Appendix A

NOTES

Health OSC Steering Group
Friday 8 November– Scrutiny Chairs Room (B14a)
2.00pm

Present:

- County Councillor Steve Holgate
- County Councillor Mohammed Iqbal
- County Councillor Margaret Brindle
- County Councillor Fabian Craig-Wilson

From Lancashire Teaching Hospitals Trust:

- Karen Partington – Chief Executive
- Steve O'Brien – Associate Director for Quality
- Paul Havey – Finance Director

1. **Notes of last meeting**
   The notes of the Steering Group meeting held on 18 October were agreed as correct

2. **Lancashire Teaching Hospitals Trust**
   As part of the ongoing scrutiny of the Acute Trusts within Lancashire, officers from Lancashire Teaching Hospitals Trust (LTHT) had been invited to the Steering Group to talk to members about their current position.

   Members had been provided with a copy of an Intelligence Monitoring Report from the CQC and the response provided by the Trust, copies of which are appended to these notes.

   Karen, Paul and Steve attended the meeting and a general discussion about the work and performance of the Trust took place, the main points being:

   - Trust's response to the CQC report – context and how it's been pulled together
   - Issues relating to regulators that came out of the Mid Staffs review and how they would amend their inspection regime.
   - Quality and risk profile – been reviewed (over 150 indicators of quality) – 87 applicable to LTHT
   - There are 3 categories of risk – as per document
     - 80 no risk
     - 3 risk
     - 4 elevated risk
   - 6% rating of risk – placed all trusts in a banding – LTHT in band 2
   - Some indicators are less patient focused as not all data relates to patient care.
   - Coding takes time so use 'flex data' (how much activity has taken place but not necessarily coded) and 'freeze data' (all coded activity) – freeze data determines the payment that the Trust receive.
   - Felt that this process will mature in terms of what indicators are important and those that aren't.

- Felt that whistle blowing events should be seen as a positive rather than a negative.
- Management Team have been made aware of whistle blowing and tried to determine a solution, take it very seriously and they trigger an internal investigation – disappointed that this hasn't been reflected in the scoring
- Mortality alerts accumulate over time until they go through a threshold and trigger a target. – Trust look at it as a rolling 12 months (on a monthly basis) – use the same tools as the CQC. – Many ways of looking at the data, constantly monitor this area.
- Role of non-execs as champions to work alongside the data crunchers but need to clear about what's being looked
- HSMR -standardised mortality ratio to try to even out the playing field and be able to compare to other trusts. LTHT mortality rates has dropped year on year
- 27 mortality ratios - but HSMR is the one most recognised and used.
- Don't look at all patients but 56 diagnostic groups. They adjust the data in response to case mix (i.e. older patients, multiple conditions, at end of life) to get the ratio.
- In terms of coding the Trust feel they can be stronger (i.e. that they under code for complexity) – making steps to improve this. The first response is not to challenge the data but to determine the indicator of harm.
- Steve asked how many risk levels that the Trust currently use – didn't really answer the question instead they replied with the factors used i.e. age, conditions, what's wrong with you, gender and post code element of social deprivation. Trust said that they don't determine the level of risk, that's it's a national criteria set.
- What the Trust are going to do – looking at all in hospital deaths (were they appropriate/expected). Concentrating on and understanding avoidable deaths.
- Just because the Trust is meeting targets are they still striving for improvement? The safety/quality strategy document potentially addresses some of these issues. – e.g. should they be putting in percentage targets to reduce mortality year on year?
- Are they minimising harm, are they reducing avoidable harm – felt that this was the most important issue
- The Trust hasn't just waited for the CQC report to be produced but they have already been putting actions in place to address the issues raised.
- Data looked at weekly – in the past had a responsive attitude but now look at each individual death to see if there are any patterns. Some seasonal, some due to major trauma, found areas of improvement but no single incidence where a lapse in treatment has contributed to someone's death. Higher level of mortality over the weekend but feel it's not due to the interventions of the Trust
- The Trust argues that the data applied didn't seem to reflect the risk associated with a patient or take into account the community based services that could be asked. – expectation as per national pathways
- The hospital is the end point so quite often they are the recipient of the result of the health economy if there isn't an adequate patient pathway.
- Working with clinical senate – all Trust CEOs, LCC, CCGs and NWAS (in its early stages) – to work across pathways.
- Trust has an issue with social care and 7 day working – one of their biggest concerns is the period over Christmas when social care offices are closed.

- If hospitals are open 7 days the rest of the system needs to be too.
- How do we move towards a more integrated service? They feel that there should be more focus and responsibility for health onto local authorities – how are councils going about planning for an integrated service.
- £3.9billion is coming out of health in April 2015 – coming to LAs instead. Political argument as to how that money is used within councils' (public health) to prevent admissions. The conversation needs to start now so the trust can work out what it needs to stop doing.
- Staff morale – internal satisfaction survey pretty good (although this is not what the data says), under a lot of pressure, depends on where within the Trust that staff are – Karen is getting back in uniform and getting back to the floor.
- Feel that staff who want to answer do so but often it's those most satisfied and those most unsatisfied will respond – feel that they are doing lots to get out and about to give staff an opportunity to voice concerns.
- Have trackers – given to patients and staff to provide feedback (real time)
- When staff flag concerns full investigations are carried out – staff email Karen individually – admit that they don't have the communications right.
- Every staff group is represented in their internal survey and they are sampled. They do an email survey but the national staff survey is impendent
- What % of return - last year 60% for internal survey.
- Annual opportunity for every member of staff to feedback
- Having a special meeting of governing body to go through the figures next week. Want to reassure members that they are doing everything possible to address the issues re avoidable deaths.
- Specialised services - PCTs used to commission these services – now its NHS England LATs (and not CCGs) but the Trust want them to have significant influence over it.
- As Lancashire as a whole we are underprovided for renal services – but patients are presenting at hospital, not going to their GP first for referrals and its often not shown as the cause of death (its often down to heart failure as a result)
- Bear in mind that complex services need to be consulted upon in a very clear and plain manner – need to identify the benefits as a first point
- With regard to staff – it became us/them when 2 services combined and need to make sure this won't happen in the future – particularly important when you have 2 sites
- Finances – not hit the financial targets for 3 qtrs, relatively poor financial position, and drive to hit the targets impacting on their finances. At least 40 beds more in the system than needed, spending lots on A&E pressures, and spending to hit the 18 weeks targets.
- Reconfiguration of services –at very early stage, appointed a Strategic Director and will be done within a wide range of stakeholders – (if starting 6 months prior to a general election the NHS is instructed to stop anything that may become a political issue.)
- Using consultants to look at clinical priority and need, but clinical care will not be compromised.
- Chorley is not a trauma unit because Preston is the trauma centre. Chorley is where the majority of the elective orthopaedic work takes place
- The future of LTHT? – all options are being looked at, nothing will happen overnight, no surprises, full consultation will take place, proper

engagement. Trust have met with Chorley campaign group and agreed to meet with them again
- Want people to understand how good LTHT is and the complexity of Royal Preston – Liverpool and Manchester have their specialism's in separate hospitals
- Communication and clarity was requested so the Trust can explain clearly and more people understand – i.e. patient pathways, locations of services etc.
- Feel the Trust should be smaller if more services are provided within the community, shouldn't be an empire. Particularly interested in preventative measures through our public health role
- Specialised services - may be a desire to move services back to Manchester – Steve asked Paul to email him and CC Ali outlining their concerns re this as they are meeting with Lancashire MPs over the next few weeks. Paul will provide information to explain the nature and implications (they are saying access doesn't necessarily mean location)
- Trust provide superb services for cancer and are disappointed re knock on effect for staff. Christie may subcontract back to LTHT
- Given the public's expectations it's an opportunity to challenge the central decisions taken given we've got an ageing population. It's not about integrated provision but what do we want to spend on health in this country
- Buckshaw – do they get VFM?, 20 beds, quite often they're empty, problem finding the right type of patient, is there a monitoring of people who free up hospital beds, what's the re-admissions rate to the less intensive beds? Providers are not paid for re-admissions within 28 days; only 5% were as a result of something the Trust could have done better. 95% because not adequate support available in the community or residential sector
- Massive shortage of some specialities, Medicine is £2m overspent due to agency staff
- 'Case for Change' – within this Chorley has a significant role to play in the delivery of services but his hasn't been formulated yet for the future
- National shortage of nurses – as a result of Francis enquiry every Trust is looking to increase the number of nurses. Problem recruiting theatre staff, national shortage of A&E staff. Training numbers have been reduced
- Feel that CQC Intelligence Monitoring Report was harsh
- Will achieve a risk rating of 3 (Monitor), not where they want to be, have the plan but need the time to implement
- Have a cadet ship within the Trust, looking to expand. Bank staff can also be trained up
- Asked members to reiterate positive messages about the NHS as lots of negative press

3. **Work plan and updates**
   Members considered future topics for Committee and Steering Group and discussed progress on previous issues considered.

4. **Dates of future meetings**
   - 29 November – Leslie Forsyth, Chief Executive of Healthwatch
   - 20 December – FWCCG: Development of the Health & Care Strategy
   - 10 January – Domiciliary Care review
   - 31 January - ELCCG