HEALTH SCRUTINY AND PERFORMANCE PANEL

Tuesday, 23 April, 2013 at 6.00 p.m.

Conference Room, Council House, Walsall

Panel Members Present

Councillor M. Longhi (Chair)
Councillor D. James (Vice-Chair)
Councillor M. Flower
Councillor E. Russell
Councillor H. Sarohi
Councillor V. Woodruff

Officers Present

Andy Rust - Head of Commissioning
John Bolton - Executive Director. Social Care and Inclusion
Peter Davis - Head of Community Care
Nikki Gough - Committee Business and Governance Manager
Wendy Godwin - Head of Planned and Urgent Care
Sue Crabtree - Head of Palliative and End of Life Care
Richard Kirby - Chief Executive, Walsall Healthcare Trust
Dr. David Pitches - Consultant in Public Health
Paulette Myers - Consultant in Public Health
Amir Khan - Medical Director
Simon Swift - Mott McDonald
Paul Baylis - West Midlands Ambulance Service
Nick Henry - General Manager for Black Country West Midlands Ambulance Service
Salma Ali - Walsall Clinical Commissioning Group
Dr. Esther Waterhouse - Consultant in Palliative Medicine
Dr. Radka Klezlova - Consultant in Palliative Medicine

224/13 **Apologies**

There were no apologies received for the duration of the meeting.

225/13 **Substitutions**

There were no substitutions for the duration of the meeting.

226/13 **Declarations of interest and party whip**

Councillor V. Woodruff declared an interest as an employee of Walsall Healthcare Trust.

227/13 **Minutes**

The minutes of the meeting held on 12 March, 2013 were approved as a true and accurate record subject to the following amendment:-

> Page 4, Paragraph 3 - The Chair asked if this Group were more likely to be geographically placed in the west of the Borough.

Resolved

The minutes of the meeting held on 12 March, 2013 were approved as a true and accurate record, subject to the stated amendment.

228/13 **Walsall community based end of life strategies and pathways**

The Panel were informed that the Panel had previously received this item and wanted to better understand this area generally and the pathway an individual may go through when they have reached their end of life.

The Consultant in Palliative Care tabled a document 'Key enablers along the end of life pathway' and discussed the steps of life pathway. Although it was stated that this was simply a guide as to how to move forward.

The following case study was given:-

A 65 year old man had been admitted to hospital unwell, he was diagnosed with cancer. His case was discussed with the Clinical Team, including surgeons and oncologists who confirmed the treatment and progress; he was considered too unwell to receive anti-cancer treatment and was reaching his end of life. The process for planning his end of life was described and the pathway that was followed to get him home.

Pain management of patients in their end of life and living at home was discussed, and officers reassured Members that family were able to access support in a panic situation through contact with the hospital switchboard. Officers stated that pain relief can be facilitated very quickly but that families may need reminding of this.

When discussing improvement of the service, the Head of Planned and Urgent Care stated that the process of starting palliative care and holding difficult conversations with individuals could be improved but that a professional development pack was being rolled out for Clinicians to improve this area. The Medical Director stated that it was recognised that proper timing and communication was important and work was underway to get this right.

Another issue discussed was that it could sometimes be difficult to arrange 'rapid discharge', or quick and easy access to beds, equipment or care. Another problem was where patients did not have families to assist them to stay at home during the end of their life and also out of area care.

In response to questions about the wider impact of changes at Mid Staffs on hospital capacity in Walsall, the Chief Executive of Walsall Healthcare NHS Trust offered to brief the Committee in more detail at a future meeting.

Case Study 2 described a 90 year old patient with organ failure and severe renal failure his condition was deteriorating leading to more frequent hospital stays. A nurse would start conversations with him to explore his thoughts for the future; he indicated he wished to avoid any further hospital stays and would rather stay at home. Patients were discussed on a monthly basis, and family were kept informed of treatment and medication. The Panel discussed the many people who may be involved in conversations with GPs, Nursing Homes etc. Within the constraints of what they were asked to do he felt that they had a good view of the status of care and the Manor.

Resolved

That:

(1) Further information on the impact of Mid Staffs on Walsall health economy is taken to the Health Scrutiny Panel in the future;

(2) Further information on 'out of area discharges' is taken to the Health Scrutiny Panel in the future;

(3) Further information is taken to the Health Scrutiny Panel on rapid discharge pathways;

(4) Further information is taken to the Health Scrutiny Panel on the professional development of Clinicians on communication.

229/13 **Independent Review of Mortality Rates**

The Chair provided the background to the mortality review and explained that this review had been commissioned to provide a snapshot of the overall direction of travel of mortality rates and to describe findings to the Panel fully and transparently.

The Mott McDonald Consultant explained that the review was commissioned at a high level and available data which was supported by interviews. Researchers did not walk the wards, review case notes or have wider conversations with people.

Councillor P. Smith was in attendance, he asked if there was a link between resources getting tighter, an elderly population and planning for end of life care. He also asked for assurance that this was not a piece of work to ensure that mortality figures at hospital were lowered. The Consultant in Palliative Medicine stated that this process was to identify patients with deteriorating clinical conditions and Doctors needed to talk to people and try to put plans in place to get their end of life right when they may have complex and rapidly changing

needs. The Chief Executive stated that the hospital had spent more on palliative care in the previous 12 months than in previous years and the Executive Team would continue to support that.

Methods for measuring mortality rates were explained and the limitations associated with them. Historical use of a palliative care code which had a significant impact on mortality rate were raised, however, this issue was now resolved. The Panel were informed that there were elements in the population which put an increased strain on the Trust, these related to demographic and lifestyle behaviours. The Palliative Care Team had impacted on adjusted mortality rates as had St. Giles Hospice which was an additional place where more people were dying.

The review had also revealed that the new Executive Team had also pushed best practice. There was a perception that discharge was not working as intended, although there was no evidence that this was impacting on mortality, only literature evidence. An issue raised was that staffing across the Trust was uneven and needed to be better managed. There had also been concern raised about the A and E Department, which was under significant pressure and activity in A and E was increasing. However, there was the sense that the Trust, Clinical Commissioning Group, and the Council were aware and aggressive in managing the hospital and wider mortality in Walsall. A Member asked what grades of staff were interviewed. The following grades were listed by Consultant:-

- Chief Executive
- Medical Directors
- 4 Associated Medical Directors
- 4 Clinical Directors
- Director of Nursing
- Clinical Commissioning Group Director
- 2 Lead Nurses of Urgent Care
- Director of St. Giles
- Range of people, including SHA and related individuals

The Panel were informed that to interview a wider range of people would have meant the review would have been more expensive. A Member commented that it was reassuring that each death was considered to ensure the Trust learnt lessons.

The Chief Executive of Walsall Healthcare Trust stated that the hospital were clear that the work on mortality rates was not a finished piece of work. The focus for 2013/14 would be a 6 day system embedded consistently and to make appointments for a consultants in elderly care and respiratory departments. A and E was a top priority for the Trust as it was designed to treat 40,000 people a year but it currently treated double this amount.

A query was raised about why mortality from genito-unitary disease was so high. Officers stated that a big contribution to this was UTI, and that this was a problem with how patients were classified as the primary diagnosis was the main condition treated and may not be the cause of death. The Medical Director

stated that a plan to deal with UTIs would be taken to the Board in June and a renal specialist had also been appointed in Walsall.

In response to criticism of the review, the Chair of the Panel stated that in light of the Mid Staffs events, this review was considered necessary to ensure that the Scrutiny Panel had adequate reassurance that the hospital was moving in the right direction. He refused claims of collusion and that it was a PR exercise. The Consultant from Mott McDonald also refuted these claims. A member of the public expressed her support for the Management Team at the hospital.

In response to a query about the A and E reference in the report the Chair stated that this would be added to the Panel's work programme in the future where they would consider it in more detail.

Resolved

That the following items are taken to a future meeting of the Panel:-

- Ongoing work on mortality rates by the Clinical Commissioning Group work,
- The A and E review at Walsall Healthcare Trust
- Discharge as part of rapid discharge
- Information on UTIs and related mortality rates

It was agreed that Item 9 would be taken prior to Item 8.

230/13 **West Midlands Ambulance Service (WMAS) Service Transformation**

The General Manager for the Black Country presented to the Panel and explained that he had been asked to provide a comparative picture for the previous 12 months. Increased activity in March was discussed and it was thought that this was due to the introduction of '111'. The significant increase in call volume impacted on the ability to get to the patient. Overall the service provided by WMAS was improving in Walsall.

As the meeting had lasted for 3 hours, Members agreed that it would continue.

The Panel agreed to hold a future meeting at a WMAS venue and receive further information on '111' telephone service.

231/13 **Care Quality Working Group**

The background to the Group was discussed, the terms of reference were agreed, and Councillors H. Sarohi and M. Longhi agreed to join the membership of the Group.

Resolved

That:-

(1) The terms of reference were approved;

(2) Councillors M. Longhi and H. Sarohi joined the Group.

232/13 **Work Programme 2012/13**

The Work Programme 2012/13 was noted.

Termination of meeting

The meeting terminated at 9.05 p.m.

Signed: ……

Date: ……