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Committee and Date	Item No
Joint Health Overview and Scrutiny Committee	Public

MINUTES OF THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE MEETING HELD ON 11 APRIL 2012

Responsible Officer Fiona Howe
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Present

Shropshire Council:
Karen Calder and Tracey Huffer

Telford and Wrekin Council:
Derek White (Chairman), John Minor and Co-opted Members Jean Gulliver and Richard Shaw.

In Attendance

Adam Cairnes, Chief Executive, Shrewsbury and Telford Hospital NHS Trust
Kate Shaw, Programme Manager, Shrewsbury and Telford Hospital NHS Trust
Chris Benham, Assistant Director of Finance, Shrewsbury and Telford Hospital NHS Trust
Chris Needham, Associate Director of Estates, Shrewsbury and Telford Hospital NHS Trust
David Taylor, Corporate Director People, Shropshire Council
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 Gerald Dakin (SC) and Veronica Fletcher (TWC), and co-opted Member David Beechey, Pamela Paradise, Mandy Thorn (SC), and Dilys Davies (TWC).

2. DECLARATIONS OF INTEREST

2.1 No declarations of interest were noted.

3. MINUTES OF THE LAST MEETING

3.1 **RESOLVED:**
That the Minutes of the meeting held on 15 March 2012 be approved and signed by the Chairman as a correct record.

4. THE FUTURE CONFIGURATION OF HOSPITAL SERVICES: FULL BUSINESS CASE

4.1 Consideration was given to a presentation of the Full Business Case Executive Summary, with amendments. Adam Cairns, Chief Executive, Kate Shaw, Programme Manager, Chris Needham, Director of Estates, Chris Benham, Assistant Director of Finance, from the Shrewsbury and Telford Hospital NHS Trust (SaTH) were in attendance for this item.

4.2 Members were updated on timescales for the approval of the Full Business Case and associated works, and were advised that planning permission had been granted for a new Women and Children's Unit at Princess Royal Hospital site, and the Trust was awaiting approval for the small extension at the Royal Shrewsbury Hospital site, expected around 16 April 2012. The Full Business Case was due to be considered for approval by the Trust Board on 16 April, followed by the PCT Cluster, with a final decision by the Strategic Health Authority being made on 24 May 2012. During this period SaTH would continue to work with, and receive feedback from, focus groups and clinical teams, as well as continued engagement with the public and stakeholders to ensure any concerns were identified and allayed.

4.3 Since approval of the Outline Business Case, the Trust had undertaken work to develop several areas, including the transport plan, workforce plan, estates and facilities, as well as developing a robust communication and engagement process, and assurance and governance through an on-going review of progress and delivery recommendations.

4.4 Members were advised that the Trust had removed the Integrated Assessment Unit (IAU) from configuration plans, and were currently in discussion with the Clinical Commissioning Group over health provision for the County, stating that progressing the provision of an IAU would be the preferred option, but indicated that they had not reached that stage in discussions.

4.5 The Trust had focused on productivity, and over the past year had recorded 100 fewer events than over the same prior the previous year, which had resulted in existing space in clinical areas being made available at both acute hospitals. During the development of the FBC the Trust had found a proven need to move Paediatric Outpatients at the Royal Shrewsbury Hospital adjacent to A & E, which had not been identified in the OBC.

4.6 One of the most important changes since the OBC was the pursuance of an alternative funding source, from the Department of Health, and it was noted that the Public Dividend Capital of £35 million had been confirmed to fund the Scheme. In financial terms, with revenue costs being finalised and the Guaranteed Maximum

Price to be agreed for all construction work prior to the commencement of main works, the Scheme remained affordable and within budget.

4.7 Mr Cairns, Chief Executive, reported that although the Public Dividend Capital did not attract interest, as it was an investment, the Trust would continue to a pay a dividend of £1.118m for the asset in perpetuity, which was consistent with financial protocols for the existing buildings. The dividend would be paid for the life of the building, which was common place practice for hospital developments.

4.8 The Trust had continued to seek assurances for the proposed reconfiguration. A Gateway 3 Review took place in March, which used the Treasury Principles to review the plan, and delivery, and the scheme was given a clean bill of health. The Clinical Assurance Group held periodic meetings to review proposals, and at the last meeting was reassured over the degree, and emphasis made by Paediatric Consultants in promoting the changes to service.

4.9 Assurances had been given to the Joint Health Overview Scrutiny Committee over the reconfiguration process.

Paediatric Services: Identified benefits of bringing the Paediatric Assessment Unit adjacent to A & E at Royal Shrewsbury Hospital, and ensuring that clinical staff were heavily involved in service design and development.

Neonatology Services: Proposals to provide an additional isolation cot on the neonatal unit. The benefits of joint working, training and development with neonatologists at the Royal Wolverhampton Hospital, with the potential for shared posts, had been expressed by staff.

Paediatric Oncology: The Trust had been working with parents and families on the design and feel of the new unit. The design would enabled day treatment facilities, and access to high dependency bends, to be separated off from children's outpatients. Concern had been raised previously over the loss of the Rainbow Unit, and Members were assured that the Trust was working with all parties who took part in initial fundraising for the unit to decide on its legacy.

Maternity Services: 'Skill Drills', which provided MLU practice runs/rehearsals, had been broadened, and a senior staff member was working with Powys Teaching Health Board to review the policies and processes to assess levels of risk, and implement best practice.

Acute Surgery: An Abdominal Aortic Aneurysm (AAA) Screening programme was due to be rolled out, and had only been made possible through the reconfiguration process. It was hoped that the consolidation of surgery at the Royal Shrewsbury Hospital and transfer of inpatient Head and Neck Services to Princess Royal Hospital would take place in 2012.

Travel and Transport: The Trust had secured a cross-border agreement with WMAS and WAS, with consideration of the Travel and Transport Plan due to take place in summer 2012. The Chief Executive stressed the need for input by the Local

Authority in the development of the plan, indicating that focus groups for staff and patients on travel plans would also feed into the plan.

Public & Staff Engagement: The Trust had set up staff, patient and public focus groups, along with producing regular newsletters, and updates at the Town Council, LJC and community meetings.

4.10 Members were advised that since the OBC was approved, there had been a small reduction in the number of posts, but these could be managed through the removal of vacant posts from the current staffing structure, which would reduce the risk of redundancies. Key elements to changes to staffing structures include additional hours against Consultants and Nursing provision, and the need to reduce provision in areas where services had been combined.

4.11 Mr Cairns advised the meeting that the FBC's impact on income and expenditure indicated that net costs would reduce over time, and additional decanting costs had been built in for 2013/14 to allow for the transition of services from one site to another, while maintaining a constant provision for patients. He stressed that if the Trust had not taken any action, the cost for maintaining both sites would increase significantly. The long term financial position for the next 5 years suggested that the Trust would achieve a surplus of £2 million, which was in line with the Monitor Financial Risk Rating of 3.

4.11 The next steps for progressing the configuration of SaTH included the commencement of building work and refurbishment of existing buildings in August and September 2012, respectively, commence the implementation programme from summer 2012 onwards, including moving some services, training staff and putting new clinical pathways in place. The Trust intend to start publicising the changes later in 2013 in order that the public had a good understanding of where they should go for care and treatment. The Women and Children's Unit was expected to open at Princess Royal Hospital in July 2014, with all other service reconfigurations expected to be in place by this date.

4.12 Mr Cairns then responded to a number of questions, which had been submitted by the Committee prior to the meeting, along with questions raised at the meeting:

- Can you give clear details about how the impact of the £8m shortfall in funding from the PCT for 2012/13 has affected the FBC, and what impact will the reduction of funding have on services?
  Response: The Trust had been in discussions with Commissioners over the changes to service delivery across the health economy, and that the shortfall in funding would be offset by these changes. Members should note that the shortfall did not relate in its entirety to the reduction in funding, but also to changes in the way health care was to be provided in the future. The Trust were expecting to save £1.7m, which had not been factored into the long term financial plan, and would give them additional security in the future.

- When exactly will the Finnamore report be available? The Joint HOSC would like to see a copy.

Response: Members were advised that there was no published timetable for the completion of the working being undertaken by Finnamore, but SaTH expected it to be complete by June 2012. Work was ongoing and the size quantum for Shropshire health economy needed to handled, and shared with the wider health community.

- Can you give assurance that the reconfiguration will ensure A & E will be sustained on 2 sites?
  Response: There would be no changes to A & E provision at either site, and the reconfiguration process did not change the scope, need or scale of A & E provision for the county.

- Assurance Grid 1.1 – How long does it take for the on-call paediatric consultant/s to travel to RSH out of hours?
  Response: Contracts for consultants require them to live within 30 minutes or a 10 mile radius of base, but most lived nearer. Those who didn't, made arrangements to stay in temporary accommodation while they were on call. This practice would continue, which would ensure that an on-call paediatric consultant would be a matter of minutes away from base.

- Assurance Grid 2.1 – Can you provide more information about how the skills/techniques of clinicians delivering services in rural areas are being enhanced? Can you explain what the 'Skills Drills' in the MLUs are, and how the Skills Drill has been broadened out?
  Response: Skills Drills involved undertaking practice runs for events, or 'rehearsing', to ensure that Midwives were prepared if, and when, events occurred. A senior member of the nursing team had been working with MLUs in Scotland and Powys to identify best practice and implement them at SaTH.

- Assurance Grid 3.6 – Can you give assurance that if patients at PRH cannot be stabilised and transferred to RSH that the consultant will travel to PRH?
  Response: The Chief Executive confirmed that if a patient was unable to be stabilised and transferred to the RSH that a consultant would travel to PRH as patient safety was a priority.

- The Joint HOSC would like to see a copy of the Risk Register, and to receive regular updated copies.
  Response: The Programme Manager tabled a copy of the current Risk Register for Members information, and confirmed that regular updates would be made available at future meetings.

- Can you confirm the timetable for "going live" with Telemedicine across service areas. What opportunities will this present for the repatriation of angioplasty (and other) services to the county?
  Response: The Chief Executive was unable to confirm a timetable for plans to go live with Telemedicine. The Trust was working with external partners to provide a more rapid implementation of a scheme, and it was hoped that they would have more information on progress over the next 12 weeks. It was important to note that the Trust was working on a private/public funding option, as it would be difficult for the Trust alone to identify capital to take the plan forward.

Individual groups had been appointed to review repatriation of services to SaTH, including angioplasty, but the Trust needed to show that they had adequate staffing and procedures in place before they could move the plan forward. It was noted that if the Trust was successful in repatriating services, they would likely be based at a single site. Mr Cairns indicated that it would take the groups 6 months to complete the work, and 12 months before the Trust would be able to show all referral pathways were in place to support services.

- Is staff moral low, and if so, how is this being addressed?
  Response: The responses to SaTH's staff survey in October 2011 was not as favourable as the Trust would have hoped. Mr Cairns indicated that the survey was undertaken at a time when the Trust was restructuring management structures and there was also considerable uncertainty over the reconfiguration process.

  The Trust was now focusing on promoting the Trust as a good place to receive treatment as well as work, which would in itself improve staff moral in the future. It was noted that staff were keen to move the process forward, although there were still a few people uncertain over how the reconfiguration process effected them, and those uncertainties needed working through, and provide those members of staff an opportunity to get involved in the process.

- Can SaTH confirm what assurance/audit process the FBC financial case has gone through?
  Response: The Trust had utilised technical design, build and transport planning specialists when preparing the scheme, and independent cost advisors were appointed to test and validate the finances.

- Who is on the Clinical Assurance Group? Were there any concerns raised at the meeting and if so what were they?
  Response: The Clinical Assurance Group was made up of clinicians, GPs and managers. The Group held periodic meetings to review proposals, and at the last meeting had been reassured over the degree, and emphasis made by Paediatric Consultants in promoting the changes to service.

- What were the risks flagged up by the Gateway 3 Review?
  Response: There were no material risks flagged up by the Gateway 3 Review.

- What is the material effect of the removal of the Integrated Assessment Unit from the plans at RSH? Is this being delayed, or abandoned?
  Response: Members were advised that the delayed implementation of the IAU was being considered by Commissioners and SaTH, and discussions were progressing to combine services in the long term. Clinicians indicated that in the next 3 – 5 years, medical, surgical and paediatric assessment units which would circle A & E would provide the required integrated provision.

- What are the options for the alternative accommodation for Shropdoc out of hours service?

Response: Discussions were ongoing as to how to deliver Out of Hours and urgent care, and a number of options were being considered. It was hoped that Shropdoc could be relocated within the existing facilities next to A&E. Once discussions had concluded the Trust would be in a position to identify where Shropdoc fits in to the development.

- In what ways has the building design deviate from applicable standards?
  Response: Mr Cairns confirmed that that the new build achieved development standards. The refurbishment would be slightly more challenging as they were having to work within the physical restraints of an existing building which meant that not all standards could be met, but the plans had met the requirements of all regulators.

- Workforce plans – the FBC states that all medical workforce plans, job plans and rosters will be reviewed again at the end of April 2012 in the light of recent changes in the availability of middle grades from the Deanery. What does this mean?
  Response: The Trust had a commitment to review medical workforce plans, job plans and rosters for senior doctors on an annual basis to reflect changes in demand, need and service. Workforce plans needed to keep pace with changes in training and services.

- What progress has been made on training the APNPs and how much more is to be done? Are there long-term plans for the PAU to be a completely nurse-led services?
  Response: Training was ongoing, and broadening, for APNPs as discussed previously in the meeting, and there were no plans for the PAUs to be nurse-led services. A medical presence would be maintained as it would not be considered clinically safe to run without them.

- What overall reduction of beds will there be in the surgical inpatient wards and surgical assessment unit compared with existing capacity? Even with new ways of working, will there be enough capacity?
  Response: Members were advised that there would be a reduction of 22 beds in the surgical inpatient wards and surgical assessment unit compared with existing capacity. It was noted that many of the surgical beds were occupied by medical patients, but that the new plans and ways of working would resolve this situation, for example the separate surgical assessment unit would identify patients who could receive day treatment. Clinicians were confident that the plans would provide adequate capacity.

- How will re-grading of medical staff in all surgery and anaesthetic specialities affect staff? Is it likely to affect moral or retention?
  Response: The Trust would not be changing banding for nursing staff, and the re-grading of medical staff referred to national improvements to terms and grading for junior doctors.

- There is £3.5m plus budgeted for fees, what does this include?
  Response: Mr Needham confirmed that the budgeted fees were in line with fees expected for this size of capital project. They included professional fees related

to the physical works such as architects, engineers, surveyors (e.g. ground works, ecological surveys), BREAM assessments, building inspectors, transport, and planning fees, and professional fees for developing the business case such as cost advisors. The scheme would be delivered to a high standard and a team would be in place to oversee the process.

- Is the Optimism Bias in line with the required level?
  Response: Mr Cairns confirmed that the Optimism Bias was in line with required levels.

- Are there any contingencies other than the Optimism Bias and Planning Contingencies built into the budget?
  Response: The Trust had no further contingencies in place for the project as the biggest risk mitigater was covered by the provision of Guaranteed Maximum Price for all construction work prior to main works commencing.

- How was the 2.1% reduction in income representing the reduced income given to the Trust by local QIPP schemes arrived at?
  Response: The Trust had been in discussion with Commissioners over changes to the delivery of services for the health economy, and the figure of 2.1% had reflected those changes.

4.13 The Chairman thanked Mr Cairns and his staff their attendance, and assisting Members in their deliberations. The Committee also thanked Mr Cairns for his drive and dedication whilst being in post at SaTH, and wished him well in his new position.

RESOLVED:
That the Joint Health Overview and Scrutiny Committee support the proposals laid down in the Full Business Case, subject to approval by the PCT Cluster and Strategic Health Authority, and the assurance that the financial business case, submitted by Shrewsbury and Telford Hospital NHS Trust (SaTH), is robust, and that the Trust has taken account of reductions in funding provision in future years.

The Committee thanked Adam Cairns and his staff for their dedication in driving the reconfiguration forward. Members felt the plans were the best possible option for protecting, and enhancing, hospital services in the county, and that the changes would be very positive for the people of Shropshire.

5. CHAIRMAN'S UPDATE

5.1 The Chairman reported that correspondence had been received from the Midlands and East Specialised Commissioning Group, inviting Members to contribute their views on the current proposals for developing Children's Neuroscience Network to coordinate care for children with health conditions requiring neurosurgery and related care.

5.2 The Chairman indicated that if Members wished to receive a copy of the correspondence, they should contact the Committee Officer in the first instance, and respond to the consultation by 5 p.m. on 16th May 2012.

5.3 It was noted that the new regional Trauma Network had been launched on 26th March 2012, which saw Royal Shrewsbury Hospital playing a vital role as a Trauma Unit, and working closely with Major Trauma Centres in Stoke and Birmingham.

6. FUTURE AGENDA ITEMS

6.1 Members agreed to include the following items on the work programme:

West Midlands Ambulance Services

- Engagement with development of clinical pathways and Travel & Transport Plan
- Update on implementation of 'Make Ready'
- Workforce development needs – recruitment and training of paramedics, advanced paramedics, coverage and training of community first responders
- 111 Update

Shrewsbury and Telford Hospital NHS Trust

- Ophthalmology Services
- Configuration Process:
  - Implementation Plan
  - Travel and Transport Plan
  - Workforce development/transformational change programme
  - Update on training and support for GPs and midwives
  - Risk register
  - Hospital at Home

6.2 The Committee stressed the need to review all aspects of Transport, and ensure that they were satisfied that the travel plan was robust. It was noted that a Transport Task and Finish Group was carrying out a review on transport provision across the county, and that information considered through the Joint Healthy Communities Scrutiny Committee should be fed back to this Group, and vice versa.

6.3 Members indicated the importance of a Hospital at Home service, ensuring that there was a clear understanding of how services were going to be provided, and ensure savings were realistic. Hospital at Home services implemented in other areas, had seen varying degrees of success, but there was no evidence presently to show that any of the schemes worked well.

10.00 a.m. – 11.27 a.m.

Chairman:……

Date:……