SHROPSHIRE COUNCIL,TELFORD & WREKIN COUNCIL

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Minutes of the meeting of the Joint Health Overview and Scrutiny Committee held on Wednesday 19 September 2018 2.00 pm – 5.10 pm in the Shrewsbury Room, Shirehall, Shrewsbury

Members Present:

Shropshire Councillors: Karen Calder (Co-Chair), Heather Kidd, Madge Shineton
Telford and Wrekin Councillors: Andy Burford, Rob Sloan
Shropshire Co-optee: Ian Hulme
Telford and Wrekin Co-optees: Carolyn Henniker, Hilary Knight, Dag Saunders

Others Present:

David Evans, Senior Responsible Officer - Future Fit and Chief Officer Telford and Wrekin CCG
Deirdre Fowler, Director Nursing and Midwifery, Shrewsbury and Telford Hospital Trust
Simon Freeman, Senior Responsible Officer - Future Fit and Accountable Officer Shropshire CCG
Amanda Holyoak, Committee Officer, Shropshire Council (minutes)
Julian Povey, Chair - Shropshire CCG
Rod Thomson, Director of Public Health, Shropshire Council
Stacey Worthington, Senior Democratic and Scrutiny Services Officer, Telford & Wrekin Council
Simon Wright, Chief Executive Shrewsbury and Telford Hospital Trust

1. Apologies for Absence

Apologies were received from David Beechey, Shropshire Co-optee.

The Chair reported that Shropshire Co-optee Mandy Thorn had resigned her membership and said the Committee had benefited enormously from her knowledge experience and expertise in social care and health and had been extremely grateful to her for giving her time to attend meetings. A new co-optee would be appointed by Shropshire's Health and Adult Social Care Overview and Scrutiny Committee on 24 September 2018.

2. Disposable Pecuniary Interests

Members were reminded that they must not participate in the discussion or voting on any matters in which they have a disclosable pecuniary interest and should leave the room prior to the commencement of the debate. Madge Shineton declared a connection with the Health Concern Group Wyre Forest.

3. Minutes of the last Meeting

The minutes of the meeting held on 15 August 2018 were confirmed as a correct record.

4. Shrewsbury and Telford Hospital NHS Trust (SaTH) – Enforcement Action Taken by CQC

The Chair thanked NHS representatives for making time to attend the meeting, acknowledging the pressures they were under. She had asked for a timeline to be provided to the Committee in order that it could understand the events leading up to the recent CQC findings and enforcement action. She said that the Committee understood the issues in the workforce, particularly in Accident and Emergency, and also that repeated calls for assistance that had been made. Members were concerned that many NHS organisations had been aware of the problems, but as set out in the Laming Report or Francis Report, no one had taken responsibility and taken measures to provide support.

Simon Wright, Chief Executive, Shrewsbury and Telford Hospital Trust (SaTH), outlined the workforce shortages and the inability to attract substantive staff to accident and emergency for a number of years and the resultant pressures on staff and the service. He also outlined events and subsequent actions taken by SATH and the CCGs which had resulted in a Regional Risk Review, and Risk and Quality summits as recently as 13 September 2018.

CQC Visit

Deidre Fowler, Director of Nursing and Quality reported that in August 2018, the CQC had made a formal unannounced visit and had raised concerns around safety of patients in the Princess Royal Hospital Emergency Department patients, and the practice of boarding. The CQC had notified conditions in relation to those activities in accordance with section 31 of the Health and Social Care Act.

Boarding was a process which should have been used only in exceptional circumstances or surges of demand but had become normal practice. The SaTH Board had taken immediate decisive action to cease boarding and there had been zero tolerance since 24 August 2018. Additional Health Care Support workers had been put on night duty and there had been an increase in overview by senior personnel.

There was now an increased audit of patient observations and records at 10.00 am and 10.00 pm, two hourly sweeps of the department to ensure safety and sepsis bundle compliance, outcomes of which were shared with CCGs and NHS England on a daily basis. The Trust had felt that what was observed by the CQC was the result of a very fragile work force with high reliance on locum staff.

Staffing

Members asked about the Regional Risk Summit that had taken place, which organisations had attended and what more could have been asked of them and in particular, what requests had been made of Health Education England.

Mr Wright explained that the Trust had made requests through its Medical Director and through the offices of the STP in October 2017, asking for additional doctors to be put onto the rotation in February to support middle grade doctors. In August, the number of doctors had been slightly better than last year, but more middle grade doctors were needed to stabilise the team. The clinical professionals were carrying a great level of strain in terms of volume of patients because of the pressures related to number of nurses and doctors of middle grade.

In July 2018, the Trust Board had talked about having to establish an end point to these circumstances, as too much was being expected in terms of discretionary effort in those teams, especially of nurses. The Trust had informed external agencies that a line was required at which point support was needed, otherwise appropriate action would need to be taken. This had brought the Trust to the position it was currently in.

The Chair asked if Health Education England had any powers to direct staff into fragile services and heard that there had been occasions where staff had been directed, and that this action had been requested by SATH. However with the current pressure on all systems, feedback to SaTH had been that trying to direct them into the Trust would not be successful.

Members also asked about the powers of the CCGs in relation to workforce issues. Mr Evans, Chief Office, Telford and Wrekin CCG, reported that both CCGs had been proactive and had supported the Trust throughout all of its meetings with NHS England and others, especially when it came to requesting middle range doctors.

In subsequent discussion members also asked about turnover and heard that it was 9%, an average rate for the NHS. The Trust would have liked it be lower but there were benefits to turnover and concern was focused in A&E and Acute Medicine. Since the capital decision had been made in relation to Future Fit, three consultants had been appointed to A&E and 60 nurses had signed ‘golden tickets’. Another 30 were to be recruited this year and these were significant strides in the right direction but immediate pressures would not go away. Work extending nurse skill sets was underway. Nurses were coming into the Trust, but not enough into areas of concern such as A&E.

There was also a national problem related to ageing profile of nurses and the demanding work involved, particularly with numbers of elderly patients and those suffering from dementia. He expressed gratitude to the 1000 plus volunteers throughout the organisation and stated that this was one of the largest number of volunteers of any hospital in the NHS.

Boarding

Members asked how it had been possible once the CQC letter had been received to stop the practice of boarding and increase supervision and why this had not been

done before. Mr Wright explained that legacy issues in relation to fire safety and the need to secure a fire certificate in what was an old building had led to the requirement to take some capacity out. 24 hours after this work had been completed, the ability to use that space had become available.

There had also been significant improvement through work with system partners on stranded patients with numbers dropping from 120 to around 40 and this had helped provide the capacity to make the decision to end boarding. Large numbers of ambulances were arriving at small A&E departments, resulting in delays and the balance between the risk of discharging a low risk patient awaiting a short period of care to enable space to be freed up for someone who was acutely unwell was a conflicting tension and had led to the environment where boarding had been required.

The Co-Chair commented that it had been fortunate that this release of space had been possible, but there remained a question around sustainable staffing and whether the measures in place were going to be sufficient to avoid the issues identified during the CQC inspection. Mr Wright explained that checks and balances were a daily issue and safeguards were in place to establish if measures taken were adequate. The hard reality for all was that this would be a particularly challenging winter for the NHS.

Winter Capacity

Members asked what would happen if demand were to exceed capacity during the winter. Mr Wright reported that the Trust had successfully bid for an additional £2.5m funding to create a new urgent care environment at the front of PRH A&E and this would be opening in November. It had also been successful in securing £3.1m to upgrade an existing ward at RSH to create more medical capacity for winter. However, it was not just about creating capacity, a workforce was needed to service and care for patients in that environment. The Trust had established training for Advanced Nurse Practitioners and had developed a series of alternative ways to recruit, train and spread the nurse skills mix with 120 Associate Nurses due to join the Trust.

As the winter approached, additional ways of balancing risk across the wider community were needed to minimise the risk of hospital attendance, eg through use of technology. He reiterated that the hard reality was that there was a fixed amount of capacity, and that if capacity was reached there was not any other means to provide for patients successfully.

Health Service Journal Article / Conditions Set out In CQC Letter

Members asked about the Health Service Journal article and whether this was a fair reflection of the content of the CQC letter as this had stated there were four concerns but only two were referred to in the report before the Committee.

The Director of Nursing and Quality explained that the report in the Health Service Journal had stemmed from an initial CQC letter which was a letter of intent providing the Trust with an opportunity to respond. As a direct result of the response made,

some concerns had been removed. The report before members outlined the issues the CQC were still expecting weekly reports on. It was also confirmed that the advice to the Trust regarding legal advice in the letter was standard CQC advice. Mr Wright added that the Trust always referred to its legal team if it needed to and that it fully accepted its responsibility to address the issues highlighted. It was confirmed that the suggestion that patients had been detained unlawfully had been dropped by the CQC.

Staff Morale

Members asked what was being done to address public perception and staff morale after a sustained period of criticism.

The Director of Nursing and Quality said that SaTH staff had integrity, compassion and needed job satisfaction. On a daily basis she heard staff stories relating to frustrations, and disappointment that they could not fulfil duties in the way they came into the profession to do so. It was very difficult but one of the ways to deal with this was to be visible, listen and be honest that there was not a magic solution. Mitigating actions included a 9am matrons meeting to consider the nursing workforce and risks for that day and to move nurses as necessary, although it was acknowledged that nurses wished to provide continuity of care for their patients. Nurses agreed to move as it was understood that this was the safest thing to do but there was only so long that such good will could last. The Trust had to scale its capacity to suit the workforce but it could not scale the workforce to suit capacity, a system approach was needed to solve this problem.

Mr Wright added that whatever the Future Fit decision, once made it would be possible to address difficult legacy issues, create a more attractive environment for staff, and have less demanding rotas. Since the capital decision had been made there had been a two fold increase in consultants joining the Trust.

Discharge

Mr Wright referred to the attempts of the system as a whole to reduce hospital attendance and frequency particularly with the frail elderly group. The Trust was working very closely with both Shropshire and Telford and Wrekin Councils, there was already a good length of stay against national parameters but further improvement was needed to help avoid patients attending a hospital setting. The frailty service available at RSH was currently being explored for PRH. and currently prevented 15 admissions every week.

The discharge process still needed improvement and a protocol led discharge that nurses could use was under consideration. There were 4.00 pm ward meetings held to discuss who might be able to go home the following day and to ensure that discharge summaries and medications would be ready. More work was needed in this area.

Night Closure of an Emergency Department

A Member asked about the options provided to the Trust Board regarding night time closure, it appeared that there was no doubt that the PRH Emergency Department

would be closed and she asked if this would be a permanent arrangement, as it would be a long time before the outcome of Future Fit became a reality. The Chief Executive stated that any decision would be taken with safety as the focus, and that any decision would result in a curtailment of service. There was not the workforce available to continue the 24/7 model of care without additional staff, this had been requested and would need to be confirmed before the Board meeting on 27 September 2018. A Fellowship Programme was being explored with Wolverhampton University, based at the Telford campus and work was underway on a model that would provide a greater number of doctors. An additional £250,000 had been spent on additional training facilities to provide an attractive location for place for people to come and learn. The development of different roles was underway and included physician associates, advanced nurse practitioners, and pathways to middle grade doctor roles but there were long lead times involved.

The Board would take all these factors into consideration and decide on what would constitute a safe level of staffing. Mr Wright emphasised that none of the Trust Board, Commissioners or Partners wanted to see a curtailment of services. Future Fit provided a strategic solution but it was not a short term one and services must be safe. Workforce was a challenge for every other hospital in the region too and they could not be expected to act heroically to provide indefinite support.

Dr Freeman, Accountable Officer, Shropshire CCG, added that the overriding issue for CCGs was 'is there a safe A&E service'. This was not just about numbers of substantive staff – but also about the large proportion of locum staff operating on shifts. Unless there was a significant increase of staff from elsewhere, any decision taken regarding business continuity was not likely to be short term.

The Co-Chair said that closing one of the Emergency Departments, albeit temporarily, would not address the staffing or capacity problems. He acknowledged that it might make them easier to organise and manage but it was not a solution. Fundamental time and investment in community and primary services was needed, but there was no evidence that resources were there to make that change. He said the bulk of the paper on the continuity plan did not provide enough emphasis on how to get people out of hospital. Mr Evans said that investment into primary and community services was happening but not as much or as quickly as would be liked. Both CCGs were very committed to changing the model of care for patients. This was not just about discharge, it was about making the population healthier in the short, medium and long term.

Dr Freeman pointed out that the business continuity plan would go through a rigorous assurance process with NHSI and NHSE, interdependencies and clinical pathways between sites would be properly considered and understood. There was no predetermined view on that process which would establish the most clinically safe solution for patients to be treated safely, there was no other agenda. It was confirmed that the SaTH Trust Board would make the final decision. CCGs had been asked to input into continuity plans and understand implications for West Midlands Ambulance Service, Wolverhampton's capacity, repatriation issues and social care for patients in other hospitals.

The Chair referred to the appointment of four new non-executives joining the Trust Board and asked if they would be fully informed before taking the decision. Members heard that there had been a formal process of induction and of the activity undertaken to bring them up to speed.

Mr Wright confirmed that no changes were planned to any other service. Had spoken to six other organisations which had experienced similar circumstances regarding closures and the majority of patients had tended to come in the following day with low risk injuries.

It was also reiterated that recommendations in the paper to the Board had been produced alongside Councils, CCGs, partner organisations, regulators, doctors, therapists, stakeholders.

Agency staff – Tablet/Paper observations

The Chair asked whether the high dependency on agency staff in A&E was why the tablet triaging system was currently not in use, and whether training of agency staff was an issue. The Director of Nursing and Quality explained that pausing the use of electronic tablet observations had been due to the high levels of agency staff, usually around 50% of nurses and also because the national standard was changing to another system. Paper and pen systems were in use and there were two hourly sweeps to ensure compliance.

Members asked if tablet systems would be reintroduced once the new national system was in place. The Director explained that the professional expectation at the point of registration was for all nurses to take observations. Although processes differed from hospital to hospital, standard competencies remained the same. Fail safes had been added such as an induction check list, nurses not known to the Trust undertaking a risk assessment and Trust and Agency Nurses signing to say that they were competent.

Care challenge/Rurality

A Member referred to a previous comment by the Director of Nursing and Quality that patient needs had to fit staff rather than the other way round and she referred to schemes to prevent hospital admissions. There were a large number of these but getting these established over a huge geographical area would not happen overnight, especially with an increasingly elderly population, and there would always be a gap between numbers of patients and staffing. Mr Wright acknowledged that discharge and obtaining care in rural areas combined with a diminishing workforce resulted in real challenge. Work underway with the Community Health Trust included intermediate stoke rehabilitation which would free capacity in hospital. It was hoped to get this in place before Winter. In response to a comment about the length of time to get measures in place, Dr Freeman referred to the effect of delays on the Future Fit process. Mr Evans referred to a significant amount of work underway to ensure sufficient capacity in acute and primary care for the winter. This would be signed off at Delivery Board next week.

In terms of the community element, Dr Freeman said that Shropshire and Telford and Wrekin patients made relatively low use of hospital and emergency services, particularly Shropshire. Mr Wright said the CQC looked at use of resources and there was a relatively low length of stay and admission rate.

Mr Evans also drew attention to differential referral rates from GPs to A&E and the higher than regional average of calls to 111 made by Telford and Wrekin population. There was more information to gather about the reasons for this.

Keeping Committee informed

A member asked about the action plan developed since the CQC visit and if reports made to CQC could be shared with scrutiny. Dr Freeman was of the view that the JHOSC should ensure an action plan was in place and complied with, but that it should not receive the detail, as assurance was provided to CQC and there was no need to duplicate this. Mr Wright said he thought it would be possible but expressed reservations as much material had already been inappropriately leaked to the media which without context had created anxiety for the public. SaTH met with commissioners every day and the CQC every week.

The Co-Chair said the Committee wanted information on a regular basis so that it could ensure the action plan was progressing and being taken seriously. He said that this was a matter of public assurance that would allow the Committee to undertake its responsibilities seriously, rather than being surprised by information that had been leaked to the media.

The Chair referred again to the Francis Report and to the expectations placed upon the Joint HOSC and reiterated the importance of keeping the committee informed. Members would like to see a clear line of information as the CQC action plan was addressed. Mr Wright said the Trust was committed to transparency, but it was still within an inspection period with CQC about to undertake scheduled well led interviews with senior leadership. The final report was expected in about 12 weeks and as with the last CQC inspection, SaTH would be happy to attend the Joint HOSC and address the findings. The Chair said that Committee Members would be more than willing to talk to CQC inspectors and Mr Wright said he would pass that message on to them.

Mr Wright reported that the CQC had never previously been aware of a leak of correspondence between it and a hospital Trust at this stage of an inspection and staff had felt the brunt of this. To provide some balance he said that the problems identified related to two parts of a provision which offered over 400 services.

The Chair thanked NHS colleagues for addressing these issues and asked to be kept informed of the next sequence of events.

5. Maternity Services

The Committee had requested a report on the investigations into maternity care, related legal processes and any interim findings. The Chair acknowledged that discussions would be limited because of the ongoing investigations but emphasised that the Committee wished to understand the scope and process.

The paper set out the background to the establishment of the Legacy Resolution Group following the Secretary of State's request to NHS Improvement to undertake an independent review into historic cases in April 2017. It outlined current activity and numbers of current legacy cases and also the subsequent enquiries following media coverage of maternity services in June 2018 and August 2018.

In summary, the paper stated that a total 15 of the 31 legacy families had contacted the Care Group in response to letters received, and following media coverage in June and August 2018 a further 20 families had contacted the Care Group with queries regarding the Secretary of State's Review, Legacy Case Review and with questions regarding their care.

In response to questions from the Committee, it was confirmed that the 20 families who had made contact following the media coverage would be invited to meetings to discuss their care and the same process would be followed if further learning was identified.

Members stated that it was important to know whether concerns of families who had made contact following the media coverage were historical as if they were recent this would be extremely serious. The Director of Nursing and Quality said that it was not possible to pre-empt those cases but that internal governance assurances, external assurance, and other assessment had shown evidence of significant learning in the Care Group.

The Chair queried whether the statement in the report 'Following the media coverage in August 2018; a further 14 families have contacted the care group outside the legacy review terms of reference' was included in the total figure stated and was informed that it was.

Members asked if consideration would be given to other cases which had not resulted in deaths and trauma but had been near misses. The Director said that a pillar of good governance was a supportive culture based on reporting of low harm and near misses as learning through these would help prevent moderate or severe harm. She referred to work with Virginia Mason Hospital on a patient safety value system. The Maternity service was participating in a national safety maternity collaborative and utilising learning from the last 18 months.

The Director of Nursing and Quality was thanked for the report and Members asked that a report on all learning be presented to the Committee following the conclusion of the reviews.

6. Chair's Update

The Chairs reported that there that there had been over 17,000 responses to the Future Fit consultation which had now come to a conclusion. They had asked to see the raw data and had been informed this would be too difficult due to the need for confidentiality, they had nevertheless felt that some indication of the type of responses submitted, unfiltered by Participate, would be useful for the Committee.

They had been given reassurance that resources were in place to analyse the results but an extension of the six week period for this purpose was likely. All were mindful of the Telford and Wrekin election purdah period in 2019.

The meeting concluded at 5.10 pm