Minutes of the Healthy Staffordshire Select Committee Meeting held on 28 January 2014

Present: Kath Perry (Chairman)

Attendance	
Frank Chapman	
Bob Fraser	
David Loades (Vice-Chairman)	
Shelagh McKiernan	
Trish Rowlands	
Stephen Smith	East Staffordshire Borough Council
Colin Eastwood	Newcastle Borough Council
Amyas Stafford Northcote	Stafford Borough Council

Also in attendance:

Apologies: Charlotte Atkins, Chris Cooke (Leader of the Independent Group), Michael Greatorex, Christine Mitchell, Sheree Peaple, David Smith, Mike Worthington, Brian Gamble (Cannock Chase District Council), Brenda Constable (Lichfield District Council), Val Chapman (South Staffordshire District Council), Elaine Baddeley (Staffordshire Moorlands District Council) and Andrew James (Tamworth Borough Council)

PART ONE

63. Declarations of Interest

Councillor Loades declared that he was a Trustee of Healthwatch Enter and View

64. University Hospital of North Staffordshire NHS Trust

Mark Hackett, Chief Executive of University Hospital North Staffordshire NHS Trust introduced the report and advised members were advised that the Trust continued to work on all current national initiatives to control hospital associated infection, to ensure compliance with the Care Quality Commission: Standards for Better Health and the Health Care Act 2008 in respect of “Quality and Safety”.

Trust Apportioned MRSA Bacteraemia. He advised that there had been 4 this year but ultimately the Trust would only be satisfied with zero rating. Members were assured that the issue was being addressed by internal detailed reviews by clinical teams. He explained that the risk was heightened when the patient presenting was suffering from an acute or long term condition and that the situation was made more difficult when a patient presented with an infection acquired at another hospital or elsewhere, as in either case the Trust had no control.

He explained to members that the total number of Trust Apportioned cases of C.Diff Toxin for the year of 38 recorded was within trajectory. The figures were positive when compared with 5 years ago the Trust suffered with 170 cases of C.Diff per month. The current figures were particularly pleasing as there was no evidence of transmission of the infection throughout the hospital. Members were informed that the vaccination for influenza of frontline staff, targets had been exceeded; 4½ thousand vaccinated which was in access of the 75% target.

Members were advised that patient access had been improved and that targets for A&E were being met. The “Friends and Family” test relating to performance and care in A&E and ward initiatives, “Patient Ward Observations” supported by “Quality Walkabouts” was explained. He advised in relation to the Patient Experience that six “Real Time Patient Diaries” had been introduced intended to improve the understanding of the patient experience, and that that Safety Express continues to exceed the national target of 95% for harm free care with a return of 97.47; he also reported in relation to NHS Safety Thermometer, Venous Thromboembolism (VTE) Risk Assessment monthly targets were consistently being achieved and a reduction in pressure ulcers.

Members were advised that the reduction in the number of pressure ulcers was largely attributable to the correct number of nurses on wards with a nurse to bed ratio of 2.7, and a permanent nurse to every 8 patients in accord with the National Institute for Health Care and Excellence “NICE” guidelines.

In respect of the dementia strategy he advised the members of a proactive Dementia Working Group led by senior clinicians which ensured that they were compliant with CQUIN requirements. A dementia pathway had been introduced which included of patients with a diagnosis of or suspected dementia. The dementia strategy was supported by a three year training plan and the Trust was a member of the Dementia Alliance. He advised that 90% of patients over the age of 75 admitted as an emergency were screened and assessed for dementia.

Members were advised that the Trusts finances and the national approved financial plan for 2013/14 was £31.4m. The financial performance for the previous year as at November was overall forecast to be £3.4m better than the predicted £28m deficit at the end of the financial year.

Members were informed that a cash support application submitted would be processed before the end of the financial year, and with the Cost Improvement Plans are delivering against the £22.5m target with savings of £29m identified. He explained the medium long term strategic and financial plan to financial sustainability, and that it was anticipated that within 2 to 3 years the Trust would break even financially.

In relation to performance and the A&E 4 Hour Wait Standard members were informed that in December there was an 11% increase in admissions. This was over and above the 7% planned and had an impact on performance. The winter plans had been put into place and the Trust had seen a 12% increase in December/January on previous year's figures.

He advised that the discharge figures had improved with a 10% decrease in readmissions, performance against cancer targets year to date had been achieved and that the figures for mortality reduction were favourable. The mortality reduction plan was outlined: change of key elements of patient care, rigorous performance reviews, quality assessment, mortality review process and the new Consultant Mortality and Morbidity Lead.

He was asked what the financial forecast in particular the intention to become self-sufficient financially through taking on extra work, in particular large joint elective surgery. Also was it intended to redress the deficit over the next 2 years and ultimately would it be necessary to reduce services.

Mark Hackett responded that there was an integrated plan looking forward for the next 5 years. He did not have the figures but there was currently more emergency then elective work being carried out. He recognised that there was a balance to be achieved, elective work was considered to be profitable and emergency contributed to the deficit. He advised of a serious shift towards the delivery of emergency work by other means which were more financially viable without a threat to patient safety.

In relation to the profit and loss, ways of tackling waste and inefficiency were being explored with four Directors and their teams charged with the task. He added that there was an intention to transform outpatient service as 30-45% could have care delivered by other means. He mentioned a positive drive to improve time spent in hospital beds and the intention to give appropriate patients at discharge access to the "Health Care at Home Scheme". He was also of the view that the productivity of medical and clinical staff was an important factor in making the process as whole successful.

The Trust were asked was there a role for the Local Authority in supporting the Trust and Clinical Commissioning Groups (CCGs) to keep people out of hospital. Liz Rix, Chief Nurse responded, that this had been recognised as an area where there was work to be done work and that she had an imminent meeting with the Local Authority.

A member referred to Health Care at Home and asked was it monitored properly. Members were advised that the process was monitored on 3 levels, every patient had a questionnaire, and ultimately adverse comment could affect payment to the commissioned care provider. Secondly, there would be a Patient Panel for Leek and Newcastle with the ability to monitor levels of care. Additionally that the Trust Board would have overarching responsibility to monitor and evaluated performance basis in accordance with national guidelines.

A member raised the use of bank and agency staff and asked if there was reason. Liz Rix responded that it was always the intention to ensure that the correct number of nurses were on ward with the right skill sets. It was fundamental to provide good quality care, this made for happy wards, staff and patients. It was the wish of the permanent

staff that agency staff should not be used unless unavoidable as can cause disruption. In relation to “bank staff” there was also a proactive drive to grow the bank staff reservoir as it was a means to negate the need for agency nurses. The practices had ensured that there were few vacancies the promotion of a culture of aspiration through education and training. This was good for the existing staff and was seen as a means of attracting and retaining the right calibre of people, ultimately this would result in a good patient experience being sort.

In relation to Health Care at Home a member asked if this was a duplication of service or the creation of competition with the hospital. Members were advised that it was important to understand that patients stable but not fit for medical discharge were different than those who were suitable to have care delivered in the community.

A member asked what the overall effect and cost of staffing to the Trust was in particular in the employment of agency doctors. Mark Hackett responded that agency doctors cost approximately £450,000 per month a figure that they were trying to reduce with medical productivity work, recruitment of permanent staff and less reliance on the employment locums. There was an acknowledgement that in some areas it was difficult to recruit consultants but there was a drive to make the Trust a “magnet environment” and they had a proactive policy to recruit staff.

A member on the recruitment of doctors into permanent positions, and newly qualified medical students asked did the problems at the Stafford Hospital have a detrimental effect. Mark Hackett acknowledged that there was an issue of association but with the integration of the Trusts and change of name the issue would be overcome. He added that the feedback from medical students who had attended Stafford Hospital on placements was positive.

In relation to waiting times data a member asked for reassurance that the information contained in the report was accurate and had benchmarking been used.

Members were informed of a dedicated Performance Manager and a constant internal and external auditing of waiting times. There would be specific review next year in respect of waiting times and that benchmarking was against the top 25 performing Trusts nationally in the specific areas.

For patients over 75 for dementia on emergency admissions a member asked was there any other assessment available. Liz Rix responded that the national audit indicated that 25% admissions as a result of age could have impairment due to dementia. It was policy to they assessed everyone over 75 and informed members that other patients were assessed as part of their overall care plan.

In relation to Mid Staffordshire NHS Foundation Trust, Stafford Hospital members were informed that the amalgamation and integration of the hospitals had reached a critical point. The final date for the Secretary of State’s decision was the 26th February and the legal plan prepared that was in place enshrined the principals previously agreed for the integration of the two hospitals.

Members were informed of the benefits that the integration of services would bring to Stafford Hospital: more staff ,outpatient services, pre and post natal care, step down

beds, diagnostics, day case surgery, 14/7 consultant led A&E, medical, frail and elderly and paediatric assessment. There would also be critical care with step up and anaesthetic cover together with midwife led delivery. He explained to members that there would not be any acute surgery, in patient paediatrics, trauma, heart attacks or stroke facilities.

It was anticipated that as a result of the integration there would be 3 to 5 extra patients each day at UHNS for planned procedures, 17 to 20 extra each day for emergency, 4 to 5 increase in A&E attendance, 2 to 3 births, 25 beds would be freed up for better step down for patients to Stafford and a likely reduction of outpatients. He assured members that there were no plans to transfer services from North Staffs residents to Stafford Hospital.

Members were advised that an additional £91m funding had been secured,£31m of which would be used at Stafford Hospital to achieve more capacity, a refurbishment of theatres, refurbishment and reconfiguration wards.

In relation to transition process members were advised that the Business Case and Acquisition Agreement set out the funding for the UHNS, Stafford and City General Sites. In preparation the UHNS had commissioned an external “due diligence plans” to encompass all aspects of financial and clinical due diligence. Members were advised that the Trusts Special Administrator’s plans recognised the need for funding above the tariff beyond the transition period and that this may be an issue.

A member of the public referring to t clinical due diligence asked what input patient’s representative groups and patient’s organisations had in the process. Liz Rix responded saying that an independent review of due diligencewas due will take part.

A member referring to the £91m capital secured asked what part of this figure would be spent at Stafford and in what area.

Mark Hackett advised members that £35m had been put aside for Stafford and it would be spent on refurbishment of surgeries, orthopaedic services, a new MRI, ward accommodation, day case areas, children’s services, a midwifery unit in respect of the issues around surgery it was a decision of the Secretary of State.

RESOLVED:- that the report be noted and accepted by the Committee

Chairman