Minutes of the meeting of the Health Overview and Scrutiny Committee, held in Committee Room 1 County Hall, Chelmsford, Essex on Wednesday, 08 February 2017

Present:

County Councillors present:

J Reeves (Chairman)	R Gadsby
K Bobbin	K Gibbs
J Chandler	R Howard (morning only)
A Durcan	K Twitchen (substitute)
M Fisher	A Wood (Vice-Chairman)

Borough/District Councillors present: J Murray (Chelmsford City Councillor).

Also in attendance:

County Councillor A Brown, Cabinet Member for Communities and Corporate
County Councillor M Maddocks, Deputy Cabinet Member for Adults and Children
Hannah Fletcher, Healthwatch Essex observer

The following Officers were present in support throughout the meeting:

Graham Hughes	-	Scrutiny Officer
Fiona Lancaster	-	Committee Officer

1 Apologies and Substitution Notices

Apologies for absence had been received from County Councillors D Harris (substituted by Councillor A Durcan), P Channer (substituted by Councillor K Twitchen), D Blackwell, and Chelmsford City Councillor M Sismey (substituted by Councillor J Murray).

2 Declarations of Interest

Councillor A Wood declared a personal interest as a Governor of the North Essex Partnership University NHS Foundation Trust (NEPFT).

3 Minutes

The minutes of the meeting of the Health Overview and Scrutiny Committee held on 11 January 2017 were approved as a correct record and signed by the Chairman.

4 Questions from the Public

There were no questions.

5 Mental Health - merger of Trusts and strategic oversight

The Committee considered a report (HOSC/08/17) on current performance issues and preparations for the proposed merger of the two providers which included responses to questions submitted in advance by the HOSC to lead commissioners and providers.

The following were in attendance to participate in a joint question and answer session:

- Sipho Mlambo, Senior Commissioning Manager, Castle Point and Rochford CCG
- Lisa Llewelyn, Director of Nursing & Clinical Quality, North East Essex CCG
- Nigel Leonard, Executive Director of Corporate Governance, South Essex Partnership University NHS Trust
- Sally Morris, Chief Executive, South Essex Partnership University NHS Foundation Trust
- Christopher Butler, Interim Chief Executive, North Essex Partnership Foundation Trust

Sally Morris introduced the item and commented that the preparations for the merger of the two Foundation Trusts were still on track as a result of good partnership working and support from commissioners. She explained that by the autumn the shape of a new clinical services model would be known, and that around six months had been set aside for consultation with service users and other stakeholders.

During the discussion the following was acknowledged, highlighted or questioned:

<u>Merger preparations/future service provision</u>:

- Collaboration between the two Trusts was already underway, and they were sharing services wherever possible, such as with IT, pharmacy and a joint Operations Director;
- It would be 'business as usual' for the service users, although there would be an increased demand for services;
- Processes for a merged organisation were already in place;
- It was anticipated that corporate support services would be reduced;
- The Trusts were working with the Stakeholder Reference Group, which involved Healthwatch Essex champions, to deliver a consultation process which had time built in specifically for the Trusts to reflect on feedback. The Group had been involved from the start of the merger discussions in summer 2016, and around 30-40 people attend each meeting. The principles of the new clinical model had been agreed with the Group and the Senate;
- There would be a new Interim Board with Sally Morris as the Interim Chief Executive, and there would be a TUPE transfer of staff to the new merged organisation;
- A maximum staff vacancy rate of 10% had been set for the first year of the

new organisation;
- There were no planned changes to West Essex services;
- The new clinical services model would include better links and support with Primary Care;
- The delivery of talking therapies and the involvement of the community sector was being reviewed to see how these could be improved. Hub based models were also being considered;
- Staff were already working together across the Trusts, and there had not been a large number of leavers to date. It was envisaged that there would be more opportunities for staff working in a larger organisation;
- Links with the two Essex Universities gave the Trusts direct access to qualified staff, and there was significant potential to attract new staff with the apprenticeship route;
- The challenge of agreeing the financial Control Total with the Regulator to ensure that the new organisation was not put into 'special measures' on its start up. A deficit of £13m for the first year was expected for the new organisation (which could be supported by reserves) and it was likely that it would be back in surplus in 4 to 5 years' time. Failure to agree the Control Total could also have a detrimental impact on investment being available to the organisation;

Monitoring performance:

- The significant variation in waiting times across Essex and the need to provide fair access to services regardless of location;
- The need to co-produce with commissioners and involve service users;
- A uniform service quality standard was needed whilst recognising different needs across the county;
- What was being done to improve the memory service and Dementia diagnosis KPIs. The Trusts were working with the CCGs regarding targets and capacity, and due to the high volume of referrals, had agreed a new 12 week target;
- The Medical Director of SEPT was undertaking a review of cases to look at memory services;
- Dementia diagnosis involved a number of partners and was an evolving model of care. Members expressed concern that delayed assessments impacted on acute admissions although they acknowledged that not all assessments required MRI scans. National standards on liaison services with the acute sector needed to be achieved by 2020;
- The Trusts were also looking at delayed transfer of care in their own services, and how their beds could be used more efficiently to minimise travel for treatment out of county. The Dementia Intensive support team in south Essex had proved very effective in dealing with unavoidable admissions and helping with earlier discharge. Given its performance, further investment had been secured and the team extended;

Partnership working:

- The challenges of working with four STPs in Essex and to ensure mental health has a 'voice' and is embedded in the plans;

- The challenges of dealing with numerous Clinical Commissioning Groups, although these helped to provide local insight into what services were needed;
- The Trusts worked with Essex Police, and the introduction of street triage was proving successful and had benefited the police awareness on how people in crisis are helped. There were various opportunities to co-produce work with the police and extend training to them;
- The number of recorded S136 incidents that did not then result in hospital admission suggested many of the incidents were not serious and there was a missed opportunity to refer elsewhere. Some incidents were as a result of drug/alcohol abuse, rather than mental health issues, so those service users did not need to be detained. Members were reassured that anyone in need would be found a bed, although it could be out of county;

Social care:

- Members expressed concern and disappointment that there was no plan to have a dedicated Director of Social Care in the new organisation, although they acknowledged there was an Associate Director and a new Director of Partnerships. Carla Fourie, Associate Director for Social Care and Partnerships at SEPT confirmed that she could input into the Board and Executive team. The Trusts indicated that they were trying to reduce their significant management costs and felt that with a new integrated clinical model of service it was not necessary to separate social care away from this with the introduction of a new Director. A new Director would also not resolve the problem of bed blocking.

The Committee **agreed** that the Lead Commissioners and providers would liaise with the Scrutiny Officer to plan attendance at a future HOSC meeting which would enable the Committee to scrutinise the public consultation engagement plans at an early stage.

The Chairman thanked the contributors for their attendance and input on this item.

6 Update on the Urgent Care Review engagement by the North East Essex Clinical Commissioning Group (CCG)

The Committee considered a report (HOSC/09/17) from the North East Essex Clinical Commissioning Group (CCG) which provided an overview on how public and stakeholder engagement activities were progressing in relation to the CCG's Urgent Care review.

Councillor Wood commented that local residents were concerned about the potential approach to stop providing the Walk in Centre and Minor Injury Unit services. There had been a very high turnout at residents meetings held in connection with the review, and a petition had recently been submitted to the CCG.

Simon Morgan, Head of Communications and Public Engagement, North East

Essex CCG, confirmed that the CCG's board would make a decision on 31 May 2017 regarding the approach to be undertaken.

The Committee **agreed** that Simon Morgan would liaise with the Scrutiny Officer to plan attendance at a future HOSC meeting after a decision had been made.

The meeting adjourned at 12.45 pm and reconvened at 2.00 pm.

7 Princess Alexandra Hospital, Harlow - regulatory concerns

The Committee considered a report (HOSC/10/17) regarding the issues raised on Princess Alexandra Hospital in the October 2016 Care Quality Commission's (CQC) report which gave an inadequate overall rating. The report also included the hospital's response to advance questions submitted by the HOSC on regulatory concerns.

The following were in attendance to participate in a question and answer session:

- Phil Morley, Chief Executive, Princess Alexandra Hospital
- Nancy Fontaine, Deputy Chief Executive/Chief Nurse, Princess Alexandra Hospital

Phil Morley introduced the item and reported that he was standing down as Chief Executive in March 2017. He considered that CQC concerns were largely around process issues, capacity and staff not being heard. He highlighted the planned next steps and some of the successes which had already been achieved, particularly in the areas of maternity services and enabling the workforce to have a 'voice' with the introduction of a Staff Council.

During the discussion the following was acknowledged, highlighted or questioned:

<u>Partnership working/collaboration</u>:

- Discussions were underway regarding the introduction of joint posts with other partners, for example, to help build End of Life training packages. Clinicians already worked at the local hospice, but ideally a full team approach could be introduced;
- The opportunity for an empty building to be used by other social care partners to help alleviate discharge/bed blocking issues;
- Services were being reviewed to see what could be outsourced to other community partners, such as chronic pain injections and alternative locations for blood tests;
- The Walk-in Centre had been closed as it had not functioned effectively and staff TUPE transferred to the hospital;
- The hospital was looking at the Walk-in service at Herts hospital to see whether it could extend the service's opening hours and rotate its nurses;
- An external audit had indicated that people were being conveyed to hospital when other care was available in the community and this had

been fed back to the Ambulance service;
- A Stakeholder Oversight Group had been established to monitor improvements and actions to address CQC concerns;

Finance/Capacity/Governance:

- A new strategic plan was needed for a new hospital site in the next 10 years to replace the current building which was increasingly unfit for purpose. In the long term a new hospital would have to cope with the impact of a new Garden Town which would double it's current catchment area;
- The lack of investment in IT had led to the shortfall in providing information to the CQC;
- A new Urgent Care Centre was needed to cope with increasing demand;
- The intention to be the first hospital to help to pay off student loans;
- The lack of national health education funding for training;
- There was a high reporting culture of around one thousand reports a month, but the majority of these were of no or low harm (97.7%);
- Risk management needed to be understood throughout the organisation. The hospital was working with a 'buddy' Trust at Milton Keynes to review and share learning on how this could be improved;
- The hospital had been given £300k of extra funding for the year;
- The lack of cubicles needed to assess patients and the low number of hospital beds per size of the local population;
- Members noted the issues relating to the use of old portacabins for surgical operations and the danger of the site being closed if not fit for purpose;
- Concern that the workforce still felt they weren't being listened to because of issues such as those relating to the state of the building could not be resolved;
- A Board Capacity Assessment had been undertaken and the team had been approved to lead the hospital for the future;

Quality of services and patient safety:

- The high number of patients in hospital who do not need to be in such an acute setting, particularly those in the last year of their life. The length of time it took to fast track patients with End of Life preferences (approx 10 days). Members noted that the absence of an End of Life team had affected performance in this area, as well as the lack of social care services available outside of hospital. There was a shortage of places available in Essex care homes as a result of places being used by London residents;
- There was a 20% vacancy rate for Registered nurses as the hospital was constantly competing against the attractions of London and Cambridge. Although there was a strong reliance on agency staff, there were many long-serving staff members committed to quality improvement;
- International recruitment of nurses for emergency care had proved successful;
- They were exploring using former trained ambulance service

paramedics. A new cohort of trained associate practitioners was to start and PAH were working with Anglia Ruskin University to help bring in locally based student nurses;
- Health Education England funding for staff training had been significantly reduced;
- The high levels of flexibility to enable senior staff development through secondments, rotations, shadowing, leadership programmes and involvement with the patient at home service;
- There were 7 current midwifery vacancies compared to 25 in 2016;
- Patients were still being treated in a safe and timely fashion regardless of the capacity issues;
- The strong Research and Development and Clinical Leadership programmes;
- The emphasis on getting the basics right, and the introduction of a new meaningful appraisal system;
- A new Resuscitation trainer had been appointed and equipment updated and streamlined. Their simulation training was highly regarded and the University of Leicester had now produced a formal package to sell to others;
- The challenge of reserving beds for in-patient gynaecology with such few numbers of patients coming in, but the patient experience in this area remained very good;
- In response to a question, the Chief Nurse confirmed there had been no outbreaks of superbugs during the past two years;
- How three wards had been streamlined in December which had led to improvements in patient repatriation to the right wards;
- The hospital was running at a 95-99% bed occupancy rate. The national standard occupancy rate should be nearer 85%. New patients were often put in the next available bed and not always in the specialty area for their condition and symptoms.

The Committee **agreed** that it was satisfied with the responses received to the advance questions and other evidence, and on the assurance given regarding improvement actions being taken.

The contributors were thanked for their attendance and input and they left the meeting at this point.

8 General update

The Committee **noted** a report (HOSC/11/17) from the Scrutiny Officer outlining updates on health news, primary care service changes and variations, and forthcoming meeting dates for 2017 public meetings.

The Scrutiny Officer mentioned that Ian Stidston had been appointed joint Accountable Officer for both Southend Clinical Commissioning Group (CCG) and Castle Point & Rochford CCG for the next six months.

The report was **noted**.

9 Work programme

The Committee considered a report (HOSC/12/17) from the Scrutiny Officer setting out the Committee's scheduled work for the last meeting of the 2016/17 municipal year.

The report was **noted**.

10 Date of Next Meeting

The Committee **noted** that the next meeting would take place at **10.30 am on Monday 20 March 2017**, in Committee Room 1 at County Hall (preceded by a private pre-meeting for Members only at **9.30 am**).

Chairman