worcestershire county council

Health Overview and Scrutiny Committee
22 May 2012, County Hall, Worcester – 2.00pm

Minutes

Present:

Worcestershire County Council:
Mr A C Roberts (Chairman), Mrs M Bunker, Mr A P Miller, Mrs P J M Morgan, Mr J W Parish, Mr T Spencer.

Bromsgrove District Council: Dr B Cooper
Redditch Borough Council: Mrs P Witherspoon
Worcester City Council: Mr R Berry
Wyre Forest District Council: Mrs F M Oborski

Officer Support:
Siân Clark – Democratic Governance Manager
Sandra Connolly – Overview and Scrutiny Officer

Available papers:

A. The Agenda papers and appendices referred to therein (previously circulated);

B. Presentation on Worcestershire NHS Joint Services Review, Update to the Health Overview and Scrutiny Committee (circulated at the meeting);

C. Presentation on Worcestershire Acute Hospitals NHS Trust's Finances (circulated at the meeting);

D. Quality Accounts, Trips and Falls, A View From Public Health (circulated at the meeting);

E. The minutes of the meeting held on 17 April 2012 (previously circulated).

A copy of documents A-D will be attached to the signed Minutes.

Chairman's Announcements

The Chairman welcomed guests and members of the public in attendance and Pat Witherspoon who was the new representative on the Health Overview and Scrutiny Committee (HOSC) of Redditch Borough Council. The Chairman also congratulated Roger Berry on his recent appointment as Mayor of Worcester City.

557. (Agenda item 1) Apologies

Apologies were received from Maurice Broomfield, Jan Marriott and Gerry O'Donnell.

558. (Agenda item 2) Declarations of

Andy Roberts declared a personal interest in relation to agenda item 6 as his daughter was due to start a job within the stroke service in Bromsgrove.

Interest and of any Party Whip

Terry Spencer declared a personal interest in relation to agenda item 5 that Dr Anthony Kelly, one of the meeting's attendees was his family's GP.

Roger Berry declared a personal interest in relation to agenda item 5 as his daughter-in-law was employed by Worcestershire Acute Hospitals NHS Trust.

Fran Oborski declared a personal interest in relation to agenda item 5 as a member of the Joint Services Review Stakeholder Reference Board.

559. (Agenda item 3) Public Participation

Mr Brendan Young thanked the HOSC for allowing him to address them regarding acute stroke services in Worcestershire. Since his last attendance at the HOSC in January 2012, Mr Young had participated in the stroke service options review as one of 5 patient representatives. Mr Young considered that the review had been robust and comprehensive and all participants had had the opportunity to voice their preferences regarding the future of acute stroke services. The outcome of the review was unambiguous and would provide a safe, high quality, 24/7 service which had the potential to save up to 44 deaths a year and reduce stroke related disability. Mr Young urged the HOSC to accept the recommendations of the review, highlighting that time was of the essence for stroke victims and a commitment to a timescale for implementation was needed.

560. (Agenda item 4) Confirmation of Minutes

The Minutes of the meeting held on 17 April 2012 were confirmed as a correct record and signed by the Chairman subject to the amendment on page 12 that Alan McMichael, Consultant in Dental Public Health was from NHS Worcestershire, not Worcestershire Health and Care NHS Trust.

561. (Agenda item 5) Joint Services Review – The Future Configuration of Acute Services in Worcestershire – Emerging Options, Evaluation Criteria and Financial Issues

Attending for this item were Penny Venables, Chief Executive, Worcestershire Acute Hospitals NHS Trust, Eamonn Kelly, Chief Executive, West Mercia Cluster, Christine Fearns, Director of Strategic Development, Worcestershire Acute Hospitals NHS Trust and Project Director for the Joint Services Review (JSR), Dr Bryan Smith, Chairman, JSR Project Steering Group, Dr Anthony Kelly, Chairman, Worcestershire Clinical Senate and Dr Richard Harling, Joint Director of Public Health. Also attending from Worcestershire Acute Hospitals NHS Trust to discuss the Trust's finances were Harry Turner, Chairman and Chris Tidman, Director of Finance.

Members of the Health Overview and Scrutiny Committee received a presentation outlining the case for change and

the joint services review, developing the outline clinical models and short list of options and next steps.

Members were advised that it was not surprising that a review needed to be undertaken in Worcestershire as there were national challenges facing all acute trusts such as demographic pressures, increasingly specific guidance from Royal Colleges, scrutiny of quality, increasing financial pressures and a national quality drive to achieve £20 billion savings. Locally there were significant demographic pressures and a £50 million funding gap was predicted in the County by 2014/15 if there was no change. Worcestershire Acute Hospitals NHS Trust needed to achieve foundation trust status by 2014 and so needed an affordable configuration by then. It was also noted that the Clinical Commissioning Groups (CCGs) would hold the budgets by 2013/14.

Worcestershire's elderly population was growing at over 3% more than the national average every year. Additionally, year-on-year demand for urgent and emergency care amongst the over 65 population was rising as a proportion of the Trust's attendances. In terms of workforce, the Trust would need to comply with emerging evidence and guidance for 24/7 acute care. The review needed to plan services designed to tackle this gap. A key element of the pressures facing the Trust was the need to take into account recommendations from key Colleges to enable better 24/7 services. The review needed to take account of such recommendations.

From a financial perspective, locally a £40-£50 million funding gap was predicted which needed to be closed through productivity measures, reducing unwarranted variation and lowering the cost base through the JSR and reconfiguration efficiencies.

The vision for the JSR was to ensure high quality, safe and sustainable services, producing a business case setting out a programme of strategic change for the County's acute services. Since the initial timetable of the review was drafted there had been a 1 month delay to allow more time for clinical discussion development and to bring in experts from outside to support the process. Public engagement had been undertaken throughout and would continue on an ongoing basis up to and including public consultation on final options.

It was possible to demonstrate how the Acute Trust had achieved 'easy' efficiency gains, changed operating models and was sharing and integrating services and it was acknowledged that reconfiguration across sites would be important in delivering ongoing sustainability. Scale was also a critical factor as expert guidance suggested that

quality of care was often improved by consolidating and increasing the scale of services. Reconfigurations were happening in many parts of the country and it was anticipated that they would also become even more widespread than at present.

Members were advised how the JSR had gone about reviewing clinical activity to design models of care and options for future delivery. Emergency and A&E standards which draw on Royal College guidance were shared with Members, covering access to senior and specialist skills, access to multi-professional teams and processes. The JSR had not wanted to overload the HOSC, but this provided an example of the sort of evidence being used in the JSR.

An important issue was the inter-dependencies between services which would drive clinical models of care. It had been necessary to work through the alignment of services to ensure 24/7 access to the right standards and the right people. Inter-dependencies had been driving all of the clinical debate.

Nationally, there was a range of delivery models. These models ranged from local hospitals, to 'warm sites' where A&E was provided but not with a full range of adjacencies, to 24/7 major acute hospitals and elective centres, also known as 'cold sites', where patients were generally 'well'. The JSR had looked at the different types of hospitals and how services were designed nationally.

The review had been clinically-led, with approximately 120 clinicians involved in the 4 Clinical Working Groups (CWGs). The CWGs reported into a Clinical Reference Group which comprised 30 clinicians and synthesised the views of the CWGs to feed into the Clinical Senate which made recommendations to the JSR Steering Group.

Each CWG had had 4, 3 hour sessions, each being co-chaired by an acute and a community service representative. The first meetings had considered the case for change, the second had considered aspirations and evidence, the third had looked at pathway configuration options and the fourth had been to agree emerging clinical models. Co-chairs had met Focus Groups to explain how the CWGs were moving through the process and sought their input.

Themes emerging from the CWGs were outlined. In Emergency Care a variety of options were being considered having reviewed how services were delivered now and options for moving services forward. The Elderly Care CWG discussions had been themed around

admissions prevention and reducing length of stay. Planned Care CWG had looked at co-dependent services and how services could be delivered in the acute setting. The Women and Children CWG looked at staffing requirements and their implications for reconfiguration or redesign of services.

The CWGs reported their outcomes to the Clinical Reference Group which included clinicians from the Acute Trust and from the CCGs. Taking the outcomes from the CWGs, the Reference Group would be modelling how services could be redesigned. In building the clinical models, the Reference Group looked at the current 3 site model. The Group then mapped services, recognising that where an A&E service operated, it needed an enormous panoply of services to back-up A&E. Modelling was a long and ongoing process. Outcomes from the mapping process would be assessed for their clinical feasibility and viability.

It was noted that whilst the status quo model but with gaps in rotas addressed would have the benefit of resolving staffing issues and meeting professional guidance, a number of challenges would still remain. These included concerns about safety and quality, that even with additional funding and goodwill, rotas may still possibly not be filled and care may not be delivered to best practice quality standards. There had been consensus that major concerns would remain about clinical viability given concerns about the ability to recruit and meet training standards.

It was highlighted that the review was clinically-led and focussed on what was clinically feasibly rather than being muddled with the financial picture. It was not being suggested that services were not safe today, but if the Trust was to go forward as it currently operated, it would not be able to achieve the necessary recruitment and provide the required quality of care.

In addition to the ongoing work looking at clinical models and how services could be organised, work was also being done on how they could be delivered once options were agreed. Additionally, a working group of 20-30 people, including clinicians and patient representatives, had been working on evaluation criteria. Five categories of non-financial criteria had been identified including:

- clinical quality to ensure the best outcomes
- access, including travel, car parking, opportunities for co-location of services with partners
- training, teaching and HR needs
- resources and the best possible use of people and buildings

- deliverability, including speed of implementation.

The proposed weighting of these criteria was shared, with clinical quality being at the forefront. As these were shared with the public there would be the opportunity to comment on the weighting and suggest how they should be adjusted.

There were 2 important factors when looking at the financial aspect. The overall affordability of options needed to be considered, including looking at the options' contribution to closing the funding gap, capital spending needs and enabling costs, such as staffing exit costs. Value for money also needed to be considered to ensure the best value for the public purse and that options made sense for the taxpayer, for example, not transferring costs to other parties. Options would be looked at over their medium term affordability. Some options may be unaffordable.

In looking at the financial modelling, a number of assumptions had been used. The Acute Trust was unable to wait for changes and had to drive efficiencies and to address the forecasted 2014/15 £17 million recurrent deficit, this assumed the delivery of £30 million of efficiencies, approximately 10% of the Trust's income. Whilst this was a big challenge, it was no different to many other trusts. The base line assumption was that the status quo was not tenable.

Modelling assumptions, such as patient flow, were quite complex. A lot of time had been spent with external consultants building models to test the sensitivities and the impact of changes on patient flow, both inside and outside Worcestershire. It was highlighted that as more services moved into a single site and patient flows followed, there was not necessarily a financial increase for the receiving site as there was an increasing cost to the organisation receiving the work and real costs were released when work was transferred out. Such issues were being worked through and were highly sensitive. Members were advised that the review team was not attending the HOSC with analysis of travel times, etc. but important information on scale was really complex and was a work in progress. Members were advised that they should have confidence that work was being done to a high standard to show review details both diagrammatically and in numbers.

In terms of next steps, the JSR Steering Group would consider evaluation criteria and a communications plan for the phase 4 wider review of the decision criteria and clinical models. Clinically feasible models would be finalised at the end of May with input from external experts. Public engagement on the long-list of clinical models and

weighted decision criteria would start in June. In early July the decision criteria would be applied to the long-list of options to create a short-list for detailed modelling to understand the options better. As the clinical work was resolved, in July-August external formal review would be undertaken on the clinical feasibility of those options.

During the ensuing discussion, the following main points were raised:

- Members asked about the membership of the Clinical Working Groups, particularly for Elderly Care and whether it included representatives of the Health and Care Trust and County Council given the potential for demand to be pushed onto those organisations, highlighting that the Council was also stretched. Members were advised that all of the CWGs included representatives from the Acute Trust, Health and Care Trust, primary care and social services;

- the JSR team was congratulated on the amount of work undertaken to-date and Members recognised that the problems were not easy to crack;

- whilst it was considered that ultimately clinical criteria were the most important, Members flagged up that the anticipated outcomes of the review would make it necessary for people to travel and something therefore needed to be done about hospital parking and charges as they were always flagged up by the public as concerns. When patients were called to a hospital appointment they often had no way of knowing how long they might be there and concern was expressed about those on a tight budget who could find themselves needing to top-up their car parking payment during an appointment. Some Members were appalled by some of the charges patients had experienced and the review needed to look into this as a serious consideration. Whilst Members recognised the review needed to be clinically-led and address financial issues, the HOSC was also bothered by social and political factors. Members had previously heard of a patient needing to attend Kidderminster from Worcester and being charged £22 for community transport. Whilst this might be a reasonable rate for that journey, it would be a significant proportion of a pension and concerned HOSC Members. Members were advised that the JSR Steering Committee included Trish Haines as a member and there were representatives of lay views rather than just clinicians. Whilst it was recognised that there would be no easy answers, social and political factors were taken very seriously;

- County Council representation on the Clinical Working

Groups was questioned. Members were advised that Jonathan Monks was on the Elderly Care CWG;

- it was requested that the County's older people's fora needed to be included in forthcoming consultations;

- it was highlighted that if services such as women's and children's services were moved to a single site this could cause problems, for example in Redditch where it was considered that transport was dire. An example was provided of a Redditch woman without transport who had been offered a 7.30am appointment at Kidderminster Hospital. She had approached a community transport provider who quoted £40 for the journey which was unaffordable for the woman. Councillors had intervened, spoken to the hospital and transport had been arranged but concern was expressed that people would not generally know what support they could access. It was highlighted that a lot of people did not have cars and used public transport and an appeal was made to pay particular attention to such issues especially if there was a risk of services moving out of Redditch. Members were assured that transport and access were included in the evaluation criteria and when they were consulted on, people would be able to indicate if they considered that they should have a greater weighting, but there would need to be a trade-off with another criteria, such as clinical quality;

- Members reiterated that the County could have the best services but if patients could not get to them, they would not be used. There were examples of patients spending £60 on a taxi to attend an ophthalmology appointment which was a significant amount from the patient's £400 monthly income. Transport was a vital issue if the review was talking about moving women and children's services for example, highlighting that if a pregnant woman needed to spend 2 hours travelling to an appointment, possibly with other young children, she may not attend her appointment and a greater reliance on community midwives could develop. It was suggested that the review needed to get a grip on transport issues before other issues and it should not be a question of deciding on a service model and then thinking about transport;

- in response to a question about clinical involvement in the Clinical Working Groups and particularly the Women and Children's group, Members were advised that there was a panoply of healthcare professionals and the importance of midwives was recognised. One of the external experts working with the review was a midwife. A recent radio programme was highlighted

which noted that women laboured better when closer to home, that the caesarean section rate had increased over recent years and that 85% of babies were now delivered by a midwife. It was urged that childbirth should be thought of as a normal process and not medicalised;

- it was noted that transport and access to hospitals was not just an issue for patients. When Kidderminster Hospital was downgraded, staff were made promises about buses but some of the services no longer existed. It was highlighted that it was not possible to get to Kidderminster Hospital by 7.30am from Kidderminster itself by public transport or after 6pm;

- an example was highlighted of a bus being stuck in traffic within the Worcestershire Royal Hospital site for an hour and it was noted that it could be easier for a patient from Malvern Link to attend a hospital appointment by train in Birmingham than by bus in Worcester;

- Members were advised that the review was doing sophisticated work on the clinical models. Broader implications were a core part of the work and there would be travel time analysis. The review would not deal with transport itself, but rather what it could mean for patients;

- it was noted that the CWGs had been established just for the JSR process and once outcomes were implemented the CWGs would end. The future of the Clinical Senate would be a matter for the CCGs and providers to decide what mechanism they wanted in Worcestershire to bring clinicians together. It was hoped that it would continue and would be used by the Health and Wellbeing Board;

- the JSR was mindful that patients used services outside Worcestershire and that Worcestershire's services were also used by patients from outside the County. Members were advised that discussions were needed with external providers and that patient choice also needed to be recognised. It was highlighted that radiotherapy services were being brought into the County and a key reason behind this was to give better access and improve uptake demonstrating that the local NHS did recognise the importance of access. Bringing such services in-County, including cardiac and renal services, not only benefited patients but also the local organisations and their reputations and helped recruiting staff. Members were advised that there had to be a lot of ambition too and there would be difficult trade-offs;

- the time-consuming nature of the work under the JSR was noted and the local NHS organisations were congratulated on the amount of work done;

- it was questioned whether the Acute Trust's application for foundation trust status was helpful in the review or a complication. Members were advised that the review and application were linked as the Trust had to have viable clinical and financial strategies. All trusts needed to be a foundation trust or become part of a foundation trust by 2014 and the Trust's view was that secondary care in Worcestershire would be better if managed within Worcestershire. Commissioners were supportive of both the review of acute services and the Acute Trust's application for foundation trust status. The Strategic Health Authority (SHA) was very happy with the progress of the JSR and all would work to ensure the review was not compromised by the foundation trust application process;

- in response to a question about whether the review was reinventing the wheel and could lessons be learnt from other areas, Members were advised that similar reviews were already taking place around the country or soon would be as all were expected to deal with financial challenges and the need for 24/7 consultants. The JSR was looking to learn from others and drawing on their experiences and models, such as 'warm hospitals'. The SHA had pointed out other operating models and it was suggested that the HOSC might wish to visit other examples;

- concern was expressed about the relationship with reviews taking place outside the JSR, such as acute stroke services and a recent options appraisal undertaken by the Health and Care Trust regarding acute psychiatric beds when some of those patients may also require services from the Acute Trust. At the options appraisal event, it was confirmed that it was not part of the JSR and needed to be completed by October. Members were advised that whilst the detail of the Health and Care Trust's option appraisal was not known, all needed to be clear about interdependencies. Within the last 2 weeks it had been decided that in order to be able to deliver against core assumptions, 30% less beds would be provided in the County. To do this, local NHS organisations would need to explain it in detail and convince all that services would still be available. A piece of work was to be undertaken with colleagues from social care to work up a detailed business case specifically regarding out of hospital elderly care. A critical part of elderly care was that it

had to deal with multiple morbidity issues including cognitive impairment and psychiatric needs. Eamonn Kelly undertook to pick this up with the Health and Care Trust to ensure the direction of travel was not compromised.

The Chairman noted that a lot of complex work had been undertaken and the overarching concern of HOSC Members was that reassurances were needed that factors such as travel would be addressed in the JSR's solutions.

Members received a presentation on Worcestershire Acute Hospitals NHS Trust's finances, outlining the history, borrowing powers, today's position, nursing spend, emergency admission trends and the future.

The Trust had run up large debts in the last part of the decade, to almost £35 million at one stage. Improvements had been made and the legacy debt was now £18.4 million.

The Trust was applying for a £21 million capital cash loan to address the legacy debt and the loan would be repaid in 7 years from surpluses. The Trust would also be borrowing money to invest in new services, for example the planned radiotherapy development and increased cardiac services. Members were assured that it was appropriate for the Trust to borrow money.

Whilst there had been a deficit at the start of 2011/12, the Trust had balanced its books. The Trust had reduced its costs, been paid for the work done and received the right level of transitional support from commissioners all of which had helped the Trust achieve financial balance.

Members were advised that it was noted in the March Trust Board financial papers that nursing spend had risen and this had been the case in the winter. The Trust had deliberately put additional bed capacity in to address expected seasonal pressures but the pressures were not expected to have been as challenging as they were and the Trust saw demand increase and pressures increase with Norovirus outbreaks. The Board had been disappointed that the Trust had needed to rely on agency staff rather than using its own bank of nurses but it had been necessary to do this, using accredited agencies. Members were advised however that nursing spend remained in-budget. It was also highlighted that emergency admissions appeared to be showing a 6% increase year on year. Other than an increase in February due to Norovirus, nursing spend per bed day had been broadly constant over the year.

The past was an issue for the Trust and it was in

discussions with the SHA and Department of Health about how to deal with the legacy debt in the transition to foundation trust status. It was recognised that the Trust could be both clinically and financially viable but the debt could remain a constraint. Finances would be squeezed in the public sector over the next 3-5 years and whilst the Trust's overall budget remained flat, demand continued to grow by about 5% every year. It was also noted that NHS tariffs were being reduced by 4% and CCGs were also under pressure too. Acute trusts would therefore all be looking to make annual savings of 5%. Whilst the Trust needed to become more efficient, this could only achieve so much and the Trust needed services to be redesigned.

- it was queried how the Trust planned to pay off the £21 million loan when the Trust also needed to make 5% savings and it was suggested that the Trust was facing an incredible challenge. If the historical debt could be wiped out the position would be clearer but Members questioned the planned surpluses. Members were advised that within the planned 5% savings, 1% of this was surplus and equated to £3 million annually, amounting to £21 million over 7 years. Members were also advised that the JSR needed to leave the Trust with a modest surplus or it would leave the Trust with no contingency and reinvestment funds;

- it was noted that the Trust's plans were based on current budgets yet national decisions could impact on NHS budgets. Members were advised that it was not possible to predict what the Treasury might do in future years. The Trust was planning as best it could and would respond to any challenges as necessary and it was highlighted that it was difficult for all of the public sector. The Trust's Chairman advised that there was hope that something might happen regarding the historical debt following indications from the Secretary of State that if the future picture looked good for trusts with historical debts, there might be an option to deal with the debt;

- there was a suggestion that taxes should be increased to fund a decent NHS;

- in response to a question about provision to retrain the staff no longer needed in the acute setting to deliver community-based care given the movement of patient care to community settings, Members were advised that this was being considered under the JSR. The JSR recognised that if different models of care were implemented, the review needed to look at what was needed in other settings, as there was no sense in losing clinical skills. Members were assured that work

was being done on what out of hospital care would look like and the Acute Trust was working with the Health and Care Trust on pathways, staffing and skills;

- it was noted that the Government had stated that the NHS was one area where money would not be reduced and there would be increases in spending. It was questioned where this could be seen. Members were advised that whilst overall there was real terms growth in spend, it was miniscule, at 0.1 or 0.2 of a percent. It was highlighted that acute trusts would not necessarily see this money. As demand continued to increase, funding was not keeping pace so better models of service delivery were needed. Government funding protected the NHS against inflation but not against increasing demand;

- it was queried whether it was known yet whether CCGs would require the same levels of hospital activity as at present or if this remained unknown. Members were advised that planning assumptions were taking into account the CCGs' 3 year assumptions and work was being done to align planning assumptions as much as possible;

- Members were assured that work was being done across health and social care on the nature of the out of hospital care needed in Worcestershire. It was recognised that the 2 key aspects of reducing numbers and length of stay would impact on both community care and social care and work was being done to look at what was needed and the resources needed, with a focus on the elderly care pathway;

The Chairman thanked all guests for their attendance.

562. (Agenda item 6) Acute Stroke Services in Worcestershire

Attending for this item were Eamonn Kelly, Chief Executive, West Mercia Cluster, Chris Emerson, Deputy Director – Delivery, NHS Worcestershire, Menna Wyn-Wright, Service Improvement Manager, Herefordshire & Worcestershire Cardiac and Stroke Network/NHS Worcestershire and from Worcestershire Acute Hospitals NHS Trust were Harry Turner, Chairman, Penny Venables, Chief Executive, Jonathan Lofthouse, Interim Director of Emergency Care and Simon Hellier, Clinical Director of Medicine.

Members of the Health Overview and Scrutiny Committee received an oral presentation outlining the background to acute stroke services and developments since the last update to the HOSC.

Members were advised that previously acute stroke service commissioners and providers had been concerned about the ability to deliver key quality indicators and there had

been a debate about whether service provision should be from a single site or 2 sites. Since then, it had been agreed that in order to comply with national stroke strategy and NICE guidance, a centre of excellence was needed and the development of a single site service at the Worcestershire Royal Hospital (WRH). Previously there had been concerns about capacity at WRH. However, there had been changes since then, including the development of an 8-bed unit at the Timberdine Unit in Worcester which released capacity at WRH. There would be no change of services provided at WRH.

There had been improvements in the current service since January, including access to screening, scans, thrombolysis and the time patients spent on a dedicated stroke unit. However, concerns remained about the current service provision, including access to stroke beds and the sustainability of the service. There was also increasing evidence of centralised stroke services increasing the quality of care, reducing mortality, long-term disability and length of stay.

In April, an options appraisal was undertaken. This involved a wide representation, including Worcestershire Local Involvement Network (LINk), the stroke tsar and other key stakeholders. The outcome of the appraisal was that there was now even stronger evidence to support a centralised service for Worcestershire. Consideration had also been given to some flow out of county, for example to Dudley, the Queen Elizabeth Hospital (QE) in Birmingham and to Warwickshire. In looking at a site for a centralised service, WRH would offer the best option for the greatest number of patients reaching hospital within 45 minutes. WRH also offered the benefit of being able to link with vascular services based there. It was hoped that today the HOSC would support the development of an implementation plan without the need to conduct formal public consultation given the support received during the optional appraisal process.

The option appraisal had involved patient representatives, the Ambulance Trust, service providers and commissioners and built on the review work previously undertaken. In 2011, options considered had been to continue the service at both WRH and the Alexandra Hospital or just on one of those sites. In 2012, an additional model was considered, providing thrombolysis on both sites with 1 acute stroke unit, either in Redditch or Worcester. In assessing the options, for consistency, the same evaluation criteria as had been used previously were used again. These criteria included clinical quality, access, development of existing or provision of new services, strategic fit, training and teaching needs, more effective use of resources and ease of

delivery.

The team reviewed the options and agreed that a centralised service should be developed at WRH as soon as possible as this option offered good access for all of Worcestershire and would serve the larger critical mass, leading to improvements in mortality. A detailed plan needed to be developed by the Acute Trust and discussions were needed with partner organisations as soon as possible.

From a clinical perspective, stroke was a very complex event to respond to and there were very stringent standards nationally to be achieved. It was clear that where organisations centralised services into centres of excellence, services improved exponentially and this applied in both urban and rural areas as well as in larger conurbations. Stroke treatment had changed in the last 5-10 years and where care had previously been managed by generalists, stroke care was now an area for specialists, providing CT scans and interpretation and thrombolysis, all within short timescales. It was suggested that it would soon be unusual not to have a full-time, dedicated stroke unit. It was recognised that the acute care was not the entirety of stroke care and provision of rehabilitation services more locally was also key. Putting acute care onto a single site would give patients a higher level of care.

Members were advised by the LINk that this country currently had the worst survival rates for stroke in the developed world and were 3 times worse than Denmark, for example. It was essential therefore to concentrate acute stroke services on a single site. In the absence of a 24/7 service, care at weekends was often lost and length of stays subsequently increased, survival rates were worse and quality of life afterwards was worse too. To do the best for Worcestershire, a robust stroke pathway was needed and it would be possible to reduce overall bed numbers if there were 24/7 therapy services rather than just Monday-Friday access.

During the ensuing discussion, the following main points were raised:

- concern was expressed that the proposed service would principally benefit the south of the County, being based at WRH, yet over 50% of the County's residents lived in north Worcestershire, with the nearest hospital for some of them being Russells Hall Hospital, Dudley or the QE. Whilst it might be easier for ambulances to take patients from Wyre Forest to Dudley, travel for visitors to WRH would be a breeze in comparison to travelling to Dudley and it was highlighted that as most stroke victims were elderly, many of their visitors would

be elderly too. There was concern about the over-development of patients from the north of the County being sent where was convenient for the Ambulance Trust, but inconvenient for visitors. Members were advised that of the approximate 800 stroke patients treated by the Trust each year, about 500 were at WRH and 300 at the Alexandra Hospital;

- the travel times stated in the paperwork were questioned, with Members suggesting it took 20 minutes to travel from Kidderminster to WRH rather than the 30-40 minutes in the documentation. It was also suggested that the A449 should be made back into a dual carriageway. Members were advised that the mapping of journeys had been provided by Public Health;

- it was highlighted that targets for scans were currently not being hit a lot of time and it was questioned whether there was confidence this would improve if the service was provided on a single site. Members were advised that a single site service would ensure clinical leadership and extended therapies such as occupational therapy and physiotherapy 7 days a week and greater access to CT and Doppler scans, etc. Clinicians were confident that a single site option would better maintain a centre of excellence, meeting national stroke strategy and NICE standards;

- it was noted that in the Joint Services Review, it had been clearly stated that for the Acute Trust to remain viable, it needed in-County service provision but this proposed model for acute stroke services would see some patients currently treated in-County, in future being treated outside Worcestershire. Members were advised that not all of the 300 stroke patients currently treated at the Alexandra Hospital would be treated outside the County under the proposed model and approximately 150 of them would be treated at WRH. Members were also assured that repatriation was not a key or a sole factor in determining the financial sustainability of the Acute Trust. Members were also advised that a key issue was the repatriation of services not currently provided in-County, for example radiotherapy and some cardiac services. Emergency flows were a different group and patients needed to get to their nearest hospital;

- it was also highlighted that the service had experienced difficulty attracting consultants and therapy staff and if the service was located on a single site, it would be more attractive;

- Members were assured that the aim of such reviews was to achieve the best clinical outcomes. The recent review of trauma services now meant all major trauma being sent to the QE. Key factors were saving lives and reducing injury and disability. Where clinically appropriate, services would be provided in Worcestershire, but if more appropriate, they would be provided elsewhere. For stroke services, the benefits of the proposed model in terms of reduced deaths and long-term disability were highlighted, recognising that there would be a short-term cost to families if they needed to travel to the QE or Dudley;

- whilst it was noted that London's stroke services now produced outcomes which were amongst the best in the world, Members noted that London also had a good transport system. However Members were advised that stroke patients tended to arrive at hospital via the ambulance service;

- it was suggested that for the best outcomes to be achieved, provision must also include services in the community. It was noted that there was a resource in south Worcestershire to treat those with an acquired brain injury, but not in the north and it was not known why this was;

- it was highlighted that the people of Redditch did not feel that they would get a better service under the proposed model. When the news broke in the previous week of the proposed change, there was a storm locally and a lot of anger. Concern was expressed that accessing WRH might be OK if you owned a car, but not everyone did. Most patients would be elderly and their relatives would not be able to get in to visit them and service commissioners and providers were doing nothing about this. Members were advised that a key benefit of the proposed model would be the reduced length of stay patients would need before being able to transfer to a community setting, closer to their relatives;

- concern was also expressed about the planned changes to ambulance provision which would see cars sent initially with an ambulance arriving possibly 30 minutes later. Residents of Redditch would prefer to continue to use the Alexandra Hospital. Members were advised that the days of ambulances being sat in ambulance stations had long-gone and were instead stationed around the County so they were able to respond more promptly. It was proposed to close Redditch ambulance station and open 3 alternative sites and whilst people were being told such changes were not about money, people did not feel that these changes were about improving patient care;

- it was noted that how everyone told the story was critically important. There were 2 major objectives for Worcestershire's health services, i.e. ensuring clinically sustainable services and facing the productivity challenges. Whilst the feelings of the people of Redditch about their local hospital could be understood, it was questioned how honest the local NHS had been about outcomes of the current stroke care and the number of unnecessary deaths and levels of disability. If the NHS was honest, people may better understand why changes were being proposed. It was necessary for the local NHS organisations to use their skills and resources to communicate messages clearly. Where national stroke standards were implemented, there were significant reductions in deaths and this needed to be brought into Worcestershire. What was critical was how to get patients back into their community quickly. What people were being told was key and this was the local NHS's responsibility;

- it was questioned whether, once patients moved from a centralised acute stroke service to their locality, they would have access to the essential tools needed to maintain progress, such as speech therapy, occupational therapy and physiotherapy. It was also questioned that whilst the additional 150 patients to be treated in WRH could be accommodated as a result of the additional 8 beds at the Timberdine Unit, whether there would be a similar in-County provision for those 150 patients who were treated outside the County for their acute stroke care. Members were assured that significant work had been done to develop services across the County to ensure robust early discharge with rehabilitation services in a patient's locality. Members were further assured that Worcestershire's out of hospital care was amongst the best nationally and whilst it could perhaps be better, it was starting from a good strong base;

- concern was expressed that there had been huge concerns historically about the provision of speech and language therapy for children and it was also important for stroke victims. Members were advised that a single site service would allow all therapies to be provided 7 days a week;

- it was suggested that the case had been overwhelmingly made and was difficult to ignore and additionally the cost envelope meant there was a dilemma with the resources not available to provide 2 centres of excellence in Worcestershire. However there was concern that this was the thin edge of the wedge

and the Joint Services Review would see the continued centralisation of services and ignore the needs of local people and it was questioned what WRH would lose to accommodate a centralised stroke service. Members were advised that bringing the service together on a single site would enable more efficient use of the bed stock. At present, clinicians and therapists did not operate 7 days a week so current resources were not maximised. The proposed service had been modelled and it was planned that 26-28 beds at WRH would meet the service's demands and was also economically sensible compared with the 42 beds currently in place in Worcester and Redditch;

The Chairman considered that the HOSC recognised the case had been made and the proposed model would result in better outcomes. HOSC Members would not always agree on site decisions and in reality would represent their locality. The HOSC was not comfortable that the case for change had been made to the public and highlighted concerns raised in the local media, for example by MPs and encouraged the local NHS to do more to get the message across. Concerns remained amongst Members about post-acute care and Members would wish to keep an eye on this.

The Chairman thanked all guests for their attendance.

563. (Agenda item 7) Quality Accounts – Health Overview and Scrutiny Committee Comments

Members considered the draft Quality Accounts of the 3 local healthcare organisations which were required to produce Quality Accounts. Health Overview and Scrutiny Committees were invited to submit up to 1000 words on each organisation to be included verbatim in the NHS organisations' Quality Accounts which were to be submitted to the Secretary of State for Health by 30 June 2012.

Each draft Quality Account (QA) was considered in turn by the HOSC.

West Midlands Ambulance Service NHS Trust
The Chairman welcomed Adele Pearson, Regional Head of Professional Standards and Quality and Tony Gill, Clinical Performance and Governance Manager from the Trust. Members were advised of the Trust's priorities for improvement for 2011/12, performance against those priorities and the Trust's priorities for 2012/13.

In discussing the Trust's Quality Account, the following comments were made:

- Members suggested that the Trust would be increasingly busy in Worcestershire with the anticipated structural changes to acute services, including acute stroke services and it was hoped the Trust would have

the necessary provision in place. Surprise was expressed that the Trust was not more involved in the County's ongoing Joint Services Review;

- it was noted that Members had already done some work outside the meeting to consider the draft quality accounts and some words had been drafted. It was considered that the draft QA provided a fair reflection of the Trust's services and the Trust was to be congratulated on the clarity of the QA which was a document to be aimed at the public;

- Members were interested that within its falls pathway priority for 2012/13, the Trust intended to focus on prevention and education;

- given the HOSC's interest in the quality of stroke care, Members welcomed the Trust's priority regarding the management of onset of stroke;

- it was suggested that there should be discussions between NHS Trusts about their priorities to enable more integration in target setting;

- the Trust was congratulated on its achievements over the last 12 months as detailed in the draft QA;

- the Trust's use of GPS and local knowledge in transporting patients to acute hospitals was questioned, with an example given of a patient from Fernhill Heath in Worcester transported through the city centre rather than around the outskirts which had proved a quicker journey. Members were advised that in the absence of local knowledge, ambulance crews did work off GPS. Members highlighted that concerns had been expressed about the loss of local knowledge when Worcestershire lost its dedicated ambulance trust and had predicted that this would be a major problem;

- the reality of patient choice was questioned in relation to patients being transported to an acute hospital by the ambulance service. Members were advised that in an emergency, patients were transported to the nearest acute hospital. However, if a patient was receiving ongoing care, they were not in a life-threatening situation and their preferred hospital was not unreasonable, there could be patient choice;

- the Chairman advised that the Trust's Chief Executive had requested that he attend a future HOSC and it was suggested that questions such as these would be best discussed with him at that meeting.

Worcestershire Acute Hospitals NHS Trust
The Chairman welcomed Helen Blanchard, Director of Nursing and Chris Rawlings, Head of Clinical Governance and Risk Management from the Trust. In discussing the Trust's Quality Account, the following comments were made:

- surprise was expressed that although in the Chief Executive's statement in the draft QA it was stated that the emergency access target in A&E had been disappointing all year and this was a key priority of the Board, it was not identified as one of the Trust's 2012/13 priorities for improvement in the QA. Members were advised that this related to the structure of draft QAs and that there would be a focus on emergency access;

- Members noted that the draft QA picked up the Care Quality Commission's inspection and the lessons learned. However Members expressed concern that there needed to be a clear structure for safeguarding. The definition of a vulnerable adult could apply to all patients and it was suggested that the Trust needed to be clearer about safeguarding. Members were advised that the Trust had received a very favourable assessment following the West Midlands Quality Review Service assessment of vulnerable adults in acute services but the point was taken about safeguarding work.

Worcestershire Health and Care NHS Trust
The Chairman welcomed Sandra Brennan, Director of Quality (Executive Nurse) and Della Lewis, Quality Governance Manager from the Trust. In discussing the Trust's Quality Account, the following comments were made:

- the draft QA did not include any targets or measures for the 2012/13 priorities. Members were advised the Trust considered that quality was central to the organisation and had decided that it would include its QA within the Trust's Annual Report and together, the documents provided a full picture. Members were also advised that consultation had led to the addition of 2 of the Trust's 5 priorities, i.e. dementia and no incidents of avoidable pressure sores;

- Members suggested that it was depressing that the Trust needed to prioritise improving pressure care when there had been systems in place even in 1965 to ensure their prevention and cure and it was questioned what had changed that now required the Trust needing to make this a priority. Members were advised that over the years, priorities in nursing had changed but the

Trust was now going back and reflecting on the role and was, for example, reintroducing care rounds. The Trust was aiming to get 'back to essential care'. It was highlighted that one particular challenge for the Trust was that it provided a lot of care in people's homes and therefore had less ability to control things. For example, even though the Trust could provide the necessary pressure mattresses, etc. there was less the Trust could do if patients did not use them, although questions could be asked about whether this might be a safeguarding issue, recognising that this would need to be balanced with people's freedoms and liberties;

- it was noted that at the recent Royal College of Nurses' AGM, there had been some very disturbing comments about the ratio of qualified nurses to patients. Members were advised that the Trust did not have just 1 trained nurse covering any of its areas. A recent RCN document had been published making recommendations about elderly care and the Trust considered it was very applicable to the Trust and was just starting the work to look at the recommendations;

- assurances were sought that mental health matters had not taken a backseat at the Trust following the merger of mental health services and community services under the formation of the new Trust. Members were assured this was not the case and an example was shared that demonstrated the benefit of shared practice and knowledge which saw patients with cognitive impairment in the community hospitals benefiting from improved care due to access to specialist nurses when they would not have received mental health care previously. Staff coming together from separate organisations into one had seen the pooling of skills and resources. Members welcomed the improving care for patients with dementia and were advised that different types of training was provided for different staff groups.

564. (Agenda item 8) Health Overview and Scrutiny Committee Round-up

Ongoing issues around the County were discussed:

- Cllr Bunker had attended a meeting organised by Worcestershire Health and Care NHS Trust regarding planned bed reductions. The Chairman would follow this up with the Trust;

- Hereford and Worcester Fire Service had scheduled a meeting which clashed with a meeting of the HOSC. The HOSC meetings were detailed on the Council's calendar of meetings and it was asked that the Fire Service be advised where to access the up-to-date calendar to avoid future clashes;

- concern was raised that the Worcestershire carers of people with mental health issues were feeling in limbo and in need of help and that they no longer had access to the Community Psychiatric Nurses they used to. It was suggested that this needed to be addressed with Worcestershire Health and Care NHS Trust. Cllr Bunker advised that the Trust had indicated that its proposed bed reductions were planned as a result of improvements to community based services;

- concern was expressed that there appeared to be a void between what the HOSC was being told and what GPs were doing. Examples included that GPs had only just come on board the Children's and the Adults' Safeguarding boards and it was considered GPs had also not had a focus on Child and Adolescent Mental Health Services and children's speech and language therapy. Members considered that they needed to meet the lead GPs from the County's 3 Clinical Commissioning Groups. The Chairman undertook to follow this up;

- an update was requested on out of hours GP services.

The meeting ended at 5.10pm.

Chairman ....