Minutes of the Healthy Staffordshire Select Committee Meeting held on 7 October 2014

Present: Kath Perry (Chairman)

Attendance	
David Loades (Vice-Chairman)	
Charlotte Atkins	
Bob Fraser	
Sheree Peaple	
Trish Rowlands	
Mike Worthington	
Andrew James	Tamworth Borough Council
Thomas Marshall	Lichfield District Council
Stephen Smith	East Staffordshire Borough Council
Amyas Stafford Northcote	Stafford Borough Council
Chris Baron	Stafford Borough Council
Maureen Bowen	Stafford Borough Council
Ann Edgeller	Stafford Borough Council
Maureen Freeman	Cannock Chase District Council
Mike Hampson	South Staffordshire District Council
Hyra Sutton	Cannock Chase District Council
Ann Bernard	Cannock Chase District Council

Apologies: Philip Jones, Shelagh McKiernan, David Smith, Elaine Baddeley (Staffordshire Moorlands District Council), Val Chapman (South Staffordshire District Council) and Colin Eastwood (Newcastle Borough Council)

PART ONE

37. Declarations of Interest

There were no declarations of interest.

38. Mid Staffordshire NHS Foundation Trust

Maggie Oldham, Chief Executive advised the Committee that her intention with the support of her colleagues was to update the members on past performance and of the agenda going forward. She explained that the report following the recent Care Quality Commission was imminent and early feedback indicated that the services were considered to be safe but fragile, recruitment remained a challenge with 100 nurse and 30 consultant vacancies at the Trust, and that the fragility in services had been reflected in the Trusts Self-Assessment Report. In relation to Inpatient beds had been reduced to a level that could be safely managed by the level of staffing available.

Suzanne Banks, Director of Nursing informed the members that following the Care Quality Commission (CQC) responsive review report, the Trust had set up a Learning from Experience Group (LEG).The group through an integrated governance approach had taken the lead role on behalf of the Quality Committee to identify lessons learned from Serious Incidents(SI), Complaints, Patient Experience and Claims and that the outcome was the provision of a forum to enable the Trust to review serious incident reports on investigations and that the Divisional Performance Review Group would ensure and timely action. Members were informed that the Trust continued to contribute to the Safety Thermometer on the middle Wednesday of each month, an important audit to provide an overview of “harm free care. The principal type of harm was outlined, pressure ulcers, falls, VTE and catheter associated urinary tract infections (UTI). The improvement of “harm free” performance in certain areas in particular the incidence grade 2, 3 hospital acquired ulcers and the apparent inconsistencies in other areas was described. She provided an overview of the work and progress ongoing in relation to falls and reported good level of performance against National Patient Safety indicators.

She acknowledged that Clostridium Difficile (C.Diff) remained a challenge, 5 incidents had been recorded in July with no outbreaks and fortunately they had a different Ribotype making the risk of transmission unlikely. She informed of work in progress with Clinical Commissioning Group to address this issue. In relation to the “Patient Experience” inconsistencies in performance in relation to complaints, the method of Net Promoter Scoring, evaluation of Friends and Family Test and the monthly Patient Surveys was explained to members. In respect of the Hospital Standardised Mortality Ratio (HSMR) Suzanne Banks reported that it was lower than expected and that the Trust continued to perform well when measured against peers.

In respect of operational performance Mark Partington, Director of Transition/Chief Operating Officer reported on a number of improvement achievements that included;

- 18 weeks Referral for Treatment (RTT).
- Cancer access targets
- Diagnostic 6 week waits
- Stroke

In relation to these areas of operational performance he advised members the criteria and targets were being achieved.

He reported that in relation to A&E that the 4 hour access target was a challenge due to fragility of service and staffing shortages. The Trust was 10% below the National Standard of 95%. The focus was on the provision of a safe service and a determined effort to improve access. He informed members of challenges in the area of daily discharges due to the high number of agency nurses and locum doctors. He advised of 11 delayed discharges and of work with the Emergency Care Intensive Care Support Team to address the issue (this is the lowest figure for some time often at 25 plus).

Jeff Crawshaw, Deputy Chief Executive, advised the members that despite the difficulties in recruitment and retention of permanent staff. manadatory training and appraisal rates remained strong and compare well against other NHS Trusts. He acknowledged the difficulty in recruitment and the need to reduce the dependency on agency and bank staff. These staff played a vital role in assisting the Trust to meet peaks in demand. Ultimately that, with the restoration of the Trusts reputation, recruitment would cease to be a problem in the future.

John Doyle, Director of Finance gave members an overview of income and expenditure. The Trust had a planned deficit of £20.5m which would increase with the investment necessary to increase clinical staffing levels. In relation to the Cost Improvement Programme (CIP) he advised that it was £0.2m ahead of plan saving £0.54m.It was expected that the Trust would £2.6m CIP against the annual requirement of £7.49m.Detail of capital expenditure was explained and that the Trusts Capital Plan for 2014/15 had been approved by Monitor and the Department for Health. He advised of expenditure on schemes to improve fire safety, patient environment, new equipment and the investment of £6m for a new Endoscopy Unit to be opened during October 2014.

A member of the public asked if the Trust could clarify safeguarding measures in the contract or contractual obligations on Wolverhampton Hospital to ensure the longevity and future of the Minor Injuries Unit (MIU) at Cannock Hospital.

Jeff Crawshaw responded, he advised that the MIU was a service of the Trust, located at Cannock Hospital. It was probable that the commissioner of services for the Unit was paying rent to the Clinical Commissioning Group. His view was that the Trust would hand over the whole site to Wolverhampton Hospital with the existing tenants in situ. Ultimately it would be the decision of the CCG and Wolverhampton Hospital on the location of the Unit and whether it would remain in its present form or replaced by other services. Dr Diarmuid Mulherin, Deputy Medical Director added that the main risk to the MIU would be from the CCG but in respect of the contractual issues there would presumably be a Lease in existence and that it was a matter to be taken up with the David Loughton Chief Executive of the Royal Wolverhampton NHS Trust.

In response to the question from a member in advance of the meeting the Committee were informed that the question had been answered. The member referred to recent attendance at a Board meeting of the University Hospital of North Staffordshire and made the comment that as the A&E service was in crisis at the Stoke and Stafford sites due to finance and staffing issues asked why the proposed consultant led GP service programmed for April 2015 and why wasn't it a 24/7 service.

Maggie Oldham responded advising that the eleven beds referred to was a vast improvement on previous numbers that had be as high as 30. As the usual ward bed

configuration was 21-28 the figures were significant and that was an area that the Committee should focus when assessing future performance and that the provision of social care was critical to the success of the process. The ongoing work to create a GP model and of plans for GPs in A&E to triage patients was outlined. Members were informed that the greatest challenge was training and the selection to ensure the right mix of skills and ability and that the 40% shortfall of GPs in Stoke-on-Trent did not help recruitment.

A member asked when risk assessments would be carried out at the receiving hospitals in accord with the recommendations. Figures up to 3 September indicated that throughout the region there was a shortage of beds with obvious patient safety implications. A break down for the region up to that date and the implications was outlined. The comment that persons did not wish to work at Stafford for reputational reasons was challenged. It was more likely that people were leaving for the fear of job loss. Finally in the interest patient safety when would the Chairs and Chief Executives listen to the voice of the people?

Maggie Oldham responded that it was not for the MSFT to instruct or organisations to carry out risk assessments In respect of other organisations she was not privy to their assessments and it might be a matter to be referred to the UHNS.

Prof. Hugo Mascie-Taylor, Trust Special Administrator responded that in relation to patient safety that it was primarily the responsibility of the Board of the Trust. That there was already a considerable number of safety measures in place outlined in the TSA Report, additional safeguarding as the CCGs had responsibility to ensure compliance. Additionally the Development Authority and CQC had responsibility to monitor the Trust. He explained that before transfer of services the Trust would undergo inspection by an external Medical Director and Chief Nurse. In relation to capacity he advised that it was not in the gift of the Trust.

Jeff Crawshaw acknowledged that staff turnover was too high but despite this the work force had been remarkably stable given the circumstances. The trust had experienced a continued but small decrease in nursing staff. He advised of a challenge to get people in the NHS to work at Stafford Hospital. He explained that from a local perspective for junior doctors Stafford Hospital was a good place to work. In respect of recruiting reputation was a problem that could be expected to continue until the Trust became part of another organisation and staffing problems was not exclusive to Stafford but was a national problem.

A member referred to Healthwatch Staffordshire and Stoke-on-Trent and the Interim Transition Group/Advisory group commissioned by UHNS. At a recent meeting of the group it had been the decision that there was a dire need for an Impact Assessment and that one would be carried out over the next 2 months. In respect of the statements made that Stafford was not a good place to work they were unhelpful.

A member referred to the issue of complaints and expressed concern that the two principal areas were in communication and attitude, and asked if there was a correlation between agency temporary or permanent staff.

Members were advised that the principal complaints nationally were communication, attitude and the delivery of bad news. These were issues that had been recognised and were being addressed by the LEG across the wards. There was no obvious correlation between permanent, agency and permanent staff but it was important that the worth of the temporary worker should not be overlooked, without them the hospital would have ground to a halt. Temporary staff worked to the highest level but there was a reporting mechanism in place back to the agencies if necessary.

Jeff Crawshaw and outlined the key points, and advised that it was the last presentation of the MSFT leadership before the hand over to UHNS and RWT .He explained of past failings, the improvement of patient safety, the Trust was still financially unsustainable and although safe at the moment it remained fragile due to problems of recruitment and finance. Members were advised that on 1 November Cannock Hospital would transfer to RWT and Stafford Hospital to UHNS. That the TSA had prepared a detailed transition, disaggregation and that as far as possible it would be “business as usual”. The legacy, challenges and the makeup of the new management teams was explained.

A member referred to Maternity Services and asked what they would look going forward at Stafford Hospital as there was still a wish locally for a full obstetrics service. In respect of the CQC as it appeared to that the report was delayed further would be advantageous if the Committee wrote to the CQC, the delay was creating uncertainty and preventing the progress at Stafford hospital. The member referred to the detail of use of locums and agency staff at A&E and asked for information concerning their employment in other specific areas, what measures had been put in place to address the issue and had any effects been noted as a result of the measures.

Hugo Mascie-Taylor endorsed the comment of the member in relation to the delay in publication of the repot of the CQC. He was of the view that it would be out in the public domain next two or three weeks.

Jeff Crawshaw referred to the staffing issues and explained that the shortages were across the acute emergency pathways notably acute medicine and elderly care He also advised of shortages in Radiology, Pathological and Acute Surgery and explained of the difficulties in recruitment. Due largely to a national shortage resulting in fierce competition for a finite resource number, staffing implications of a safe 24/7 service was outlined to members.

In respect of the apparent lack of critical beds following a recent event when a patient had to be taken to an hospital outside of the area. A member asked how many beds were there locally.

Prof. Hugo Mascie-Taylor responded that he did not know the exact number but that the TSA had reported that there were two issues, the absolute need and distribution. He added that the UHNS were creating a number of additional beds and that transport could not be overlooked as delivery from the smaller hospitals to larger organisation made a significant difference to patient survival rates and that going forward would be challenges for t Commissioners of service.

A member asked when the local hospital boards would take responsibility or the lead in the event cross border problems. This because that there appeared to be a lack of

responsibility and it was incumbent on the board to have a mechanism to get answers for the general public.

Prof. Hugo Mascie -Taylor responded that as a public servant he shared the frustration and that the problem was that the health service was designed by politicians. In the past there had not been the will to make the fundamental changes now necessary. The focus had been on a change to the middle tiers of management but ultimately it was about the re-organisation but a change in the provision of healthcare services.

A member asked for clarification in relation to the response to an earlier question concerning delayed discharge and asked if the problem was a lack of Social Workers, Social Services or a lack of agencies able to provide care in the home setting and had the deficiencies led to patients being discharged to care or nursing homes to relieve bed blocking.

Mark Partington, Director of Transition, Chief Operating Officer acknowledged that all of the circumstances outlined were present and that recently the Community Patient Trust had struggled with capacity. He explained that the biggest single reason for delay was the when the person going home had complex needs and they were unable to put the complex plan together.

In relation to Infection Control, a member noted the figures for C.Diff and asked what had been the Trusts performance in respect of MRSA .Members were advised that all trusts had an annual trajectory for C.Diff but that in the case of MRSA there was a zero tolerance. In 2013/14 The Trust had reported two cases that related to the same patient who was particularly unwell As with all cases a root cause analysis was carried out and Public Health NHS England and the Commissioners had been satisfied with the outcome. The period April 2014 to date there had been no cases of MRSA and that it was worthy of note that the two reported cases in 2013 /14 were the first for several years.

A member referred to the issue of complaints and commented in this category that there was no means of measurement and asked how they compared with other trusts locally and nationally. Maggie Oldham advised members that there was no mechanism to capture that information, the complaints process and the definition of a serious indent was explained to the Committee.

Maggie Oldham thanked the Committee for the positive contributions and the constructive challenge. She urged the Committee to remain as a critical friend to Cannock and Stafford Hospitals and that the support given to MSFT would invaluable to RWT and UHNS. She acknowledged that it would be the start of a new era but that challenges still had to be met.

The Chair thanked Maggie Oldham and her team for the open and honest presentations t this and all previous meetings. She asked for the Committees thanks to be conveyed to all staff for their efforts through very trying times. She acknowledged that there was still a long way to go but that the Committee would remain focused to ensure the best Healthcare for the people of Staffordshire.

RESOLVED:- that the Committee note the Final Report of the Trust

Chairman