ITEM 2

MINUTES of the meeting of the **HEALTH OVERVIEW & SCRUTINY COMMITTEE** held at 10.00am on 8 March 2012 at County Hall, Kingston upon Thames.

These minutes are subject to confirmation by the Select Committee at its meeting on 24 May 2012.

Members:

*	Mr Nicholas Skellett (Chairman)
*	Dr Zully Grant-Duff (Vice-Chairman)
*	Mr John Butcher
*	Mr Bill Chapman
*	Dr Lynne Hack
A	Mr Alan Young
*	Mrs Yvonna Lay
	Mr Nigel Sutcliffe
*	Mr Peter Hickman
	Mr Colin Taylor
A	Mrs Caroline Nichols
	Mr David Ivison

Ex officio Members:

A	Mrs Lavinia Sealy (Chairman of the Council)
A	Mr David Munro (Vice-Chairman of the Council)

Co-opted Members:

A	Dr Nicky Lee
*	Mrs Ruth Lyon
A	Mr Hugh Meares

Substitute Members:

In attendance:

* = Present for all of the meeting
A = Apologies

P A R T 1

I N P U B L I C

01/12 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS [Item 1]

Apologies for absence were received from Mr Alan Young, Hugh Meares, Caroline Nichols and Dr Nicky Lee.

02/12 MINUTES OF THE PREVIOUS MEETING: 21 DECEMBER 2011 [Item 2]

An amendment was made to page 6, first paragraph, line 4 from "When all but these are available…" to "When only these are available..."

03/12 DECLARATIONS OF INTERESTS [Item 3]

None

04/12 QUESTIONS AND PETITIONS [Item 4]

There were no questions or petitions.

05/12 CHAIRMAN'S ORAL REPORT [Item 5]

Health and Social Care Bill Update
A briefing on the NHS reforms has been requested for the 24 May meeting. The Bill continues to be scrutinised line by line in the House of Lords. The Government has made a raft of amendments in an effort to address Lords' concerns. Key amendments include:

- Secretary of State to retain ministerial responsibility
- CCGs also required to promote the health service and this applies to all services they commission
- Monitor is set to enforce licence conditions to enable integration and cooperation
- Monitor's seven-yearly reviews to be focused on effectiveness of competition, rather than development of it
- The list of things to which Monitor must have regard has been clarified to explicitly require patient safety as paramount
- The National Commissioning Board and CCGs must publish in their annual report an assessment of how they are meeting the health inequalities duties
- The Director of Public Health will be a statutory chief officer and the Secretary of State will issue guidance on the expected role such as happens with Directors of Adult and Children's Services

Torbay integrated care model
Dr Nicky Lee recently attended a conference outlining the innovative integrated care model currently being delivered in Torbay. Adult Social Care has been asked to update the Committee on its work in the acute hospitals, integrating with health colleagues.

Estimated Public Health Spend
The Government also released the estimated amount of Public Health spend by local authority in 2012-13 based on spend from 2010-11. The estimated NHS spend on public health services will be £5.2billion. The estimated spend by local authorities on public health responsibilities is £2.2billion. Surrey's estimated spend for 2012-13 will be £19,695,000.

Earlswood Medical Practice
Members will have received the letter on the closure of Earlswood Medical Practice. Dr Lee has asked questions that officers are looking into. The situation has changed again since the letter went out and further information will be available at a later date.

Better Services, Better Value Review
Surrey has worked with Merton and Sutton on a Joint Health Overview & Scrutiny Committee (JHOSC) previously on proposals for service reconfiguration. NHS South West London is currently working on the BSBV review, which is looking at how best to deliver health services in future given the challenges currently in terms of clinical quality and safety, finance and demographics. Public consultation on options is expected during 2012 and there may be an impact on maternity units and A&Es in southwest London. As such, NHS Surrey has had legal advice that they need to conduct their own public consultation on proposals developed alongside the BSBV consultation. A joint HOSC of the six London boroughs involved has been set up to ensure proper scrutiny. Officers will continue to monitor developments on this and report back as necessary.

Joint Health Overview & Scrutiny Committee NW London
In northwest London, a JHOSC has been set up as part of the Shaping a healthier future programme for service change. The programme will affect around two million people across the eight northwest London boroughs. Surrey has been invited to participate as a neighbouring local authority. I will not be sitting on the JHOSC but I have asked officers to monitor it and report back on any key developments.

Stocktake of service changes in South of England
NHS South of England recently released a paper outlining the new process for considering service reconfiguration proposals as well as identifying all current proposals. The new process will follow national best practice and meet the recommendations of the Department of Health. There are currently no service reconfiguration proposals for Surrey. There are proposals for maternity services in east Kent and Sussex but these are unlikely to have any major impact in Surrey.

East Surrey CQC Report
On 8 February the Care Quality Commission published a compliance report on East Surrey Hospital. They found that East Surrey was not meeting two outcomes: people should get safe and appropriate care that meets their needs and supports their rights and cared for in a clean and protected from the risk of infection. The CEO has been requested to send the response report to the Chairman when it is completed.

Visit to St Peter's A&E
The visit was cancelled, as it was inappropriate to visit given the current pressures, as all Surrey hospitals are on black alert. A new date will be fixed as soon as possible.

Estates Transition Plan
Officers have asked NHS Surrey for their Estates Transition Plan, as there are concerns about the future of community assets, such as community hospitals, next year after the transfer of assets to the national NHS Property Company. Information on this will be requested as part of the May NHS reforms update.

06/12 RECOMMENDATION TRACKER AND FORWARD WORK PROGRAMME [Item 6]

- Further information will be requested for the next performance report from NHS Surrey to cover: finance, overall performance and specific addressing of performance failures. Additionally, information on Did Not Attend (DNAs) figures will be requested.

07/12 REVIEW OF MAJOR TRAUMA UNIT DESIGNATION [Item 7]

Declarations of Interest:

None.

Witnesses:

Jackie Huddleston, Head of Urgent Care QIPP Programme and Network Manager Surrey Wide Critical Care Network & Major Trauma Lead

Dr Kelvin Wright, Clinical Director, South West London and Surrey Trauma Network and Emergency and Critical Care Consultant, Frimley Park Hospital NHS Foundation Trust

Key Points Raised During the Discussion:

1. The Trauma Designation Strategy involves a 'hub and spoke' structure with Major Trauma Centres (MTC) as the 'hub' and Major Trauma Units (MTU) as the 'spokes.' If a patient is more than 45 minutes away from a Major Trauma Centre, they will first be taken to a Major Trauma Unit for stabilisation and then transferred to the nearest MTC. The other use for MTUs is that some patients may deteriorate on the way to the MTC or be too unstable at the scene to make the journey to the MTC. These patients would then be taken to the nearest MTU for stabilisation and then transferred to the MTC.
2. Most MTCs will be hospitals with neurosurgery services as most traumas are head-related injuries. Neither Surrey nor Kent currently has hospitals with neurosurgery services, meaning that there is no option for a MTC within them. St George's is the nearest hospital

with all the relevant trauma services necessary to be a MTC. Witnesses expressed the opinion that, in the many years of Trauma Network development, the current situation is the best it has been. Members were of the opinion that they would like to see more MTCs and, specifically, one in Surrey.

3. Witnesses indicated that major trauma makes up less than 1% of A&E activity. When analysed, those with major trauma are only one or two a week for most hospitals. The worry is around multiple injuries, which NHS Surrey takes on board. The whole purpose of the trauma system is to rectify the past lack of it. It is now all about trauma rehabilitation as much as treatment. The quicker a patient can be transported to a MTC, the quicker they can receive care and be rehabilitated. NHS Surrey feel there are enough MTCs as there is no capacity, nor is it financially viable, to build another hospital with all the relevant services. The number of MTCs per population is correct in the region compared with available services.
4. Frimley Park Hospital (FPH) and Ashford & St Peter's Hospitals (ASPH) have been designated as Major Trauma Units. Royal Surrey County Hospital (RSCH) and East Surrey Hospital (SASH) were assessed as not meeting the criteria. They have been requested to provide an action plan for addressing the identified concerns and will be reassessed.
5. RSCH has provided an action plan and NHS Surrey are confident they will meet criteria and be able to sign off on their designation from 1 April 2012. NHS Surrey is in discussions with their Chief Executive, who has committed to recruiting three additional Emergency Department (ED) consultants.
6. As yet, SASH has not provided an action plan but one is promised by the end of March. NHS Surrey is meeting with the Clinical Commissioning Group (CCG) in the area, the Chief Executive Officer and the Clinical Director on the next steps. Originally, reassessment was being looked at for June, now that is more likely to be in the autumn.
7. As SASH will not be a designated MTU, NHS Surrey is looking at instituting primary bypass in that area. This involves bypassing East Surrey Hospital to take trauma patients direct to the Major Trauma Centre at St George's or down to Brighton. The aim of this strategy is to mitigate risk to and maintain safety for patients in that area. NHS Surrey is working with Southeast Coast Ambulance Service (SECAmb) and the air ambulance on an action plan, which it is hoped will be in place on 1 April. Additional air ambulance capacity is being put in to transfer patients to Brighton that would have gone to East Surrey.
8. Members expressed concern about getting patients to St George's in time especially if it is a major incident with many critical patients or due to an M25 disaster. Witnesses explained that throughout London there are four major trauma networks. The Southeast London trauma network is currently in discussions with Kent, looking

to set up 'staging posts' where MTUs will be used prior to longer journeys to MTCs. Getting patients to the MTC quickly is crucial and air ambulances help to do this but it is dependent on the hospital having a helipad. St George's has just got planning permission to build one. Frimley Park, as a MTU, is also just about to open one.

9. The Trauma Plan for Gatwick identifies East Surrey as the local MTU. Concern was expressed about transporting patients to Brighton in time. Witnesses indicated that they had only just finished the reviews and had begun discussions about East Surrey in relation to any incidents at Gatwick. East Surrey must still be able to respond to a major incident, with minor injuries being sent to its A&E. All more serious injuries would be diverted elsewhere. East Surrey would also be able to treat and transfer patients. The Strategic Health Authority Emergency Planning team is looking at this as a matter of urgency and will be discussing with Gatwick how to mount a response. The plan will involve different hospitals taking different levels of patients and this must tie in with ambulance service plans.

10. Dr Kelvin Wright indicated that NHS Surrey was clear that all large institutions would need to re-visit their trauma plans. East Surrey still needs to be able to deal with self-presenters who are not classified as major trauma; but in the case of serious injuries, patients are better off going to the nearest MTC. Evidence shows that if the first hospital to which a patient is taken cannot treat effectively, transferring from that hospital to a secondary hospital does not provide good outcomes. Dr Wright stated that he was also unhappy with East Surrey's problems and was pleased that the Committee was saying the same. NHS Surrey wants to work with them and is making that clear, but they can only work with those that are willing.

11. Members expressed concern about the infrastructure to deal with multiple incidents, specifically whether Brighton had the same facilities available as St George's. Witnesses indicated that Brighton is close to being designated as a MTC. It has the infrastructure and the relevant services alongside very strong institutional commitment. They are in the process of appointing neurosurgery consultants and other additional capacity which NHS Surrey feel confident will ensure they can be designated as a MTC in June/July. NHS Surrey will form links with the Sussex trauma system when Brighton is up and running. Additionally, in the event of multiple critical patients, the London MTCs have a coordination desk that would agree where patients would go to avoid overwhelming one hospital.

12. Members queried the use of blood in air ambulances as this can be of great benefit to critical patients. London air ambulance has started carrying blood in their ambulances and Kent, Surrey & Sussex air ambulance is looking to introduce this shortly. Where it is most valuable is when there is a prolonged scene time. Land ambulances do not currently carry blood and there are no plans to do so, but the Regional Transfusion Committee Chair is keen to implement a protocol where blood can be delivered to the scene.

13. Witnesses indicated that further monitoring is in place in the form of three-monthly trauma reviews and peer reviews.

Actions/Further Information to be Provided:

- Updates via email regarding the outcome of further reviews at Royal Surrey County Hospital and East Surrey Hospital.

Recommendations:

1. That the Committee congratulates Frimley Park Hospital and Ashford & St Peter's Hospital for successfully being designated as Major Trauma Units;
2. That the Committee expresses concern at the failure of East Surrey Hospital to produce an action plan in response to the panel review;
3. That the Chairman raises the concerns of the Committee in relation to overall performance of SASH at the 15 March West Sussex HOSC where they are scrutinising the issue in-depth; and
4. That the Committee receives updates via email regarding the outcome of further reviews at RSCH and SASH.

Select Committee Next Steps:

Chairman to attend and raise concerns about East Surrey Hospital at West Sussex HOSC on 15 March 2012.

08/12 NHS SURREY ONE PLAN AND QIPP INCLUDING REVIEW OF A&E SERVICES AND ADMISSIONS PROCESSES [Item 8]

Declarations of Interest:

None.

Witnesses:

Helen Atkinson, Director of QIPP and Performance, NHS Surrey

Jackie Huddleston, Head of Urgent Care QIPP Programme and Network Manager Surrey Wide Critical Care Network & Major Trauma Lead

Geraint Davies, Director of Commercial Services, SECAmb

Dr Jane Pateman, Medical Director, SECAmb

Andrew Liles, CEO, Ashford & St Peter's Hospitals

Sarah Tedford, Deputy CEO, Kingston Hospital

Dr Dan Harris, A&E Clinical Lead, CEO Kingston Hospital

Key Points Raised During the Discussion:

1. NHS Surrey was asked to highlight the performance concerns and what is being done about it. They stated that there had been improvement on the 18 weeks target – all trusts have met the target for January and February. There is an improving picture on stroke and mixed sex accommodation. All are complying with mixed sex accommodation apart from Epsom Hospital and East Surrey Hospital but there was improvement in the previous quarter and they are expecting improvement this quarter. There are still performance issues around health checks, smoking cessation, breast-feeding and Improved Access to Psychological Therapies (IAPT). Improvement plans have been submitted to the Strategic Health Authority (SHA) on all these and they are being monitored monthly.
2. Financially, NHS Surrey indicated they were £1.4m down on where they wanted to be. They are expecting to achieve the QIPP savings plan by end of year.
3. Members had chosen to focus on A&E performance as the main part of discussion of this item.
4. NHS Surrey indicated they were working with East Surrey Hospital (SASH) and Ashford & St Peter's Hospital (ASPH) on making improvements to their A&E performance. Both hospitals are still dealing with winter pressures; for example the last few weeks had seen a lot of respiratory infections in older people. All acute trusts had seen increased A&E activity in the past month. All trusts are at black alert, so they are not meeting the four-hour wait targets easily. NHS Surrey is working with ASPH and SASH, utilising a small pot of funding from the SHA to get improvement plans delivered for quarter 4. There is an issue that not all services are 24-hour across the system. NHS Surrey is working with Surrey County Council Adult Social Care on improving community hospitals and the virtual wards to build up preventative and community services. The focus currently is on northwest and southeast Surrey as there is a higher population of frail/elderly in these areas. There are weekly management meetings at SASH and ASPH to improve whole systems working.
5. Members expressed displeasure at the continuous message of weekly meetings, improvement plans, etc. but reports continue to show targets not being met. Specifically, trying to reduce the number of unnecessary admissions is a key priority but reports keep coming back that it is not working. There are continuing problems with East Surrey.
6. Witnesses explained that the information provided is a summary of the national targets. There has been a reduction in the ambulance conveyance rate to East Surrey, which is an improvement. NHS Surrey is working on alternatives to A&E in East Surrey, in the form of Rapid Access Clinics (RACs). RACs will also go into the A&E to pull patients out that ought not be there. Improvements have been

seen following its introduction. Additionally, SASH has just appointed two new A&E consultants.

7. Members were concerned that the population in East Surrey presented problems in either not enough capacity or resources and infrastructure or that it was not being managed properly. Witnesses stated that a lot of development work has been done to put infrastructure in place as well as the opening of two modular wards. The additional beds should be sufficient for them to manage given the population.

8. The problem at SASH is complicated by the fact that the out-of-hours base recently moved to Caterham Dene hospital. This has resulted in people going to East Surrey A&E instead of using the out-of-hours clinic. Data shows 60% of activity in acute hospitals is self-referral. The root cause is primary care; if the GP is unavailable the public will go straight to A&E. Work is being done with primary care to address this and the CCG leads are being given data on primary care opening times. There is a lot of provision for urgent care (i.e. walk-in centres) but the public is not effectively using them.

9. NHS Surrey is looking to bring the out-of-hours service back in to East Surrey. There has also been work done around the population data in the area, breaking it down by self-referrals, healthcare professional referrals and ambulance conveyances. The public's behaviour in the area needs to be changed, to persuade them to use alternatives to A&E, but this is a difficult process. The urgent treatment centre in East Surrey is part of the hospital.

10. Ambulance conveyances are down at East Surrey and SECAmb has worked hard to produce this improvement. There is also an improvement in delayed transfers of care. SECAmb relies on healthcare professional to assess patients; therefore there is the potential for their behaviour to impact on the level of demand and rate of response. Currently SECAmb don't have any ability to triage someone from a care home. Other issues affecting ambulance performance at East Surrey has been the building works, which led to ambulances waiting outside A&E. NHS Surrey is looking at changing the overall escalation process as some hospitals are not following it properly.

11. There has been a lot of investment in SASH, including recruiting more A&E consultants. NHS Surrey indicated that if they do not see improvements, further action would be taken. East Surrey already has to report daily to the SHA and the Department of Health.

12. The Chief Executive of Ashford and St Peter's (ASPH) attended to answer questions about its A&E performance. ASPH is working with SECAmb on how best to support paramedics in the field and how best to bring them into the hospital. ASPH now have critical care paramedics based there, working both in hospital and in the field. They are also working on new pathways where paramedics can bring patients straight into hospital, bypassing A&E. It is a modern

way of integrating care given by paramedics with that given by hospitals.

13. ASPH has struggled with the A&E four-hour targets. At the beginning of February, they got up to 95% but this month has been very difficult. The figures are beginning to improve again. Northwest Surrey has seen an increase in A&E attendances in the last year. As SECAmb has got better about not conveying people that don't need to, the number of self-referrals has increased. Analysis done with GPs shows two reasons for the increase in A&E attendances. Firstly, alternatives to primary care need to be addressed. Secondly, the length of stay in hospital has increased. There is an extra 40 beds' worth of activity a year. This is not down to treating more patients; rather, they are staying longer. The discharge processes need to be improved and alternatives to hospital need to be in place and used.
14. As a Member request, representatives from Kingston Hospital were invited to attend and answer questions about A&E performance as many Surrey residents in the Elmbridge area use this as their primary hospital. They indicated that Kingston A&E was working well, having met all performance targets. Similarly to other A&Es, it had its busiest February on record, with a 10.6% increase compared with 2011, which equates to upwards of 380 patients a day. They are managing to meet targets, helped by a recent increase in the number of A&E consultants and a change to their hours. Their strategy is to frontload with A&E consultants.
15. Elmbridge Members raised the issue of a lack of community services for Surrey patients once they are discharged from Kingston Hospital. The data shows that most delayed transfers of care from Kingston are from Surrey residents. Kingston's A&E Clinical Lead indicated that this is not as much of a concern as it was in December when Members visited the hospital. The issue is that there are a lot of self-funders in Surrey and the hospital must work well with family/carers to discharge to appropriate places.

Actions/Further Information to be Provided:

- More detailed information on finance is requested for all future performance reports, along with information on specific performance failings, including actions to address them.
- Information on the Surrey Provider Trust contract is requested for the next report.

Recommendations:

1. That officers be thanked for attending and participating in the open debate about A&E performance; and
2. that the Committee continue its visits to A&Es across the County.

Select Committee Next Steps:

None.

09/12 CONTINUING HEALTHCARE [Item 9]

Declarations of Interest:

None.

Witnesses:

Marion Heron, Associate Director for Community and Continuing Healthcare Contract Management

Jon Ota, Project Director for Continuing Care

Helen Atkinson, Director of QIPP and Performance

Key Points Raised During the Discussion:

1. NHS Surrey marked Continuing Healthcare assessments as a Serious Untoward Incident (SUI) in 2010. This related primarily to those individuals in nursing homes awaiting a first assessment.
2. Members queried the assertion that Surrey County Council has 500 people with learning disabilities awaiting their first assessment. NHS Surrey indicated that there around 500 total in the last month still awaiting a first assessment but that only 100 of these were people with learning disabilities, according to their records.
3. There were timelines in place to ensure those awaiting assessments were being managed but the issue is reassessments and reviews, especially for older people with learning disabilities. The likelihood is that they will not be eligible for CHC when they are reassessed. Adults with learning disabilities can be assessed as eligible for CHC when they have challenging behaviour and when they are reassessed in later life this challenging behaviour may have subsided and they no longer qualify. This has been raised with NHS Surrey Board by LINk and they are working together on it. NHS Surrey is doing a piece of work on people with learning disabilities.
4. Members queried whether NHS Surrey has been able to recruit to the full capacity of additional nurses identified as necessary. Witnesses indicated that since March 2011 an additional six nurses had been recruited but that recruitment was still difficult.
5. Members queried what was a ‘normal’ number to be awaiting an assessment. Witnesses indicated that the aim is to have 90% of all assessments done within 28 days. The aim is to only have around 100 people awaiting a first assessment. They are a long way from achieving this due to the backlog.

6. Members were concerned about the large overspend on CHC and queried who will commission this in the future. Witnesses stated that the budget had been set on a year-on-year rolling basis so when the SUI was identified a new process was put in place. The effectiveness of the team in identifying the correct number awaiting assessment led to an increase in numbers. Witnesses felt that NHS Surrey is probably assessing more correctly now than three or four years ago as there are now fewer disputes with the local authority on CHC decisions. This growth was not anticipated in the budget, leading to the overspend. It is looking like the CCGs will be responsible for CHC but they will probably have to commission someone to do assessments. The whole process needs to be managed more effectively.

7. Members further queried CCG involvement, seeking assurances that the amount having to be spent had been accepted by CCGs as a budget item. Witnesses indicated that this is based on real numbers and the reablement project. A workshop was recently held with the CCGs on the way forward. They are aware of the expenditure and committed to working on the reablement pathway being piloted by NHS Surrey as the preferred option. Historically, patients were simply put in nursing homes. Now they may go into community hospital beds or have home-based care. Witnesses pointed out that the health reablement pathway was different from that offered by Surrey County Council Adult Social Care.

8. Witnesses expressed the opinion that NHS Surrey has a much better understanding of what's happening in the local health economy now. NHS Surrey is now spending more than others in the southeast on CHC so there is a need to look at how it is being spent. There are three identified reasons for the better understanding. Firstly, there is better working with Children's Services on transition cases. Secondly, an issue has been identified in which many of the referrals for CHC assessment from care homes are from self-funders that realise they may be eligible for CHC or Funded Nursing Care (FNC) once they are already in a home. NHS Surrey is working with care homes to address this. Thirdly, hospital colleagues are working on ensuring patients are not assessed in the acute setting, as this does not offer the best assessment outcome. They will be discharged on the reablement pathway for three months, and then assessed for CHC.

9. Members queried who is ultimately responsible for the improvements needed on CHC. It is ultimately NHS Surrey's responsibility; however, in order to decide if a patient is eligible for CHC information is required from the health care provider, such as children's services or a nursing home. Then, if the patient is transferred between services, all of them must agree on this. Patient care is the care provider's responsibility. The backlog is currently the PCT's responsibility but will become the CCG's responsibility.

10. Members indicated that, going forward, it would be beneficial to receive further information and assurances that sufficient funding for CHC is agreed with CCGs.

Actions/Further Information to be Provided:

- The Committee to receive information on the outcome of the pilot.

Recommendations:

None.

Select Committee Next Steps:

None.

10/12 DISTRICT AND BOROUGH CO-OPTEE REPORT [Item 10]

Declarations of Interest:

None.

Witnesses:

Rachel Yexley, Scrutiny Manager

Leah O'Donovan, Scrutiny Officer

Key Points Raised During the Discussion:

1. Members would like to see the protocol developed into a working relationship; however, many have concerns about the NHS reforms first and foremost.
2. Locally there may be issues that emerge that are more appropriate for the local committees to deal with; however, one of the co-opted Members felt there was no capacity at the local level to look at health issues and that this would represent a duplication of the work of HOSC.
3. Members agreed that the way forward was to send the protocol to Members for review in the first instance. It would then be sent to the Leaders of each Borough and District to decide on their own local arrangements.
4. The HOSC will not automatically deal with all local issues, but will get involved if it has policy implications for the whole of Surrey.

Actions/Further Information to be Provided:

- Protocol to be sent to HOSC Members.

- Protocol to be sent to all Leaders of Boroughs and Districts to determine their own local arrangements.

Recommendations:

None.

Select Committee Next Steps:

None.

11/12 HEALTH OVERVIEW & SCRUTINY COMMITTEE ANNUAL SURVEY AND REPORT [Item 11]

Declarations of Interest:

None.

Witnesses:

Rachel Yexley, Scrutiny Manager

Leah O'Donovan, Scrutiny Officer

Key Points Raised During the Discussion:

1. Some Members felt the report did not properly highlight the work of the HOSC effectively. It was felt the report highlighted more the work of engagement with witnesses. Members agreed that there was merit in seeking witness feedback following each meeting but that it was not necessary to make a formal report.
2. Members would like to see, going forward, an annual report of the work of HOSC, focussing on the main workstreams and how it performed.
3. The Chairman proposed an informal meeting to be held once next year's membership is confirmed. This meeting will include a discussion of the work programme to pick out key topics and areas on which Members wish to focus, as well as training in effective questioning and a tutorial on national NHS performance targets.

Actions/Further Information to be Provided:

None

Recommendations:

That the HOSC consider producing an annual report to Council detailing performance.

Select Committee Next Steps:

An informal meeting will be held in May to focus the work of the Committee for the next year on key priorities and topics as well as provide training in effective questioning and national NHS performance targets.

12/12 EPSOM AND ST HELIER HOSPITALS DE-MERGER UPDATE [Item 12]

Declarations of Interest:

None.

Witnesses:

Matthew Hopkins, Chief Executive, Epsom and St Helier University Hospitals NHS Trust

Jon Sargeant, Transaction Director, Foundation Trust Transaction Board

Andrew Liles, CEO, Ashford & St Peter's Hospitals

Key Points Raised During the Discussion:

1. Epsom and St Helier representatives began by reassuring Members that it was business as usual at both hospitals and they continue to remain devoted to patient care as a priority.
2. Members were concerned that further uncertainty could lead to staff being distracted, which could affect patient care. Witnesses agreed with this concern, assuring the Committee that they were working thoroughly on plans for the St Helier Hospital site to keep uncertainty at a minimum. However, the Board is not going to rush into a decision; it must assess the situation properly and determine the correct route.
3. Members queried the timeline for the process. The transaction with Ashford & St Peter's (ASPH) is currently planned for 1 January 2013 and this is being kept to. The timeline once this is completed is for St Helier (including Sutton Hospital) to reach Foundation Trust status by September 2014. The Department of Health must have final sign-off on the transaction and a paper is due to go to the Transaction Board in July 2012 on the options for St Helier that will inform this evidence. The Transaction Board is rightly focusing on the ASPH bid and the Trust Board was focused on St Helier.
4. Witnesses explained one of the potential options for St Helier would be treated as a last resort. There was a mechanism in the 2009 Health Act called the 'Unsustainable Provider Regime'. It makes provision for a special administrator to oversee any NHS acute Trust deemed unable to achieve foundation trust status. The appointee would be external but supported by NHS staff, and would investigate the situation, including talking to stakeholders, and come up with a plan to resolve the situation within 40 days. There would

be a mini-consultation for 30 days with stakeholders and then the full report would be presented to the Secretary of State. The Secretary of State would then decide whether or not to implement the administrator's plan. There was currently no policy or procedure in place to provide any guidance on this. Importantly, these special administrative powers take away the requirement for public consultation without the need to involve patients, the public and staff .

5. Members were concerned about the scenario where a partner was found for Epsom Hospital but not for St Helier and the Government decreed the two must remain merged. Witnesses stated that key stakeholders on the Transaction Board were in agreement that the ASPH bid was the correct one for Epsom Hospital. Members were concerned that the clinical safety of patients at St Helier was the key going forward and must be assured. The scenario would only come about if the Trust cannot convince stakeholders that clinical safety remains. When the Better Services Better Value Review of services in southwest London was completed, the likelihood was that there could be service changes that may affect St Helier. The Trust was fully committed to getting a good deal with ASPH and going ahead with the transaction. They were also working diligently to get proposals for St Helier to ensure it was clinically viable and financially stable.

Actions/Further Information to be Provided:

- Members request to be kept updated on the progress of the transaction between Epsom Hospital and Ashford & St Peter's Hospitals.

Recommendations:

None

Select Committee Next Steps:

None

13/12 DATE OF NEXT MEETING [Item 13]

Noted that the next meeting of the Committee would be held on Thursday 24 Mary 2012 at 10.00am.

[Meeting ended: 1:41pm]

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Chairman