BIRMINGHAM CITY COUNCIL AND SANDWELL MBC

JOINT HEALTH SCRUTINY COMMITTEE (BIRMINGHAM CITY COUNCIL AND SANDWELL METROPOLITAN BOROUGH COUNCIL) 5 MARCH 2014

MINUTES OF A MEETING OF THE JOINT HEALTH SCRUTINY COMMITTEE (BIRMINGHAM CITY COUNCIL AND SANDWELL METROPOLITAN BOROUGH COUNCIL) HELD ON WEDNESDAY 5 MARCH 2014 AT 1000 HOURS IN COMMITTEE ROOM 3, COUNCIL HOUSE, BIRMINGHAM

PRESENT: - Councillor Susan Barnett (Chairperson); Councillors Sue Anderson, Dr Trevor Crumpton, Ann Jarvis, Narinder Kooner, Karen McCarthy and Paul Sandars.

IN ATTENDANCE:-

Kam Dhami – Director of Governance, Sandwell and West Birmingham Hospitals NHS Trust
Liz Green – Senior Programme Manager for the Stroke Services Review
William Hodgetts – Healthwatch Sandwell
Paul Holden – Committee Manager
Sharon Liggins – Chief Officer for Partnerships, Sandwell and West Birmingham Clinical Commissioning Group
Nighat Hussain – Programme Director for the Stroke Services Review
Rose Kiely – Group Overview and Scrutiny Manager
Colin Ovington – Chief Nurse, Sandwell and West Birmingham Hospitals NHS Trust
Jayne Salter-Scott – Engagement and Commissioning Lead, Sandwell and West Birmingham CCG
Sarah Sprung – Scrutiny Officer, Sandwell Metropolitan Borough Council

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APOLOGIES

1 Apologies were received on behalf of Councillors Joy Edis and David Hosell for their inability to attend the meeting.

DECLARATIONS OF INTERESTS

2 No interests were declared.

MINUTES OF PREVIOUS MEETING

3 The Minutes of the meeting held on 15 November, 2013 were confirmed subject to amendment of the final name in the list of Councillors present to read Paul Sandars and to the substitution of Hateley Heath for references to Hadley Heath.

(This item of business was brought forward on the agenda)

SANDWELL AND WEST BIRMINGHAM CLINICAL COMMISSIONING GROUP OPERATING PLAN

Sharon Liggins, Chief Officer for Partnerships, Sandwell and West Birmingham Clinical Commissioning Group (CCG) presented the following PowerPoint slides to the Joint Committee:-

(See document No. 1)

In the course of the discussion that ensued the following were amongst the issues raised and comments made further to questions:-

a) The Chief Officer for Partnerships was asked to make available a list of Procedures of Limited Clinical Value (POLCV).
b) It was acknowledged that there was an educational issue in respect of members of the public knowing when it was appropriate to attend Accident and Emergency (A&E). Furthermore, there were system issues that needed to be addressed.
c) Members were advised that once members of the public had registered at the front desk they were in the A&E system notwithstanding the Triage system in place to redirect patients.
d) Reference was made to the need to advise and educate people who should not have visited A&E so that they did not unnecessarily use the service in the future. It was reported that there were examples of GP Practices subsequently asking patients why they had visited A&E when their condition had not warranted it.
e) Jayne Salter-Scott, Engagement and Commissioning Lead, Sandwell and West Birmingham CCG reported that there was behavioural insight work taking place into why people visited A&E or Walk-in Centres. The CCG wished to create an alternative offer. Members were also advised that a children's illness guide for parents was being produced.
f) The Chief Officer for Partnerships reported that the CCG would comply with any national programme of shared patient records that was introduced. She highlighted that data sharing was very limited between primary care and secondary care and also limited between the NHS and social care.
g) In response to a question further to f) above, the Chief Officer for Partnerships advised the meeting that as far as she was aware there was no intention to share confidential information with companies or organisations that were for profit.
h) Reference was made to different types of data sets (e.g. for medication; anonymised; personal records) and Members agreed that a report should be submitted to a future meeting of the Joint Committee explaining the different categories and in what ways they interlinked.
i) The Chair indicated that she would welcome information on the programmes for 2014/15 and 2015/16 being reported to Members when available.

4 **RESOLVED**:-

That, further to h) above, a report be submitted to a future meeting of this Joint Committee providing an explanation of the different data sets available and how they interlinked.

The Chair thanked the representatives for reporting to the Joint Committee and Members for their contributions and questions.

UPDATE ON STROKE RECONFIGURATION PROGRAMME

The following report was received:-

(See document No. 2)

Nighat Hussain, Programme Director for the Stroke Services Review and Jayne Salter-Scott, Engagement and Commissioning Lead, Sandwell and West Birmingham Clinical Commissioning Group (CCG) presented the following PowerPoint slides to the Joint Committee:-

(See document No. 3)

During the discussion that ensued the following were amongst the issues raised and comments made further to questions:-

a) It was reported that there were currently facilities at 8 sites (services having moved from City Hospital to Sandwell Hospital last year) and that in October 2014 in accordance with previous decisions taken this would reduce to 6 Hyper-Acute Stroke Units (HASUs) following the transfer of services from Good Hope and Solihull to Heartlands Hospital.
b) A Member stated that he was deeply concerned that consideration was being given to reducing the number of HASUs from 6 to 3 and highlighted that no indication had been given as to where these might be located.
c) Ambulance crews would automatically take patients to the nearest HASU. In response to concerns expressed that someone who had experienced a stroke might be taken by a relative to a hospital without a HASU, the Programme Director concurred that there was a need to ensure that the public were made aware of service changes.
d) The Joint Committee was informed that in London patient care had improved by reducing the number of stroke units from 32 to 8 HASU's.
e) It was indicated that when configuring services how much time elapsed before a patient received a scan, drugs etc were as important factors to consider as travelling time.
f) Analysis was taking place at present on whether it might be appropriate to reduce the number of HASU's from 6 to 3. Emerging options would be shared with the Joint Committee if there was shown to be a case for change.
g) A Member indicated that she was disappointed that the report had not been clearer in describing the current and already approved arrangements.
h) Information would be provided on community and rehabilitation pathways when the service specifications had been developed. The CCGs would be responsible for the implementation of these pathways.

i) Transient Ischemic Attack (TIA) and Hyper-Acute clinical pathways of providers were being reviewed by an independent Clinical Advisory Group.

j) The representative of Healthwatch Sandwell indicated that the transfer of stroke services from City Hospital to Sandwell Hospital had resulted in the most positive feedback ever received following a service reconfiguration in Sandwell and Birmingham. The HASU therefore needed to remain at the location.

k) Members were advised that whether there was a case for change was being investigated and not advocated. A further reconfiguration of services would only be recommended if this would improve the quality of care.

l) The indications were that stroke mortality rates in the Birmingham, Solihull and the Black Country had reduced since 2012. Data was hoped to be available in about four weeks' time.

m) It was enquired how it would be publicised that anyone living near the boundary whose local hospitals were Solihull or Good Hope would need to take a stroke victim to Heartlands Hospital. In addition, it was questioned whether they would be able to reach the HASU quickly enough.

n) The Joint Committee was informed that each CCG had nominated a lead individual to ensure that there were communication and engagement plans in place.

o) West Midlands Ambulance Service and hospital data were being analysed to assess the time it would take before stroke patients began to receive treatment. The objective was not to have any adverse impact on people who lived on the peripheries of the CCG areas.

p) The Programme Manager indicated that she understood that assessment of aids and adaptations needed by patients at home would be undertaken at a very early stage and commented that this was a key component of providing a seamless pathway.

The recommendations set out on the final slide were put to the meeting. In response to a question, Members were advised that any consultation period would run for twelve weeks.

It was:-

5 **RESOLVED**:-

(a) That the programme, scope and approach, including governance arrangements, be noted and endorsed;

(b) that this Joint Committee's primary points of contact (i.e. local commissioners, supported by Sandwell and West Midlands CCG) be noted;

(c) that it be noted that if consultation is required this will be determined in September 2014; proposals would be subject to a twelve week period of formal consultation;

(d) that a further progress report be submitted to this Joint Committee in July / August 2014.

The Chair thanked the representatives for reporting to the Joint Committee.

(The meeting was adjourned at 1130 hours for a short break and reconvened at 1142 hours)

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST – RESPONSE TO THE FRANCIS REPORT HIGH LEVEL SUMMARY / QUALITY ACCOUNT 2013/14

6 Following an initial introduction, Kam Dhami (Director of Governance) and Colin Ovington (Chief Nurse), Sandwell and West Birmingham Hospitals NHS Trust jointly presented the following PowerPoint slides on the Trust's response to the Francis report:-

(See document No. 4)

The following PowerPoint slides that focused on this year's Quality Account were then presented to the Joint Committee:-

(See document No. 5)

In correcting inaccuracies, the Chief Nurse reported that the Trust was currently consulting with internal and external stakeholders on their quality priority areas for 2014/15 and that progress would be reported against its five priorities for 2013/14 not 2012/13.

In the course of the discussion that ensued the following were amongst the issues raised and comments made further to questions:-

a) It was enquired what measures were taken by the Trust to ensure that the needs of elderly patients with dementia and particularly people with learning disabilities were met. Furthermore, reassurance was sought that there would be higher staff to patient ratios on wards where there were vulnerable adults.
b) Members were advised that there were champions for safeguarding and vulnerable adults; moreover, in relation to people with learning disabilities external specialists had been commissioned. A passport / hospital book and "About Me" tool were used - and information on patients chased-up should this be necessary.
c) The Chief Nurse concurred that it was important that "whistleblowing" was open to all employees not only medical staff. He considered that if an employee approached the Care Quality Commission (CQC) this showed a failure of the mechanisms available at the Trust.
d) Members were advised the views of the Trust's Board would be sought on the possibility of widening the scope of those who could use a proposed new external hotline to include patients as well as staff.
e) In relation to monitoring actions taken in response to concerns, it was reported that there were also a number of sub-committees (including one which addressed quality and safety) which reported to the Trust's Board.
f) All responses to complaints would be seen by the Director of Governance / Chief Nurse and signed-off by the Chief Executive of the Trust notwithstanding the key action relating to the introduction of a devolved model to deal with complaints.

g) Members were advised that anonymised information relating to the management and investigation of complaints was published and case studies made available on the Trust's website. In addition, there was also communication with Healthwatch.
h) The Chief Nurse advised the Committee that he was keen to change the information shown on notice boards in hospital so that patients and visitors could more easily assess safety standards and the quality of care being provided. Furthermore, it was proposed to introduce display screens.
i) Members were advised that there was a lot of auditing of clinical practice. However, the Chief Nurse considered that there should perhaps be a little less and more focus on providing good quality care. He also highlighted that a system of ten fundamentals that the Trust had to get right for every patient from day one would soon be introduced.
j) The Friends and Family test showed what percentage of patients would recommend the service to others. It was reported that the Chief Resident was a resident doctor who though not a medical consultant was a senior member of the clinical team.
k) Explanations were given of acronyms used as follows: Key Performance Indicator (KPI); Red, Amber, Green (RAG); Integrated Quality Performance Finance (IQPF); Venus Thromboembolism (VTE); and Job Evaluation Survey Tool (JEST).
l) The Chief Nurse reported that there were increased pressures at Manor Hospital owing to a reduction in services at Cannock Hospital but that as far as he was aware this was not resulting in the displacement of patients who lived in Sandwell to other acute hospitals.
m) Members were advised that if a patient in hospital had respiratory TB in its active phase there should be a notice on display and aprons, masks and gloves issued to staff and visitors. It was also confirmed that if a patient was approaching the end of life there should be open visiting hours.
n) It was reported that benchmarking against other organisations would feature in the Quality Account for 2013/14 and should help Members to assess whether the Trust was providing good quality care.
o) The Chair highlighted that the Birmingham Health Overview and Scrutiny Committee would be considering Quality Accounts from a number of Trusts on 30th April 2014 and then provide feedback.

The Chair thanked the representatives for reporting to the Joint Committee.

DATE OF NEXT MEETING

7 The Chair highlighted that she and Councillor Paul Sandars would set a date for the next meeting after consulting Members.

The meeting ended at 1252 hours.

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CHAIRPERSON