MINUTES OF A MEETING OF THE HEALTH/NHS OVERVIEW AND SCRUTINY COMMITTEE HELD ON 14 SEPTEMBER 2011 AT 10.05 AM AT COUNTY HALL, CHELMSFORD

County Councillors:

	G Butland (Chairman)	*	R Gooding
*	Mrs J M Reeves (Vice-Chairman and Chairman of the meeting	*	Mrs S Hillier
*	Mrs M A Miller (Vice-Chairman)	*	E Johnson
	J Baugh	*	J Knapman
	R Boyce		Mrs L Mead
*	Mrs M Fisher		C Riley

District Councillors:

Councillor N Offen - Colchester Borough Council

(* present)

Cabinet Member Ann Naylor, County Councillors A Brown and P Channer and John Carr from Essex and Southend LINk were also in attendance.

The following officers were present in support throughout the meeting:

Graham Hughes - Committee Officer
Graham Redgwell - Governance Officer

56. Apologies and Substitution Notices

Apologies for absence had been received from County Councillors G Butland (in his absence Councillor Mrs J Reeves chaired the meeting), J Baugh, C Riley and Borough Councillor N Offen.

57. Changes to Committee Membership

It was **Noted** that Brentwood and Rochford District Councils to date had not nominated anyone to be a co-opted member of the Committee.

58. Declarations of Interest

The following standing declaration of interest was recorded:

Councillor Sandra Hillier	Personal interest as member of Basildon and Thurrock Hospital Trust

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

Councillor Knapman declared a personal interest for item 61 of the minutes in that close family had used the maternity services at PAH recently.

59. Minutes

The minutes of the meeting of the Health Overview and Scrutiny Committee held on 6 July 2011 were approved as a correct record and signed by the Chairman of the meeting.

60. Questions from the Public

There were no questions from the public on this occasion.

61. Princess Alexandra Hospital

The Committee received a report (HOSC/28/11) in relation to changes at Princess Alexandra Hospital, Harlow (PAH). The Chairman (Gerald Coteman) and Chief Executive (Melanie Walker) of the PAH Trust were in attendance to introduce the report and supplement it orally and to respond to members questions.

(a) Introduction

PAH faced significant financial pressures and had identified a financial gap of £17 million (to be met by a £10 million activity reduction and £7 million in efficiencies) for 2011/12, which represented 10% of its total annual turnover. In addition PAH faced a further savings challenge of £12 million and £10 million in the following two financial years.

Various contributing factors were suggested for the financial challenge, including adjusting to the general cost pressures on the NHS through an ageing population, increased costs of medicines and higher expectations from the public whilst , at the same time, the national shift in focus away from hospital based care to care closer to home which would result in a reduction in demand for hospital services. In addition, new incentives, such as using best practice tariffs and non-payment for unplanned emergency re-admission, required hospitals to do more to improve safety, outcomes and patient experience, by working more efficiently and in an integrated manner.

The report submitted to the Committee outlined PAH's Commitments and Principles to ensure that the transformational plan was implemented in a safe and rational way and Ms Walker particularly highlighted increased clinician engagement in decision making and leadership, that there would be reductions in back office staff before front line clinical services, and that considerable work was being undertaken to improve customer communications and stakeholder buy-in to the plans for change.

(b) Meeting the financial challenge

The savings challenge identified by PAH meant that the hospital would need to reduce in size by as much as 25% over the next three years, and achieve

concomitant reductions in its costs and improve the quality of its services year on year. The reduction in capacity was seen as the first step in the cost reduction process.

Most of the savings in the first year were back loaded and would 'kick-in' from October onwards. Systems and processes were in place to continually monitor progress and to mitigate risk as much as possible.

The rate of inflation within the NHS environment (cost of medicines and care) generally ran higher than domestic inflation by as much as 4.5% per annum and the effect of this would need to be met by productivity gains to counteract it. Similarly, the effect of an NHS Price Deflator of 2.5% on the price that PAH could charge for some services also had to be absorbed by efficiency gains. Members questioned the long term viability of this approach. In particular they highlighted that a significant up front reduction in staffing (as proposed in the first year of the financial plan) considerably limited the scope for achieving continued productivity savings without significantly reducing the scale of activity and services being provided. Whilst it was acknowledged that reductions in staffing would be greater amongst backroom staff rather than clinicans, Members questioned whether there needed to be a Plan B. It was stressed that the financial plans outlined were primarily focussed on the current financial year and that PAH senior management were still working through financial plans for subsequent years. It was acknowledged that it was easier to make up-front cost savings and that the greatest challenge was to continue productivity savings in subsequent years.

(c) Effect on staff

The financial plan had identified around 90 WTE employee redundancies after allowing for natural turnover and current vacancy rates. Mechanisms had been put in place to reduce the number of compulsory redundancies to a minimum.

Clinicians had been challenged to further improve the efficiency of clinical services. Formal discussions were underway on standardising the provision of medical secretaries for clinicians (one to every two consultants), and support was to be made available to encourage those who had not obtained the relevant medical secretary professional qualification to undertake training to qualify.

An explanation was given of the term 'non consultant career grades'.

(d) Productivity and efficiencies

The focus on the current year had been on back office functions to increase productivity and efficiencies. For example PAH had been working to ensure more consistency on the length of the overall patient stays in hospital. Care pathways through A&E also had been reviewed, in consultation with GPs, to reduce unnecessary emergency admittances and thereby reduce the demand on beds,. Approximately 20 beds had been freed up by this process.

PAH had ongoing discussions with social services, GPs and provider partners regarding improving the cost effectiveness of patient services and the likely level and type of services required in future. The West Essex Primary Care Trust (WEPCT) had indicated that it was likely to commission less services in future from PAH.

(e) Consistency in service

Whilst many PAH services could be provided to a high level there was an acknowledgement of a lack of consistent performance in some areas which needed to be addressed. Historically, the A&E unit at PAH had not achieved the 4 hour national target for A&E admittances to receive initial treatment. However, for the last three months it had met this standard.

Mr Coteman emphasised that PAH senior management were managing and balancing the financial and patient care challenges.

The number of complaints received was broadly static when compared to the same period last year at approximately 60 a month.

(f) Nursing care

Concern was expressed that nursing had moved away from being multi skilled and holistic and had become too specialised. Through the 'Competent Ward' programme PAH were seeking to move nursing care back to a higher holistic level and further developing the nursing skill mix.

Whilst there had been good patient feedback on dignity, respect and nutritional matters, a problem had been identified with pressure sores, which indicated a breakdown with at least one core area of bedside care. An 'Essence of Care' programme would focus staff attention on one basic nursing care task each month to re-inforce the expected standards of care.

Members were invited to a tour of PAH facilities to gauge for themselves some of the improvements being developed in patient experience.

(g) Recording of information

It was acknowledged that some of PAHs computer systems were up to 20 years old and that there were plans to update and replace them. Until this replacement process was completed paper based recording of a considerable amount of patient information would have to continue. Clincians were involved in the replacement process to ensure that changes would be practical for them. However, working practices in some areas already were highly computerised such as in the X Ray department.

(h) Partnership working

Members emphasised the importance of effective and efficient co-operation between health and social care partners and the consistent provision of intermediate care beds for the elderly. It was acknowledged that these were important relationships and that good consistent patient care was a priority. There were ongoing discussions with ECC and other partners to identify further improvements to working relationships and patient care particularly in view of a rapidly increasing elderly population. The Intermediate Support Team worked with social services to ensure a smooth care pathway for

patients, especially the elderly. A six week cut-off for the provision of intermediate care beds after which the patient was often (re)admitted into hospital was being reviewed. PAH were aware of the project co-ordinated by AHCW at Mid Essex Hospital Trust to improve the hospital discharge process and would seek to learn from this and apply at PAH where appropriate.

(i) Commitments and principles and engagement

Members were concerned that PAH's Commitments and Principles had only referred to patients once and that, as a consequence, it was possible that PAH could lose sight of the people for whom they provide services. PAH acknowledged that the language used could have been better.

There had also been a general concern that communications with patients and the public as a whole had not been as good as they should be and this was being reviewed. It was acknowledged that PAH needed to engage in more effective public consultation and demonstrate that the consultation process itself was seen to be at the core of the planning process.

(j) MacMillan Nursing

It had been reported in the local media that WEPCT was reducing its grant funding of MacMillan Nursing services. It was clarified that the grant reduction primarily related to the Information Unit and did not impact on the funding of the MacMillan Nursing team (which provided the personal support) which was managed and funded by a local hospice. Whilst PAH acknowledged the financial pressures facing the PCT they had also emphasised to them the importance of good level of information being easily available for prospective patients and their families. PAH had offered to host the Information Unit on their site.

(k) Foundation Trust status

There was an excellent staff commitment to obtaining Foundation Trust status. Members emphasised the importance of obtaining such status as it would automatically increase patient involvement through the Trust Board of Governors and governance structure.

(l) The future

Members suggested that a reduction in PAH services being commissioned by WEPCT could mean that the long term viability of PAH was uncertain. However, it was stressed that a hospital was needed at the current site and that the issue was really about the capacity and services that the hospital provided in the future. Population growth in PAH's catchment area was faster than the national average which should provide the basis for ensuring that the hospital's future was secure. However, it was also recognised that provider and commissioning decisions being made in adjoining London facilities could impact on PAH and could lead either to patient flows to those London facilities

instead or from London to PAH. An opportunity existed for PAH to become the 'Hospital of Choice' for a substantial catchment area.

It was confirmed that 60% of PAH's income came from services commissioned by West Essex PCT, with 35% from Hertfordshire PCT, and the balance from adjoining London PCTs (primarily maternity services).

After further Member questioning, PAH acknowledged that that there were two elements driving their decision making at the moment: that current capacity and the level of services had to adapt, reduce and reconcile to the level of services being commissioned and demanded at present whilst, at the same time, leaving a structure that was flexible enough that it could increase capacity again in the future. Maternity services were cited as an example where neo natal services had increased and additional labour wards had been built in response to the number of births at PAH having increased significantly in recent years. However, these services were flexible and could be reduced (with wards mothballed but still there as a contingency if needed in future).

(m) Conclusion

The Chairman and Chief executive of the Trust indicated that they would welcome a visit by HOSC members and it was **AGREED** that the Governance Officer would discuss arrangements with Councillor Butland upon his return from holiday.

The PAH representatives were thanked for their attendance and for assisting a constructive discussion and invited back in 12 months time to update the Committee on progress made. They then left the meeting.

62. South West Essex Community Contracepton Services

The Committee received a report (CWOP/29/11) from the Governance Officer in relation to restructured staffing arrangements within South West Essex Community Contraception Services. The action taken was **Noted.**

63. HealthWatch

The Committee received a report (HOSC/30/11) on Essex HealthWatch membership from Duncan Wood, Head of Research and Analysis, who was also in attendance to introduce the item and to answer any questions.

At a meeting the previous week the Community and Older People Policy and Scrutiny Committee (COP) had considered the background and alternative proposals for membership of HealthWatch. Two membership models had been considered and witnesses for each model made representations to the Committee. During the discussion on the most appropriate membership model the Committee had considered three key questions: How representative? How accountable? And How skilled would the decision makers be? The COP had favoured and recommended an Appointed Member model but emphasised that there was still a critical role for volunteers in locality and project work, that

the appointment process had to be clear and transparent and that the appointment panel had to have credibility. Members stressed that clarity was needed on who would be the appointees. The Essex Pathfinder bid would recommend that non executive elected representatives, community representatives and service users should form the appointment panel.

Members suggested that there needed to be established criteria for instance where vested interests should preclude a person from HealthWatch membership. It was expected that this would be included in Ministerial Regulations but these would not be consulted upon until mid 2012 at the earliest.

Members endorsed the approach proposed and recommended by COP, with one exception; Councillor Knapman doubted that the proposed HealthWatch structure would improve patient experience and stressed that the current LINk model worked well, and he consequently voted against the proposal.

64. General update

The Committee received a report (HOSC/31/11) from Graham Redgwell, Governance Officer, advising on a number of local health issues arising since the last meeting. These were **Noted**.

65. Date and Time of Next Meeting

It was confirmed that the next scheduled meeting of the Committee would be held on Wednesday 12 October 2011, at 10.00 am in Committee Room 1 (please note this is the second Wednesday of the month rather than the usual first Wednesday).

The meeting closed at 11.25 a.m.

Chairman
12 October 2011