Minutes of the Meeting of the HEALTH LIAISON PANEL held on 14 September 2015

PRESENT -

Councillor Jean Steer (Chairman); Councillors Richard Baker, Rekha Bansil, Jane Race, Humphrey Reynolds, Guy Robbins and Peter Webb

In Attendance: Councillor Dr Lynne Hack *(Portfolio Holder for Health and Ageing Well, Reigate and Banstead Borough Council)*

Presenters: James Blythe *(Director of Commissioning and Strategy, Surrey Downs Clinical Commissioning Group)* (for items 5 to 7); Daniel Elkeles *(Chief Executive, Epsom and St. Helier University Hospitals NHS Trust)*

Absent: Councillor Liz Frost

Officers present: Simon Young *(Head of Legal and Democratic Services)* and Fiona Cotter *(Democratic Services Manager)*

5 MINUTES OF PREVIOUS MEETING

The Panel was informed that amendments to the Minutes of the Meeting held on 15 June 2015 had been received after publication of the Agenda. In particular, it was highlighted that Ms. Walker, Surrey County Council's Public Health Lead, wished it to be recorded that while it was difficult to determine the exact causes, there was some evidence to suggest that increased risk drinking (more than 3-4 units a day on a regular basis) was more prevalent in affluent communities and that deaths from liver disease were currently being analysed. It was also noted that the summary of the structure of the various Surrey Public Health units and teams had been clarified.

The Minutes would be duly amended and re-circulated. The Panel agreed that the Chairman accordingly be authorised to sign the Minutes, as amended, as a true record of the said meeting.

6 DECLARATIONS OF INTEREST

No declarations of interest were made by councillors regarding items on the agenda.

7 SURREY DOWNS CLINICAL COMMISSIONING GROUP

The Chairman welcomed James Blythe, Director of Commissioning and Strategy to the meeting. Mr. Blythe was attending the meeting to provide an update on

the work of the CCG on behalf of Karen Parsons, Chief Operating Officer, who was unable to attend.

Community Hospital Services Review

There had been a number of changes over recent years at all of the five community hospital sites. The current challenge facing the CCG was around the appropriate service model and the sustainability of services in the longer term.

The CCG had a contract for in-bed services at four of the sites: Molesey, Leatherhead, Epsom and Dorking. Beds had been moved to Dorking from Leatherhead to ensure safe levels of staffing.

A review of the service had commenced in March this year. It involved observation work in each hospital by an experienced clinician, a review of activity and outcomes and what other models were used around the country. At the start of the review process a Programme Board had been convened to oversee the review process. The Community Hospital Review Programme Board was chaired by Dr Jill Evans and included two members of Surrey County Council's Well-being and Health Scrutiny Board, County Councillor Tim Hall and Mole Valley District councillor Lucy Botting.

A draft review report had been published in August. In particular, Mr. Blythe highlighted that the draft report considered how the rehabilitation service should be run and set out a number of options for the future configuration of in-patient beds. In summary, the general recommendation was that beds were sustainable on three sites and the options for their configuration (which would be the subject of further consultation) were:

- In-patient services to be retained at Epsom, Moseley and Dorking

- In patient services at Moseley to be moved to Cobham (built in the 1990s, this facility had accommodated in-patient beds in the past and there was likely to be demand for facilities in that locality in the future)

- In-patient services at Epsom to stay at their current site or be co-located on the Epsom Hospital site (this had been piloted last year when the current site had been under refurbishment and was linked with the Hospital's estates review). If some beds from West Park were relocated then consideration would be given to the services left on the site. If all beds were relocated then the site would be potentially vacant and available for redevelopment but the future of the site would be a decision for NHS property services.

- In-patient services at Epsom and Moseley to be moved as stated above.

Each option included the retention of Dorking because of its service catchment area, particularly south of Dorking, and its out-patient services. None of the options included beds being re-instated at Leatherhead and the in-patient ward would be closed permanently. The future of the Leatherhead site lay in the development of the site for out-patient service delivery as a planned care hub. This was because of the excessive costs and unsuitability of the Leatherhead

site for reinstating in-patient bed services and the availability of other suitable sites (NEECH, Epsom and Cobham) in the Epsom locality.

The draft report was due to be considered by the CCG's Governing Body on 25 September 2015 and the options (three sites with a number of options on configuration) would go forward for public consultation in October. Services were likely to be under pressure over the winter months and so changes were not likely to be implemented until spring next year.

A number of public engagement events had been undertaken up to this point involving several hundred people and the CCG had received relatively strong feedback in those areas affected by the proposed changes. Leagues and Guilds of Friends had been very helpful but it was disappointing not to have had slightly wider representation. The CCG was working hard to publicise the consultation and encourage engagement.

It was confirmed that ancillary issues had been taken into consideration such as understanding the geographical location of long term patients and the impact of travel time. Clinical safety and sustainability of services were the CCG's first priority.

CCG's Financial Position

The CCG incurred a £10.7m deficit in 2014/15. This was the result of two main factors: overspend on planned care services and accounting allocation adjustments. Two thirds of the deficit was the result of overspend on planned care services. The CCG had identified a high level/demand for such services. Some demand on planned care had gone up by 6.2% and the CCG had identified a 5% recurring growth but was only funded for 1% – 2%. Therefore the CCG already faced significant cost pressures going into this year. A savings programme had been drawn up which hoped to save £12.8m but, even with those savings, the CCG faced an £18m deficit for 2015/16.

Work was being undertaken on a financial recovery plan for 2016/17. A deficit of £8m was projected for 2016/17. It was hoped to break even by the end of 2016/17 so that there would be no deficit in 2017/18. The seriousness of the situation had been the subject of scrutiny by NHS England and the CCG was currently under directions to support the CCG with in its financial recovery plan to achieve a financial balance in 2016/17. The CCG had been directed to appoint a Turnaround Director and a Capability and Capacity review had been commissioned by NHS England.

Mr. Blythe attributed the deficit to the CCGs aim to transform services rather than cut them. The CCG was working with GPs to try and reduce system costs and looking at proactive services to prevent acute admissions. Organisational change had been challenging with the move away from PCTs and the Better Services Review but the CCG had been pursuing its vision. There were no cuts in the current savings plan but if the plan was not supported or did not succeed, more aggressive measures might have to be considered. Options regarding the

Stroke Unit were currently being worked through. No decisions had yet been taken but the CCG would ensure appropriate services for the local area.

8 EPSOM & ST. HELIER UNIVERSITY HOSPITALS TRUST

Mr. Daniel Elkeles, Chief Executive, Epsom and St. Helier University Hospitals Trust, provided an update to the Panel on the Trust's latest performance, financial position and its estates review.

The Panel was reminded that the Trust had five corporate objectives. Mr. Elkeles was pleased to report that the Trust had a lower infection rate than last year and that staff sickness was also low (3.52% as at end of July against a target of < 3.65%).

In terms of creating a positive patient experience, recommendation rates from the patient Friends and Family Test (FTT) continued to score between 93% and 97% and staff FFT (% of staff who would recommend the Trust's hospitals as a place of work and as a place to receive treatment) indicated that staff would want to be treated there.

In respect of providing responsive care, the Trust was the second highest performing Trust in London with 96.5% of patients spending less than 4 hours in A&E. The 62 day cancer standard had been challenging and was still not being met. However, the Trust was doing everything it could to treat patients as quickly as possible. The Trust was investing in additional CT and endoscopy capacity, changing pathways to enable investigative procedures to be carried out more quickly and was working with GP partners to ensure plans were in place for increases in demand.

The Trust's financial position was very challenging with a £7.6m deficit as at the end of July. A financial recovery plan had been developed which focussed on three areas: in particular, continuing to reduce the Trust's reliance on agency staff in both nursing and medical posts. Mr. Elkeles was pleased to report that, having started the year with 550 clinical vacancies, by the end of July this had been reduced to 90 posts and there were almost 100 new starters due to take up their posts by the end of September. The Trust had filled all its midwifery posts and all current clinical posts were full. This would significantly reduce the pay bill.

The Trust also continued to work in partnership. In particular, Mr. Elkeles highlighted the exemplary work around care of the elderly which ought to make a real difference.

Mr. Elkeles also wished to highlight the annual Volunteers Tea Party which took place last week at Epsom Racecourse and which he had the privilege of presenting long standing service awards. Volunteers provided much valued support to the hospitals, patients and visitors and provided over 78,000 hours of their time per year.

Finally, the Panel was informed that work was also well underway to prepare for the Care Quality Commission Inspection of the hospitals commencing on 10 November 2015.

In regard to the estates review, Mr. Elkeles reiterated the commitment to retaining consultant led, 24/7 A&E, maternity and inpatient paediatric services at both Epsom and St. Helier hospitals over the next five years but that the focus for Epsom would be on the provision of planned care. However, in addition to challenges around staffing, financial viability and clinical variability, the Trust also faced major challenges relating to its estate (as illustrated by a number of photographs displayed at the meeting). The aim of the Trust was to provide an estate which was affordable and well utilised, environmentally friendly, safe and easy to maintain. This would facilitate a healing environment and infection prevention in which high quality care could be delivered and patient privacy and dignity maintained.

The Trust had commenced a consultation process with key stakeholders and the public, including two open days at the hospitals on 17 and 23 September 2015. An engagement booklet had also been produced to seek people's views which included specific questions around different patient journeys to help inform decisions. Multiple options were likely to emerge and it would be a complex process to choose them. However, what was clear was that the cost of implementation would be over at least £500m based on future capacity needs. Therefore, the Trust needed to answer four questions:

- How much hospital-based healthcare would the Trust need to provide in 2025? (This was already known)

- How would the Trust ensure this care was high quality, delivered to sufficiently high standards, around the clock? (the current conversation with stakeholders and the public would answer this)

- How much space would the Trust need, paying particular regard to bed numbers? (this would be informed by bullet points 1 and 2 above)

- How much would it all cost and how would the Trust pay for it? (The Trust would need to borrow and would have to demonstrate a business case to make investment, particularly to the Government, more attractive. PFI funding was an unlikely option based on the current experiences of other NHS Trusts, but Mr. Elkeles did not rule out different private sector funding models if they were out there).

In response to questions from the floor, the following points were noted:

- Regarding stroke care, outcomes were better if acute care was concentrated in a number of specialist centres. Epsom was the smallest area so it was unlikely that acute beds would be located in here. However, Mr. Elkeles considered that there was a strong case to retain rehabilitation services in the area but stressed this was a decision for the CCG. The Trust would want to

play a role in encouraging home recovery and was willing work with community providers in this regard.

- The Trust was exploring all options in securing investment in its estates, including private charitable donations, and was putting together a robust business case. However, if enough funding was not secured, compromises would have to be made.

- In regard to revenue streams, it was not permissible to invest NHS funds into private health care but there was a private market out there and the Trust was open to working with a private sector partner within permitted boundaries;

- All consultants worked weekends. Mr. Elkeles stated that the issue was far more complex than presented in the media: in particular, the fact that there were not enough trained consultants nationwide to deliver a 24/7 service.

The meeting began at 7.30 pm and ended at 9.07 pm

COUNCILLOR JEAN STEER
(CHAIRMAN)