The **HEALTH OVERVIEW AND SCRUTINY COMMITTEE** met at **WARWICK** on the **31st AUGUST & 1st SEPTEMBER, 2006**

Present:-

Members of the Committee:

County Councillors:	Jerry Roodhouse (Chair) Anne Forwood (Vice Chair) John Appleton Sarah Boad Jose Compton John Haynes Marion Haywood Sue Main Frank McCarney Helen McCarthy Raj Randev June Tandy
District Councillors:	Anthony Dixon (Stratford-on-Avon District Council) Michael Kinson (Warwick District Council) Richard Meredith (North Warwickshire Borough Council) Bill Sewell (Rugby Borough Council)

Other County Councillors:

Bob Stevens (The Deputy Leader of the Council)
Barry Longden

Officers:

Graeme Betts – Strategic Director of Adult, Health & Community Services
Victoria Cook – Assistant to the Labour Group
Louise Denton – Assistant to the Liberal Democrat Group
Jean Hardwick – Principal Committee Administrator
Phil Maull – Senior Committee Administrator
Ann Mawdesley – Senior Committee Administrator
Alwin McGibbon – Health Scrutiny Officer
Nicole North – Assistant to the Conservative Group

Advisors:

Maria Duggan – Centre for Public Scrutiny
Iain Roxburgh – Warwick Business School

1. Programme for the 31st August 2006

(1) Introduction by Councillor Jerry Roodhouse (Chair of Committee)

The Chair welcomed those present and, in particular, Councillor Sue Main to her first meeting of the Committee. He said that Maria Duggan and Iain Roxburgh would attend throughout the meeting with a view to giving the Committee an overarching view of the proposals. Following the two day consideration of the proposals by the Committee they would be debated at the County Council meeting on the 12th September.

He said that there were a couple of housekeeping tasks to complete before the main business of the meeting could start:-

(i) Apologies for absence

An apology for absence was received from Councillor Bill Hancox.

(ii) Members Declarations of Personal and Prejudicial Interests

Personal interests were recorded in respect of the following members by virtue of being members of the Borough/District Council indicated:-

Councillor John Appleton – Stratford-on-Avon District Council.
Councillor Jose Compton – Warwick District Council.
Councillor Anthony Dixon – Stratford-on-Avon District Council.
Councillor Michael Kinson – Warwick District Council.
Councillor Sue Main – Stratford-on-Avon District Council.
Councillor Richard Meredith – North Warwickshire Borough Council
Councillor Jerry Roodhouse – Rugby Borough Council.
Councillor Bill Sewell – Rugby Borough Council
Councillor Bob Stevens – Stratford-on-Avon District Council.

(2) Public Questions

The Chair explained that this was not a public consultation meeting but was a meeting of the Health Overview & Scrutiny Committee. He asked members of the Patient & Public Involvement Fora to let Alwin McGibbon have a note of any questions so that they could be fed into the debate via Committee members.

He thanked those members of the Committee who had taken up special areas of the Acute Services Review for the extra work they had done.

(3) A&E Services – Warwick and Stratford Hospitals

Health Service representatives: Peter Hawker and Paul Devlin.

The following points were raised during the discussion:-

(i) It was noted that over half of the callers for the ambulance service did not need hospital treatment. An assessment would be made of the patient's condition and, if necessary, he or she would be transferred to the appropriate hospital.

(ii) The new Ambulance Trust supported the proposals in the Acute Services Review.

(iii) The hospitals were committed to the air ambulance service. The University Hospitals Coventry and Warwickshire NHS Trust (UHCW) had a primary landing site, enabling the helicopter to land on the site of the hospital whereas the other hospitals had identified landing sites close by with the facility to use ambulances to convey the patients the rest of the way to the hospitals.

(iv) Proposals to reduce services at the Alexandra Hospital and elsewhere would mean that the ambulance service would become even more vital in the west of the County as distances to hospitals would increase.

(v) Peter Hawker said that he had over twenty years of diagnostic skills but even he would on occasions take some time to determine a diagnosis and it was essential to have a hospital available to take the patient to when in doubt.

(vi) The helicopter and pilot was leased by the charity operating the service and there was no other helicopter when it was undergoing essential maintenance. If it were used on a twenty-four hour basis, its operational time would be shortened. There would be a need for a second helicopter to enable a full twenty-four hours a day service to be operated.

(vii) Peter Hawker said that he and his colleagues had concerns over the proposal to remove emergency provision at Warwick Hospital at night. The danger was that the momentum for change might result in its implementation and once done the decision would not be able to be reversed if key staff were lost to the hospital. If the consultants were to be left at the hospital, it was difficult to see what savings could be achieved by the proposal. It was not possible to say in advance which patient would deteriorate and transferring patients after they had become critically ill would pose danger to the patient. If surgical staff were not available at night, it must be considered whether it would be safe to accept those patients.

(viii) The proposed use of the minor injury units at Stratford and Shipston was seen as very effective because it was logical to go to there if there was no need to go to Warwick. Patients would be referred to minor injury units by GPs or ambulances or they might attend by their own choice.

(ix) It was possible for some cancer operations to be carried out at Warwick Hospital.

(4) A&E Services – George Eliot Hospital

Health Service representatives were Paul Develin, Gary Ward and Sharon Beamish.

The following points were then raised during the discussion:-

(i) Clinicians were very closely involved at all levels of the Review.

(ii) The suggested emergency care network already existed in South Warwickshire.

(iii) Clinicians at George Eliot embraced the proposals in contrast to the clinician at Warwick Hospital. This inconsistency between health professionals led to a lack of clarity around the proposals, which in turn gave the Committee serious concern that the proposed reductions at Warwick and George Eliot hospitals would leave patients at serious risk.

(iv) Gary Ward was present to give the view of the UHCW and not George Eliot Hospital. Members were concerned that the appropriate health professional had not been sent to enable their questions about George Eliot Hospital to be addressed properly.

(v) Theatre facilities would remain at George Eliot for trauma.

(vi) The number of hospitals within Warwickshire meant that a greater number of staff resources were required than normal for the size of population.

(vii) Paragraph 7.3.14 stated that it was important to make sure children and young people received services as locally as possible. Although it was proposed to set up a 24 hour paediatric assessment unit at Warwick, the unit proposed for George Eliot would be restricted to 12 hours.

(viii) The ACR proposal was based on George Eliot Hospital not being able to provide the full service. The reduction in junior doctors hours made it more difficult to provide services.

The Committee adjourned from 11.03 a.m. to 11.15 a.m.

(5) Maternity & Paediatrics Services Warwick
(6) Maternity & Paediatrics Services George Eliot Hospital

Health Service representatives were Sharon Beamish, Nigel Coad, Helen Walton, Richard de Boer and Robert Jackson.

The following points were then raised during the discussion:-

(i) The people of Nuneaton & Bedworth and North Warwickshire felt that they were losing their paediatric and maternity services.

(ii) There were 2,536 births at George Eliot, 4,500 at UHCW and 2,500 at Warwick. In Solihull there had been a 30% reduction in births from 3,600 to 2,600.

(iii) Ante natal visits would continue at George Eliot and if there was history of problems there would be discussion with the mother about the best place for delivery.

(iv) In those cases where a mother might be attending George Eliot but unexpectedly the birth was early and she was taken to Walsgrave, the records would travel with her.

(v) Centralisation of expertise would mean that the maternity service could be run better with fewer staff.

(vi) Members were concerned at proposals for increasing the use of the maternity facilities at Walsgrave when there were obvious signs of pressure on that unit with 90% of cots full. 219 admissions had been refused because of a capacity issue. George Eliot was 70% full. There were doubts that Walsgrave would be able to meet the additional demands.

(vii) The health professionals admitted that there was a need to increase capacity at the new hospital to enable it to take the additional numbers. The funding for this would come from the reductions in other maternity units. However, with parents choice, it might be that mothers might choose to go elsewhere than Coventry to have their babies.

(viii) It was known that there was a correlation between a high birth death rate and an area with high rates of ethnic population, teenage mums and poverty. The reduction in services proposed at George Eliot would hit the area in the county where those groupings were the highest.

(ix) NHS finances were partly responsible for changes in paediatric services but there were other factors. Improvements in public health had reduced a lot of infections. For highly specialised care there was a need for a minimum number of cases to enable medical staff to gain and retain skills. Even if the funding were available for 24 hour provision at George Eliot, it would not be possible to provide this.

(x) Mothers would go where they felt services were safe.

(xi) There were inequalities in the NHS with Warwickshire coming off badly for funding. In addition there was a need to repay £53m of PFI.

(xii) There was no problem in recruiting high quality staff to vacancies at Walsgrave.

(xiii) There was concern that there was an emphasis of providing service to the north-east of Coventry when the main population of the County was to the south.

(xiv) There was a major logistical transport problem, not only for the patients travelling to Coventry but also for visitors.

(xv) It was noticed that 24 hour paediatric services would continue at South Warwickshire.

The Committee adjourned from 12.45 p.m. to 1.20 p.m.

(7) Proposals for Rugby St. Cross Hospital

Health Service representatives were Nicholas Balcombe and Adrian Canale-Parola

The following points were then raised during the discussion:-

(i) It was noted that transport between Rugby and Coventry had been an issue when services had been taken away ten years earlier and was still unresolved. This did not bode well for a solution being found to transport issues associated with the Acute Services Review.

(ii) It was accepted that there was no quick fix to transport problems and it was not something that the NHS could deal with in isolation from other agencies.

(iii) It was intended to establish St. Cross as a separate business unit but with close links with UHCW, including interchange of services.

(iv) Smaller hospitals were not able to provide many of the advancements in treatment and it would be clinically unsafe for them to do so. However they could specialise in other areas such as rehabilitation.

(v) There was a need for collaborative work between the NHS and social services to keep people out of hospital. Collaborative work in the community had already started. It was recognised that there were gaps in the community provision for older people that needed to be addressed.

(vi) The Review document showed no evidence of having taken into account the need for work to be carried out between the agencies to enable the change to take place. There was no indication how social services was supposed to fund their share of the cost of care in the community nor any appreciation that this would be a problem.

(vii) Specialist high level rehabilitation would be provided in hospital but there was still a need for local provision in the home for when patients left hospital.

(viii) Following the reduction in the number of hospital beds, there would be a need for contingency plans to deal with epidemics. It was not acceptable to maintain permanently empty beds to cope with this.

(8) Clinical Support

Health Service representative was Neil Anderson.

The following points were then raised during the Discussion:-

(i) It was important for pathology laboratory services to be maintained at George Eliot Hospital and not lost to UHCW.

(ii) Those services were not being transferred to UHCW. Although it was logical for there to be a single pathology laboratory service for Coventry and Warwickshire, it was not intended that this would be run on one site.

(iii) IT links could bring about savings without lowering standards and users of the service should not notice any difference.

(iv) Neil Anderson could not answer questions concerning pharmacy service because he was a pathologist. However he could see how centralised purchasing for pharmacy could bring advantages.

(v) The volume of pathology work was split 50/50 between hospitals and GPs.

(vi) It was not clear from the Review document how the governance arrangements would work in respect of a single laboratory service provided across three or four sites.

(vii) Neil Anderson confirmed that this was still the subject of discussion.

The Committee adjourned from 2.15 p.m. to 2.35 p.m.

(9) Primary Care – Community Matrons, GPs

Health Service representative was Julie Whittaker.

The following points were then raised during the discussion:-

(i) Access could be an issue on the boundaries of the Warwickshire where the hospital normally used was out of county. Would the PCT suggest to GPs where they should send patients or would it be prepared for them to use hospitals outside the county?

(ii) Under patients choice patients could choose where they wanted to go and GPs would not be restricted as to where they sent them. GPs were getting more involved in commissioning.

(iii) Julie Whittaker was unable to comment on the implications of the PFI.

(iv) The Review had provided the opportunity to look at all services in the light of the impact of care in the community. Not all carers were coping.

(v) It was difficult to get GP appointments. More flexible bookings were being looked at and some GP practices were taking on evening work.

(vi) There had always been a problem of inequalities with funding in North Warwickshire being below the national average.

(vii) The LDPs of the three existing PCTs would be harmonised into one document. The PCT was just in a position to recruit and was working on an eighteen month incremental staged approach.

(viii) There had been a growth in stroke patients. Each patient would have a individually designed care pathway and it was intended to reduce a 21

day stay in the acute hospital to 4 or 5 days with care then continuing in Community Hospitals or Community Care.

(ix) An Audit Commission report had criticised North Warwickshire over partnership working. However there was now full partnership working.

(x) On the question of the cost impact of new services, it was pointed out that some would cost less. However it was not possible to say what extra cost might be involved.

(xi) The Community Matron was a government initiative. They worked around managing elderly patients in the community who were continually being admitted to hospital with a view to controlling their condition so that they did not need to keep going back to hospital.

(10) Older People – Social Care/Community Hospitals

The Chair said that he was disappointed that there was no NHS representative for this item but Graeme Betts had kindly agreed to deal with this issue.

The following points were then raised:-

(i) He was disappointed at the lack of a thorough needs analysis in the proposals and he was not convinced that the ASR Board had looked into the future.

(ii) He had a fundamental concern in the area of finance. It was essential that the funding for the proposals should be identified but was not done.

(iii) There seemed to be a lack of understanding that time was needed to develop services in the community.

(iv) There was a lack of planning – the only strategic plan for older people was five years old. The elderly had a need for a diverse range of services and this was not reflected in the Review.

(v) Services needed to be introduced incrementally.

(vi) He was not aware of the involvement of the NHS representatives working with officers in his directorate.

(vii) He would like to have a joint vision with the health service and across the board working.

(viii) There was a need to address inequalities and the first step would be to carry out a needs analysis.

(ix) The voluntary sector had an important part to play and could be contracted to provide certain services. The County Council could take on a commissioning rather than providing role.

(x) There was a rash assumption that there would only be one provider.

(11) Cancer Services

Health Service representatives were Dr. Peter Hawker and Richard Hancox

The following points were then raised during the discussion:-

(i) There would be specialisation of complex cases at UHCW but most cancer cases could be and should be dealt with at the local hospitals.

(ii) There was no point in moving chemotherapy from George Eliot Hospital as that was clearly the right place for it. It was proposed that this should be extended to Warwick Hospital.

(iii) Unfortunately there was no funding included for this proposal. It was hoped that meetings like this one would bring pressure on the PCT to provide that funding.

(iv) Although money had been invested in the NHS, new treatments for cancer were very expensive.

(12) Summing up/Concluding remarks

It was regretted that the ASR Board were not sending the right people to answer the Committee's questions.

The Committee adjourned from 4.30 p.m. to 9.00 a.m. the following day

2. Programme for the 1st September 2006

(1) Introduction to second day

The Chair welcomed those present.

(2) University Hospitals Coventry and Warwickshire NHS Trust

Health Service representative was Dr. Robert Higgins

The following points were then raised during the discussion:-

(i) The hospital was open and functioning well, cleaning maintenance had improved over the last two weeks. Car parking would not be completed until after the demolition of the old hospital buildings. This was on schedule.

(ii) He was not able to comment on bed modelling, as he had not been part of the workshop that dealt with the issue.

(iii) He was unable to answer specifically why 219 neonatal cases had been refused over the past six months but said that there was always occasions when this would happen.

(iv) Staff were being recruited into appropriate posts.

(v) Relevant specialties were able to take on the additional work.

(vi) He believed that the Hospital was able to take on the additional workload. This would mean some changes in work practices.

(vii) The proposals in the Review were based on clinical need. Even if there had been unlimited finance available there were certain services that could not be provided locally because of the lack of work to maintain skill levels and lack of staff.

(viii) Although services in South Warwickshire and George Eliot were not clinically unsafe, it was prudent to undertake a review before that situation was reached.

(ix) He was not in a position to answer in detail any financial question. However, he said that the Trust had been in a break-even position for some years and expected to be so again this year. Members were disappointed that there was no one present who could answer financial questions.

(x) Although there were risks under the tariff system UHCW could compete.

(xi) He maintained that the transport of very sick patients could be performed safely.

(xii) The population of Coventry and Warwickshire was 0.85m and this needed to increase to 1.5m to 1.8m to maintain and sustain a good high class tertiary unit. Those numbers would vary for some specialities, for example renal units needed a population of 60m to become viable.

(xiii) The hospital was too new to have meaningful figures about infection control. Initially the cleaning had not been managed properly but that had now been rectified. MRSA rates were as good as peer group hospitals nationally.

The Chair thanked Dr. Higgins for his time and hoped that he would take the Committee's comments back with him to UHCW.

(3) <u>Transport</u>

The Chair regretted that there was no representative from the ASR Board for this item. Vicky Porter and Margaret Smith from the Environment and Economy Directorate were present to assist the Committee.

The following points arose:-

(i) Welcomed the proposals to keep services as local as possible. More serious cases were to be dealt with further away but there was no figures given as to the volume involved.

(ii) A preliminary meeting had been held with Mark Newbold to discuss transport issues and further work would be needed with the NHS.

(iii) The review glossed over the travel times to Walsgrave Hospital.

(iv) There were insufficient parking spaces at hospitals.

(v) Patients needed to be advised as to what assistance there might be for helping with travel costs.

(vi) Mrs. Tandy had experienced difficulty in travelling to the Hospital recently and that was outside the school term.

(vii) The transport section of the Review was very light and yet this was one of the main worries of people in Warwickshire. Travel problems were experienced by both patients and visitors.

(viii) It was suggested that when an appointment was made the patient should be supplied with a leaflet containing what assistance was available to help with the cost of transport/parking.

(ix) At least a quarter of the population in the north of the county had no access to a car.

(x) The cost of transport from UHCW to the north of the county was prohibitive. People discharged from hospital may not be fit enough to travel by public transport and it should be the responsibility of the hospital to get them home.

(xi) There were volunteer drivers but use of them could be affected by capacity and lack of public awareness.

(xii) There was no consistency with the level of car parking charges between the hospitals

(xiii) 80,000 people access George Eliot from Hinckley and Bosworth and that number would not go to Coventry.

(xiv) It was noted that hospitals received no money for car parks. Charges should be reasonable with no profit motives.

The Committee adjourned from 10.52 a.m. to 11.00 a.m.

(4) Strategic Health Authority – Health Economy

Health Service representative was Rob Checketts.

The following points were then raised during the discussion:-

(i) The consultation exercise should result in services that were a strategic fit in the widest sense in the West Midlands, took account of the financial situation and were acceptable to the public.

(ii) It was important that the NHS could demonstrate that it had worked with local government and others in arriving at the proposals.

(iii) The frustration of the Committee and the public in not getting answers was understood and it would be necessary for there to be an open and honest discussion.

(iv) The accumulated deficit would not go away and would have to be dealt with.

(v) The Strategic Health Authority would have to ensure that the Review proposals knitted together strategically with plans for neighbouring areas.

(vi) Members were pleased with the statement that the Strategic Health Authority was willing to work with local authorities.

(5) University of Warwickshire/CfPS – Overarching View of Proposals for NHS/LAs/Residents

Iain Roxburgh and Maria Duggan gave the Committee a summary of their view of the ASR. They considered that the methodology had been fundamentally flawed and there was little concrete evidence given to explain the rationale and assumptions contained in the review. There was an absence of both a rigorous risks assessment analysis and a race equality impact assessment. The review should have indicated the vision of where they wanted to be in the future in principle. Proposals should have options, outlined action plans and details of resources.

The Committee adjourned from 12.35 p.m. to 1.15 p.m.

(6) Mark Newbold – Project Manager Acute Services Review

Health Service representative were Mark Newbold and Madeleine Atkins, Independent Chair of Review Board.

The following points were then raised during the discussion:-

(i) Coventry and Warwickshire were well off for hospitals, with three Acute Hospitals, St. Cross and a number of community hospitals, which presented challenges to the Health Service.

(ii) The vision was as far as possible to achieve collaboration between the hospitals to benefit of patients.

(iii) UHCW would not be able to take on all the additional work proposed straightaway. What the review was suggesting was a direction of travel and there would need to be capacity building to achieve it.

(iv) The intention was that some services would be made more local with the use of community hospitals having an enhanced role. 80% of services would continue to be delivered from Warwick and George Eliot.

(v) Transport was a considerable concern but it was not something the Health Service could solve on its own. It did not have any control over private bus companies.

(vi) There would be a shift of resources from acute hospitals to the community but it would take a long time to build up capacity in the community.

(vii) It was recognised that maternity provision at UHCW needed to be strengthened to meet increasing demands.

(viii) Although the Review could make recommendations about the direction of travel for cancer services, it could not guarantee that the money would be available.

(ix) The shift from acute hospitals to care in the community was government policy.

(x) The review did not have a remit to design services for the elderly in the community. This was a matter for the PCT and local authorities to tackle.

(xi) The likely impact of patient choice was not known.

(xii) The intention was that surgeons based at UHCW would go out to the other hospitals to carry out surgery there rather than move critically ill patients.

(xiii) Financial analysis of proposals was continuing but it had not been helped by the reorganisation of the various health bodies.

(xiv) The Review had been carried out from the ground up with assessment by expert bodies locally looking at how medical care developed.

(xv) The current system of three 24 hour paediatric services was difficult to sustain.

(xvi) There would be a need for a lot of joint working from next year.

(xvii) It was in no ones interest to cause financial instability in the health economy.

(xviii) The recommendations were fully in line with the LDPs.

(xix) Networking would mean that surgeons could be moved between hospitals, rather than moving patients.

(7) Concluding remarks from the evidence given

The following points were then raised during the discussion:-

(i) The status quo was not an option.

(ii) Review flawed by the absence of a risk assessment.

(iii) There were substantial deficits that needed tackling.

(iv) There were many aspects of the Review that were inescapable and correct in philosophy and approach but the question whether there was confidence in the ability of the NHS to put the proposals into effect in the same spirit.

(v) There should be as much local provision as possible.

(vi) The Review did not reflect the inequalities in provision.

(vii) It was not possible to move people out of hospitals unless provision existed in the community for them.

(viii) The proposals would have a ten year timescale.

(ix) There was no business case made for the changes.

(x) No evidence of consultation in building up the recommendations from the Review.

The Chair thanked Alwin McGibbon for all the work she had done to make the make the meeting possible.

(8) Recommendations

1. Opening Statement

1.1 Warwickshire County Council Health Overview and Scrutiny Committee places on record its thanks to the NHS organisations, PPI Forums, other bodies and individuals who have provided evidence, submissions and contributions to the scrutiny exercise and for their attendance at the two day hearing conducted by the Committee on 31 August and 1 September 2006.

1.2 Health Overview and Scrutiny Committee requests the Primary Care Trusts and NHS Hospital Trusts (or the Acute Services Board on their behalf) provide, within 28 days, a written response to the comments and recommendations below.

2. Warwickshire County Council's Health Overview and Scrutiny Committee's overall Response to the Evidence Base and Consultation Process.

2.1 During the two-day hearing the Committee responded positively to some proposals emerging from the Review, specifically those addressing the reconfiguration of cancer services and clinical support services. However, in general terms the Committee believe that the proposals set out in the consultation document and the verbal evidence presented contain a number of inconsistencies, elaborated below, and that there are deficiencies in the consultation process.

2.2 Broadly, the Committee believes that the Acute Services Review consultation document, in a number of important respects, lacks sufficient detail to enable consultees to come to a robust judgement about how the implementation of these proposals might impact on the health and well being of residents of Warwickshire.

2.3 The committee understands that the review board has undertaken a great deal of detailed and rigorous research, which provide the evidence base for its proposals. However the lack of this evidence in the consultation document contributes to a number of concerns amongst Committee members. The Committee deplores in particular the lack of the following:

a) a health impact assessment which would enable consultees to appraise specific, differential impacts on access to comprehensive, high quality health care by groups and communities within Coventry and Warwickshire and in particular any adverse impacts on health inequalities ,

b) a race equality assessment as required by all public bodies under the Race Relations (Amendment) Act 2000. All health

care bodies have a statutory duty to work to eliminate unlawful racial discrimination and promote equal opportunities and good race relations under the Race Relations (Amendment) Act 2000.

c) or detailed risk assessments in relation to the various proposals set out in the consultation document

d) In addition to this there appeared to be no business case, hence no identification of the resources, including the finances, to support many of the proposals.

2.4 The Committee is disappointed at the lack of meaningful involvement of local communities at the early formative stage of the Review, which has led to confusion about the principles underpinning the review and a lack of confidence generally in the proposals.

2.5 The Committee recognise that the maintenance of the present status quo in health service configuration in Coventry and Warwickshire is not an option. It fully accepts that the way health services are provided invariably reflects a range of dynamic factors within the environment including the changing needs of populations, developments in evidence -based medicine and in changing clinical practice. The committee also acknowledges the current financial pressures on the NHS locally and nationally and the thrust of national health policy towards greater contestability. In this context, it is important for the NHS and local government to work together to consider the evidence and determine a way forward that will put in place the best possible responses to the healthcare needs of the populations, which we jointly serve.

2.6 However, the Committee considers that many of the specific proposals of the acute services review are not justified by the evidence presented. In addition, it appears to the Committee that the concentration on the acute segment of care alone, without any consideration of the consequential impacts of the proposed changes on other parts of the system, has the potential to destabilise the local health and social care economy and create further pressures on fragile and overstretched primary, community and social services and therefore to threaten the health of local populations.

2.7 The Committee believes that a review of acute care can only effectively be undertaken as an element within a broader review of the best configuration of services to support the whole pathway of care, including both primary and secondary preventative services,

2.8 The Health Overview and Scrutiny Committee considers that there has been insufficient time and insufficient information available to consider the potential impact of some of the proposed changes, which are extremely complex and far-reaching in nature. The Committee believes that there should be further, more detailed

consultation on these issues before any steps are taken to implement the proposals.

2.9 The Committee requests that the Acute Services Board (or the relevant PCT and NHS Trusts) establishes as a matter of urgency a dialogue with Warwickshire County Council's Health Overview and Scrutiny Committee to ensure that there is a joint understanding of the evidence for its proposals and to ensure that there is maximum collaboration between key partners in relation to the ambition of providing a world class health service for local people in Coventry & Warwickshire.

2.10 In summary, the Committee believes that a number of the proposals do not appear to be in the best interests of the (Health Service) in Warwickshire. It serves notice that it is minded to refer these particular matters to the Secretary of State for Health unless a local solution can be found.

3. <u>Responses to Specific Proposals</u>

3.1 The Health Overview & Scrutiny committee requests that the Acute Services Review Board take account of the preceding comments and the following recommendations:

4. <u>Proposal 1 Consolidate emergency surgery operating at night</u>

4.1 The Committee consider that there was a lack of clarity in the evidence given on the proposal being made. The clinicians who presented verbal evidence at the hearing had differing opinions on whether the proposal was safe to implement and concerns were raised that patients could be put at risk if the emergency facilities were downgraded at George Eliot or Warwick Hospital.

4.2 The Committee makes the following recommendations:

(1) That the theatre facilities for emergency & inpatient emergencies should continue to be provided at George Eliot and Warwick Hospital at night and weekends.

(2) That the arrangement for A & E consultants at both hospitals to attend at night be strengthened, especially bearing in mind the small number of consultants at George Eliot Hospital.

Note that the Committee are minded to refer this particular matter to the Secretary of State on the grounds that the proposal would not be in the interests of the health service in Warwickshire, unless a local solution can be found

5. Proposal 2 Develop a new model of care for acute medicine

5.1 This proposal covers emergency illness not needing surgery such as heart attacks, strokes or chest infections. The proposal is that patients to be seen by senior staff soon after they arrive at an assessment centre at a prearranged time. This will provide expert care to the patient without the need to wait in an emergency department.

5.2 The Committee supports this proposal, but it is not evident from the consultation document whether there would be sufficient staff or resources to implement this change in working arrangements especially where there are existing recruitment difficulties.

The Committee recommend that:

(1) A risk assessment is conducted before implementation and resources are made available.

6. Services for older people

6.1 The growth of the numbers of older people is a considerable factor in providing social care and the Committee recognises the benefits of enabling older people to remain in their home and reducing admissions into hospitals. It also recognises the benefit of minimising hospital stay. However, if this was not properly implemented it may result in poor aftercare, pass the burden of care to the Local Authority and place pressures on the already limited resources it has available.

6.2 Concerns have been raised that the Acute Services Review, to date, has not fully involved the County Council with the proposals being made, but this needs to change. It was suggested early on that either Jim Graham (Chief Executive) or the Strategic Director for Adult Services should be invited on the Review Board and a letter was eventually sent to request the portfolio holder for health to be invited. This may have given the review the strategic direction to understand the implications of the proposals being made from a local authority perspective. It is essential that the NHS and the local authority develop a process together on how older people move from acute care into the community.

The committee recommends:

(1) That there should be a needs analysis – without this it will be risk that health inequalities may be exacerbated
(2) That partnership working is essential and needs to be strengthened
(3) That there is a proper review of health and care resources to be used jointly to best effect

(4) That the public should be engaged before the proposals are implemented

(5) That this Committee must meet with GPs and practice based commissioners to understand how advanced their plans are to reduce activity in acute sector and their capacity to do so.

(6) That there should be a process of sharing findings between Warwickshire and Coventry City Councils' Health Overview and Scrutiny Committee. It must involve the County Council and the Executive.

(7) That a joint commissioning group for acute services should be established involving PCTs and the local authorities for Warwickshire and Coventry.

7. Services for Children & Maternity

7.1 The committee's main concerns were with the proposals for George Eliot Hospital. The Committee felt that there was no evidence of a health impact assessment being done. This is important because we know for example that in some parts of Nuneaton and Bedworth the population are in the top 10% for deprivation in the country. There also seems to be no clear business case for the proposals being suggested, for example, there appears to be no business sense in moving the money or resources from George Eliot Hospital to the University Hospital of Coventry and Warwickshire (UHCW) when there is not the capacity to take the additional births required.

7.2 Clinicians did indicate that staff shortages were not always due to lack of people with the necessary skills, but because there was no money to employ them. The Committee was not convinced that existing staff at the George Eliot would necessarily move to the UHCW.

7.3 The Committee had also heard that maternity patients from the George Eliot were already being referred to the UHCW with a suggestion that the maternity building at the George Eliot was going to be demolished. They were concerned that this was happening in advance of the consultation being completed.

7.4 Because of the high levels of deprivation in Nuneaton and Bedworth and the increased risk to mother and child the Committee recommends:

(1) That the Review Board look at ways of ensuring the Maternity Unit remains at George Eliot Hospital without downgrading the services being provided.

(2) That additional resources be provided for George Eliot Hospital so that more staff can be employed to maintain the excellent facility at George Eliot and Royal College status required for the

SCBU. Suggest this could be done by savings made in not moving resources to the UHCW.

(3) That the Review Board confirm whether or not mothers from the George Eliot are already being referred to the UHCW and, if they are, the reasoning behind this change in service provision.

Note that the committee are minded to refer this particular matter to the secretary of state on the grounds that the proposal would not be in the interests of the health service in Warwickshire, unless a local solution can be found

8 Proposal 3 Paediatric Assessment units

8.1 The proposals suggest that there should be a 12 hour paediatric assessment unit at George Eliot Hospital and a 24 hour paediatric assessment unit at Warwick Hospital.

8.2 Again the committee was not convinced that a strong business case for this proposal although were told that it could not remain the same. The committee had concerns about the provision of paediatric emergency services and whether there could be delays in treatment. For example if the parents take the child to George Eliot and it becomes apparent due to lack of paediatric cover that the child will have to be transferred to the UHCW.

8.3 During the hearing the committee asked and received confirmation that, if there is a proposal to change the services at Warwick Hospital to 12 hour, that there will be a further consultation.

8.4 Also during the hearing the committee were made aware that the Review Board are going to take a strategic view of the proposals being made taking into account changes to maternity and paediatric services in neighbouring counties.

The committee make the following recommendations

(1) That the committee consider that paediatricians can be moved as suggested for emergency surgery.

(2) That the committee would want to retain the 24 assessment unit at George Eliot Hospital so that it can continue with providing SCBU facilities to those babies that require these specialist services

(3) That if the proposals for phase 2 for Warwick Hospital go ahead the committee expect residents and the committee to be consulted.

(4) That the Health Overview and Scrutiny Committee welcomes the plan for a strategic view of maternity and paediatric services, taking

account neighbouring counties, and expect to be involved with this consultation.

Note that the committee are minded to refer this particular matter to the secretary of state on the grounds that the proposal would not be in the interests of the health service in Warwickshire, unless a local solution can be found

9. <u>Proposal 4 Create a Single Specialist In-patient Children's unit at University Hospital</u>

(1) The committee consider that a 24 hr facility stills needs to be retained at George Eliot Hospital to ensure the hospital can provide a SCBU.

Note that the committee are minded to refer this particular matter to the secretary of state on the grounds that the proposal would not be in the interests of the health service in Warwickshire, unless a local solution can be found

10. <u>Proposal 5 Combine the University Hospital and George Eliot Hospital Units into a single service on two sites.</u>

(1) As the recommendation above the committee would want to retain the 24 hr cover at George Eliot Hospital.

Note that the committee are minded to refer this particular matter to the secretary of state on the grounds that the proposal would not be in the interests of the health service in Warwickshire, unless a local solution can be found

11. <u>Cancer Services</u>

11.1 The Committee recognises that this is a continuation of the work started by the Arden Cancer Network and support the following two proposals but recognise that no finances have yet been allocated to support these changes

12. <u>Proposal 6 Centralise complex cancer services in the University Hospital</u>

12.1 The committee recognises the importance for patients with cancer to be treated at the most appropriate hospital with the necessary resources for treatment to ensure the best outcome for them and their families.

The committee support the proposals but recommend:

(1) That finances and resources to be made available as soon as possible to implement this change.

13. Proposal 7 Develop ambulatory cancer units at University and Warwick Hospitals

13.1 The Committee supports the proposal to provide ambulatory services at Warwick Hospital and welcomes the move to provide more care and support in the community for what is a very distressing time for patients and their families, but notes that finances are needed to bring about this change.

Again the committee recommends:

(1) That finances and resources to be made available as soon as possible to implement this change.

14. Clinical Support

14.1 The committee support the proposals being made to move to a single managed pathology laboratory service for Coventry and Warwickshire and the centralisation of pharmacy purchasing and stockholding. The committee recognises the cost benefits and value for money the proposals are making and have been assured that the time taken to get results will improve and single managed pharmacy service will avoid duplication.

14.2 The committee would like to be informed of the location of services as soon as it is known.

Further steps that need to be taken by the Acute Services Review Board or Primary Care Trust(s) and NHS Hospital Trusts (whichever is most appropriate)

To ensure:

(1) The local authorities in the county along with local residents are kept fully informed of progress and

(2) The following matters are addressed in more detail and the Health Overview and Scrutiny Committee advised of the outcome of that work before any steps are taken towards implementation of changes to services proposed in the ASR consultation paper

i) The arrangements for the local health economy in relation to the flow of resources towards developing community hospitals and community services as envisaged within the white paper.

ii) Commissioning: that a joint group is established that can develop a robust commissioning model for Coventry and

Warwickshire that takes account of the diverse population and geographical spread.

iii) That the Acute Services Board should work with the Strategic Director for Environment and Economy to ensure that the transport implications of the proposals are clearly identified and that the relevant health authority make funding available to secure necessary improvements to transport arrangements and infrastructure. Please see attached Appendix A with suggested areas of activity where the PCT, Acute Trusts and County Council could work together.

iv) That the Acute Trusts in Coventry and Warwickshire improve information on the reimbursement of travel and parking costs for residents on benefits, where possible, and local provision be made for patients receiving chemotherapy or regular treatment such as dialysis.

v) That the Review Board as a matter of urgency should conduct:

(a) a health impact assessment
(b) a risk assessment
(c) a race equality impact assessment

Appendix A

Scope of works

Stage 1: Identify the transport implications of the Acute Services Review

Stage 2: Quantify the impact of the proposals on Warwickshire residents, including:

- number of patients (and visitors) affected by the proposal to centralise specialist services at University hospital
- the difference in accessibility between access to the nearest hospital and accessing the University hospital, including comparison of:
  - the % residents within set time thresholds (by public transport and car);

- calculation of journey times (taking into account congestion);
- cost of travel (by car / pt / voluntary transport);
- parking availability and cost.

Stage 3: Develop options for improving access to hospital, to include:

- improving travel to hospitals
  - capacity and suitability of voluntary transport
  - capacity of non-emergency ambulance service
  - options to extend mainstream public transport to University hospital
  - options to extend community transport to University hospital
  - use of taxi-bus / taxi contracts
  - opportunity to utilise downtime of social service transport
  - parking cost and availability
- flexibility in booking appointments to fit in around available transport
- improving information on travel to hospitals
- review eligibility for travel assistance

Stage 4: Costing of transport options and review of resources available to fund them

Stage 5: Consultation on options with stakeholders

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Chair

The Committee rose at 4. 24 p.m.