford NHS Hospital Trust
Fiona Howe, Committee Officer, Shropshire Council
Stephanie Jones, Scrutiny Officer, Telford and Wrekin Council

1. APOLOGIES FOR ABSENCE

1.1 Apologies were received from Councillors Veronica Fletcher (TWC) and John Minor (TWC), and co-opted Member Pamela Paradise (SC).

2. DECLARATIONS OF INTEREST

2.1 Mrs M Thorn declared a personal interest as a director of Shropshire Partners in Care.

3. MINUTES OF THE LAST MEETING

3.1 **RESOLVED:**
That the Minutes of the meeting held on 23 August 2011 be approved and signed by the Chairman as a correct record of the meeting.

4. THE FUTURE CONFIGURATION OF HOSPITAL SERVICES: SERVICE VARIATION STATUS

4.1 Consideration was given to a report of the Communication Director, Shrewsbury and Telford Hospital NHS Trust (SaTH) in respect of the future reconfiguration of hospital services in the County.

4.2 The Chief Executive, SaTH, was in attendance and addressed the meeting, providing a presentation relating to the ongoing work the Trust was undertaking towards the formation of a Full Business Case (FBC). A number of key issues had been identified through the Outline Business Case process, which required further development. These included the configuration of Hospital Services, configuration of Pathology Services, Bed Bundles, Car Parking, Mortality Rates and the financial plan.

4.3 Future Configuration of Hospital Services

4.3.1 Members were advised that the Outline Business Case approval had been subject to a robust and formal process, and gave support to the Trust's plans to progress with the development of the next stage of the FBC. The New Women's and Children Unit was taking shape, and the design process was underway, ensuring involvement of front line staff, and that clinicians, patients and carers views were considered. The Trust had appointed specialist architects to work on incorporating ideas and discussions into the plans for designed clinical areas, with plans expected to be submitted in the new year. Balfour Beatty had been appointed through the Procure 21 framework, and would be bringing in a range of professionals with specialist skills to develop the plans.

4.3.2 The FBC development showed that capital costs were unchanged since the consultation period, with an absolute maximum spend of £35 million, with £28.6 million of the funding being utilised to develop the Princess Royal Hospital. Members were advised that the draft FBC would be completed at the end of March 2012, when there would be an opportunity to discuss the plans further with the Committee, prior to being submitted for approval.

4.3.3 The Trust was continuing to work with patients and the community to address the concerns raised, and as a result had undertaken a review of working practices with the West Midlands Ambulance Services and the Welsh Ambulance Service to consult on the travel and transport plans for general services, to ensure timely transportation of patients to the most appropriate facility and between sites.

4.3.4 Members were advised that the Royal Shrewsbury Hospital had been designated a Trauma Unit for the county, as it had been able to demonstrate its capability to offer

a high standard of emergency care. The Trust had also developed an Abdominal Aortic Aneurysm (AAA) screening programme with advanced practitioner training underway and pathways being developed, and were on target to start screening from April 2012.

4.3.5 Concerns raised previously over the opening hours of the Paediatric Assessment Unit (PAU) at Royal Shrewsbury Hospital were considered during the development of the plans, and it was noted that the PAU at Royal Shrewsbury Hospital would be available 13 hours a day, with a consultant being on-call in A & E outside those times. It was noted that 90% children do not require to be seen by a Paediatrician, but if the need arose, an on-call Consultant Paediatrician would be available 24/7. However, the changes would only affect 2% of patients.

4.3.6 The Trust was developing Telehealth Care plans to enable them to provide more care outside the hospital setting, using the latest technology to provide safe and convenient care closer to patients' homes.

4.3.7 In respect of changes to Maternity, it was noted that all antenatal and low risk cases would be treated locally, and only those patients who have been identified as high risk would need to be admitted to the Princess Royal Hospital under the planned changes. The Trust was working closely with midwives in Powys to ensure Shropshire's midwives were adequately trained to deal with the issues of rurality.

4.3.8 The planned children's cancer unit at PRH was 30% bigger than the existing unit at RSH, and it was anticipated that there would be a significant increment in the quality of the offer.

4.3.9 Members were advised that plans were progressing and being implemented, and development of the Full Business Case was continuing as anticipated.

4.4 Configuration of Pathology Services

4.4.1 The existing configuration had not been optimally laid out in the NHS, and a national independent report by Lord Carter set out proposals for sustaining the quality and cost-effectiveness of pathology services across the country. Locally consultations had been undertaken with other Trusts, and they were now working together in a 'Central and West Pathology Network Cluster' to develop sub-regional pathology network arrangements. It was expected that discussions would lead to changes in the way in which pathology laboratory services were delivered in the future. Evaluation of the options for appraisal would be defined, and evaluated by the end of 2011, and recommendations would be put forward for consideration to the Trusts in the Central and West Pathology Network in January 2012 to meet QIPP targets.

4.4.2 The Cluster had invited bids to be a Human Papillomavirus (HPV) testing centre, as currently no one provider had reached the required threshold of 30,000 testing samples. At this time Walsall had been put forward to provide this service for the Cluster group. Other services were also being considered, where a Trust within the Cluster would take on the responsibility for specialist services. Members were

advised that patients would see no changes to the service provision locally, and no additional travelling would be incurred with the proposed changes.

4.5 BED Bundles

4.5.1 Members were advised that earlier in the year the Trust undertook a comparison with other hospitals across the country. It showed that SaTH had more beds than the average hospital, and if they moved a quarter of the way to length of stay the number of beds would be reduced by 113, which would bring them in line with the average hospital. It was noted that in order to be in the top 10%, the hospital would need to have 200 fewer beds.

4.5.2 By talking to front line staff and patients, it emerged that the main issues facing patients were delays and lack of information, which was unsatisfactory. The Trust looked at all the evidence available, and tested it out using recognised improvement methodology, and found that if they carried out processes consistently, then patient flow improved. By implementing BED Bundles, hospitals saw improved quality, safety and a better patient experience. These were based on four simple practices, including board round by 9.30 a.m., expected date of discharge that patients, staff and visitors were all aware of, discharging 50% of patients before midday, and moving patients from Medical Assessment Unit to medical wards before 10 a.m.

4.5.3 Members were advised that BED Bundles had been introduced in late October 2011. A daily audit of BED Bundle components on each ward was being undertaken to assess implementation progress, and as a result it was noted that compliance was improving and currently stood at 80%. Members were advised that readmissions were not increasing, hospital stays were reducing, and the number of patients in beds overnight was declining. It was concluded that the implementation of BED Bundles was beginning to have a marked change on the way the hospital was working.

4.6 Car Parking

4.6.1 The issues identified through the consultation process related to lack of parking and the Hospitals charging policy. Members were advised that there were differing views on parking charges, but it was evident that there was a lack of advertising over concessions.

4.6.2 In order to address the parking issues facing Princess Royal Hospital, additional car parking spaced were being planned for the new women's and children's unit. The Trust was also looking at encouraging individuals to use alternative transport options, especially staff living within 1 mile of the sites. The Trust was in discussions with their contractor over offering different payment methods, and was considering the views put forward on parking charges when developing a new charging structure. Mr Cairnes stressed that parking fees should not be a barrier to receiving care, and the Trust would maintain its concessions policy.

4.6.4 It was noted that the Trust could no longer maintain car parking charges at the current rate without it having an adverse impact on hospital services, and assured Members that any changes would be fair and based on feedback received from patients. It was their intention to improve facilities, signage and the patient experience.

4.7 Mortality Rates: HSMR from April 2010 to September 2011

4.7.1 In 2010, hospital deaths were 18% higher than average hospitals across the country, and further work needed to be done to look at the reasons behind these figures. There had been two areas of concern in respect of these figures, the first related to the hospital not collecting additional coding information, and the second was ensuring that the Trust was providing appropriate care for its patients.

4.7.2 It was noted that HSMR peer comparisons showed that the Trust was in the middle of the pack for the current year although there was a downward trajectory, but further investigations in respect of mortality rates should be undertaken to assess if people dying in hospitals was generally declining, were more people surviving illnesses, or were patients choosing alternative place than hospitals to die.

4.8 Financial Update

4.8.1 Members were advised that the Trust was on course to end the year in recurring financial balance for the first time since it was established, and to do this they had needed to address a £14.1 million deficit built up over 11 years.

4.8.2 The Trust had received a one-off transitional revenue support of £6.5 million through the Strategic Health Authority. Members were advised that the monies were not repayable, and did not relate to the future configuration of hospital services.

4.8.3 It was noted that Trusts would be expected to make 4% efficiency savings in the coming financial year, which equated to £11 million for SaTH, and that the health economy had a responsibility nationally to find savings totally £20 billion. In addition to this, there was a need to address commissioning intentions, and ensure that any areas of excessive demand were identified and flagged up with Clinical Commissioning Groups to ensure that adequate provision was agreed. Members were advised that in order to address the challenges facing the Trust, it would continue to identify areas where they were less productive, and continue to learn from other hospitals, and implement improvements.

4.9 A number of questions had been submitted prior to, and tabled at the meeting. The Chief Executive advised that the responses to the questions raised prior to the meeting had been included in the presentation, but provided the following responses to the additional questions:

4.9.1 The Trust would achieve the identified QIPP savings for 2012/13 and beyond, by continuing to change delivery methods, such as the introduction of BED Bundles, which would help ensure improved quality, safety and patient experience. Members were assured that the Trust had developed a bed plan to cope with winter

pressures, which included bringing 79 beds back online for the current winter period, if needed.

4.9.2 The Trust was working with other health partners, including the local authority, to provide appropriate care packages for patients to reduce the risks of post hospital mortality rates in patients. It was noted that the introduction of BED Bundles would help ensure that dedicated plans were followed, and the patient could be discharged in a good state of health. It was stressed that they hospitals were not cutting corners, but simply working more efficiently.

4.9.3 A question was raised over ambulances exceeding the 15 minute waiting time figures at both hospitals, and as a whole the West Midlands was a poor performing region. Mr Cairnes confirmed that the current systems were not working, and that work was ongoing to introduce a booking/scheduling system that worked. It was expected that a review of the current process would take 9 months to conclude.

4.9.4 Members were advised that SaTH no longer had a dedicated Hospital Ambulance Liaison Officer (HALO) on site, but it was stressed that if a hospital was facing problems, the PCT would make a HALO available as a priority to address the situation. Currently Shropshire had an average turnaround time of 24 minutes, and was performing well in the West Midlands. It was anticipated that the implementation of better systems, such as BED Bundles, could bring improvements to turnaround delays currently facing the Trust.

4.9.5 Concern was raised over the removal of PCT funding for HALO positions, and the possible negative impact that was having on both the hospitals and ambulance crews. It was noted that at a recent Health Overview and Scrutiny Committee meeting, Members had been advised by Ambulance crews that delays were an issue for their service. It was agreed that the notes of the meeting would be made available to SaTH, and further investigation would be undertaken.

4.9.6 A Member requested clarification on the work SaTH was undertaking to support the independent health provider, ensuring when patients were discharged into a care home, or their own home they were properly supported. Concern was raised over the possible financial burden being placed on local authorities if patients were being discharged early through the BED Bundle scheme. Members were assured that SaTH's Frail & Elderley Team was working with health partners to develop the urgent care network, and ensure that an integrated care plan was in place to provide support, and ensure the patient received the most appropriate care and support, both in hospital and once they were discharged.

4.9.7 Further information was requested on treatment for dementia patients, and whether specialised training had been made available for hospital staff. Members were advised that more work was required to improve provision, and that strategy development work was being carried out by SaTH in conjunction with the Mental Health Team. It was noted that the hospitals were experiencing issues with people in crisis attending A & E units. The Trust had undertaken staff training events, implemented a Dementia Strategy Group, but there was more that could be done to improve the situation for both patients and staff.

4.9.8 With regard to waiting times for appointments, Members were informed that the waiting time standard was set by the PCT and issues about this would need to be referred to the PCT. It was acknowledged that the appointment booking system was not good, and a team had been put together to carry out a complete redesign of the booking and scheduling system which would take around 9 months to complete, A number of ways of communicating with patients would be built into this.

4.9.9 Mr Cairnes indicated that a number of questions submitted at the meeting would require further investigation before a response could be submitted to the Committee. These were as follows:

- What are the issues with bed management. Are patients being transferred between wards in the middle of the night, and if so what is being done to address this.

- What are the discharge arrangements for patients from maternity wards. What support do they receive before discharge (e.g. advice on breastfeeding) and what are the follow-up arrangements for home visits by midwives especially for patients who have had a caesarean and require dressings to be changed.

- What is the process for people moving into the county and registering with a new local GP for getting appointments with hospital consultants for treatment and do the wait times start again when a person moves? There have been difficulties with people feeling there are too many "gatekeepers" which have made it a difficult and lengthy process to get an appointment.

4.10 The Chairman thanked Mr Cairnes for his presentation and assistance during Member's deliberations.

RESOLVED:

(a) The Committee accepts the update, and supports the preparations for the Full Business Case.

(b) The Committee notes and acknowledges the consultation work undertaken with staff, stakeholders, public and partners.

(b) The Committee note the conditions set out by the Strategic Health Authority moving forward to develop the Full Business Case.

(c) The Committee welcomes further updates as Shrewsbury and Telford Hospital NHS Trust develop the Full Business Case.

5. CHAIRMAN'S UPDATE

5.1 The Chairman addressed the meeting, advising Members that following a meeting of SaTH and the Joint Health Overview and Scrutiny Committee Chairmen, it had been agreed that the Committee would receive reports at least two weeks prior to a

meeting, whenever possible, to enable time for Members to formulate questions, and submit them to SaTH for a response. The approach would enable Members to concentrate on drilling down on specific areas of concern.

5.2 A future off-line meeting had been arranged for February 2012 to consider the Full Business Case timetable, and to confirm the Committee's expectations, in order that a schedule of meetings could be drawn up. It was noted that Members would be advised of the outcomes of the meeting in due course.

5.3 Members were advised that the West Midlands Regional Health Scrutiny Chairs Group would be meeting on 12 January 2012 at WMAS Oldbury.

6. FUTURE AGENDA ITEMS AND MEETING DATES

6.1 The next Joint Health Overview and Scrutiny Committee would be held on 15 March 2012 at 10.00 a.m. in Telford.

6.2 Members were advised that Kate Shaw, Programme Manager, would be attending this meeting, with Clinicians to provide an AAA screening demonstration. The Committee were also expecting to receive an update on the audit of patient pathways for Gynaecological Cancer Services.

2.00 p.m. – 3.52 p.m.

Chairman:…….

Date:……..