Minutes of the special meeting of the Board of Directors held on Monday 14 April, 2014

Agenda Item No: 4

The Royal Wolverhampton NHS Trust

Minutes of the special meeting of the Board of Directors held on Monday 14 April 2014 at 09.30am in the Board Room, Clinical Skills and Corporate Services Centre, New Cross Hospital, Wolverhampton

PRESENT:	Mr J Vanes	Acting Chairman
	Dr J Anderson	Non-Executive Director
	Ms R Edwards	Non-Executive Director
	Ms C Etches OBE	Chief Nursing Officer
	Mr D Loughton CBE	Chief Executive
	Mr R Dunshea	Non-Executive Director
	Ms G Nuttall	Chief Operating Officer
	Dr J Odum	Medical Director
	Mrs S Rawlings	Non-Executive Director
	Mr K Stringer	Chief Financial Officer
	Professor D Kelly	Associate Non-Executive Director
	Ms M Espley	Director of Planning and Contracting
IN ATTENDANCE:	Mr A Sargent	Trust Board Secretary
	Ms C Robinson	Estates Development
OBSERVERS:		
	Dr H Hibbs	Wolverhampton CCG
APOLOGIES:	Mr M Swan	Lead Shadow Governor
	Ms M Martin	Non-Executive Director

Part 1 – Open to the public

TB.4960: Acting Chair's Opening Remarks

Mr Vanes welcomed Dr Hibbs of the Wolverhampton Clinical Commissioning Group. He also welcomed Roger Dunshea, recently appointed Non-Executive Director, to his first meeting as a member of the Board.

TB.4961: Declarations of Interest from Directors and Officers

There were no declarations of interest.

TB.4962: Proposed New Emergency Centre – Full Business Case

Dr Odum presented the full business case for the development of a new Emergency Centre. He reminded the Board that it had approved the outline business case in October 2013, which had then been approved by the CCG Governing Body in November 2013, and by the Trust Development Authority in January 2014.

Dr Odum went on to summarise the case for change within the Strategic Case, including the 5% increase in attendances, and a 5.4% increase in ambulance attendances in the last year, coupled with a dip in performance against the four hour wait target. The current care model

and pathway was now considered to be inefficient, with duplication of effort, difficulties in achieving collaborative working, and care plans/investigations being developed only after the patient's transfer out of the Emergency Department into other parts of the hospital. He also referred to workforce issues within the case for change, including the difficulty of flexing staffing between various portals and achieving different ways of working in different portals. He added that the current Emergency Department imposed various restrictions in terms of capacity and environment.

Dr Odum then referred to the Urgent and Emergency Care Strategy, public consultation on which had been completed on 2 March 2014 with more than 90% expressing support for the strategy. The Wolverhampton City Council overview and scrutiny committee had supported the methodology for consultation in March. He pointed out that the secondary care component of the strategy provided for the construction of the Urgent and Emergency Care Centre, which was also in line with national strategy and the Keogh Review of Urgent and Emergency Care. He reminded the Board that the strategic case contained a patient centred vision of the future service, which included such factors as 24/7 senior decision-makers cover with involvement earlier in the process, a single portal for the majority of patients including primary care, a one-stop shop for diagnostics, and a shared pool of junior doctors.

Dr Odum referred to sensitivities within the strategic case. Since consideration of the outline business case, the Wolverhampton CCG had served notice of an intention to tender for urgent care services, the implications of which were covered by (a) base model less walk-in centre activity (a potential reduction of 22,000 attendances) and (b) base model less walk-in centre less all urgent care activity (a potential reduction of 45,000 attendances). Both of these sensitivities would increase the affordability gap and had been shared with the CCG for financial planning purposes.

Mr Stringer guided the Board through the key changes since the OBC. Activity at the first full year of opening (all areas) had been increased to reflect Stafford activity. The start on site date had been brought forward to November 2015 based on the assumption that £10m additional public dividend capital would be secured. There had also been a change in the net revenue position between 2014/2015 and 2017/2018, to reflect Stafford activity, thereby reducing the underlying non-recurring affordability gap. He also indicated that the capital costs had increased marginally to £29.9m, and the procurement strategy had been changed to Procure 21+ for the main construction contracts and enabling works.

Mr Stringer confirmed that the revenue affordability of the base case was as outlined in tables 5D and 5E, and was also contained in the LTFM. The Trust would have to identify savings of £7.3m across the lifetime of the model for the tariff deflator, and would have to consume the cost of capital charges of £1.6m per year recurrently when the new facility was open. He also reminded the Board that there would be an affordability gap from 2016/17 to 2020/21 of £2.1m non-recurrently due to the increased fixed/semi fixed cost of staffing/running the building.

Finally, Mr Stringer confirmed that the governing body of the Wolverhampton CCG had approved the FBC on 8 April, subject to the CCG being involved in the development of the unused space in the building, the Trust supporting the development of service specifications for urgent care, and developing robust models of care across primary and secondary care. He explained that it was now necessary to obtain written expressions of support from other neighbouring CCG's, such as Stafford, Cannock and Seisdon Peninsula. The FBC was expected to be considered by the TDA on 15 May.

Professor Kelly noted that the CCG had served notice of its intention to invite tenders for a certain amount of primary care activity, and asked whether it was feasible for another

organisation to take that on. Dr Hibbs responded that it would be possible for a third party to provide that service, but equally the acute trust could itself bid to do the work. Mr Loughton said that the Trust would submit a bid with a partner, such as salaried GPs. He referred to the intended collaboration with the CCG prior to the formal tender process. Mr Stringer indicated that if the Trust lost that bid, the affordability gap would widen to approximately £8m, and for that reason it would be actively and vigorously engaging with the bidding process. In response to Ms Edwards, Mr Stringer said that the contract period for this tendered service would be for up to 5 years. She noted that during the Board discussion of the outline business case, concerning the question of whether the 20% of emergency care that would be classed as urgent care would be put out to tender, the CCG representative attending had said it was not their intention to do so. Mr Loughton indicated that the CCG's current stance reflected more recent interpretation of guidance from the centre.

Dr Anderson referred to a recent national announcement regarding £50m being made available to help general practitioners to increase the number of appointment slots and potentially resulting in less attendances at hospital emergency departments. She asked whether this would have an impact on the activity model. Mr Loughton suggested that the Board should bear in mind that the potential impact of developments at Stafford Hospital had been understated in the activity model. Dr Hibbs said that the CCG believed that this new facility was needed in the city and that there would be no problem in filling the building. She said that general practitioners were presently overwhelmed by consultations and that there would continue to be great demand for the services of an emergency centre. Dr Anderson said that she thought the manner in which out of hours services were now provided was a significant factor. Dr Hibbs acknowledged this, but pointed out that it seemed unlikely that this would change significantly and therefore services would have to be planned accordingly. Mr Loughton added that numbers attending the Emergency Department were still running at high levels and it appeared that the public had now learnt different behaviour patterns in regard to how they obtained help for urgent and non urgent medical needs.

Dr Anderson noted that less elderly patients were being brought to the hospital close to the point of death and Mr Loughton confirmed that this was the case, progress having been made with nursing homes to reduce unnecessary admissions. However, the fact remained that with an ageing population the hospital was dealing with a growing number of dependent and frail patients. Dr Hibbs said that the Emergency and Urgent Care Strategy was tied into other CCG strategies, but there would still be a need for people to attend an emergency department in the hospital. Dr Anderson emphasised the need to minimise the number of times that elderly patients were transferred during their care pathway and asked whether the emergency centre had been designed with this in mind. Dr Odum indicated that much work remained to be done around the transfer of patients to ensure the pathways were as short as possible. He confirmed that it was the intention to transfer patients to a specialist ward as soon as possible, and then to keep them there. Dr Hibbs added that GPs were also concerned that pathways of care were developed appropriately, which was why the CCG approval had contained a caveat to this end.

Mrs Rawlings asked about progress in obtaining the £10m PDC. Mr Stringer replied that it was expected that a decision on this would be made at the highest level in the TDA, and that it would be linked to capital and revenue costs for services from Stafford Hospital. Mr Loughton added that he remained confident that this sum would be forthcoming given the condition of the existing facilities in the hospital and the fact that it is now dealing with 60% more capacity than that for which it was designed.

Dr Hibbs confirmed that the CCG had thoroughly discussed the proposals and was in support of them subject to the points already outlined. Mr Loughton responded to Mr Vanes' question about the likelihood of other CCGs also supporting the scheme by saying that he

was confident that most would express their support. It was noted that the Stafford CCG had already worked with the Wolverhampton CCG on the Urgent and Emergency Care Strategy.

Ms Edwards welcomed the good practice mentioned in the report regarding a post-implementation review.

Mr Dunshea noted that although the business case spoke of having more senior decision-makers to improve the patient flow, the numbers shown in the graph on page 16 appeared to be flat. Mr Loughton confirmed that there was currently open recruitment for A and E consultants and that the numbers in post had increased significantly during the last 18 months, but there was a national shortage which was affecting all hospitals. Dr Odum added that the Trust aspired to achieve 24/7 cover in A and E, but not all of those involved would necessarily be A and E consultants. Dr Hibbs said that the recruitment and retention of doctors in both primary and secondary care was vital and that the establishment of this new facility would greatly assist in this endeavour. Dr Anderson said that the fact that the Trust already had 11 A and E consultants in post made it an attractive proposition for potential recruits.

Mr Vanes summarised the key points which had emerged since consideration of the Outline Business Case as follows:

- The requirement by the CCG that a certain amount of primary care activity be exposed to tender
- Additional work from Stafford being included in the base case
- The intention to bring forward construction so that the facility can open by November 2015
- A smaller affordability gap underwritten non-recurrently by the CCG
- Small changes to the capital costs
- The decision to use Procure 21+
- The need to obtain written support from surrounding CCG's
- The caveats within the approval from the Wolverhampton CCG (namely, that the CCG will be involved in the development of the unused space in the building, the Trust will support the development of service specifications for urgent care, and robust models of care across primary and secondary care will be developed)
- The confidence that the £10 million of PDC will be forthcoming, although ultimately the capital funds may be from a source other than public dividend capital.

The Chief Executive expressed his gratitude for the unstinting efforts of staff involved in this project, in particular those within the Estates Development team.

RESOLVED: That the Full Business Case for the development of a new Urgent Care and Emergency Centre be approved, with the proviso that the required additional £10 million capital funding may be provided from the centre other than as public dividend capital.

The meeting closed at 10.25am.