Health and Adults Scrutiny Committee 27.11.24

Report by Michael Hanley

Chair: D Jones (DJ, LD)

This meeting was mainly about proposed changes to the bed configuration at hospitals in The University Hospitals of Morecambe Bay Trust (UHMBT).

DJ: The proposals have caused concern. The committee has convened to examine these concerns. We welcome an opportunity to scrutinise these decisions to strengthen the voice of the local community. It is recommended that we consider the proposals and the approach taken by the trust with regard to consultation. Also there is a need to monitor these changes.

CEO of UHMBT: We definitely have some lessons to learn. No decisions have been made about the reorganisation of the beds. In the local newspapers there is talk of closure of Furness General Hospital (FGH). That is not in the plan. There will always be a general hospital in Barrow.
The second issue is the confusion about a mixed sex ward, that is not allowed. There is some confusion about gynaecological patients going to a mixed surgical ward.
All the evidence says you should only come into care for acute care. Some of these services can be provided in the community. We have been working with the local authority (to provide these services). We are focusing more on prevention. We have invested tens of millions of pounds in FGH.
We have the new hospital programme (extra central government funding) , which will allow us to focus on Lancaster Royal Infirmary. This will allow extra funding for FGH.
The shift of care into the community is part of national policy. We knew that waiting times in A/E are too long and it also takes too long to get into a hospital bed (after a patient who is to be admitted arrives at the hospital). Today we have 45 medical patients in surgical beds. The doctors are overstretched because they have their patients all over the hospital. The changes will allow us to cope with the present staff. Our trust is very good at responding to feedback. We need to be able to ring-fence surgical beds because if they are taken up by medical patients then surgical procedures are cancelled.
CEO discussed NMC2R (non-medical cause to reside, ie those patients who are ready for discharge but cannot due to lack of support or lack of residential care home bed). At times we have had up to 160 of these patients, 30% of all beds. We have 16 beds at Park View Gardens (Barrow) for NMC2R
and the number will rise to 24. Also there will be an increase in virtual wards (in their own homes) for the frail and respiratory illness patients. This will help accelerate discharges.
As a result of these changes there will be an increase use of beds with improved patient care and increased resilience in the winter. There is no plan to downgrade FGH and the changes are not financially driven.
Tabitha Darman (TD,Chief Nursing Officer): Discussed the proposed changes.
Ward 1, currently a 15 bed gynaecological ward will become an assessment ward for gynaecological and surgical patients with no overnight stays.
Ward 5: Now 18 ambulatory care (not confined to bed) care patients and will become a 24 bedded surgical ward.
Ward 4: Currently a 24 surgical bed ward will become a 34 bedded medical ward. There is more demand for medical beds.
At Westmorland General Hospital (Kendal) there is low bed occupancy at 40%. 16 bed rehabilitation ward will be closed.

A person from Adult Social Care (WAFC) discussed rehabilitation and reablement. There will be beds at Park View Gardens (Barrow). The average duration is 20 days to get patients home (mainly elderly frail, 70-79 plus 85+).
In the last year there were 835 patients who were admitted recurringly, three or more times. 75% were admitted within 8 weeks.
To reduce this an Integrated Wellness Service has been started (a pilot). This is highly targeted, rapid response and multi-disciplinary. It looks at social and medical factors. This is hoped to reduce admissions and improve wellbeing.
CEO: Discussed the main concerns: lack of privacy of gynaecological patients on the ward 1 (FGH). He denied this would happen. As for concerns about the closure of Abbey View (FGH) there was concern of a lack of palliative care, but this is not a palliative care ward.
Conclusion: We are still in consultation with our medical colleagues. We will respond to feedback. No jobs will be lost. There will be savings because we will be able to reduce agency locum usage. A/E and Urgent Care will see improvements. This will show the success of these changes.

Questions (from the committee):

V Hughes (VH, LD): Asked about mixed sex wards. You say that no decisions have been made but Ward 6 gas been closed. Also asked about failed discharges.
CEO: Failed discharges will be monitored. Ward 6 is a catch-all ward. We are closing this ward to repurpose it.
T Biggins (TB, L): Asked about a proper public consultation.
Dr Levy (Medical Director of the Integrated Care Board): There are no plans for a public consultation. Once we know what the final proposals are we can take this forward.
TB: There has been recent downgrading of FGH, what confidence do we have that this will not continue.
CEO: We haven't been able to recruit enough anaesthetists. Patients with a higher need (more severely ill) will need to be transferred to RLI (Royal Lancaster Infirmary). This is a temporary issue around the staffing. We need to make FGH more attractive so that more consultants would like to work there.
TB: Asked about the privacy of gynaecological patients. Will Ward 5 be a single sex ward?
TD: We will make sure that the dignity of the women is maintained.
DJ: Asked about the time-line.
H Hodgson (HH, LD): We need to see dates about how you propose to deal with the problems. There will be increased pressure on other services such as Adult Social Services and increased costs for patients having to travel further.
CEO: One question is about time and dates, the other about the readiness of GPs and the local authority.
TD: We will be looking at the gaps in the skills of the staff.
Dr Levy: Currently there are medical patients on the gynaecological and surgical wards. The staff are gynaecological and surgical nurses, so they are on the wrong wards now. Barrow (FGH) has some of the highest numbers of patients stuck in beds, up to one third of the beds. We plan to prevent a large percentage of these patients who were admitted from coming into hospital in the first place. 90% of patients are cared for in the community.
D Cassidy (DC, L): Asked whether the changes had been checked with the unions. Also asked about discharge of patients with dementia.
CEO: Confirmed that the unions had been consulted.
VH: Concerned about the closure of Abby View. Please can you take this out to a public consultation.
CEO: That will have to go to the ICB (Integrated Care Board).

M Hanley (MH, L): Explanations about whether both sexes would be on the one ward was very unclear. Asked to clarify this.
CEO: Currently this does happen occasionally, especially in Critical Care (ICU) but we have to report any occurrences (mixed sex breaches) of this. We hope that the changes will improve this parameter. It is easier to recruit to RLI and WGH. We have been working in partnership with colleagues in BAE. We do a lot of forward planning. Discussed Critical Care transfers, there is some risk concerned with this. We are seeking more doctors to staff the ICU at FGH (currently understaffed).
DJ: Asked about virtual wards.
Rep: The patient is issued with various technology so that the patient can be monitored remotely (BP, pulse, oxygen level etc). They can be stepped down (discharged) from hospital.

DJ: to conclude:

1, The trust will work with the committee to put better measures in place to communicate service changes with the public.

2. The time frame will be reconsidered to allow additional engagement with the public.

3. The details of the mitigation of the planned changes to Ward 5 are highlighted in a Quality Impact Assessment and made public.