Committee and Date	Item
Joint Health Overview and Scrutiny Committee 12 April 2012 10.00 a.m.	3 Public

TELFORD & WREKIN COUNCIL/SHROPSHIRE COUNCIL

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Minutes of a meeting of the Joint Health Overview and Scrutiny Committee held on Thursday, 15 March 2012 at 10.00 am in the Reception Suite, Civic Offices, Telford

PRESENT – Councillor D. White (TWC Health Scrutiny Chair) (Chairman), Mr. D. Beechey (SC), Councillor K. Calder (SC), Councillor G. Dakin (SC Health Scrutiny Chair), Councillor V. Fletcher (TWC), Ms. J. Gulliver (TWC), Councillor T. Huffer (SC), Councillor J. Minor (TWC), Mr. R. Shaw (TWC) and Ms. A. Thorn (SC)

Also Present – Cllr. J. Seymour (TWC)
Officers – S. Jones (Scrutiny Group Specialist, TWC), F. Howe (Committee Officer, SC), P. Smith (Democratic Services Team Leader, TWC)

JHOSC-1 APOLOGIES FOR ABSENCE

Ms. D. Davis (TWC) and Councillor T. Huffer (SC)

JHOSC-2 DECLARATIONS OF INTEREST

Ms. A. Thorn declared a personal interest, as a director of Shropshire Partners in Care and a trustee of another company providing services to the NHS.

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JHOSC-3 MINUTES

RESOLVED – that the minutes of the meeting held on 19 December 2011 be confirmed as a correct record.

JHOSC-4 ABDOMINAL AORTIC ANEURYSM (AAA) SCREENING

Dr. Catherine Woodward (Director of Public Health) and Mr. Tim Sykes (Vascular Surgeon and Clinical Director for AAA) gave a presentation on the local implementation of this Screening programme.

Dr. Woodward explained the benefits of screening for AAA among men aged 65 and over. A simple ultrasound scan of the abdomen was the easiest way to investigate whether a patient had an AAA, and research had demonstrated that screening of men over 65 reduced the mortality rate from a ruptured AAA by around 50%. The phased roll-out of the national programme began in 2009, with guidance that local programmes should be based on a minimum population size of 800,000. This presented a risk to the future of vascular services in particular in Shropshire, Telford & Wrekin, and so a business case for a local screening programme and retention of vascular surgery was developed in conjunction with the reconfiguration of clinical services provided by the Shrewsbury & Telford Hospital Trust (SaTH). The business case was approved, which was a very positive outcome for the population of Shropshire, Telford & Wrekin. All men in the programme area would be invited for screening in the year they turned 65 – in 2012, this would be 2,400 in Shropshire and 1,010 in Telford & Wrekin. Men already over 65 could self-refer, although this would need to be carefully managed.

Members were then able to view a demonstration of the ultrasound screening technique.

Small aneurysms (88% of all AAAs detected) were monitored along with counselling and support provided to patients. Large aneurysms (12% of all AAAs detected) were referred to the lead vascular surgeon in the local programme. Mr Sykes explained the surgical procedures that were used to treat the different types of AAA condition, and reported that mortality rates locally arising from both elective surgery and rupture/emergency surgery were at or better than the national average.

Members asked a number of questions about the screening programme and the surgical outcomes, including:

What happens to patients when a large aneurism is detected?
Response- they are referred to a vascular surgeon within a week, or immediately if the patient presents with pain.

How do you decide which treatment option to use?
Response- the options are an open procedure or the insertion of a stent using a non-invasive procedure. The choice depends on the condition and fitness of the patient.

How was the self referral process for those already over 65 going to be managed and publicised?
Response – there would be a communications plan as part of the roll-out, and GPs would be closely involved in any referral process. It was accepted that this would need to be managed carefully to avoid putting the programme under pressure.

Why wasn't there a programme for screening women?
Response – women did suffer from AAAs, but in much smaller numbers than men and so a universal screening programme was not justified.

Did the programme include provision for re-screening (after a certain period of time) of those who were initially screened as normal?
Response – no, if the diagnosis was normal at 65 then the individual was not likely to develop an AAA later in life.

RESOLVED - the Committee congratulated SaTH on achieving the AAA screening service for local people which is key to having vascular surgery available 24/7, to save lives and protect vascular services within the county.

JHOSC-5 THE FUTURE CONFIGURATION OF HOSPITAL SERVICES: FULL BUSINESS CASE

Adam Cairns (Chief Executive), Kate Shaw (Programme Manager) and Chris Needham (Director of Estates) from the Shrewsbury & Telford Hospital NHS Trust were in attendance for this item. An assurance grid updating the Committee on how concerns raised during the consultation on the reconfiguration were being addressed in the Full Business Case was attached to the agenda.

Adam Cairns gave a presentation to Members on the latest position regarding the development of the Full Business Case (FBC) for the proposals for the future configuration of hospital services in Shrewsbury and Telford. Planning applications for the new-build work at both hospital sites were progressing, and Balfour Beatty had been appointed to undertake all design and construction work. The Full Business Case was due to be submitted to the Trust Board and PCT Cluster for approval on 16 April, followed by the Strategic Health Authority on 17 April.

Further work had been continuing to provide assurances to patients, service users and staff on the re-configuration proposals. For example, in relation to paediatric oncology, there had been some further concerns expressed, and the Trust was working hard with parents and families on both the design and feel of the new unit at PRH, which would be a third bigger and have a dedicated outside space. Day treatment facilities would be available for the first time and there would be access to high dependency beds and the ability to separate off children's outpatients. Options for the future use of the current Rainbow Unit at RSH were being considered.

The PAU at RSH would be adjacent to A&E and space for an additional isolation cot had been designed into the neonatal unit. Neonatologists were working closely with Wolverhampton to look at training and development and the potential for shared posts.

The Transport and Travel Plan was due out in summer 2012 and it was felt this presented an opportunity to work with transport providers, and Local Authorities, to improve transport overall between population centres.

In terms of acute surgery, Mr Cairns reported that surgeons were of the view that the consolidation of abdominal surgery at RSH, and transfer of in-patient head and neck services to PRH should be accelerated in order to improve outcomes for patients. Therefore, discussions were taking place about bringing these proposals forward to July 2012. The status of Royal Shrewsbury Hospital as the designated Trauma Unit had been confirmed.

In financial terms, the Scheme remained affordable and within the capital budget of £35m for all the works required. However, since the Outline Business Case stage, the Department of Health had announced the availability of £300m public dividend capital nationally for hospital schemes and the Secretary of State had confirmed that £35m of this had been allocated to the SaTH scheme. However, it was emphasised that while this money was interest-free, a dividend would need to be paid back to the Department of Health each year. The Trust therefore had two funding options: to accept the investment from the Secretary of State and pay the annual dividend, or to borrow the capital and account for the cost of borrowing through the revenue budget. It was projected that the public dividend capital option would save the Trust almost £200k per year over the cost of loan repayments so was a much better option. It was not possible for the Trust to borrow additional capital because the cost of borrowing was not affordable.

Chris Needham then showed the site and floor plans for the new facilities at the Princess Royal Hospital, particularly the new Women and Children's Unit. There would be a re-designation of car parking at the PRH site to resolve some of the current issues, and to compensate for the loss of some of the staff car park due to the new-build. A plan was also shown of the relocation of services at the Royal Shrewsbury site.

Mr Cairns then responded to a number of questions which had been submitted by the Committee to SaTH prior to the meeting:

- SaTH had assumed that QUIPP savings of 5% would need to be achieved; however, the PCT had advised that it is more likely that savings of 8-9% are more realistic. What target had been assumed in the FBC?
  Response – 5% savings had been built into the plan, but the Trust would look for and expect to make additional savings. The planning assumption in the FBC was that costs would be released in-step with the ability to release costs and in step with any falls in income from reductions of in-patient numbers.

- Has SaTH taken account of the impact of savings pressures on the wider health economy in the FBC, and what impact will the reduction in PCT funding have on the business case and future services?
  Response - SaTH had agreed the cost assumptions and expected cost reductions for this and next year with the PCT. For following years, the level of costs would be kept in-step with the level of income and the PCT was working with SaTH to redesign services to enable this to happen. SaTH was looking at reducing costs by preventing admissions, moving people through the system more quickly, and earlier discharge. For

example, the service for frail and elderly patients was being redesigned. Once they are in a hospital bed, frail and elderly patients tend to lose their independence very quickly and are harder to return to independence. A pilot had been established so that frail and elderly patients are met "at the door" by a geriatrician for quicker diagnosis, treatment and discharge. In the pilot, 32% of patients had returned home within 72 hours. This had freed up beds and created efficiencies for SaTH, and had reduced pressure on Continuing Health Care and adult social care budgets post-discharge. SaTH was now working with the PCT and partners to see whether some of these services could be provided at home. Reshaping services in this way would help to balance income and cost.

- Who commissioned the current review being undertaken by Finnamore and has the review on identifying gaps in service provision across the wider health economy been considered in the development of the FBC?
  Response – the Chief Executives of all NHS Trusts in Shropshire and Telford and Wrekin had asked for this independent assessment of how the big challenges to the NHS (e.g. current and future funding, cost pressures of new drugs and surgical techniques, ageing population and obesity etc.) would impact on the Shropshire health economy, and to identify what work needed to be done with partners to develop a better service but for less money. The report had not been published yet, but it would help SaTH to understand how we sustain hospital services as the number of patients we treat falls due to the move to more community/preventative work. The implications of the report will be worked though once they are known.

- What do the £500k 'decanting' costs, as outlined in OBC table 72, relate to?
  Response – these were to cover such things as "double running" and provision of temporary accommodation during the transition period.

- PWC cost improvement schemes in OBC: Table 75 shows a total cost saving of £17m in 2012/13, whereas Table 77 shows net total savings of £14.063 in 2012/13. What is the explanation of these differences?
  Response – the total recurring saving was £17m - the net savings figure in Table 77 is after taking account of non-recurring expenditure needed in the first year to deliver the savings.

- Why are SaTH only planning to achieve a Monitor financial risk rating of 3, instead of a higher 4 or 5 rating?
  Response – SaTH was confident that it could plan its way through all the changes and still hit a 3 rating. This was a realistic assessment, and a 3 rating represented the minimum requirement for Foundation Trust status.

- If there was a pandemic, which required beds previously removed to be brought on-line, how would these emergency services be provided and staffed, and have the costs been factored in?
  Response – the Trust has a pandemic plan which could involve managing the elective programme, re-opening beds or providing temporary accommodation. The Community hospitals could be deployed with only

the sickest going to SaTH. The plan forms part of the wider Shropshire Health economy's response to any pandemic emergency. Telehealth offered the potential in future to connect to other hospitals to treat patients who would not normally be treated in the county.

The OBC referred to an assumption in the Trust's Long Term Financial Plan of an increase in "non-clinical" income of 2% per annum to 2105/16. Could you clarify what these relate to?
Response – this related to income from SaTH's role as a teaching hospital for undergraduates and for qualified doctors, plus income from car parking, restaurants etc.

- Does SaTH have a contingency plan if the FBC doesn't gain approval and funding?
  Response – the fact that Public Dividend capital funding had been offered by the DoH gave a good indication that the FBC would be approved. The contingency was the "do nothing" option as set out in the OBC but this would mean higher costs and would result in the loss of services.

- What are the risks around a reduction in income from out-of-county commissioned services in the medium/long term, and have they been factored into the FBC?
  Response – currently around 10% of income came from Wales and 10% from other areas outside the county. It was thought that the service changes that were being proposed would mean that we could regain some patients who were currently going out of the county. The reconfiguration created the potential to increase income, but increases had not been factored into the FBC.

- How will the risks around the commissioning priorities of the CCGs and competition from the private sector be managed?
  Response – we need to make sure that services are fit for purpose and stand up to scrutiny and competition. The Health & Social Care Bill has created a stronger relationship between GPs and clinicians which enables them to work together to design a system that is affordable and meets the needs of local people.

In addition to the questions tabled in advance, Members asked further questions arising from the presentation:

- What assurances can be given that the Telecare initiative will be taken forward when Adam Cairns leaves the Trust?
  Response – A number of deliverables have been agreed over the next 5-6 months including the green light for the FBC, the proposal to start cardiology services in Shropshire, and Telehealth. Work has been done on Telehealth to develop our understanding of how to use the technology and to find a partner in the field so we can achieve the benefits of scale. We are close to agreeing a specification with payments worked out over a number of years.

- What progress has been made on the transfer of patients' records between sites, and how does the Trust communicate back to GPs?
  Response – we need to improve from where we are. There are a lot of written records, and we are looking at what options there are for getting the records into an electronic form and what systems we would need to hold all medical records electronically. Further work also needs to be done on the administrative processes for the storage and management of records between the two sites. This forms part of the IT strategy. We have been developing a discharge summary form which is almost in place which will be transferred back to GPs. GPs need more information presented in a useful way, and further consideration is being given to the summary to make sure it is right. We hope to have this in place over the next 6 months.

- There is not much information in the OBC about cost improvement schemes for 2015/16. Could you give us some more detail?
  Response – the cost improvements have been worked out in detail for the next 3 years and in less detail for the following 2 years because it is more difficult to be precise so far ahead. Further details will be firmed up over 2012/13 and 2013/14 and can be brought to Scrutiny.

During the general discussion, some concerns were expressed about misleading information being published in the press about the capital funding for the scheme. Adam Cairns stated that SaTH was planning further publicity to counter what were seen as "myths", and Members agreed that, where possible, the Committee should seek to promote the positive messages about the changes.

RESOLVED

The Committee welcomed the news about the potential alternative capital funding for the hospital configuration which would reduce the revenue costs for the scheme, and acknowledges the hard work to date that SaTH had put into securing the funding.

JHOSC-6 CHAIRMAN'S UPDATE

The Chairman updated members on the items discussed at the Regional Health Scrutiny Chairs' network meeting on 13th March 2012.

The group had received a number of presentations:

- The roll out of the NHS 111 service. The PCT clusters and Clinical Commissioning Groups had agreed to take a West Midlands approach. There would be a period of consultation and engagement including with HOSCs leading up to the launch of the service in February 2014.

- An update on service wide reviews affecting the region. The key reviews were highlighted as:

- Stoke services – likely implementation 2013/14 with consultation where necessary
- Children's surgery – possibly looking at relieving pressure on Birmingham Children's hospital by moving surgery to smaller number of hospitals – intended to complete the work programme 2012/13.
- Reduction of acute beds – this was being done as part of reshaping hospital services.

- Regional PCT Cluster update, including a report on the development of the Clinical Commissioning Groups across the region, and the key ambitions, challenges and risks associated with the health reforms and budget pressures.

- An update on the role of the CfPS Regional Advocates. The DoH has made £4,000 available to each region for support/development and the group awaited further guidance.

- Feedback from the CfPS Health Accountability Forum held in London on 12th March 2012 which considered the regulations and guidance relating to Scrutiny from the Health & Social Care Bill. The comments agreed at the meeting were tabled, and individual authorities were asked to support the comments which would be submitted to the Department of Health and the CfPS as a joint West Midlands response. The comments would inform the development of the regulations and guidance which would go out for consultation in due course.

JHOSC-7 GYNAECOLOGICAL CANCER PATIENT PATHWAYS

Attached for information to the agenda was an update report of the Greater Midlands Cancer Network on the audit of patient pathways for gynaecological cancer. Ethical approval for the audit and survey questionnaire had been obtained, and the audit would commence shortly.

RESOLVED – that a further update be received once the audit has been completed.

JHOSC-8 DATE OF NEXT MEETING

It was reported that the next meeting would be held on 12th April 2012 at Shirehall, Shrewsbury to consider the final draft Final Business Case for the Future Configuration of Hospital Services prior to its submission to the Trust and SHA Boards.

The meeting closed at 12.35 pm

Chairman……

Date……