HEREFORDSHIRE COUNCIL

MINUTES of the meeting of Overview and Scrutiny Committee held at Council Chamber - Brockington on Wednesday 18 January 2012 at 2.00 pm

Present: **Councillor A Seldon (Chairman)**
Councillor JW Millar (Vice Chairman)

Councillors: AM Atkinson, WLS Bowen, EPJ Harvey, AJ Hempton-Smith, MAF Hubbard, RC Hunt, TM James, Brig P Jones CBE, SJ Robertson and PJ Watts

In attendance: **Officers: M Woodford (Chief Executive, Wye Valley NHS Trust); T Tomlinson (Director of Service Delivery, Wye Valley NHS Trust); S Collings (Associate Director of Information, Herefordshire PCT); and DJ Penrose (Democratic Services).**

55. APOLOGIES FOR ABSENCE

Apologies were received from Councillor PGH Cutter, JLV Kenyon, Miss E Lowenstein Councillor R Preece and Mr P Sell.

56. NAMED SUBSTITUTES (IF ANY)

Councillor AJ Hempton-Smith for Councillor JLV Kenyon.

57. DECLARATIONS OF INTEREST

There were none.

58. SUGGESTIONS FROM MEMBERS OF THE PUBLIC ON ISSUES FOR FUTURE SCRUTINY

There were none.

59. QUESTIONS FROM THE PUBLIC

There were none.

60. WYE VALLEY NHS TRUST (Pages 1 - 26)

The Chairman welcomed the Chief Executive, Wye Valley NHS Trust (WVT) and the Director of Service Delivery, Wye Valley NHS Trust (WVT) to the meeting.

The Chief Executive provided the Committee with a presentation on the Trust (appended to the Minutes as Appendix 1). In the ensuing discussion, the following points were made:

The Director of Service Delivery reported that the key to the model was to ensure that care was provided for patients closer to the home and to reduce the numbers of patients admitted to the acute hospital. In reply to questions he went on to say that:

- There was a target to discharge the elderly sooner from hospital in order to allow them to recuperate in their own homes. This would allow patients to have greater independence.

- the Wye Valley Trust didn't have control over the provision of wardens in sheltered housing, and did not manage Ledbury Community Hospital. There was a focus on changing this into a resource centre for the community, with the intention of reducing the number of admissions to the acute hospital. These facilities were factored into any considerations of bed numbers in the County.

- Adult Social Care had been seconded under the purview of the hospital, but that the delivery mechanism remained the same. There was a great deal of management of the process, which was co-ordinated by the Health and Wellbeing Board, the Clinical Commissioning Group and Adult Social Care.

- whilst no-one was turned away from A&E, there was a need to educate the population as to how the service should be used most correctly. Non-attendance rates at clinics had been reduced from 10% to 5% by sending reminder letters, but further savings could be made in this area.

The Director of Service Delivery reported that there were issues associated with patients leaving hospital, and the discharge planning process was now designed to ensure that prescription were written the day before the planned patient discharge.

The Chief Executive went on to say that a great deal of work had been undertaken with the practitioner led Service Units as it was important to instil the right ethos into the organisation. In a similar fashion, the staff had been consulted widely on the values of the Trust, and the behaviour that underpinned these values. The Service offering had been designed to ensure that the Trust was a population based service provider and was not concentrating solely on acute care. Neighbourhood Teams were working with GPs to devolve care to the patient's home wherever possible.

In reply to a question, he said that there were alternative models that the Trust had learnt from, a particular example being Torbay, who were prominent in providing zoning teams for their area, which had seen a reduction in A&E admission rates.

He added that it was clear that greater development of community services was important, and an increase in the resourcing of Neighbourhood Teams was being considered. The Community Hospitals would not be closing, but changing their roles to that of a resource centre. This would providew an opportunity to promote home based care and extend healthcare with concommitent savings. If the changes were focussed and clinically sustainable then the bed base number would reduce as a result.

In reply to a comment that in an apparent desire to free beds within the Hospital elderly patients were being discharged late at night, the Chief Executive said that such practice did not accord with the Trust's own policy and best practice, and should not occur.

The Chief Executive went on to say that additional short stay surgery could now be undertaken in line with requests from Commissioners, and private healthcare facilities were being looked at to complement the work of the Trust.

The Committee noted the key performance indicators that were highlighted by the Chief Executive. He reported that the summary hospital-level mortality indicator (SHMI) for the hospital was at 108, when the national average was 100 and that there had been no

MRSA infections for over a year. There had been a CDiff outbreak in the spring last year, and the action plan that had resulted had been delivered against.

Material improvements had been made in stroke services, and they were well above the benchmark in this area. The Chief Executive concurred with a comment from the vice-chairman that this was a challenging area for a rural county.

In reply to a question regarding access targets, the director of service delivery said that there were a number of reasons why these figures had fallen slightly. Clinical urgency meant that a high volume of cases were being seen quickly and he wouldn't have expected to see a lower figure. In reply to a further question, he said that the action plan that was in place would deliver by the 31 march 2012. All available capacity had now been identified, and there was sufficient capacity within the system to accommodate patients. Risks that mitigated against a successful outcome for the plan included a bout of severe winter weather or an outbreak of influenza.

61. CLINICAL COMMISSIONING GROUP

The Committee received a presentation from the Associate Director of Information, Herefordshire PCT

the Associate Director of Information, Herefordshire PCT added that the examples of patient safety and treatment that had been mentioned in the meeting highlighted the need for a clear structure in community and all integrated care organisations.

He went on to say that the walk in centre that had been constructed in an area of deprivation in Hereford had provided a service to the wider community and had provided for a subsequent reduction in A&E admissions. GPs were also engaging with the issue of A&E attendance, and were taking care to review patients who attended A&E regularly.

The financial position of the Wye Valley Trust should be taken within the context of the wider health care economy in Herefordshire. Collaborative working had been very successful in cutting costs, and one-off efficiencies would be brought forward. It should be noted, however, that the County had the lowest per capita spend on health care in the West Midlands. He undertook to provide the Committee with a briefing note on per capita spend on health care in the County.

He went on to say that Herefordshire Health Care Commissioners (HHCC) was established in shadow form as the Clinical Commissioning Group for Herefordshire in April 2011. HHCC was then established as a sub-committee of the NHS Herefordshire (PCT) Board with delegated responsibility for the main elements of health care commissioning in Herefordshire. The HHCC group was led by clinicians and supported by corporate PCT Staff.

From July 2012 HHCC could begin the Department of Health CCG authorisation process which would enable HHCC to be established as a statutory organisation, subject to the enactment of the new Health and Social Care Bill, by April 2013.

He went on to say that in 2011/12 NHS Herefordshire developed a Quality, Innovation, Productivity and Prevention (QIPP) plan that focused on transforming the way health care was delivered in Herefordshire whilst providing £10.8m in savings for reinvestment in frontline services. By December 2011 £7.8m of savings had been delivered which was a 99.5% achievement against plan. In 2012/13 Herefordshire would need to deliver an additional £11m in QIPP savings in order to ensure the future sustainability of the Health Economy. Seventy additional suggested opportunities had been put forward to provide input to the plan, of which forty five had been taken up. High impact changes

had been flagged up under the twin topics of community services and dementia care. These would be provided by the community services team and the neighbourhood teams. He was confident that should these two areas be delivered, then the rest of the QIPP plan would be delivered.

The Associate Director went on to report on the structure of the Herefordshire Health Care Commissioners. The structure had been seen at a national level, and the work with GPs had been held up as an example of best practice. He said that the authorisation process consisted of 6 domains wherein competency had to be demonstrated, together with a number of case studies that showed where an impact had been made on the health economy. It was important that those outside the County that HHCC should be in apposition to demonstrate an understanding of all aspects of commissioning.

In the ensuing discussion the following points were made:

That the Herefordshire Health Care Commissioners was led by clinicians and the views of the local population by way of consultation.

That of the 94 competencies that were required for the Department of Health authorisation to establish HHCC as a statutory organisation, there were 61 longer term measures and 58 key lines that were emerging around the QIPP plan. It was expected that these areas would be considered on a quarterly basis.

A Member said that there was concern regarding the way in which the performance of the Ambulance Service was judged, as the present system meant that the service was liable to target response times in urban areas, where distances were shorter. The Ambulance Trust needed to be more engaged in the County as there were real concerns as to how standards of response times could be raised in rural areas.

In reply to a question, the Associate Director said that there was evidence that access to services in areas of deprivation in the County could be improved. A public patient engagement meeting was set up to explore the issues, especially concerning children, young people, and white working class males, but the audience had been made up of those involved in the public sector.

The Associate Director said that there was an over medicalisation of births in the County as the average cost of a birth in the West Midlands was £678, whilst in Herefordshire it was £1,500. This pathway would be looked at to find ways of reducing costs.

He concurred with the suggestion from a Member that more use should be made of the Third Sector, and said that some of the services that had to be delivered by HHCC could be provided more efficiently by that sector. Personal budgets would help support these organisations. The HHCC commissioned large medical pathways, and consideration would be given as to how these could be reduced into smaller units that would enable third sector organisations to bid for them.

In reply to a further question, the Associate Director said that management reductions were being achieved by mapping staff to alternative organisations. The Clinical Commissioning Group would not have more than thirty staff once it was in place. He went on to say that the GP Parliament was elected by the 24 practices in the County and it had four representatives on the Herefordshire Health Care Commissioning Board who were elected by specialist field.

He added that when the PCT ceased to exist, responsibility for the health of the population of the County would fall to the Council, not the Clinical Commissioning Group.

He concurred with comments that public engagement with public health service was important, especially in areas such as South Wye and Leominster.

The meeting ended at 16:15 **CHAIRMAN**

Wye Valley NHS Trust

A new organisation to support a new model of care

Overview & Scrutiny Committee 18th January 2012

Wye Valley NHS Trust Update Report

right care, right place, right time ….every time

A provider of health and social care.

Wye Valley NHS
NHS Trust

Delivering the change: the story so far…

- Wye Valley NHS Trust was created as an Integrated Care Organisation (ICO) in April 2011
- Acute, community and adult social care services in one organisation
- First ever ICO in England
- Foundation Trust status in 2013/14

Wye Valley NHS
NHS Trust

The organisation as it stands…

- £165m turnover
  - Acute services £120m
  - Community services £35m
  - Adult social care services £10m
- 2,450 wte staff (2,750 individuals)
- Acute services covering:-
  - Emergency care, planned (surgical) care
  - Outpatient services
  - Maternity and paediatrics
  - Cancer services

The organisation as it stands…

Wye Valley NHS Trust

- Community services covering:-
  - District nursing, health visiting, school nursing
  - Community based therapy services
  - Community paediatrics
  - Community hospitals
  - Community equipment and telecare
- Adult social care services covering:-
  - Social workers
  - Day care services (learning disabilities)
  - Adult placement
  - Safeguarding
  - Benefits advice, financial assessment & transport

An organisation with a difference

Wye Valley NHS Trust

An organisation which:-

- Is ‘owned’ by the staff it employs and the people it serves
- Puts quality at the heart of what it does
- Genuinely embraces ‘customer service’
- Engages with local communities (social capital)
- Practices true partnership working and engagement with stakeholders
- Is led by its clinicians and practitioners
- Empowers its front line staff to succeed (‘upside down management’)

Service Units

Wye Valley NHS Trust

Care Closer to Home

Elective care

Urgent Care

Integrated Family Health Services

Care Closer To Home – Dir: Sara Keetley. Mgr: Lynn Kedward

Neighbourhood Teams –
Mgr – Sharon Mayglothling

Neighbourhood Teams (Including Therapy, District Nursing & Section 75 staff)

Therapies
Mgr – Sue Moody
Physiotherapy, Occupational Therapy, Orthotics, Dietetics, Speech & Language Therapy,

Countywide Specialist Teams **Mgr – Jackie Noble**
Community Equipment &Telecare, Financial Assessments (inc welfare rights), Community Stroke Rehabilitation, Health Psychology & ABI, Podiatry, Hospital Social Work, Sensory Impairment, Adult Placement, Operational Safeguarding, Transport

LD & Day Services
Mgr – Mandy Appleby

Learning Disability, Day Care Provision,

Integrated Family Health Services - Dir: Dr Peter Wilson. Mgr: Marcia Perry

Women & Sexual Health
Mgr: Milo Gawler

Delivery Suite, Maternity Ward

Antenatal Care, Midwifery

Special Care Baby Unit

Obstetrics & Gynaecology

Women's Health, Sexual Health

Children's & Families Services
Mgr: Jane Terry

Paediatrics - inpatient, Community & palliative care

Child Development Centre

Child Health Department Health Visiting

School Nursing, Looked after Children

No1 Ledbury Road, Kite centre, Travelling Families

Urgent Care: Dir: Dr Vicky Alner /Jan Reynolds Mgr: John Sharman

Emergency & Inpatient
Mgr: Sandi Vaughan

Emergency Department, SPA

Medical Wards (inc. community hospitals)

Acute Stroke Care, CCU

Medical Specialties
Mgr: Linda Howells

General Medicine, Geriatric Medicine , Cardiology

Renal, Diabetes, Endocrinology, Neurology

Rheumatology, Respiratory, Gastroenterology

Clinical Haematology

Support Services
Mgr: Mel Bolton

Radiology, Pathology, MortuaryEmergency Planning

Elective Care: Dir: Dr Neeraj Prasad Mgr: Judith Ratledge

Theatres, Anaesthetics, ITU, Endoscopy
Mgr: Tracy Hill

Theatres, Anaesthetics, ITU, Endoscopy

Surgical Specialties
Mgr: Catherine Davies

Preoperative assessment, Surgical Wards & Day Case, Trauma & Orthopaedics Podiatric Surgery., Surgery – General, Emergency, Breast, Colorectal, Vascular, Urology, Plastics, Dermatology, ENT, Salaried Primary Care Dental Service, Maxillo-Facial, Orthodontics, Ophthalmology & Orthoptics

Cancer O/P & Audiology
Mgr: Helen Byard
Out Patients , Oncology & Palliative Care, Audiology

Pharmacy & Medicine Management
Mgr:Tony McConkey

Pharmacy & Medicines Management

Vision, Mission & Values

Wye Valley NHS Trust

Vision

" To improve the health and well being of the people we serve in Herefordshire and the surrounding areas"

Mission

"To provide a quality of care we would want for ourselves, our families and friends"

Vision, Mission & Values

Wye Valley NHS Trust

Which means:-

" right care, right place, right time…every time."

Values

- People First
- Passion for excellence
- Personal responsibility
- Pride in our team
- Promoting thriving communities

Reshaping our service offering

Wye Valley NHS Trust

Principles

- A population based service provider
- Emphasis on prediction & prevention rather than simply diagnose and treat
- Care at or close to home (local where possible centralised where necessary)
- Protocol or pathway based delivery
- Seamless, integrated, multi-disciplinary provision
- Choice, personalisation and independence

Reshaping our service offering

Wye Valley NHS Trust

Strong focus on community and social care services

- Strengthening neighbourhood teams
- Community hospital resource centres
- Service extending into
  - State and self funded personal care
  - Extended healthcare offering to reduce CHC spend

Reshaping our service offering

Wye Valley NHS Trust

Focused, clinically sustainable acute services

- Activity shift and reduced bed base
- Services geared to key principles e.g.
  - Front end decision making
  - 7 day working
  - One stop services
- Service portfolio reviewed and refined
  - Core services meeting key criteria e.g. Trauma Unit
  - Networked or partnering solutions for services requiring critical mass or expertise
  - Targeted divestment

Reshaping our service offering

Wye Valley NHS Trust

Focused, clinically sustainable acute services cont…

- Extended service offering in
  - Short stay surgery
  - Diagnostics (? interventional radiology)
  - Private market

Outsourced or partnering solutions for selected near / non core services

- Shared back office (Hoople Ltd)
- Administration etc…

Key Performance Indicators 2011/12

Wye Valley NHS Trust

Quality indicators

Mortality

- SHMI for 2010/11: 108.0 (100 = average)
- Dr Foster HSMR Sept 2011: 99.3 (100 = average)
- Casenote review of all hospital deaths to be implemented by February 2012

Key Performance Indicators 2011/12

Wye Valley NHS Trust

Quality indicators

Infection Rates

- No MRSA bacteraemia cases since January 2011
- 37 CDiff cases at County Hospital year to date against trajectory of 38
- 7 Community hospital CDiff cases against a trajectory of 5
- Action plan implemented following early 2011 outbreak

Key Performance Indicators 2011/12

Wye Valley NHS Trust

Quality indicators

Stroke Services

- 84% of patients to end November 2011 spent at least 90% of stay on a Stroke Unit (target 80%)
- 60% of TIA patients scanned and treated within 24 hours (target 60%)
- Hillside Stroke Rehabilitation Service now fully operational

Key Performance Indicators 2011/12

Wye Valley NHS Trust

Quality indicators

VTE Risk Assessment

- 90% target for completion of assessments achieved consistently since July 2011

Never Events

- None in year

Key Performance Indicators 2011/12

Wye Valley NHS Trust

Quality indicators

Neighbourhood Teams

- 8 teams operational – 238 admissions prevented year to date against 200 target full year

Clinical Decisions Unit

- 250 plus patients placed on CDU protocols – 80% discharged within 6 – 8 hours

Key Performance Indicators 2011/12

Wye Valley NHS Trust

Access Targets

<u>18 weeks referral to treatment</u>

- 99% plus of non admitted patients seen within 18 weeks (target 95%)
- Decline in % of admitted patients treated within 18 weeks to 92% November (target 90%)
- Action plan to clear treatment backlog in orthopaedics by March 2012

Key Performance Indicators 2011/12

Wye Valley NHS Trust

Access Targets

Accident & Emergency

- 96% of patients seen within 4 hours to end December 2011 (target 95%)
- Action plan to address poor performance November 2011 onwards

Cancer Waits

- All targets met in November 2011 (2 weeks / 31 days / 62 days)
- Breast symptomatic wait target for year under pressure due to mid year dip

Key Performance Indicators 2011/12

Wye Valley NHS Trust

Finance

- £2.6m deficit to end November 2011 with year end prediction of £3.3m - £4.2m
- Predicted savings plan delivery (£6.1m) broadly in line with target (£6.2m)
- Discussion with PCT Cluster about transformation support

Wye Valley NHS
NHS Trust

Trauma Care System Process

July 2011

- Wye Valley NHS Trust (WVT) enters selection process by application

September 2011

- Confirmed by West Midlands Specialised Commissioning that WVT eligible for Trauma Unit Status

Wye Valley NHS
NHS Trust

Trauma Care System Process

November 2011

- WVT Business Case presented
- Business case and Action Plan submitted to West Mercia Cluster

January 2012

- WVT Implementation Programme Board established and clinically led by A&E Consultant

Wye Valley NHS
NHS Trust

Wye Valley NHS Trust Commitment to the Trauma Network

- Delivery of trauma unit standards within current PbR tariff
- Participation in the SHA Quality Review Service Trauma Peer Review in 2013
- Active membership of the Trauma Network

Wye Valley NHS
NHS Trust

Many thanks...

Martin Woodford
Chief Executive

A provider of health and social care.