Council – 7th November 2011

Notice of motion – NHS reorganisation

The following notice of motion has been submitted by Councillors Robertson, Sarohi, Chambers, Russell, Thomas and Young:

> Council notes that our NHS is undergoing the most radical reorganisation since inception by a Labour Secretary of Health Aneurin Bevan in July 1948 , with the costs of £5 billion of these changes set to probably exceed savings.
>
> Council expresses concern at recent reports indicating that currently there are serious issues to monitor here in Walsall.
>
> - waiting times of over 1 year at the Manor hospital for those wishing to have treatment has increased by 600%
> - the report went to the Board of the Walsall Healthcare Trust in September revealed that an average of 22 incidents or near misses occurred per week over the year to March 2011 in our hospital's maternity services
> - that the recent CQC inspection revealed some failings in nutritional and hydration needs in the care of our elderly patents.
> - note that all professional NHS bodies such as the BMA and 7 out of 10 of our doctors, still oppose these changes and believe that these are not in the best interests of their patients.
>
> Council proposes that our Chief Executive writes to the Secretary for State for Health relaying the fact that the majority of elected members of this Council have voted supporting the view that the proposed changes contained in the NHS bill are not in the best interests of patients here in Walsall and that this Bill should be withdrawn as it does not comply to the 'Clegg' principles that:
>
> - GPs should not be forced into signing up to commissioning consortia
> - The pace needs to be slowed
> - All artificial deadlines need to be removed
> - The NHS needs to be protected rather than undermined.

Background information

The Health and Social Care Bill was introduced into Parliament on 19 January 2011. The Bill sets out the Government's vision to modernise the NHS so that it is built around patients, led by health professionals and focused on delivering world-class healthcare outcomes.

The Bill takes forward the areas of Equity and Excellence: Liberating the NHS (July 2010) and the subsequent Government response Liberating the NHS: legislative framework and next steps (December 2010), which require primary legislation. It also includes provision to strengthen public health services and reform the Department's arm's length bodies.

The Bill passed through the Committee stage in the House of Lords with some minor amendments during October 2011. There is extensive guidance documentation on the

content of the Bill on the DH website, and there is continuing comprehensive media coverage of the variety of expert and political opinion about it's implications for the future of the NHS.

Walsall Healthcare Trust Board Reports are publicly available on the Trust website and the September 2011 Board included standard reports on the latest performance and financial situations and a specific report on midwifery services.

18 weeks

At the end of August 2011, the Trust had 40 patients waiting over 52 weeks for treatment. This was only 0.3% of the total number of patients waiting for treatment, but did represent an increase of 207% compared with August 2010.

The increase is partly due to an increasing number of patients who need other medical treatment before they are fit for surgery.

By the end of September 2011, the number waiting over 52 weeks had dropped to 26 compared with 22 in September 2010, and the Trust continues to work hard to ensure that these numbers reduce further.

CQC Report

Introduction

On 13 April 2011, the Care Quality Commission undertook an unannounced inspection to determine how well older people are treated during their hospital stay at the Manor. In particular, the regulators focused on whether patients were treated with dignity and respect and whether their nutritional needs were being met. Walsall Manor was one of many Trusts visited nationally.

Highlights of the Report

Overall, the CQC have confirmed evidence of good practice in relation to both outcomes assessed. Minor concerns have been expressed in some areas resulting in the need for improvement actions to be deployed to ensure continuous compliance.

*A minor concern means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard

The report focuses on two outcomes:-

Outcome 1: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

The report highlights a number of examples of good practice and includes positive comments directly from patients and relatives about their personal involvement in their care and the range of food available within the hospital environment. In most cases the regulators observed patients being spoken to in a respectful and appropriate manner. Call bells were generally in reach of patients and on the whole patients felt that they did not have to wait long for call bells to be answered. Staff were able to competently talk to the regulators about the organisations commitment to privacy and dignity including the

campaign held last year, organisational policies and procedures and plans to further develop the 'single sex agenda'.

The regulators identified minor concerns* relating to this outcome and requested that improvement actions** be deployed to maintain compliance with this regulatory outcome. Improvement actions were developed into an action plan and submitted to the CQC, centring on the following:

- Continuous assessment plan to be modified to include reference to people's cultural/religious beliefs
- Patients preferred name to be documented in the assessment record
- Publicise the availability of phones for use by patients on wards
- Ensure that curtain hooks and curtains around beds are in place and are adequate to protect the dignity and privacy of patients

Outcome 5: Meeting Nutritional Needs (ensuring people are supported to have adequate nutrition and hydration)

Patients generally stated that they enjoyed their food in hospital and felt that their nutritional needs were being met. Protected meal times were in place and patients were supported by both nursing staff and volunteers during meal times. Special diets were evidently catered for and included in menus. The regulators noted that even during busy periods on the wards, patients were not rushed to eat their meals and the atmosphere was conducive to eating.

The regulators identified some minor concerns relating to this outcome and requested that improvement actions be deployed to maintain compliance with this regulatory outcome. The improvement actions were developed into an action plan and submitted to the CQC , centring around the following:-

- Patients to be asked if they have any likes and dislikes relating to food
- Staff to ensure consistency and accuracy in documentation relating to nutritional and hydrational needs – the regulators identified a number of lapses in consistency/accuracy of documentation during their visit and this matter will be fully looked into in a future review of the Trust by the CQC
- Patients to be offered the opportunity to wash their hands before having their meal
- Patients to be given assistance (where required) when they need to have a drink
- Development/review of organisational policy for patients who are fasting
- A copy of the full report is publicly available on the CQC website. Walsall Council Health Scrutiny and Performance Panel of 24 October received a presentation from Walsall Healthcare Trust on the improvement actions undertaken in response to recent CQC visits to look at care of elderly people within the hospital, and will continue to receive further reports from Walsall Healthcare Trust as appropriate.

Maternity incidents and near misses

The maternity report states that

"There have been 1159 incidents and near misses reported within the time frame 1st April 2010 - 31st March 2011. 1131 graded 1-2 and 28 graded 3-5. Three serious

incidents were reported to the Strategic Health Authority. All were subjected to an Obstetric Root Cause Analysis in line with local policy. The ongoing monitoring and completion of action plans are undertaken by the senior governance team. The top four categories reported during this period were; • 110- Pregnancy and birth • 220 Communication • 240 Staffing • 270 Admission /Transfer and Discharge

Please note: maternity services report incidents within the category 100 relating to pregnancy and birth as part of a regional data set. These include a significant number of incidents which do not necessarily have an adverse outcome or are near miss events. They are reported to track trends in clinical practice and clinical outcome measures through medical notes review and audit against policy. The incidents are entered onto the PRISM data collection system as maternity managed Incidents or events"

Walsall Healthcare NHS Trust have commented that they "are proud to have a positive and open culture of incident and near miss reporting which enables the organization to promote a culture of safety and gives us an opportunity to examine our practice. Many of our maternity incidents are reported as 'managed incidents'. These relate to incidents that do not cause harm to patients, but allow us to track trends in care. The organization delivers approximately 4000 babies a year and the mums receive a range of care from ante natal treatment through to post natal care covering a 40 week period."

Opinion within the healthcare professions on the implications for the NHS of the changes set out in the Health and Social Care Bill remain divided.

Author
Andy Rust
Head of Joint Commissioning Unit
NHS Walsall Partnerships Directorate
Walsall Council SC & I Directorate

Paul Davies,
Executive Director, Social Care and Inclusion

28th October 2011