**Minutes of the Health Scrutiny Committee Meeting held on 28 November 2011**

Present: Kath Perry (Chairman)

**Attendance**

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<th>Name</th>
<th>Position/Authority</th>
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<tr>
<td>Dylis Cornes</td>
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<td>Phil Jones</td>
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<td>Brenda Constable</td>
<td>Lichfield District Council</td>
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<td>Geoff Morrison</td>
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<td>Michael Oates</td>
<td>Staffordshire Moorlands District Council</td>
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<td>Elaine Baddeley</td>
<td>Stafford Moorlands District Council</td>
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<td>David Becket</td>
<td>Newcastle-under-Lyme Borough Council</td>
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<td>Ann Bernard</td>
<td>Cannock Chase District Council</td>
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<td>Ken Gant</td>
<td>Tamworth Borough Council</td>
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<td>Janet Johnson</td>
<td>South Staffordshire District Council</td>
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<td>Amyas Stafford</td>
<td>Stafford Borough Council</td>
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<td>David Bassett</td>
<td>Local Involvement Network</td>
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<td>Erica Bayliss</td>
<td>Safeguarding Scrutiny Committee</td>
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<td>John Bernard</td>
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<td>Kathy Lamb</td>
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<td>Chris Baron</td>
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<td>Maureen Bowen</td>
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<td>Isabella Davies</td>
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<td>Ann Edgeller</td>
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<td>Gareth Jones</td>
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<td>Patricia Rowlands</td>
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<td>Julian Thorley</td>
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Also in attendance: Matthew Ellis (Cabinet Member for Adults' Wellbeing) and Robert Marshall (Cabinet Member for Public Health and Community Safety)

Apologies: Terry Finn, Michael Rodgers (East Staffordshire Borough Council), Janet Eagland (Safeguarding Scrutiny Committee) and Jean Tabernor (Stafford Borough Council)

PART ONE

95. Declarations of Interest

The following Member declared an interest in accordance with Standing Order 16.

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<th>Member</th>
<th>Minute No.</th>
<th>Interest</th>
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<tr>
<td>Janet Johnson</td>
<td>98 &amp; 103</td>
<td>Personal</td>
<td>Governor of Mid Staffordshire NHS Foundation Trust (appointed by South Staffordshire District Council)</td>
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96. Minutes of the meeting held on 31 October 2011 and the Accountability Sessions held on 26 October and 10 November 2011

RESOLVED – (a) That the minutes of the meeting held on 31 October 2011 be confirmed and signed by the Chair.

(b) That the minutes of the Accountability Sessions held on 26 October and 10 November 2011 be agreed, subject to confirmation at the next Accountability Session with each Trust concerned.

97. Engaging Communities Staffordshire

Members of the Health and Safeguarding Scrutiny Committees considered the consultation on Engaging Communities Staffordshire (ECS) by the Cabinet Member for Adults' Wellbeing.

Invited to introduce the consultation, Matthew Ellis explained that the concept of ECS had come from the issues raised during the initial Local Involvement Network (LINk) contract and its subsequent relaunch and from the lessons learnt from the events at Mid Staffordshire NHS Foundation Trust. It was clear that health and social care would be better served by:

- making it easier for people to give feedback - including to complain - through a single point of contact;
• improving the approach to responding to and resolving issues - introducing a greater degree of independence and increasing public confidence; and
• improving the way feedback information was used to give a holistic picture of how the care system was working - including early warning of problems.

The concept was for a lean, community led organisation with professional officers which could carry this out and take commissions for engagement activity.

This fitted with, and would enhance, local work in advance of the NHS reforms: the work of the shadow Health and Wellbeing Board and with GPs to improve the care system; and the transition from LINk to Healthwatch, with its additional responsibilities.

The Chair explained that (prior to the meeting) she had contacted each of the NHS trusts for the county to seek their view on this.

The Cabinet Member acknowledged some differences of opinion about complaints handling. He thought that the public sector needed to heed public perception, which he felt was on the side of separating the organisation being complained about from the organisation dealing with the complaint.

The consultation on the principles behind ECS ran from 17 October 2011 – 16 January 2012. The Cabinet Member would appreciate the view of the scrutiny Members on whether this was the right direction of travel.

Matthew Ellis was asked to expand on making services more responsive to service users and carers. He said this was about trying to get rid of real or perceived conflict of interest i.e. resolving the tension between organisation self-interest and wider healthcare responsibilities to provide seamless services. He felt that people using services should not have to work out which organisation to feedback or complain to – the system should do this for them. It was also about collaborating to consult, engage and respond with greater coherence and consistency.

Asked whether feedback from children and adults would be brought together, he said that there were moves towards bringing everything together but, in the short term, reducing the number of routes in and collating feedback would still be an improvement.

Members understood that not all NHS trusts were fully ‘bought in’ yet. Matthew Ellis responded that all were to some degree (and were represented on the ECS Strategic Group). There was support for the principles, most were fully engaged and two or three were partially engaged. The County Council had written to the trusts outlining the project and requesting some pump priming funding (including for a dedicated project manager) – the amount had varied according to the number of trusts that had contributed and because of the move to a Primary Care Trust cluster. The County Council had underwritten the whole amount. At the moment there was duplication in patient engagement activity and there would be efficiency gains to be achieved via the ECS model through collaborating to reduce costs and get better outcomes.

Asked whether full ‘buy in’ was critical to going ahead, Matthew Ellis replied that going ahead depended on the consultation but he would not move at the pace of the slowest
trust. He hoped all would choose to come on board fully, suggesting that they might be compelled to in the medium term if this kind of model was adopted nationally.

If all trusts did not ‘buy in’, a Member wanted to know what the safety net would be to make sure that complaints and feedback were not missed. Matthew Ellis said that trusts would still have to have a complaints/engagement mechanism. However, if Health and Wellbeing Board partners were serious about bringing services together and working as one Staffordshire, it still made sense to collate information to find out how this looked from the point of view of people using services.

Members sought to clarify if trusts would be expected to pass all their Patient and Public Involvement activity over to the community led organisation or whether they would be able to opt in/out of different services. Matthew Ellis agreed that passing everything over was not possible under current legislation and explained that he was aiming for a flexible but better connected way of working. Kate Waterhouse, Head of Customer Insight and Research, added that there had been meetings with partners to identify models of good practice to build on, such as the Patients Association work at Mid Staffordshire NHS Foundation Trust and the work within the Staffordshire Cluster Commissioning Support Group.

The Committees had various questions about the fit of what was being considered with current engagement mechanisms such as GP patient groups and Patient Advice and Liaison Services. In general, the Cabinet Member did not believe in maintaining things if they were not working or there was no confidence in them. Equally, ECS would not be a closed shop and he would welcome any organisation that could bring something to the table – he was not suggesting services would be taken away. The ultimate goal was to bring the system together. His experience was that this would take some time, so he wanted to shape something that could grow without causing problems. Kate Waterhouse confirmed that there had been one-to-one meetings with Clinical Commissioning Groups.

There was discussion about direct complaints, made whilst someone was receiving care, as to whether organisations should be given the chance to put something right before the matter was considered by another organisation. It was agreed that people often did not complain out of fear about the consequences or a general faith in the system. It was Matthew Ellis’s view that making sure services improved as a result of feedback and complaints required a ‘good dose’ of independence. Asked specifically about the link with the role of the Ombudsman, Kate Waterhouse informed the Committees that the ECS Strategic Group would be looking at this at the end of January 2012. Matthew Ellis added that he understood the nervousness around complaints but this was not a ‘show stopper’ – it was a matter of working out a ‘triage system’ for what would be dealt with where. In his opinion a much more human response was required when things went wrong.

Members were concerned about the risk of adding bureaucracy and asked why the functions described were not simply made part of the LINk. Matthew Ellis replied that the functions would need to be hosted somewhere. There would not be another layer of bureaucracy if things were set up as they should be, as the community led organisation would be commissioned to do work that organisations would otherwise have to do themselves.
The Committees turned to the issue of staffing, asking if staff undertaking complaints/engagement roles would move across to ECS. Matthew Ellis answered that someone had to do the work regardless of where it was done and it was not the intention to create a big organisation. The ECS Strategic Group discussions were covering issues like this – the principle was there would be one single place, so that nothing slipped through the net, but how to get there would be developed after the consultation early in 2012. Asked how ECS would gain sufficient expertise to deal with say a complex medical matter, he said again that this had got to be worked through – it wasn’t intended that ECS would develop that sort of capacity, more that it would ensure that: expert work was carried out where required; the individual had a response; and the information was used accordingly.

Members were interested in whether other options had been considered prior to consultation. Kate Waterhouse confirmed that different models had been looked at, such as an arms length organisation, but a community interest company was preferred to embed community ownership. Matthew Ellis added that the consultation would inform the arrangements but ECS seemed to match to the emerging views.

Asked to describe what the governance arrangements would be (particularly for data protection/information sharing), Matthew Ellis stressed his role as commissioner and the independence of the body. Kate Waterhouse said that this would be about how the board would be constituted, responsible and accountable (for engagement and analysis of information). The possible options and models would continue to be explored; taking on board the way the Health and Wellbeing Board was developing. Members were interested in how ECS would be community led and bring the third sector in. Matthew Ellis stated that a good starting point was the learning from the significant level of engagement and the present LINk structure.

The Chair asked to see the ECS project plan and queried what would happen on day one if it went ahead. Kate Waterhouse replied that a community interest company board would be established and there would be contracts that could be let through ECS. It would support the Health and Wellbeing Board and grow during the first year.

A Member asked about how information would be captured on complaints and concerns if patients went outside Staffordshire for care and treatment. Matthew Ellis agreed that it was trickier in this situation. This was partly about the advocacy role so that wherever people were treated, they got responses and answers (and that Staffordshire organisations did the same for people from elsewhere).

Lastly, the Committees wanted to know how people would be told about ECS if it went ahead. Matthew Ellis was of the view that advertising and promotion did not have to cost a lot. His experience of reducing the County Council contact telephone numbers was that a clever marketing campaign had meant that, after five months, 76% of calls went through the new number. It was also important that people had a good response following their first contact, being thanked for their feedback or kept informed of the progress of their complaint.

(The LINk member added that the LINk had responded to the need to reach out across the county with the appointment of community development workers. They were
obtaining Public Relations advice about promoting what they did, though this was much better now. From the engagement activity they supported, he agreed that organisations sometimes appeared disconnected from public perception.)

The Chair asked the Cabinet Member if he thought scrutiny might commission engagement activity from ECS, which he agreed might well happen.

**RESOLVED** – That the Scrutiny and Support Manager be asked to prepare a draft response to the consultation on Engaging Communities Staffordshire on the basis of the comments made at this meeting – to be circulated to the Members of the Health and Safeguarding Scrutiny Committees for comments, finalised with the Chairs and submitted by the deadline of 16 January 2012.

**98. Improving Trauma Care within the West Midlands**

Rachel O’Connor, West Midlands Specialised Commissioning Team, informed the Committee that, following the completion of the business case and option appraisal, at its board meeting on 31 October 2011 the West Midlands Strategic Commissioning Group had approved the recommendation for a new regional trauma care system to be introduced from March 2012. Three trauma care networks were to be set up in the West Midlands, each with an adult major trauma centre (MTC) at its heart and Birmingham Children’s Hospital would be the regional major trauma centre for children. This would mean University Hospital of North Staffordshire NHS Trust (UHNS) would become a MTC.

As the Committee had advised, a period of engagement was taking place from 1 November to 29 December 2011, to hear from interested people (and groups of people at particularly high risk of major trauma) about the services and local implications. For this reason, Rachel O’Connor was accompanied at this meeting by Peter Oakley, Consultant, and Mark Mould, Operations Director and Deputy Chief Operating Officer, from UHNS.

Rachel O’Connor said that planning for implementation had begun and would continue until January 2012. There were some 30 project plans for the programme board to co-ordinate and there was a well-maintained risk register. There would be a Trauma Care System Implementation Planning Day on 19 December 2011 to which Members were invited.

In January there would be a review of engagement by the Strategic Health Authority.

From January 2012 the infrastructure and governance arrangements would be assured ready for go-live on 26 March 2011. The lead in time was needed because of the complexity of the service specification. Professor Willett, National Clinical Director of Trauma at the Department of Health, would oversee the validation process.

The go-live date had been chosen to fit in with the move of Accident and Emergency (A&E) at UHNS to the new building.

Burton Hospitals NHS Foundation Trust and Mid Staffordshire NHS Foundation Trust would remain Local Emergency Hospitals, receiving less severe trauma cases and
acting as a step down for patients. No substantial changes to patient flow or pathways were anticipated. Discussions were taking place about the provision of rehabilitation at Haywood hospital – the Stoke-on-Trent and Staffordshire Partnership NHS Trust would be a key partner in regard to the rehabilitation part of the service specification. UHNS would receive children - with only the most severe cases, such as where reconstructive surgery was needed, going to Birmingham. So, the majority of patients would be maintained in the Local Health Economy.

There would be protocols and guidelines for each stage of the patient pathway. The Ambulance Service was operating a new triage system and arrangements for secondary transfer had also been agreed. A trauma care consultant would lead the team that received the patient. Resuscitation, critical care and an operating theatre would be available on their arrival. A CT scan would take place within 30 minutes where the patient was stable and this was necessary. Rehabilitation would begin from day one. Trauma Units would be ready to take patients within 48 hours if they were fit for transfer and rehabilitation beds would be available. For each stage, Key Performance Indicators would be recorded, reported and monitored, including longer term outcomes.

Engagement would continue throughout the change, including a regular newsletter, and there was also a future opportunity for Member to work with commissioners on prevention.

The Committee welcomed the designation of UHNS as a MTC.

The Chair asked what this meant for trauma clinicians. Peter Oakley replied that a partial service was already in place and they were grateful for the opportunity to offer a complete, integrated service from the field through to rehabilitation.

The Chair was disappointed that neither Queen’s nor Stafford hospital would be a Trauma Unit. Having asked about this at the recent Accountability Session for Burton Hospitals NHS Trust, she understood that the relevant patients were likely to go to Derby anyway. Peter Oakley explained that the vast majority of the county was within 45 minutes travelling distance of UHNS or Nottingham so would go straight to the MTC there. It was possible that some patients from the edge of East Staffordshire who needed stabilising might need to stop off at a Trauma Unit and therefore go to Derby. The patient pathways in East Midlands were more complex but, Mark Mould added, the new SHA cluster arrangements were an advantage in that they would support work to strengthen this patient pathway. Peter Oakley clarified that Local Emergency Hospitals would still get trauma patients just not major trauma.

A Member expressed concern about the additional pressure on sustained improvement in A&E and Interventional Radiology (IR) at UHNS. Mark Mould reiterated that planning for becoming a MTC took into account Fit for the Future and the move of A&E in March 2012. The Trust had a track record of managing moves and had recently moved 8 wards and 15 theatres. Facilities were only one part of the equation but the new A&E would have 4-8 resuscitation bays and 10 additional cubicles as well as a separate paediatrics facility. These and the co-location with critical care would make the Trust well placed to deliver the specification. This would also require an increase in staff (including medics, nurses and other professionals) to receive and track patients and start rehabilitation. This investment would go in before the end of March 2012. The
plans for the MTC, vascular surgery and IR would be aligned. (It was clarified that there were three Interventional Radiologists.) There was heightened awareness of the need for staff pull to together to meet the specification requirements. As a MTC, the Trust would serve part of the Cheshire population too and a comprehensive rota for IR, including staff from Leighton hospital, would be in place ready to go live. In response to a further question, it was explained that it took 6/7 people to provide an out of hours service (offering for example IR techniques to control bleeding such as for a pelvic fracture (within the hour)). Employing all these people in one place could not be justified for the one in 6/7 cases for which they were required. Such a rota system was used successfully in other parts of the country. It was noted that some Tamworth major trauma patients requiring IR might go to Birmingham or Coventry MTC. There were no plans to change arrangements for tertiary care.

Asked whether the Trust could foresee any problems recruiting staff, Mark Mould replied that there were always some gaps and it would be challenging as the timing was quite tight and there would be an active recruitment drive for the three MTCs across the region. The Trust had been relatively successful so far, recruiting to one additional post about four weeks ago, so remained confident.

RESOLVED – (a) That the commissioners be asked to continue to keep the Committee informed of progress.

(b) That the Committee respond to the invitation to the Trauma Care System Implementation Planning Day on 19 December 2011.

(c) That the Committee would welcome the opportunity to work with commissioners on the prevention of major trauma.

Councillors Becket and Cornes reiterated that, in following up on the subject of A&E at University Hospital of North Staffordshire NHS Trust, they would welcome a joint meeting of this Committee and the Newcastle Borough and Staffordshire Moorlands District Council committees dealing with health scrutiny in mid January 2012, when there would be the opportunity to view the facilities during the changeover.

99. Report of the Scrutiny and Support Manager

The Committee considered the report of the Scrutiny and Support Manager which covered:

- work programme 2011/12;
- meetings and events;
- consultation and legislation;
- other matters; and
- follow up of actions from previous meetings.

The Committee were reminded that they would need to keep their agreed work programme under review with regard to capacity and priorities. It was disappointing that only three Members of this Committee had attended the recent Accountability Session for Burton Hospitals NHS Foundation Trust.
The Chair and Councillor Patricia Rowlands, Chair of Stafford Borough Health Scrutiny Committee, commented on their attendance at the Care Quality Commission (CQC)/Centre for Public Scrutiny workshop on 8 November 2011. This was focused on the publication of guides for scrutiny committees and local councillors on how to work with the CQC.

Councillor Stafford Northcote had attended the meeting of the Staffordshire Tobacco Control Alliance on 16 November 2011 and provided a note.

Information requested by Members at the Accountability Session for North Staffordshire Combined Healthcare NHS Trust had been received and circulated to Members.

The answers to Councillor Beckett’s questions on Interventional Radiology from the Session for University Hospital of North Staffordshire NHS Trust and the answers to East Staffordshire Borough Council Health Scrutiny Members’ questions from the Session for Burton Hospitals NHS Foundation Trust had been received.

**RESOLVED** – (a) That arrangements be made for a briefing from the Care Quality Commission local co-ordinator with the opportunity to discuss future contact.

(b) That Councillor Stafford Northcote’s note of the meeting of the Staffordshire Tobacco Control Alliance on 16 November 2011 be circulated to Committee Members.

(c) That the answers to Councillor Beckett’s questions on Interventional Radiology from the Accountability Session for University Hospital of North Staffordshire NHS Trust and the answers to East Staffordshire Borough Council Health Scrutiny Members’ questions from the Accountability Session for Burton Hospitals NHS Foundation Trust be circulated to the relevant health scrutiny Members.

100. **District/Borough Council Health Scrutiny Updates**

The Committee considered a report on health scrutiny activity in the county’s Districts and Boroughs since the last meeting of the Committee.

Councillor Stafford Northcote reported on the meeting of Stafford Borough Council’s Health Scrutiny Committee held on 17 November 2011. The agenda included:

- an update on the matters considered by the Staffordshire Health Scrutiny Committee at the meetings held on 1 August, 5 September, 3 October and 31 October 2011, during which it was agreed to receive further information about Child Protection, Winter Mortality and Smoking Prevalence in the Borough;
- an update on Diabetes Testing for people aged under 55 years in the Borough;
- an update on associated performance indicators that fell within the remit of the Committee for the period ended 31 September 2011, during which it was agreed to receive further information about Local Business Health and Safety Standards; and
- the Work Programme for the Scrutiny Committee for the forthcoming Municipal Year, where it was agreed to add items relating to Licensing Enforcement and Psychological Services.
Councillor Gant reported on the meeting of Tamworth Borough Council’s Community and Wellbeing Scrutiny Committee held on 24 November 2011. The agenda included: Safeguarding; and Teenage Pregnancy. Councillor Gant offered to share the information received. The agenda for their meeting on 1 December 2011 included the future of the Robert Peel hospital.

Councillor Becket added that some recommendations about GP services/information had arisen from the meeting of Newcastle-under-Lyme Borough Council’s Health Scrutiny Committee meeting on 7 November 2011. He expected that when the new Health and Wellbeing Centre opened there would be provision for Phase IV Cardiac Rehabilitation but Phase III was still subject to negotiation.

Councillor Constable advised that the agenda for the meeting of Lichfield District Council’s Community, Housing and Health (Overview and Scrutiny) Panel on 24 November 2011 had included exempt items only.

No report was available from the meeting of East Staffordshire Borough Council’s Healthier Communities and Older People Scrutiny Sub-Committee held on 23 November 2011.

RESOLVED – That the report be received.

101. Health Trust Updates

There were none on this occasion.

102. Local Involvement Network (LINk) Update

David Bassett reported that the Enter and View programme was gathering pace. Councillor Brenda Constable was involved. A performance management framework was being developing in conjunction with county colleagues. The LINk was facilitating public meetings for the consultation on mental health beds in the south of the county.

RESOLVED – That the report be received.

103. Accident and Emergency Services

Following the decision to temporarily close A&E at Stafford hospital between the hours of 10.00 pm and 8.00 am for a three month period from 1 December 2011, the Committee, joined by additional Health Scrutiny Members from Stafford Borough and South Staffordshire District Councils, questioned representatives of the PCT cluster and other NHS trusts affected about how they were working to make sure that safe, responsive and high quality emergency services were in place. Apologies were noted from Julia Bridgewater and Helen Ashley, Chief Executives of UHNS and Burton Hospitals NHS Foundation Trust respectively. Both had been questioned on this matter at recent Accountability Sessions for their Trusts and Julia Bridgewater had supplied a copy of a Trust Board report about this, which was circulated.

First, the Chair asked Graham Urwin, Chief Executive, Staffordshire Cluster of Primary Care Trusts (PCTs), to comment from the point of view of the PCT’s responsibility for
business continuity. Graham Urwin told Members that the PCT was responsible for commissioning services for the population of Staffordshire and that most of the money the acute hospitals received was via the PCT. The money followed the patient and the PCT would settle the bill wherever Staffordshire patients chose to go, in this case, were taken by ambulance. The PCT also held the contract with the Ambulance Service. When the decision about A&E at Stafford hospital was made, on the grounds of patient safety, the PCT had to renegotiate to make secure alternative arrangements and make sure services would be in place. Approximately 15 patients per night were taken to Stafford hospital by ambulance. There was little seasonal variation. The latest planning assumptions were that, during the overnight closure, eight patients would be taken to UHNS, three each to Wolverhampton and Walsall hospitals and one to Burton hospital. To make sure this happened safely there would be three more ambulance crews Monday - Thursday and four Friday - Sunday (for the peak period of a fortnight around the new year there would be up to ten additional crews). Leaflets would be going out to patients’ homes and GP surgeries. There would be extended opening at the Minor Injuries Unit in Cannock and the GP Out of Hours service. This was not about cost as the temporary arrangements would cost the NHS more. In regard to safety, stroke, heart attack and major trauma patients already went elsewhere with more specialist provision delivering better outcomes.

The Chair invited comment from Peter Murtagh, Commissioning Director, and Matt Ward, Head of Clinical Practice, West Midlands Ambulance Service NHS Trust. Peter Murtagh confirmed that when they were notified about the decision, they had looked at their data and concurred with the planning assumptions. The extended travelling times would still be less than some of the existing travelling times in other parts of their patch. They had since worked out a set of divert criteria with which to brief crews so that they, working with the Emergency Operations Centres (EOCs), knew where to take patients. Matt Ward confirmed this had included work with the acute hospitals to make sure the clinical pathways were clear. 999 calls would be taken to the nearest receiving A&E or specialist centre, a small number of paediatric patients would go direct to the paediatric unit. There would be no change to where maternity patients were taken. In response to a question, Matt Ward said later that a small number of well known patients with special requirements would be taken direct to where they were usually seen to provide the best possible individual care.

A Member later referred to how busy A&E at UHNS was and asked if the Ambulance Service checked this before deciding where a particular patient should be taken. Peter Murtagh stated that there was minute by minute monitoring of this (including on a regional basis) and liaison between the EOC and crews to make the best decision for every patient. However, UHNS was quite self sufficient in its environment and he did not expect there to be diverts to Cheshire unless that was the patient’s normal hospital. Neither did he expect there to be any change to patient flow to Good Hope hospital.

David Loughton, Chief Executive, Royal Wolverhampton Hospitals NHS Trust, supported the difficult decision that Mid Staffordshire NHS Foundation Trust had to take on patient safety grounds. The arrangements for stroke patients were working well; his Trust had not received any complaints from stroke patients nor had there been any issues about ambulance transport there and there had been improved mortality rates. All district general hospitals had to look at the type of work they did. Richard Kirby, Chief Executive, Walsall Healthcare NHS Trust, echoed this and agreed that there was
a precedent for bypass arrangements working effectively, though his Trust did not have
direct experience of this. He considered his Trust was prepared to accommodate the
extra patients within current A&E/bed capacity.

A Member sought assurance that the additional pressure would not lead to excessive
trolley waits and bed blocking. Graham Urwin said that at UHNS, through the
modernisation programme, 180 beds had closed in the last 18 months and they had
capacity to bring a ward back into play. From the extra eight A&E patients, they were
likely to have to admit four/five with an average length of stay of less than five days so
the maximum number of beds they would need would be 20. There had also been a
piece of work between hospitals to support sensible decision making about repatriating
patients - closer to home for visitors and so that there weren’t empty beds at Mid
Staffordshire NHS Foundation Trust that could be used for the benefit of the Local
Health Economy. David Loughton had similarly closed 200 beds so had capacity to
open up the three/four required as long as he could get the staff. Richard Kirby had
already opened a ward and a half as part of normal planning so had capacity of half a
ward still available.

Another Member was concerned about the impact on waits for ambulances and turn
around times at hospitals. Peter Murtagh said that putting on the extra crews would
compensate for the extra travelling times. Coverage and handover at hospitals was
already carefully managed and not expected to be a bigger problem. In response to a
later question, it was confirmed that there was no issue with the availability of vehicles
as the decision happened to coincide with some new vehicles coming in. The staffing
would be covered by existing staff, overtime and bank staff to whom a short term
commitment would be offered.

A Member asked why the resources being put into alternative arrangements couldn’t
have been used to keep A&E open at Stafford hospital. Lyn Hill-Tout, Chief Executive,
Mid Staffordshire NHS Foundation Trust, confirmed that it was not about the money but
the ability of the Trust to attract staff because of the size of A&E, small rota and previous
reputation. David Loughton had three current consultant vacancies and could see a
similar difficulty for his Trust in future, particularly as larger centres were recruiting, had
larger rotas and A&E was a less popular speciality. Even with extra investment in
promoting this specialty now, it would take some years for the consultants to come
through. The Member believed that there were people willing to work in A&E if there
were sufficient training places. David Loughton, who was a member of the Strategic
Advice Panel for the Department of Health, said that there was more pressure in other
directions. Lyn Hill-Tout said that Trust had managed to recruit one associate specialist
whom they would support to become a consultant but they needed a mix of staff that
included some experienced people. In response to a question, she said that a premium
had been offered the last time a consultant was appointed and this could be considered
again. Later, she confirmed that the Trust did call to find out why people pulled out after
being offered a job – sometimes they were personal reasons but it was more about the
rotas and critical mass of patients than the money. David Loughton added that people
pulling out was not uncommon.

Asked what was happening to staff during the closure, Lyn Hill-Tout explained that
although the A&E would be shut overnight, there would be staff on duty until 1.00 am
providing some flexibility for treating patients who came in before 10.00 pm. There was
some staff redeployment but, most importantly, training was taking place in order to
meet the criteria for re-opening.

If the money followed the patient, Members were concerned that Mid Staffordshire NHS
Foundation Trust would lose money. Graham Urwin told them that hospitals were paid
under the national tariff. Services provided using bank or locum staff cost more than
services provided using substantive staff. So the Trust would be getting slightly less
money but also incurring fewer costs.

Members were concerned about the impact on the patient, particularly those who self-
presented, and the four hour A&E waiting target. Graham Urwin informed them that for
no month of the year had Mid Staffordshire NHS Foundation Trust achieved the target -
for a variety of reasons including the staff not being as broadly trained as they might be.
For the hours when the A&E was open, the commissioners were expecting a significant
improvement in performance. For those patients who attended out of hours, some
would be inconvenienced by the alternative arrangements but better than than
compromise their safety and the outcome of their care and treatment. Some people
attended who had neither an accident nor an emergency but because it was more
convenient. Members highlighted examples of difficulties with GP access and were told
that commissioners continued to work with GPs to promote appropriate access.

A Member asked if the implication was that when A&E at Stafford hospital re-opened the
quality of service would be worse then the alternative arrangements. Graham Urwin
responded that clear standards had been set and, if they were met, the service would be
safe and appropriate. There was a wider issue about what kind of work should be done
at Mid Staffordshire NHS Foundation Trust. It had to be accepted that, for certain
services, people would have to travel for more specialist care and better outcomes.
David Loughton emphasised that the Trust was not alone in looking at what it should do
in the future. Lyn Hill-Tout added that this was what the Clinical Services Review was
about.

The Chair moved discussion onto what live monitoring there would be during the
closure. Lyn Hill-Tout stated that a lot of time and resources had gone into covering
every avenue and there would be a review after the first few days. Extra people would
be on hand to redirect patients. The access road would be closed and CCTV in place.
Graham Urwin later explained that there were weekly Chief Executive meetings to look
at all the steps being taken to effect the change as well as the usual clinical quality
review meetings and arrangements with the local PCT to track Royal Wolverhampton
Hospitals NHS Trust’s performance.

Several Members asked for more detail about the repatriation arrangements and how
patients would be supported to return home. At Mid Staffordshire NHS Trust, Maggie
Oldham was leading a team of nurses looking the clinical criteria for this. Graham Urwin
pointed out that delayed discharges were at an all time low, which was testament to the
improved relationship between health and social care. Ian James, Commissioner for
Care and Independence, Staffordshire County Council, agreed with this. David
Loughton added that the issue of repatriation was complicated by patients who were
satisfied with their treatment in a particular hospital, and were only going to be there a
short time, choosing to stay there until they could go home. Richard Kirby agreed that
the challenge was to get it right for each individual patient. Graham Urwin agreed,
adding that the NHS had to manage handovers of patients and their information and the associated risks all the time.

A Member commented that co-ordinating this was a mammoth task and asked if a mutual aid arrangement couldn’t have been considered instead. Graham Urwin said that this had been tried in the past but not reported as a good experience. It had been put to Chief Executives again but considered to be more risky than alternative arrangements. The military aid was valued but really every other possible option to avoid overnight closure had been exhausted.

Members were concerned about the morale of the staff at Mid Staffordshire NHS Foundation Trust with all the adverse publicity and did not want the Trust to lose good, experienced staff. Lyn Hill-Tout was grateful for this support, referring to the meeting of a local group established to support the hospital that she had attended on the previous Friday, where she had said that the past was a place of reference not residence.

Asked for more detail about the financial implications, Graham Urwin explained that the PCT Cluster had agreed to pay the neighbouring hospital for the work that they would do at higher rate than if it was just one additional patient. The additional investment for UHNS to be a MTC would be spread across the West Midlands. Mid Staffordshire NHS Foundation Trust was running at a deficit and every pound it lost made it worse. The priority now was clinical improvement but there was a wider debate about what services were provided and the long-term financial stability of the Trust.

In response to a question, Lyn Hill-Tout gave her personal opinion that re-branding the Trust was not appropriate and could be thought superficial. She felt it much more important to focus on the quality of service at this stage.

The Chair moved discussion on to A&E at Stafford hospital re-opening. Lyn Hill-Tout and colleagues were now turning their attention towards this. The criteria had been set at what was thought to be the right level, not too high to be unachievable but not too low. The criteria most at risk were the recruitment of consultants and middle grade doctors. Regular updates on progress toward meeting the criteria were being provided to the Board, health scrutiny Members and Members of Parliament.

In regard to a long term solution, a Member was interested in what had been tried to raise the critical mass of patients in order to attract consultants. Lyn Hill-Tout confirmed that discussion with other trusts had begun about developing formal clinical networks.

Given the obvious level of concern, the Chair asked what would happen if the criteria were not met and A&E could not re-open overnight. Graham Urwin responded that this was a difficult question. At the moment there was no Plan B because, as people expected, all effort was directed towards re-opening. However, if at a future point it became clear that the standards would not be met, work would have to begin on a Plan B. David Loughton said that the targets were not being met at his A&E either. Lyn Hill-Tout clarified that the criteria for Stafford hospital would be different, bearing in mind the background, the CQC visit and the ‘immaturity’ of the team in place compared to other hospitals.
A Member expressed the hope that, as things started improving, commissioners would get behind the Mid Staffordshire NHS Foundation Trust. Graham Urwin referred to the NHS reforms and the move to Clinical Commissioning Groups. GPs generated most visits to hospital for which the PCT held the budget and were best placed to advocate for patients. He thought it right that they were involved in decisions.

There was further discussion of preventing unnecessary attendances at A&E. Graham Urwin confirmed that GPs had been briefed about their role in this. Peter Murtagh referred to the Ambulance Service’s new triage system which would help direct patients to the right service. In response to a question, he confirmed that Hospital Ambulance Liaison Officers were still in place.

The Chair thanked all the Trust representatives for attending and answering Members’ questions.

Lyn Hill-Tout spoke of her gratitude for the support that she had received from colleagues.

Asked what Members could do to help, Graham Urwin responded that they could be intelligent, critical friends. The hospital system had been designed to deal with episodic illness. The NHS needed today was different. Over the next two years, commissioners and providers would come to scrutiny with proposals for improving services. This would mean that not all services would be in the same place; Members would need to focus on patient need and not on ‘bricks and mortar’. Lyn Hill-Tout wanted Members to continue to hold the Trust to account; ask questions about anything they wanted to know about; deal in facts not myth; and encourage people to feed back about what services were like now, rather than in the past.

The Chair told Members that the next Accountability Session for Mid Staffordshire NHS Foundation Trust would be on 16 January 2011.

**RESOLVED** – (a) That the commissioner and provider trusts be asked to keep Members informed of what was happening during the overnight closure of A&E at Stafford hospital and of progress towards re-opening.

(b) That Members receive a copy of the public information leaflet.

Chairman

Documents referred to in these minutes as Schedules are not appended, but will be attached to the signed copy of the Minutes of the meeting. Copies, or specific information contained in them, may be available on request.