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TELFORD & WREKIN COUNCIL/SHROPSHIRE COUNTY COUNCIL

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Minutes of a meeting of the Joint Health Overview and Scrutiny Committee held on Monday, 10 November 2008 at 3.00 pm at the AFC Telford Learning Centre, Wellington, Telford

PRESENT – Councillor D R W White (TWC Health Scrutiny Chair) (Chairman), Ms D Davis (TWC), Councillor V A Fletcher (TWC), Councillor D Gaskill (SCC), Councillor Y Holyoak (SCC Health Scrutiny Chair), Mrs V Lindley (TWC), Councillor A McClements (TWC), Councillor V Parry (SCC), Councillor E Parsons (SCC), Mr D Saunders (TWC)

Also Present –S Conolly (Chief Executive, Telford & Wrekin Primary Care Trust), J MacDonald (Chair of the Clinical Leaders Forum / Programme Director: Strategy for Developing Health & Health Care), J Povey (Medical Director, Shropshire County Primary Care Trust) T Taylor (Chief Executive, Shrewsbury & Telford Hospitals NHS Trust) and P Tulley (Director of Strategic Planning and Commissioning, Shropshire PCT),

D Beechey (Shropshire County Council Health Overview and Scrutiny Panel co-optee); G Hossell (Telford & Wrekin Council Health Scrutiny Commission); C West (Shropshire County Council Health Overview and Scrutiny Panel co-optee); and H Williams (Telford & Wrekin Council Health Scrutiny Commission);

Officers – K Clarke (Head of Audit & Democracy, TWC); T Dodds (Lead Officer – Scrutiny & Modernisation, SCC); M Evans (Senior Committee Officer, SCC); S Kenton (Director of Joint Commissioning, SCC/Shropshire PCT); L Nicholson (Interim Corporate Director, Community Services, SCC); A Smith (Scrutiny Manager, TWC) and D Moseley (Assistant Democratic Services Officer, TWC)

JHOSC-1 APOLOGIES FOR ABSENCE

Councillor S West (SCC) and Councillor M Winckler (SCC)

JHOSC-2 DECLARATIONS OF INTEREST/PARTY WHIP

None

JHOSC-3 MINUTES OF THE MEETING HELD ON 11 JULY 2008

The notes of the meeting held on 11 July 2008 were agreed as an accurate record of the meeting.

JHOSC-4 SHROPSHIRE, TELFORD & WREKIN HEALTH ECONOMY

The Chairman welcomed everyone to the meeting and invited all parties to introduce themselves before explaining that the purpose of the meeting was to receive an update on progress on the development of an over-arcing Health and Health Care Strategy for Shropshire, Telford and Wrekin.

The Joint Committee received a summary of the clinical vision for the Health and Health Care Strategy and a presentation on the progress that had been made in

developing the Strategy, identifying challenged services, future options for acute surgery and the further steps required to reach a conclusion on the way forward.

The Chair of the Clinical Leaders Forum reminded the Committee members of the key strategic issues and objectives and the processes that had been undertaken to inform and shape the Strategy. A number of the models of care that had been examined were suggesting increasing outpatients and emergency care provision as an alterantive to hospital admission by 2012/13. This had a number of implications, and further discussions would need to be held about how long it would take to build up capacity in Primary Care and move activity to a community/primary care setting. For acute hospital services, it was being suggested that there should be a single service across two sites by 2012/13 and in the longer term, a single site for the acutely ill and injured by 2020.

The interim report from the Clinical Leaders Forum had concluded that there was a need to address the sub specialisation in acute surgery and the implications for emergency care, particularly around breast and vascular surgeons, that a better paediatric model of care was required to provide more and better care Closer to Home with paediatric assessment at both hospitals and an inpatient paediatric unit on one site but that any transition to a new model of paediatric care should be taken over time. The interim report highlighted that solutions to the key challenges could not wait until 2020.

The Chair of the Clinical Leaders Forum then went on to explain the four options for clinically viable models for acute surgery: no change; emergencies on two sites; emergencies on one site with elective and diagnostic clinics on both sites; and emergencies and elective in-patient on one site and diagnostic clinics on both sites. He further discussed the implications and clinical risks for each option, particularly paediatrics, before outlining the characteristics of the existing sites at Princess Royal Hospital (PRH) and Royal Shrewsbury Hospital (RSH) in relation to size, population, rurality, deprivation and estate.

The Chair of the Clinical Leaders Forum concluded by describing the steps which would be taken to reach conclusions and findings for presentation to the PCT Boards on 25 November 2008. There would then be an assurance process including a review of the proposals by the Office of Government and Commerce.

The Chairman thanked the Chair of the Clinical Leaders Forum for the report on progress and opened the meeting to questions and comments.

With regard to the option to keep emergencies on two sites, it was understood that eight surgeons would have to be appointed to resolve the sub-specialist problem but that this was not viable due to the volume of work. Did the opportunity exist for surgeons to engage in additional private practice or a share scheme with Robert Jones and Agnes Hunt Orthopaedic and District Hospital (RJ&AH)?
Response: The process had considered the possibility of private medicine but had concluded that there would not be the level of work to justify eight appointments since the demand to provide a private service was falling as a result of shorter NHS waiting lists.

The RSH already had an arrangement whereby it bought-in RJ&AH consultant time and the orthopaedic staff at PRH were linked to the RSH unit. Clear links between the three hospitals already existed and any notice to terminate the arrangement would be a 12 month period.

Who would be consulted as part of the Office of Government & Commerce (OGC) Review?
Response: Consultees would consist of stakeholders which would include Local Authorities and the Voluntary Sector. The Clinical Leaders Forum would recommend that the consultation should be as broad as possible and similar advice would be applied to the National Clinical Advisory Team (NCAT) visit.

It was noted from the briefing paper supplied with the agenda that the external assessment of the work had asked what critical time points by which the likes of the workforce issues (eg European Working Time Regulations or resource issues) would make change unavoidable but no clear answers had been available. Were answers now available?
Response: It was anticipated that a further six junior doctors would need to be appointed to meet the requirements of the European Working Time Directive. The Directive was due to come into force in August 2009 but there were not enough numbers currently available to fill posts. It was considered that changes did not have to be in place by that time as long as a clear timetable was in place to implement the requirements to which the Deanery could give its support. .

It was clear that there were significant issues regarding manpower and training for "Hospital at Home" particularly with regard to paediatrics.
Response: The training needs across both sites were very different and further work would need to take place to accurately assess requirements.

Clarification was sought as to whether the objectives were looking at two sites, or a single new site.
Response: The Chair of the Clinical Leaders Forum advised that with regard to the location, there were two timescales involved. Since it was impossible to build a new hospital by 2012/13, in the short-term the report had to consider how best to maintain two sites. In the longer-term (2020) it was considered that a single-site would provide the best model for acute care. There were however three options for a single site: the existing Telford or Shrewsbury sites or a new site built at a central point between the two. Full appraisals including access, management and funding would need to take place before a recommendation could be made on this aspect. It should be noted that one hospital at the mid-way point would not only require significant investment but would also be much smaller than the combined size of the current two estates and would, therefore, result in a loss of work requiring care at home to make it more viable.

Who would pay for any reconfiguration of services?
Response: There were various funding options. It was clear, however, that it would be most economical and beneficial to patients if services were provided on a single site in the long-term. There was lots of evidence to support this view relating to the duplication of services and the population in each catchment area which had thus far hindered the development of services. However, in the medium term it was important to reduce clinical risks and the Clinical Leaders Forum might feel it more prudent to wait to make a decision on the future as some options were more capital intensive.

The Chief Executive, Shrewsbury & Telford Hospitals NHS Trust (SATH) added that it was important to look holistically at the options with regard to "Hospital at Home" and reducing in-patient admissions rathe than focussing on 2012/13 or 2020. Prior assessment centres at both sites together with a Hospital at Home Service was a viable option to reduce paediatric overnight hospital stays which currently averaged

at 1.4 nights. Day care rates were currently at 80% compared to 62% three years prior and it was important to keep this rate high.

When would the Equalities Impact Assessment (EIA) take place and what would it entail?
Response: The EIA would be a required part of the next phase of work and would consider the impact on all vulnerable or minority elements of the populations once the options were known.

What is the position on Urology?
Response: The current configuration following the SSP decision had not been questioned by the report and there had been no changes proposed. If it was felt there was a need to revisit the decision for capacity issues, there would need to be a clinical argument. It was advised that day patients would continue to be seen at both sites.

Concerns were raised on the implementation of Hospital at Home, particularly relating to the support, staffing and financing of the initiative and any new building. What consultation with the Local Authorities had or would take place?
Response: The 2020 Option Appraisal would review the current sites' capacity and the possibility of new buildings. This process would involve a wide range of stakeholders including both Local Authorities, who were represented on the Clinical Leaders Forum. It was clear that if a new hospital was to be built, 5 to 7 years was too short a timescale and Hospital at Home would need to be implemented first making the best use of current resources. Some figures of between £12m and £35m had been mentioned which did not accurately reflect the costs of a new build.

Concerns were expressed over public perception of the proposals and it was suggested that public consultation and engagement should take place as soon as possible.
Response: The report was due to be presented to the PCT Boards on 25 November 2008 when a decision would be taken as to whether additional work needed to take place before any consultation process could begin. The NHS operated a new process of checks and balances which meant that it was a requirement that an NCAT Visit and OGC Review take place before a commitment to public consultation be made. However, those processes did not preclude discussions with the Local Authorities on the proposed future options although, during that time, it would need to be borne in mind that those discussions would not be based around a definite agreed outcome.

Concerns were raised on the issue of workforce training.
Response: It was anticipated that there would be a transfer of skills from acute surgery although the required development of the workforce had already begun, for example with the increase in nursing care for 'end of life' services. Workforce issues would dictate the pace of change for "Hospital at Home" services and would necessitate some recruitment of new staff.

Where will workers to the initiative be recruited from?
Response: It was envisaged that there would be a mix of new recruits, transfer from acute surgery and retraining of skills. This would be achieved through a process of continuing development, working with GPs and acute services to address the issues. Implementation would not be rushed if there was not a supporting workforce.

What capacity was there for theatre and supporting infrastructure?

Response: The options appraisal would need to consider whether theatre services were in the right place to support future models. Some options would be more capital intensive than others. A clear direction of travel for 2020 would be required before decisions were made.

It was considered that the operation of three individual sites would be extremely problematic and assurance was sought that this was not planned.
Response: There was no intention to operate from three sites, with the exception of day care surgery which allowed the service to operate within a wide variety of settings. In fact, evidence suggested that it did not make sense to carry out major surgery on more than one site. The Committee were reminded that the drivers for change had been set out in the briefing paper and suggested a new building as an option for the future to replace the current two sites rather than run alongside them.

What role was foreseen for community hospitals?
Response: The role of community hospitals was seen to be an area of growth which had implications related to the 'Closer to Home' initiative which was highlighted by the maternity model which demonstrated that 25% of care was given from midwifery units.

The Committee were particularly concerned about Closer to Home arrangements for the very young and in relation to mental health care.
Response: It was important that workforce development provided the best model for paediatric care. It was acknowledged that the new initiatives would require a culture change but it would be linked to meeting the needs of and providing better services to patients in Shropshire.

With regard to Mental Health, provision for primary carers was a principle concern and it was acknowledged that a better model of care was required to offer increased and improved support, specifically targeted at dementia since there was a critical rise in the numbers of elderly people. Such a model of care would need to be managed and planned jointly with the health service and Local Authorities.

Clinical protocols would be developed to highlight risks to vulnerable patients. It was acknowledged that "Hospital at Home" was not appropriate for all patients and, for some children, it would not be the right option.

Is there an agreed position statement for clinical linkages? Where is this published?
Response: There was no single statement and the lists were based on the Royal College Guidance. The management of clinical linkages and how risk should be minimised and managed would form part of the future debate.

The Strategy would consider what was essential and what was desirable, considering how services could be set up and managed to meet local needs. The strategy would address issues such as what were the risks to services not on the same site, what were the risks to patients if operations ran from separate sites and how those risks could be mitigated. If the Royal College Guidance was followed then all services would operate from a single site.

What considerations were being made for personalisation of care, for example around patient choice and safeguarding the vulnerable.
Response: It was difficult to ascertain exactly how to take this agenda forward. It relied upon flexible services and needed associated patient rights to be clear, for example could they choose their own nurse? It was hoped that the Closer to Home initiatives would help to get these choices right, particularly for the vulnerable.

Members noted that difficulties had been encountered in marrying the NHS timescales with Cabinet processes and clearer information on the timescales involved was welcomed. It was considered that appropriate Cabinet Members should be invited to future meetings as it was likely that difficulties would always arise in co-ordinating both processes and it was imperative that the next meeting took place as soon after 25 November 2008 as possible.

RESOLVED – that a further meeting of the Joint Health Overview and Scrutiny Committee be arranged for a date as soon after 25 November 2008 as possible to consider the findings presented to the PCT Boards.

The meeting closed at 4.37pm

Chairman……

Date……