Committee and Date	Item No
Joint Health Overview & Scrutiny Committee 8 August 2013 1.30 p.m.	**A** Public

MINUTES OF THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE TASK AND FINISH GROUP MEETING HELD ON 27 MARCH 2013

10.30 A.M. – 12.50 P.M.

Responsible Officer Fiona Howe
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Present

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

Telford and Wrekin Council:
Derek White, Veronica Fletcher, John Minor and Co-opted Members Dilys Davis and Jean Gulliver.

In Attendance

Peter Herring, Chief Executive (SaTH)
Adrian Osbourne, Communications Director (SaTH)
Kate Shaw, Programme Manager, (SaTH)
Carol McInnes, Head of Programmes & Service Redesign (Shropshire County CCG)
Dr Julie Davies, Director of Strategy & Service (Shropshire County CCG)
Tracey Jones, Lead Commissioner Service Improvement (Telford CCG)
Michelle Brotherton, General Manager, WMAS
Barry McKinnon, WM Area Manager, WMAS
Fiona Howe, Committee Officer, Shropshire Council (SC)
Fiona Bottrill, Scrutiny Officer, Telford and Wrekin Council (TW)

33. APOLOGIES FOR ABSENCE

Apologies were received from Tracey Huffer (SC) and co-opted member Richard Shaw (TW).

34. DISCLOSABLE PECUNIARY INTERESTS

None had been disclosed.

35. MINUTES

RESOLVED:
That the minutes of the meeting held on 28 November 2012 be confirmed as a correct record.

36. FUTURE CONFIGURATION OF HOSPITAL SERVICES

The Chief Executive of Shrewsbury & Telford Hospital NHS Trust addressed the meeting providing an overview of the future configuration of hospital services.

Surgery had been consolidated in July 2012 in order to improve vascular surgery and as a result the Trust had been reported as the best provider in the West Midlands Cluster. Members were advised that care audits and quality were broadly stable, but there were capacity challenges on planned care and they were having an impact on the patient experience.

Head & Neck services were now sited in a fit for purpose environment receiving positive feedback from staff, patients and visitors of the new facilities at Princess Royal Hospital. The Trust had received a score of 100% from patients in response to the net promoter question, as well as receiving positive media coverage for radio interview and newspaper features. Members were advised that the staff involved in the Head & Neck Services move had recently received the Chairman's Award for their hard work and commitment.

Development work for Women's and Children's Services was on scheduled and due to complete in the Summer of 2014. The Trust was looking at phasing in moves in the context of current demand for emergency care and detailed work plans were being developed for Women's and Children's Services and the wider Trust.

Work at the Royal Shrewsbury Hospital site was planned to commence in July 2013 to create the Children's Assessment Unit and the Children's Outpatient Department, and work was progressing at pace.

Clinical and staff engagement work was ongoing with the detailed implementation of pathways, workforce, training, equipment and offices, and weekly team meetings with an open invitation to all members of staff to attend, with specific consideration of gynaecological issues. Other methods of staff engagement included a weekly 'Gossip Group', a weekly written update in 'The Future This Week', monthly focus groups, Centre to Centre workshops, clinical working groups and specific priority Task and Finish Groups.

Patient and public engagement was continuing through patient and public focus groups where specific consideration had been given to neonatology and younger women. A range of other events were also ongoing including promotion of the Trust's work through community groups and Local Joint Committees, meet the builder events, builder's hard hat competition, a photography competition in conjunction with Shrewsbury and Telford's College of Arts and Technology. A workshop was being planned in May to consider the Rainbow Unit legacy including working with patients and children to create glass tiles.

The Travel and Transport Plan was progressing and in response to concerns raised by the Joint HOSC the Trust had been developing partnership working with both Local Authorities to provide an enhanced service provision. The organisations had agreed to jointly fund a Transport Co-ordinator post, develop new cycle routes, and discussions were ongoing over the development of a 'Collector Bus' in Telford and Shrewsbury to assist staff in getting to both sites. Staff would also be encouraged to make use of Oxon Park and Ride with the introduction of an extended bus loop. The Trust was in the process of seeking tenders for the cross-site shuttle bus, and continued to work with WMAS, WAS, and NSL over emergency travel and patient transfers, and following discussions with clinicians on pathways, protocols and procedures the new models would commence in the Spring.

The Chief Executive confirmed that staff, patient and public engagement would be ongoing throughout the reconfiguration process, and the Trust would continue to develop workforce plans and staff training, and the implementation of modified staff rotas across the Trust. It was envisaged that the Trust would launch a communications campaign towards the end of 2013 to ensure patients and the public were fully aware of the changes to services through the reconfiguration process. Work had been undertaken with Greater Manchester NHS Trust to identity appropriate models and tools as they had already completed a successful reconfiguration process. It was noted that work on the new Women's and Children's Unit at the Princess Royal Hospital site was on target for completion in Summer 2014, along with the Children's zone at the Royal Shrewsbury Hospital site. The new Women's Zone would now open later than originally planned as the refurbishment work would commence following the move of gynaecology to Princess Royal site.

Members asked a number of questions, and expressed a number of comments, including:

Could the Trust confirm what services would be sited in the Women's and Paediatric Unit at the Royal Shrewsbury Hospital site.
Response – It was the intention to develop the space into front end office capacity, and ensure that clinical services were at the heart of the hospital and that offices were situated in the outer buildings. It was noted that in the future the Rainbow Unit would be used for training staff, with a focus on children.

The joined up working between the Local Authorities and the Trust and the creation of a Transport Co-ordinator was a positive move. Could the Trust provide more detailed information on progress.
Response – The ongoing partnership work had been seen as a sensible and positive approach, and once an officer was in post it was agreed that all parties would attend to update the Joint HOSC on developments. It was expected that this would come back to the Committee within the next 12 – 18 months.

Has consideration been given to linking up with the Redwoods Centre.
Response – All organisations were involved in discussions to ensure that the best use was made of the services.

Were staff available to undertake children's surgery on none core days.

Response – A lot of work had been done around core days, dedicated lists, and head and neck services and if cases were straight forward they would be placed on the afternoon lists, and more difficult cases would be taken in the morning. The Trust was working with clinicians and booking clerks to develop the system.

RESOLVED:
That detailed consideration of the Travel and Transport Plan be brought back to a future meeting.

37. PLANS AND PRIORITIES FOR THE YEAR AHEAD

The Chief Executive of Shrewsbury & Telford Hospital NHS Trust addressed the meeting providing an overview of the Trust's plans and priorities for the future.

Francis Report
Mr Herring reported on the findings of the Francis Report in respect of culture and failings at Mid Staffordshire. The main points focused on the lack of openness, defensiveness, parochial behaviour, secrecy and poor standards were accepted. Changes in culture were needed to ensure an emphasis was put on common values and regular monitoring of standards. Strong leadership was needed in all areas, and support for those leadership roles. The Government had published its initial response to the Francis Report, which detailed actions to ensure that patients were the first and foremost consideration of the health and care system. Five themes had emerged including; preventing problems, detecting problems quickly, taking action promptly, ensuring robust accountability, and ensuring staff were trained and motivated.

It was essential that the Trust was a values driven organisation, and a caring nature was a key component. Engagement with staff was ongoing to agree a care framework of expected standards including attitude, caring and competence in technical skills. The Trust was strengthening its partnership with Staffordshire University and developing nursing education, qualifications and care. Patient experience and Involvement Panel was bringing patients and carers to the heart of the Trust's approach to patient experience, with members integrally involved with ward reviews, visits, concerns and complaints.

Members raised a number of questions, including:

It would take a strong management team to openly identify faults, but it was essential to listen to staff concerns.
Response – The Trust had a mechanism in place to gain intelligence and to list to staff and the public, and they take all concerns very seriously and respond by rectifying issues going forward.

The Board had a corporate responsibility to ensure the care framework of expected standards was being delivered across the Trust, and although they were making planned ward rounds and speaking to patients, they should also undertake unplanned visits to gain an accurate picture.

Response – Members were advised that the Board undertook planned and unplanned ward visits to take feedback from patients and staff in person. It was recognised that it was very important to implement multiple routes and methods to deal with risks and issues, and the Board needed to ensure the Trust was safe and sustainable.

Discussing a patient's experience whilst in hospital would fail to provide accurate outcomes and it was more appropriate to gain the information post discharge.
Response – Feedback on independent assessment work was ongoing with Keele University and there was a need to be aware that a patient may not be in a position to respond during care, and a national mandate was in place advising that information should be gathered post treatment.

In response to a question, it was noted that work was ongoing with Keele University to develop multidiscipline training for nursing and medical personal. It was intended to bring all training together including medical education in a holistic approach. Leadership development training was also required to ensure the Trust's standards were maintained. Mr Herring stressed that unacceptable levels of care would not be tolerated and Ward Managers would be best placed to identify failings, which is why it was seen as key that the Trust developed leadership skills for their staff.

What plans were in place for future staffing to ensure inappropriate care cultures were eradicated from the Trust. Members presented anecdotal evidence of patients receiving unsatisfactory care standards whilst as an inpatient in Ward 10 at Princess Royal Hospital.
Response – It was stressed that the Trust had a zero tolerance to unacceptable standards of care through continued monitoring, and individuals would be held to account. The Trust would continue to learn from complaints as they helped monitor issues. Mr Herring stressed that they would not be able to change care culture overnight, and that a series of mechanisms were in place to ensure the required standard of care was in place. It was noted that the process needed to move forward at pace and was the Trust's top priority.

Dr Julie Davies addressed the Committee advising that it was a priority for providers and commissioners to respond to the Francis report findings. The CCG wanted to work with patients and patient groups and look at other routes to highlight issues where patients were unwilling to complain.

Successes and Challenges in 2012/13
The Trust had received financial support for the implementation of the Full Business Case and had completed the first phase of the reconfiguration work with the move of Head and Neck, the opening of a Surgical Assessment Unit at Royal Shrewsbury Hospital, and the commencement of building work for the new Women's and Children's Unit at Princess Royal Hospital. They had seen significant improvements in VTE and in-hospital mortality rates, no reported MRSA cases in the past 12 months, had launched a Frail and Complex Service, and had seen the opening of the Lingen Davies Cancer Centre.

The greatest challenges the Trust had, and continued to encounter, was the increase in attendance. This was a country wide issue but the Trust had recorded some of the

highest figures, and capacity issues were continuing to create problems. With current figures it was estimated that there was a shortage of 70 beds, but increasing the number of acute beds was not a long term answer to the growing problem, and instead the Trust was working with partners to develop a new model of care to address the capacity issues. The cancellation of day lists had been highlighted recently which were unacceptable but unfortunately necessary to maintain safety for patients requiring emergency treatment. A major in-year improvement to address the 18 week backlog had been undertaken, but a sustained position had not been achieved and elected surgery numbers had slipped. Unacceptable level of grade 3 and 4 pressure ulcers continued to be issue, and the Trust continued to be an outlier in the number of reported Serious Incidents.

The Trust had aimed to develop a high level vision and strategy putting patients first for the year ahead by seeking feedback from patients, the public and staff, reflecting the expectations of their commissioners, benchmarking themselves against other organisations to understand what they did well and where they needed to improve, and holding workshops with their clinical centres to engage frontline staff in shaping the overall plans for the Trust. The intention was to develop an environment which was well led and motivated with key priorities to work on. There were still financial challenges for the Trust and it was stressed that any future plans must be built on firm foundations.

In response to concerns raised over grade 3 and 4 pressure ulcers Members were informed that through the Quality and Safety strategic priorities all avoidable pressure ulcers were be eradicated during 2013/14. Part of the Healthcare Standards strategic priority was to ensure that bed capacity met demand and improved timely flow of patients, but until the current issues over the capacity gap were resolved they would not be in a position to move on.

A 'Vision for Healthcare' strategy would be developed for acute hospital services and wider partners. This would address challenges, maintain safe staffing levels, plan for future demographic, and develop efficiencies and productivity.

In response to a question, Members were advised that A&E clinical teams were working through options and would discuss the outcomes with the CCG before going forward with engagement with the wider public and stakeholders. The process had highlighted that it was essential that each facility had good access, adjacent clinical dependencies and provide the best care for assessment.

Members were advised that the next steps in the process would be to work with key partners on the shared vision. The Trust would be learning from other national examples, but stressed that the large geographical and rural nature of Shropshire meant that it would need a unique model. Significant discussions would need to be undertaken with clinicians, including GPs, and commissioners on the process and map up engagement process to develop an integrated service strategy approach.

The Chairman invited the Trust to bring the plan back to a future meeting of the Joint Committee.

In response to a question, Mr Herring advised that the 11% increase in presentations for the acute could not be identified to any single trend or condition, but highlighted the issue that Shropshire had a growing elderly population and more people were living longer with complex treatment needs. Members raised concern over long waiting lists, cancellation of day lists, poor performance in A&E targets, and low staff morale. Members recognised that their concerns were not isolated to Shropshire and were being experienced country wide, but may have been compounded by surgical services being relocated to Royal Shrewsbury Hospital. There were also issues with ambulance turnaround times with delays taking on average 3 units out of service each day. The Francis report was also critical of scrutiny's role and stressed the importance of receiving information from the Trust directly and in a timely manner. Members advised the Trust that addressing A&E was not just for SaTH but the whole health economy and stressed the need to work in partnership to resolve the issues affecting Shropshire. The Chief Executive advised Members that they would not hide difficulties and were already working with the Community Health NHS Trust and other partners to develop a model for the whole health economy. It was noted that the Trust expected to resolve the capacity issue within the next few months.

A member of the Committee raised concern over inappropriate GP referrals when other, more appropriate pathways were available to patients. Mr Herring advised that inappropriate referrals were an issue.

In response to a question raised by a member of the Committee, the Communications Director confirmed that information contained in the tabled reports around patient observations related to ward to ward experiences and patient matrixes. The information would be considered at the Trust's Board meeting on 28 March 2013, which members of the Committee were invited to attend.

The Chairman thanked the officers for their attendance.

RESOLVED:

(a) That Joint Health Overview and Scrutiny Committee endorse and support the work of Shrewsbury and Telford Hospital NHS Trust.

(b) That consideration of the Vision for Healthcare strategy be considered at a future meeting.

38. WEST MIDLANDS AMBULANCE SERVICE

Consideration was given to a verbal update from representatives of the West Midlands Ambulance Service [WMAS].

Ms Brotherton, General Manager WMAS, and Mr McKinnon, Area Manager WMAS, were in attendance. Mr McKinnon addressed the meeting advising that in the Autumn 2011 the WMAS Executive Board set out their plan for the future for the West Midlands region, and following consultation the first phase of 'Make Ready' was implemented in April 2012 in Hereford and parts of Shropshire, with the system going live across the county in October 2012. The Trust had identified hubs based in Donnington and Shrewsbury where ambulances would be cleaned and stocked, and

there would be paramedics out in the community where demanded had been identified. Sites had been confirmed in Bridgnorth, Craven Arms, Ludlow, Market Drayton, Oswestry, Tweedale, and Whitchurch. Patients who had previously been left uncovered by the service now had the benefit of a paramedic vehicle attending and remaining in the area 24/7, with an ambulance moving the patient if required. It was noted that the Trust had created additional response posts, 3 in Telford and 3 in Shrewsbury, which were manned by rapid response staff, and ambulances were deployed across the county from the bases. It was noted that each community site was able to accommodate a crew and vehicles 24/7.

A Member requested clarification on travelling time for an ambulance once a paramedic had responded to a call. Mr McKinnon advised that ambulances were deployed across the county, and based on criteria of condition an ambulance would be sent at the same time as the community paramedic vehicle. It was noted that ambulance crews were not always sent to a call in the first instance, but may be required following a paramedic assessment. Members were advised that approximately 35 – 50% of patients don't require conveying to an acute provider. On average response times were 17 minutes for Shrewsbury and 12 minutes for Telford, but there were issues with delays in more rural areas. WMAS raised concern over a 11% increase in demand for Shropshire, with Hereford and Worcester seeing at 10% increase in demand for services.

The service had experienced delays in turnaround times at acute hospitals across the county indicating that on average they were losing 70 hours a month in handover delays, and recently had seen a spike of 130 hours in the last month. The Trust was working with SaTH and the CCG to improve the situation, but no specific trend had been identified to explain the increase in demand.

In response to a member of the Committee, Members were advised that the Trust had worked with experienced officers in Staffordshire and taken on board their advice when rolling out Make Ready across Shropshire. The Trust had seen a 3% improvement with the resources they current had, but the independent Lightfoot report indicated that Shropshire could only achieve key 'Red 8' targets of 66 – 68%, but they were achieving 72% on average. Once the Make Ready system went live across the whole of Shropshire they achieved over 75% on target.

Concern was raised by Members over the continued failure by WMAS to reach targets in the rural areas of the county. They were advised that on average they were achieving 75% on 'Red 8', but the Trust appreciated the concerns and they would look to community first responders to areas where they were not able to achieve an 8 minute response time. The Trust was working with Commissioners to improve ambulance support in response to the increases in service demand. Dr Davies addressed the meeting advising that funding had been increased by £1.15m in 2012/13, however as a rural health economy Shropshire failed to get the appropriate weighting for funding, but commissioners, local authority and WMAS were lobbying for increases in rurality funding. The CCG and WMAS met monthly to look at demand by postcode, and worked with primary care and GPs to improve patient pathways.

In response to a question, Members were advised that WMAS were not currently part of the compact, which was made up of SaTH, Community Health NHS Trust, Mental Health providers, CCG and Local Authority. It was noted that as the compact progressed more partners would be involved over time. Members stressed the importance of WMAS as a partner and Dr Davies agreed to take the request back to the CCG for further consideration.

A discussion ensued on the benefit of HALO being reintroduced in Shropshire to help improve ambulance turnaround times, and although the WMAS indicated they wanted to start discussions with the CCG over the valuable provision, there was a funding disagreement across the West Midlands in respect of HALO provision and although the CCG agreed that a safety and timely handover was essential, both the CCG and WMAS would be attending an executive meeting with SaTH to pick up the key issue.

Members were advised that Shropshire was currently working on a pilot project with GPs working within Shropdoc to assessment patients to negate the need for them to attend A&E. The outcomes from this work were encouraging as they had seen an improvement to impact across the health economy.

A member of the Committee stressed the need for the ambulance service to ensure provisions were in the right locations for demand and consider joint locations with partners such as Fire Service, Police, and Community Hospital sites. In response, it was noted that that locations had been mapped on historic demand and the Trust had worked with partners to locate community sites in shared facilities where it was appropriate, and cost effective. There was also uncertainty over services and realignment of the police service. Members were assured that the Trust was always reviewing sites and would work with partners when opportunities arose. A suggestion was made to consider working with supermarket developments in the future as they could also be identified to help with costs.

Concern was raised over the dramatic increase in service demand. In response, Dr Davies reported that Commissioners had been unable to identify a specific trend or issue which would explain the significant increase in service demand, but indicated that they would be happy to take the matter back to providers and bring back data providing a summary of reasons for admission, but they stressed that this would not provide any helpful conclusions.

In response to a question, Mr McKinnon reported that Hereford had seen a 10% increase in demand, but their modelling targets had gone from 75% to 80% since the introduction of Make Ready. Ms Brotherton reiterated that since Make Ready was implemented fully across the county an advanced paramedic had been ringfenced to an area on a 24/7 basis unlike pre Make Ready where many areas were without a rapid response facility. It was noted that with the introduction of advanced paramedics, conveying patients to hospital had dropped by 57% as they were using more appropriate pathways to treat patients.

The Chairman thanked the officers for their attendance but highlighted the concern raised by the Committee over the response times for Shropshire and indicated that they would wish to see improvements to response times in rural areas.

39. STROKE SERVICES REVIEW UPDATE

Consideration was given to a presentation of the Head of Programmes & Service Redesign, Shropshire County CCG.

Members were advised that the Strategic Health Authority announced a regional stroke review in January 2012 to develop stroke specific standards. These were divided into 7 phases across the whole patient pathway (primary prevention – end of life care). The review considered 3 specific areas including; providing rehabilitation, early supported discharge in a home environment, and Hyper Acute Stroke Unit siting. It had been identified that a minimum of 600 patient flow was required to act as a Hyper Acute Stroke Unit (HASU), which would result in a single site service for Shropshire. Each regional area was tasked with developing a model that met the standards within the specification, and a project group was convened to undertake a non-financial option appraisal of HASU/ASU options, with a preferred clinical model for a single HASU/ASU for Shropshire County being submitted in February 2013.

The results demonstrated that it was both financially and physically viable for the service to be hosted on either site and with SaTH undergoing a wider reconfiguration of services across its two sites with particular focus on the sustainability of its emergency services, the decision around a single site HASU/ASU could not be taken in isolation. It was noted that quality and equality of access was paramount to patient safety and therefore other key issues were taken into account include demand on the Royal Shrewsbury Hospital site and travel times for patients in Powys. The preferred approach would be to have a single public consultation on the wider clinical strategy including Stroke and it was anticipated that the process would commence in September 2013 which would allow for effective planning and would ensure full engagement of both Local Authorities. The timescale for implementation would not be before April 2014. It was noted that late scores needed to be incorporated but the broad agreement was for a single site unit. The CCG were waiting to receive feedback through the legacy document which would highlight the learning over the last 12 months and recommend next steps. It was confirmed that once the full appraisal summary was available the CCG would be able to share the information with the Committee.

Members stressed the importance of retaining a service in Shropshire and following a recent visit to the sites were assured that either site would be suitable for a HASU/ASU, and it was important to provide a direct access facility. Members were advised that a decision had not been made on site location, but once the legacy report with recommendations had been received they would be in a position to feed into the wider reconfiguration process, but the SHA had indicated that the decision on location would be a local commissioning decision.

Concern was raised over demand on wider services at Royal Shrewsbury Hospital taking into account the increased demand for A&E and admissions. Ms McInnes stressed that all aspects would be taken into account, but no decision on location had been taken.

The Chairman thanked the officers for their attendance.

RESOLVED:
That the Joint Health Overview and Scrutiny Committee feed into the consultation process and monitor progress.

40. CHAIRMAN'S UPDATE

The Joint Chairs reported on the recent visit to the 111 Call Centre in Dudley where many of the concerns raised by the Committee had been considered and assurances received. Following the soft launch in March 2013 the system failed to cope with capacity and as a result Shropshire was being covered by Shropdoc 'out of hours' provision which had been retained. Dr Davies confirmed that the issues affecting the service were temporary and that Shropdoc had formally been requested to continue call handing for a further 3 months, whilst the regional team fully explored the situation.

Members concluded that NHS 111 provision, as a national government concept, would be implemented in some form, but it was an important opportunity to consider a local model. In response Members were advised that the Joint Project Board would continue to look at options to maintain a good service for residents across Shropshire.

In response to a question, Dr Davies confirmed that the formal contract would be reviewed regionally and local costs would be identified.

Chairman:……..

Date:……...