MINUTES OF A MEETING OF THE HEALTH/NHS OVERVIEW AND SCRUTINY COMMITTEE HELD ON 7 JULY 2010 AT 10AM AT COUNTY HALL, CHELMSFORD

Membership

County Councillors:

*	G Butland (Chairman)	*	R Gooding
*	Mrs J M Reeves (Vice-Chairman)		Mrs S Hillier
*	Mrs M A Miller (Vice-Chairman)		Mrs M Hutchon
*	J Baugh		E Johnson
*	R Boyce		J Knapman
	L Dangerfield	*	C Riley (until 11.20am)

District Councillors:

*	Councillor N Offen	-	Colchester Borough Council
*	Councillor M Maddocks	-	Rochford District Council
	Councillor S Henderson	-	Tendring District Council

(* present)

The following officers were present in support throughout the meeting:

Graham Hughes	-	Committee Officer
Colin Ismay	-	Governance Manager

John Carr of Essex and Southend LINk also participated in the discussion with the agreement of the Chairman. County Councillors A Brown, R Howard (until 11.25am) and A Naylor also were in attendance.

53. Apologies and Substitution Notices

The Committee Officer reported apologies from County Councillors S Hillier, M Hutchon and J Knapman. Councillor Miller was asked to convey the Committee's best wishes to Councillor Hutchon for a healthy recovery.

54. Declarations of Interest

The following standing declarations of interest were recorded:

Councillor Graham Butland	Personal interest as Chief Executive of the East Anglia Children's Hospice. Personal interest due to being in receipt of an NHS Pension.
Councillor Nigel Offen	Personal interest due to being in receipt of an NHS Pension.
Councillor John Baugh	Director Friends of Community Hospital Trust Spouse employed in NHS at Broomfield Hospital

Whilst not a member of the Committee John Carr declared an interest as being a member of the Transformation Board for West Essex.

55. Minutes

The minutes of the meeting of the Health Overview and Scrutiny Committee held on 2 June 2010 were approved as a correct record and signed by the Chairman subject to the attendance list being amended to record Councillor R Howard as being in attendance.

56. Questions from the Public

The Chairman invited questions from the Public on any matters falling within the remit of the Committee. There were no questions raised at this time but the Chairman indicated that he would invite questions on particular agenda items as the Committee considered them during the meeting.

57. Basildon and Thurrock Hospital Trust

(a) Presentation by Basildon and Thurrock Hospital Trust (BTHT)

The Committee received a report (HOSC27/10) from BTHT. The Chairman, Michael Large, the Chief Executive, Alan Whittle, and the Programme Director, Adam Sewell-Jones, were in attendance at the meeting to explain how the BTHT was responding to issues raised about its performance and what actions and timelines were planned. A hard copy of presentation slides entitled 'Addressing Regulatory Concerns – 7 months on' were tabled at the meeting and, after an initial introduction from Mr Large, the Chief Executive referred to the slides as he addressed the meeting.

The following regulatory concerns had been identified at the BTHT site at Basildon:

(a) Hygiene Code Breach
(b) High Hospital Standardised Mortality Ratio (HSMR)
(c) Slow implementation of improvements to Children's Services
(d) Risk of failure to achieve CQC registration
(e) Clinical Leadership in Emergency Care
(f) Failure to meet access targets (cancer patients)
(g) Breach of NHS Core Standards 2008/09
(h) Care of Patients with Learning Disabilities

Mr Whittle addressed each of the above listed regulatory concerns in turn.

(i) Hygiene Code Breach

As a result of a visit by the Care Quality Commission (CQC) in October 2009 the BTHT had been held to be in breach of the relevant Hygiene Code after inspection of cleaning standards in the Accident and Emergency Department and one other ward. A subsequent CQC inspection in December recorded a substantial improvement. Cleaning standards had been maintained above levels recommended by the Department of Health since then. It was confirmed that Lead Nurses now were required to sign-off daily on the cleanliness of their care environment and every member of staff was now fully aware of their own individual responsibilities for cleanliness in their respective work environments.

The Executive Team received weekly cleaning standards reports on each department and not just an overview of the standards of the whole hospital;

(ii) High Hospital Standardised Mortality Ratio (HSMR)

Annual data on mortality rates (reporting on the previous year) had flagged up issues relating to high mortality rates at BTHT. There had been a recognized problem with poor end of life care leading to many patients being admitted to BTHT towards the end of their life. For 2008/09, BTHT had a mortality rate approximately 30% higher than the national average. It was suggested that the release date for this information had been unfortunate as it coincided with the media coverage of the CQC inspection and wrong conclusions had been drawn that it was connected to cleanliness. However trend data for mortality ratios had been dropping since June 2008 and Mr Whittle felt that it demonstrated sustained improvement, although a temporary adverse blip was expected due to data rebasing for the 2009/10 year. The HSMR position for 2009/10, prior to rebasing was 97. It was suggested that there were other factors affecting patient pathways that had an impact on mortality rates that were not necessarily within the control of the hospital.

(iii) Slow implementation of improvements to Children's Services

There had been regulatory concerns over the slow implementation of improvements to Children's Services and, in particular, in the Accident and Emergency Department which had been virtually unchanged in layout and structure since the 1970s. A dedicated Children's A&E unit, had opened in November 2009 with opening hours for the unit likely to be extended in the near future. The unit was routinely delivering 90% satisfaction ratings with treatment of about 300 children each week. An increased number of staff now were trained in Advanced Paediatric Life Support.

(iv) Risk of Failure to Achieve Care Quality Commission (CQC) registration

The CQC had indicated that it could opt not to accept BTHT's CQC registration as a result of the various regulatory concerns. However registration had been confirmed in April 2010 with five conditions. All bar one of the conditions had been related to the self declaration made by BTHT in January, two conditions had now been removed, applications had been submitted for two additional removals and the final condition was on track to be satisfied by the end of July 2010.

(v) Clinical Leadership in Emergency Care

The CQC had been concerned with medical and nursing leadership with a lack of senior medical staff on site during their inspection visit in October. Senior clinical staff contracts of employment often specified 8pm as a work finishing time leaving middle grade medical staff to run the emergency care unit through the night and this was not peculiar to BTHT. As a result of the inspection report more senior clinical appointments had been made in emergency care and vacant management posts filled.

(vi) Failure to meet access targets (cancer patients)

Due to one patient of nine assessed as not having met their clinical treatment pathway deadline the BTHT had not met the 90% access target rate for cancer treatment. All cancer targets had been achieved for the first quarter of 2010/11 pending results from tertiary centres, the 18 week targets for planned surgery had been achieved in June 2010 and the current A&E performance was the 3rd best in England. The sense of achievement of meeting certain targets had been lessened due to performance thresholds being reduced recently by the Department of Health.

(vii) Breach of NHS core standards 2008/09

NHS Core Standards had now been replaced by CQC registration. The CQC had qualified BTHT's statement on core standards in relation to two particular core standards.

(viii) Care of patients with Learning Disabilities

There had been regulatory concerns about the care of patients with acute medical needs who also had Learning Disabilities (LD). A specialist LD Nurse Advisor had been appointed, all LD patients now had specialist assessments and a Learning Disability resource pack was available throughout the organization.

(ix) Establishment of Programme Management Office

In response to the regulatory concerns BTHT had agreed a programme of up to 50 improvement projects overseen by the establishment of a Programme Management Office. The Programme Office initially had been under the guidance of a team of external management consultants but BTHT had wanted to integrate their management philosophy into the office and since February the unit had been overseen by an internal Programme Director. Service management feedback had been positive to the disciplined programme based approach and the increased use of performance metrics throughout the organisation;

(b) <u>29 June 2010 CQC Press Release on current status and related questioning</u>

The CQC had announced on 29 June 2010 that it had removed two of the five conditions placed on the registration of the BTHT in April as the Trust had made the necessary improvements within deadlines set. Standards of care at Basildon Hospital had improved in some of the areas where the regulator had flagged up serious concerns, including the A&E department. However the CQC had stated that there was still some way to go before it would remove the remaining conditions on the Trust's registration. The CQC follow-up review had found that although there had been improvements in the A&E department, further improvements needed to be made with their inspectors having concerns about poor practice in the observation of acutely ill patients in the waiting area in A&E and staff had raised concerns about poor provision of training to deal with work related violence and aggression. Councillor Butland referred to this latest CQC report which still suggested significant areas of concern.

The reception area in A&E currently did not have a glass partition. Advice received on the merits of using one was mixed and the position was being assessed. All patients arriving at A&E received an immediate clinical assessment which determined priority for treatment and those not immediately treated were constantly observed by senior nursing staff for any deterioration whilst waiting. Mr Whittle added that he considered this approach as typical in busy hospitals. Staff support and training were back on track and meeting targets.

Members questioned the BTHT representatives as to whether earlier preventative action could have been taken on any of the regulatory concerns. Mr Whittle considered that certain failings, particularly cleanliness in A&E, had not been reported and sufficiently escalated within the organisation to get action taken. He was confident that it could not reoccur as reporting escalation processes were in place combined with every clinical area being visited weekly by the Executive Team.

An independent body had been employed to review Board governance and to make recommendations for change. Improved processes had been implemented as a result of those recommendations including better information cascades to all levels of the management chain. A Quality Strategy was being developed.

Members suggested and discussed involving the public in other ways other than as a patient. It was confirmed that BTHT Board meetings were held in public and that some Governors of the Trust had been appointed from patient representative bodies. Governors were encouraged to report feedback from their constituents and to attend Board, management and strategic planning meetings. Approximately 10,000 people had subscribed as members of the Foundation Trust which communicated with its members via a quarterly newsletter and staff briefings. In addition there was a patient panel which facilitated patient feedback to the Trust. BTHT intended to continue and further improve communications with stakeholders and to try and move public judgment and perception of the Trust away from adverse individual anecdote to overall evidence-based performance based on sustained delivery of high quality care.

Since 1990 management skills had been part of the internal training for clinical management with the time devoted to it determined by the size and complexity of the area being managed. The Trust also encouraged clinical directors to register with relevant clinical leadership training organisations. Due to work being done in and around the A&E unit there would not be an Open Day this summer but regular Open Days would recommence when possible after completion of the work.

It was confirmed that abolishing car parking charges at the Hospital had not been considered to date. Various concessions were available with up to 30% of users not paying any charge.

(c) Concluding remarks

Mr Large confirmed that neither Executive nor Non-Executive Directors of BTHT would be receiving any pay award for the current year. Mr Butland welcomed this announcement and suggested that the public would recognize this was an appropriate gesture in view of current regulatory sensitivities and concerns.

Mr Butland thanked the representatives from BTHT for attending the meeting, stressed that the Committee would support the BTHT team in the work they were doing but would continue to be a 'critical friend'. The Committee Noted the contents of the presentation and paper from BTHT outlining the areas for improvement as a result of the CQC recommendations and Agreed that BTHT attend the Committee in six months time to give a further progress report.

58. Colchester Hospital Trust

The Committee received a report (HOSC/28/10) from Mr Peter Dixon, Chairman of Colchester Hospital Trust (CHT), on progress and developments within the Trust since the presentation to the Committee on 6 January 2010. Members still had concerns on certain matters such as infant care, stroke care and Board governance. Members agreed that CHT should be invited to attend and present a progress report to the Committee at an appropriate meeting in the Autumn once the new Chairman and new Chief Executive had been in post for a reasonable period of time.

59. Essex Hospital Trusts – policy and procedures for discharging patients

At the April meeting of the Committee it had been agreed that a position statement be requested from each of the hospital trusts on their policy and procedure for discharging patients, including who had the final decision to discharge a patient. Replies had been received from all five Essex Hospital Trusts and had been circulated in advance of the meeting. In most cases the volume and content of papers provided by each of the Hospital Trusts had been substantial and Members were concerned that a discharge policy should actually be a short and easily accessible document that was not buried in longer patient management policies. Members felt that discharge policies needed to be focused on discharging patients as soon as possible after they had been declared medically fit.

Members discussed various initiatives in Essex to improve discharge policy. In particular, a pilot programme in Mid Essex whereby a dedicated clerk re-evaluated daily a patient's readiness for discharge had given encouraging results during implementation and was now being fully evaluated. Members also felt that timely information and explanation on the discharge process should be provided regularly on admittance to hospital. Members agreed that the Chairman should write to the PCTs to ask how in their role of commissioners of services they set and maintained standards in relation to patient discharge and their level of satisfaction with each of the Hospital Trusts' processes.

60. Dementia Task and Finish Group

Councillor Baugh updated the Committee on the deliberations of the inaugural meeting of the Task and Finish Group established to consider certain aspects of dementia care in Essex.

61 Transformation of Services by PCTs – purchaser/provider split

The Committee received a report (HOSC/30/10) from Graham Redgwell, Governance Officer, on the process for reviewing proposals for restructuring to be

published by the PCTs. These would require a formal 12 week consultation period as the HOSC regarded the changes as a substantial variation. This phase of PCT restructuring could be subject to change as a result of any announcements made by the Coalition Government for the future structure of health provisioning.

The Chairman invited any public questions at this point. Mr Peter Mitchell of the British Medical Association queried the process and viability of scrutiny of PCT proposals if it was likely that it could be overtaken by national Coalition Government proposals. The Leader of Essex County Council had been in discussions with leading members of the NHS in Essex on the PCT proposals. Any new infrastructure proposals from Coalition Government likely would need time to implement and it was recognised that in the interim it would be necessary for PCTs to take out costs to preserve frontline services.

62. Transformation programme for commissioning healthcare services in Essex

The Committee received a report (HOSC/31/10) comprising a Press Release issued by the five Essex based PCTs on personnel changes to lead the PCT transformation programme for commissioning healthcare services across Essex.

63. Date of Next Meeting

The next meeting of the Committee was scheduled for Wednesday 1 September 2010. The Chairman proposed and it was **Agreed** that the meeting scheduled for 13 October 2010 be cancelled.

There being no urgent business, the meeting closed at 11.44 am.

Chairman
1 September 2010