Extraordinary Council - 22 June 2017

Minutes of the meeting of **Council** held on **22 June 2017** when there were present:-

Chairman: Cllr Mrs L A Butcher
Vice-Chairman: Cllr D Merrick

Cllr C I Black
Cllr M R Carter
Cllr Mrs I Cassar
Cllr N L Cooper
Cllr T G Cutmore
Cllr D S Efde
Cllr A H Eves
Cllr Mrs J R Gooding
Cllr J D Griffin
Cllr B T Hazlewood
Cllr N J Hookway
Cllr Mrs D Hoy
Cllr M Hoy
Cllr Mrs T R Hughes
Cllr M J Lucas-Gill
Cllr Mrs J R Lumley
Cllr R Milne
Cllr J E Newport
Cllr R A Oatham
Cllr Mrs L Shaw
Cllr S P Smith
Cllr D J Sperring
Cllr M J Steptoe
Cllr I H Ward
Cllr M J Webb
Cllr Mrs C A Weston
Cllr A L Williams
Cllr S A Wilson

APOLOGIES FOR ABSENCE

Apologies for absence were received from Cllrs J C Burton, R R Dray, G J Ioannou, Mrs C M Mason, E O K Mason, J R F Mason, T E Mountain, Mrs C E Roe and C M Stanley.

OFFICERS PRESENT

S Scrutton - Managing Director
J Bostock - Assistant Director, Democratic Services
S Worthington - Democratic Services Officer

ALSO PRESENT

T Abell - Chief Transformation Officer (Basildon, Broomfield & Southend Hospitals)
Dr R Fenton - Medical Director, Mid and South Essex Sustainability and Transformation Partnership
Dr C Howard - Clinical Director, Emergency Medicine, Southend University Hospital NHS Foundation Trust
I Stidston - Accountable Officer, Castle Point and Rochford Clinical Commissioning Group

128 DECLARATIONS OF INTEREST

Cllr T G Cutmore declared a non-pecuniary interest by virtue of membership of the Essex Health and Well-Being Board, chairmanship of the Castle Point and Rochford Health and Well-Being Board and being a non executive governor of Southend Hospital NHS Foundation Trust.

Cllr M J Webb declared a non-pecuniary interest by virtue of being a non executive governor of Southend Hospital NHS Foundation Trust and by virtue of his wife's employment at Broomfield Hospital.

129 FUTURE OF HEALTH AND CARE SERVICES IN THE ROCHFORD DISTRICT

(Note: Cllr T G Cutmore declared a non-pecuniary interest in this item by virtue of membership of the West Essex Clinical Commissioning Group).

Pursuant to Minute 88/17, Council received a presentation from NHS representatives providing an update on current developments and discussions to improve health and care for people in the Rochford District.

During the presentation the following points were noted from Dr Fenton and Mr Stidston:-

- There were no plans to close any of the A&E departments at any of the three hospitals; all of the proposed options included provision of an A&E department at each of the three hospitals.

- There were currently no firm proposals.

- The intention was to look at options for the entire health care delivery across the region to 1.2 million people, with clinicians actively involved in leading this development.

- There would be full public consultation for matters that required public consultation.

- Health and care services needed to change to meet the increasing demand from the local community. 81% of GPs were reporting that they were seeing patients with more complex conditions, including diabetes, COPD, dementia, asthma, as a result of the fact that people are living longer.

- There has been a big increase in the number of people using A&E services; there has been an increase of 4.6% in mid and south Essex compared to the national average increase of 1.6%. This has placed considerable pressure on services and pointed to the necessity of identifying a different way of providing sustainable health and care services shaped to meet the needs of the local population.

- There will be more 85 and overs in the local communities within the next ten to fifteen years than before.

- Out of hospital services, including GP, community, district, pharmacy and dental services are too fragmented, with gaps in service provision. There is a need for seamless provision for patients outside hospital, in hospital

and then back out into the community.

- Current health workforce is not sustainable; current GPs are getting older and are already stretched; in addition, current GP practices are finding it difficult to recruit new GPs and it's also difficult to recruit nurses.

- The NHS has engaged with residents in mid and south Essex and asked what they believe needs to be improved in respect of local health and care services. A list of the top twelve issues has been produced as a result of feedback received, the top one being that of access, and particularly access to GPs, but also including better access to community care; prevention/self-care and the last on the list being improvements in hospital services.

- An overall plan was therefore being developed to tackle all these issues with the aim of transforming how local services would be delivered, in a more joined up way ensuring that people were able to live well longer and able to access the treatment they needed at an earlier stage. This would mean that they would not need to access hospital services such as A&E and other non elective services. This should release resources to be re-invested into primary care services to further strengthen interventions within the local community.

- Services have been commissioned within Castle Point and Rochford (in Rochford, Rayleigh, Benfleet and Canvey Island) for planned GP appointments at weekends; currently 20 out of 25 GP practices had signed up for this, with the intention of all 25 being included by the end of the year. Staff within those practices were working together on how services might be transformed, with resources brought in and new staff recruited to free up GPs to be able to spend more time with more complex patients. Pharmacists and emergency health practitioners have been appointed to work across some of the practices within this area, as well as an advanced nurse practitioner specialising in long term conditions working across several practices. Call-in care implementation had also been introduced for more complex, vulnerable patients, which was a nurse-led service across practices which resulted in a health/care package being made available for such patients within the community, with specific points of contact for patients. 1700 patients were now registered with this service, which was making a real difference in their lives, maintaining their health and enjoying joined up health and social care services. Care homes in Rayleigh had a dedicated GP practice offering services focused on the complex needs of patients and focused on early intervention with the aim of reducing the need for A&E visits.

- The CCG was looking at introducing different services aimed at improving access, including telephone consultations, e-consultations and text services.

- One of the biggest challenges for the CCG was a high level of patients not turning up for GP appointments – around 25%. Currently piloting a system that reminds patients of next day appointments, while at the same time allowing patients to cancel appointments by text, thus freeing up GP appointments, increasing access.

- Audley Mills practice in Rayleigh introduced a new system a week ago giving patients the facility to receive a telephone triage by doctors, which could result in the patient being seen at the surgery on the same day, if deemed necessary during the triage process. At the end of the week GPs found that although they had had contact with more patients, more of their time had also been freed up due to the efficiency of the system.

- It was important to try and separate emergency care from planned care in respect of hospitals and to recognise that some specialist emergency care would be better delivered in specialist centres and to streamline specialist care.

- There was a general consensus that the tertiary referrals service for burns and plastic surgery at Broomfield Hospital, the cardiothoracic centre at Basildon Hospital and the cancer and radiotherapy unit at Southend Hospital should all remain. This would, however, have an impact on what services should be wrapped around that.

- It was important that at each of the three hospitals there should be medical and surgical assessment units, frailty assessment units, children's assessment units, outpatient clinics, day surgeries, maternity units and the ability to re-patriate patients to specialist units.

- It is anticipated that there should only be around a 5% change in local hospital services. Discussions have been around having a specialist focus for each of the three hospitals: one on emergency care, focusing on the sickest people who need expert care there and then (red hospital); another would balance emergency care with elective care (orange hospital), , and the final one would be more focused on planned care, resulting in less cancelled operations (yellow hospital).

- An appraisals options process was commissioned of the various options for focusing the three hospitals of all stakeholders, the outcome of which was to focus on options 2A and 1A: Basildon – red, Broomfield – orange, Southend – yellow, and Basildon – red, Broomfield – orange, Southend – orange, respectively.

- Many clinicians were closely involved in the process leading up to the appraisals options process and not all clinicians were comfortable with the changes being considered. This was, however, positive, as it would force every aspect to be re-evaluated in order to move forward change.

- All of the options proposed in terms of specialist care for the hospitals would result in all three hospitals having an A&E capable of dealing with the emergency presentation of any patient, stabilising the patient, triaging the patient and then sending them on to wherever was most appropriate to meet the patient's needs, i.e., either home, somewhere else within the hospital or to another hospital, as was currently the case. This all required close working with Primary Care and with the Ambulance Service.

Dr Howard confirmed that she had been closely involved in the process, attending many meetings with the Lead A&E Clinicians of Basildon and Broomfield Hospitals, as well as other staff from the three hospitals, including Lead Nurses and managers, over several months. She stated that the Lead Clinicians from all three hospitals did not agree with the options that had been put forward for the options appraisal process. They did not agree with a red hospital option for accident and emergency and felt that at this moment in time it was the complex needs of frail and elderly patients that was affecting hospital emergency departments and the lack of frail medical beds on any of the three sites. There would therefore always be overspill into the elective areas. They perceived that the crux of the matter was not about how the emergency departments were functioning, but rather how elderly patients could be prevented from going into hospital and how emergency department staff could turn around elderly patients quickly so they weren't in hospital for a long time and how it might be possible to prevent elderly patients going back to the hospital. The Lead A&E Clinicians from the three hospitals did not believe that the options on the table addressed any of these issues.

She confirmed that there were staffing issues within the A&E departments, and pointed out that in order to staff option 2A, more staff would be needed than currently worked in the three A&E departments. The options only resulted in shuffling staff between the three hospitals, rather than increasing numbers in any way. The Lead Clinicians were also concerned about the definition of an A&E. For example, ambulances would bypass a yellow hospital, either in totality, or at certain hours of the day. I would not want to work in a yellow hospital as it would not meet my professional needs in terms of treating acutely ill patients and it is not what I trained for; other A&E doctors would, similarly, not want to work at a yellow hospital. She stated that it was a misnomer to suggest that there would be a 24/7 A&E on each of the three sites. This would, in their view, result in a downgrade to a walk-in centre. If it didn't, they believed that this would be dangerous. Currently, as patients presented themselves at Southend A&E, which did receive a high volume of patients with serious medical pathology, staff were able to manage and treat them, as this was what happened in response to the average of 70-100 ambulances arriving daily at Southend A&E. If those ambulances were to bypass Southend A&E in the future, staff would no longer be able to recognise serious pathological conditions and would not be able to treat those patients, who would therefore have a worse outcome and not do as well. The clinicians therefore believed that this should not be called an A&E, but rather a walk-in centre.

She agreed that there was evidence that demonstrated that groups of patients would fare better being treated at specialist units. However, this was something that already happened, e.g., paramedics currently ran diagnostic ECG's on patients suffering suspected heart attacks and around 2 patients per week were subsequently transported directly to the specialist cardio thoracic centre in Basildon, not Basildon A&E; similar pathways already existed for other serious conditions. The clinicians were concerned that all the evidence demonstrated that the longer a patient had to travel, the more likely a patient was to die. Southend A&E treated a high number of patients with serious respiratory problems, 2% of whom were more likely to die if transported a greater distance. Clinicians were trained to do the best for their patients, but did not believe that any of these specialist options were in the best interests of patients.

She emphasised that it was positive that health staff were all working together on this, but was concerned that clinicians had not been listened to, nor had their preferred option been taken forward as part of the options appraisal process.

Dr Fenton stated that it was intended to adopt a phased approach to change, testing out each individual element in a gradual way. Despite the differences in views between himself and Dr Howard - and not all medical staff agreed on which option was the best one – they would nevertheless work together with patients' best interests as their priority.

Mr Abell emphasised the Local Success Regime's commitment to listen to clinicians and the local communities, to their concerns and issues, over the summer. The intention was to work closely with colleagues in the clinical commissioning groups within mid and south Essex to help them accelerate some of the initiatives aimed at managing the frail and elderly outside the hospitals. In addition, a clinical reference group had been set up comprised of senior clinicians, which would meet imminently and four groups had also been initiated to work through 'blueprints' for changes in the hospitals that would deliver benefits to patients. These groups would focus on emergency care and the functionality of each of the A&E departments; how to address some of the issues identified by Dr Howard around the core general medical and core emergency surgical admissions; whether any separation could be done with any of the planned care to try and reduce cancellations of planned operations; and on paediatrics. This work would be led by senior clinicians from across the three hospitals working on a patient condition by patient condition level.

Discussions would continue with local communities and local clinicians up to September 2017. A pre consultation business case would then be completed to undergo a national assurance process. A formal public consultation exercise would then be conducted, and this was likely to commence in December 2017 and run to the end of March 2018. Proposals would be refined in light of feedback received. It was anticipated that a decision would be made in May 2018.

The following questions and answers were noted in respect of the presentation:-

Q: *If there are going to be longer ambulance journeys, can you assure us that you are going to increase the ambulance service and that these will be staffed by appropriately increased and to take on the right people with the right skills to staff those ambulances?*

A: Dr Fenton:
This could not be done without involving the East of England ambulance service. It would not be a simple equation to upskill staff and change the way they operate, however it would be necessary.

Q: *Have agency staff from Spain and the Philippines been brought in to bridge any staffing shortages at Southend Hospital?*

A: Dr Howard:
There are staff shortages in A&E. Two years ago around 50% of Consultant or Senior Registrar posts were vacant in the UK. At Southend A&E is one of the better staffed departments for Senior Registrars in the country. There has been some nursing recruitment from the EU, from the Philippines; however, staffing is still the biggest problem for the hospital.

Dr Fenton:
At Broomfield Hospital we have increased our nursing staff substantially over the past five years and managed that through international recruitment at times. This has been driven by increased standards and requirements for more nurses. There is constant flux and we would never be at full establishment and that's not uncommon.

Mr Stidston
On the primary care side there is an initiative to attract 50 GP's from the EU to mid and south Essex. That recruitment process has started and 8 GP's have been placed within practices in mid and south Essex. We are beginning to get more GP's from that route. That isn't the answer, as we need to change how general practice works and have to attract GP's in this country to south east Essex. We believe that this fresh approach to primary care will attract more GP's into this area. However, in terms of short term planning, this is helping to ensure that we deliver fast and effective treatment to patients in primary care.

Q: *If the hospital options outlined in the presentation are not the clinical leads' preferred option, what is the alternative?*

A: Dr Howard:
The three clinical leads would favour a 'treat and transfer' model. Each of the three A&E's would continue to receive the patients, as

they do now; those who would be transferred for specialist treatment, e.g., heart attack patients would be transferred to the cardio thoracic centre in Basildon, as is currently the case; and we would then treat and stabilise and then diagnose those patients. Currently the East of England ambulance staff are not able to diagnose patients and pick out the ones before they get to hospital. Once we had a diagnosis we would then look at what patients would do better either going to a specialist unit or what patients it would make sense from a service provision perspective to go to a specialist unit. A good example of that is some patients with a gastro intestinal bleed from the gut would have a higher mortality rate if transported longer distances to specialist units. They would therefore go to their local A&E, where they go now, and would be stabilised. At the moment at all three hospital sites there is a GI on call rota. Anecdotally, two patients per month at Southend Hospital go for an emergency GI procedure overnight. It makes no sense therefore to have three on call rotas across the three sites. What makes sense is to have one site on call or even a mobile GI team going to where the patient is. From a lifestyle, rota, manpower and safety for the patient point of view this makes better sense.

Q: *There appears to be a lot of confusion between clinical care and social care and a problem with bed blocking – how will this be addressed?*

A: Dr Fenton:
The flow through the system is the biggest problem. The ability to find appropriate social care to re-enable patients is critical to resolving this issue. It is not unusual within a hospital for there to be an entire ward of patients who could be somewhere else.

Q: *Is it the intention to repatriate patients to recuperate at a local hospital after their initial hospital treatment has been completed?*

A: Dr Fenton:
In some models, the initial acute treatment of a patient may happen in one centre, for example, a trauma patient being treated in Addenbrookes, once stabilised, would be repatriated to one of our hospitals. This pathway exists and might also be a pathway we would want to employ.

Dr Howard:
This is of great concern from the repatriation point of view. The possibility of taking frail and elderly patients away from their support network is also a cause for concern. The impact of moving frail and elderly patients from ward to ward can have a detrimental impact on their length of stay, but also can cause deterioration, particularly for those suffering from dementia, as you are taking them from somewhere unfamiliar to somewhere else that's unfamiliar. The

factor of transporting them across hospital has not been fully accounted for and the effect that will have on the overall length of stay and therefore bed blocking would increase even further.

Mr Stidston:
This has to be looked at as a whole system; you can't look at one element in isolation. To get patients out of hospital we need to look closely at how health and social care work together, to ensure we have the right placements in the right places. Different elements have to be looked at together: avoiding people going into hospital; the treatment; what to do with patients when they come out of hospital. We can ensure that across the NHS sustainability and transformation partnership (STP) we look at it together as a whole system and find effective ways of reducing such instances.

Q: *What are you looking to do to deal with the ever increasing population locally? GP services are crucial to how people interact with hospitals – what are you doing to get our own GP's through the system and into practice to replace ageing GP's who are seeking to retire? The St Luke's drop-in centre has now closed, although it would have helped prevent some of the impact on the Southend A&E department – should you not be looking to provide services like that, rather than closing them down?*

A: Mr Stidston:
There is an exciting development at ARU where a new medical school is being developed that will have links in Essex. That is a component of bringing GPs into Essex and keeping them in Essex. We also have training practices where we bring in GP's who are in training to become GP's. They stay in Essex a lot longer than those that come in from outside. There is a real move in Essex to bring in and train new GP's for the future and we will tap into that. Part of this will be how we change how general practice works. When you speak to GP's they love their job but they are over burdened with the pressure. We have to find a way to take that pressure off them and change that primary care provision. We are starting to do that; we are starting to bring in more professionals working in general practice and it's starting to free up the time. If you take that step further and ask how these groups of practices can support each other, still retaining their identity and the services they deliver and start to say 'we have a GP who has a specialism in diabetes', that has a team associated with it and patients can be seen there while still under their own GP. You are shifting pressure and changing the way that services are delivered and you are making a practice again an attractive place to come and work at and stay. The wealth of nursing expertise can be used more effectively and can be trained to deliver more services.

St Luke's was a Southend CCG-commissioned service. The decision was taken to close it. It didn't have the impact on A&E that some people were concerned it would have. There was an element of activity at St Luke's that we were paying for twice because individuals were registering with another practice but still using St Luke's as a walk-in centre. We are, of course, looking at urgent care outside hospitals and that was a component that was within St Luke's that can be looked at and fine tuned to be delivered more effectively for the locality. There are lots of lessons we can learn from that and there are components of that service that can be re-focused as we start to re-shape a service for a locality. This may look different for services that are near a hospital to those that are further away.

Dr Howard:
The Anglia Ruskin Medical School will be of great benefit to the Essex health community. This will, however, be a 10-year plan to get students trained as GP's, so won't be an immediate answer. We have the second highest number of GP vacancies in the area and the second highest number of GP's due to retire within the next five years so things will get a lot worse before they can get better. The community sorting will need to happen beforehand as that is what is crippling the whole of the health service in Essex now.

Q: Has the removal of the nurses' bursary caused a reduction in applicants to train as nurses and are any of these proposals dependant on having any more nurses?

A: From what I understand, there has been a significant reduction in the number of applications – around 60%. This does concern me as every hospital in the country has a large number of nursing vacancies. I also head the medical directorate now and at the number there is a high number of vacancies, which is very difficult to manage. There's a lot of work for the nurses who are there so retention becomes a problem. Looking at the individual modelling, downgrading to a yellow, with a walk-in centre run by emergency nurse practitioners, you'd need a significant increase in numbers. If you look at the red centre, which would increase its patient attendances; Basildon currently has 130,000 patient attendances per annum, in four years that would rise to 220,000. To manage those numbers of patients, although there would be a reduction on another site, I have one majors area at the moment and that has one majors nurse in charge and one majors co-ordinator. I couldn't double the size of my A&E and still have one majors nurse and one majors co-ordinator. Whilst the proportion of nurses to cubicles, like nurses to beds on a ward remain the same, I'd need a few more chiefs to run the shop floor so would be concerned that more would be needed.

Q: *Will clinical outcomes in response times get worse or better by categorising Basildon as red, and the other two hospitals as A&E?*

A: Dr Howard:
Worse.

Dr Fenton:
Better

Mr Stidston:
Better.

Mr Abell:
Better.

Q: *ICT systems for the three hospitals – often residents report going to the hospital to find that, e.g., blood tests can't be located. If patients are to be transferred to specialist units, will you have their records to hand?*

A: Mr Abell:
That's a big piece of work that's already started. The same IT system for, e.g., radiology imaging, can be accessed across the three sites. There will be a great deal of work to be done in terms of test results, medical records, etc being integrated across the three sites, but this work will have to be done before any of the changes can happen.

Dr Howard:
Regardless of whatever model we end up with, we should be doing that anyway because you might live near Basildon but you might work near Southend and you might become ill in Southend rather than Basildon.

Q: *It appears as though some of the concerns/issues raised by Dr Howard have already been taken off the table and so some of the opposition views have already been dismissed so the public has had no opportunity to review these comments in full.*

A: Dr Fenton:
That is the reason we are both sitting here. Nothing has been taken off the table. We are looking in detail at the 'treat and transfer' model, and working through it phase by phase. We will do nothing that isn't better so if we find the red option isn't better, we won't follow through with that option. It's not been taken off the table, and we haven't actually started the official public consultation yet but have spoken at over 100 events during the past 12 months.

Mr Abell:
The public are being kept updated as we go along. As we listen to your views we are changing and iterating our model, so hopefully whatever we get to in December is something that you recognise and you understand more about than you would have done if we'd followed the old way of doing public consultation in the health service whereby proposals would have been presented in December that you didn't understand or know anything about, without allowing sufficient time for you to think about and give informed views on. We have decided to be open and transparent, but this does mean that there is more uncertainty and more movement over time, but this shows that we are trying to listen and to adapt our processes, to address concerns and to moderate our approach as we go along. This means we can't answer every question now but can tell you where we're at.

Q: *How can we avoid transferring over GP practices in mid and south Essex to expensive private companies?*

A: Mr Stidston:
We have a good group of GP's here with good practices across our locality. We want to retain those practices, those GP's and that ethos. We would look to disperse within the local community rather than re-procure from another provider, if a contract was to come to an end. If we were in a position where there wasn't a practice able to absorb those patients we would then go through a procurement process but would be looking for a service that was in line with our vision, which is about a local provision of services linked with local practices to deliver services, linking with the acute service.

Q: *What are you going to do to increase resources – how are you going to bring in more funding to do all that you need to do, including buying new technology, IT, staffing, infrastructure? A lot of what has been set out appears to be more a question of re-configuring resources, rather than boosting them.*

A: Dr Fenton:
If we got more funding we'd still change because it wouldn't solve the GP problem, or the nursing problem, or the staffing problem, but more money would certainly be welcome.

Mr Abell:
If we get a good plan together that we can all get behind there are various funding pots held by the Department of Health and other agencies that we can apply for. We could use this to support some of the plans to be taken forward. We can apply for funding to improve the estates.

The plan will act as leverage in funding discussions so if we can finalise a plan over the summer we are in a stronger position to obtain funding from some of the available funding pots.

Q: *Have these proposed changes been costed? How will they be funded? Will additional funding come from the Government to help implement such serious changes?*

A: Mr Abell:
Previous answer applies. What we're trying to do is to cost the proposals as we go along to understand what the financial impact will be on the three hospitals and on the NHS more broadly. If our plans for community services pay off, meaning there will be less people needing to be admitted to hospital, this will help to free up resources. Any finalised document for formal consultation will be fully costed. We can then demonstrate what impact that would have and how any change would be funded over the implementation period of that change.

Q: *Who is championing Southend hospital and standing up for its interests within this process?*

A: Mr Abell:
We're all standing up for Southend. I'm legally responsible as an executive director of Southend Hospital. I am accountable to you and the population of Castle Point and Rochford to make sure that Southend delivers safe, effective services, day in day out. We know that we can't do that consistently all the time now so we do need to change.

Q: *In terms of the STP board, can you please clarify your roles and governance? To what extent is it possible for the decisions of an STP to override those of the consultant body?*

A: Mr Abell:
The STP board is made up of chief executives from the CCG's and key NHS provider organisations. They will make recommendations; they do not make any decisions. The decision around any consultation or any service changes will be made by the clinical commissioning groups across mid and south Essex. They have the legal responsibility and legal duty to do that.

Q: *If Basildon Hospital was to become the red hospital it would see an increase in patients to 220,000 – how will the hospital cope when those patients don't just go into A&E, but are dissipated throughout the hospital.*

A: Mr Abell:
It would be an increase from 130,000 to 220,000 and if that was to happen a number of changes would need to be made to the Basildon A&E department; we would need to expand it; we'd need to recruit. Any document going forward for formal public consultation would clearly set out the proposed changes to any of the three departments.

Q: *The areas that the hospitals cover – how far to the west and the north is your responsibility?*

A: Mr Abell:
West it's broadly to the M25 boundary and up to Harlow; north, we cut off around Uttlesford.

Q: *The health groups that border us – are they making similar changes?*

A: Dr Fenton:
They are making changes; all STP's in the country are making changes, many of them are similar to our proposed changes. There are patients from outside our borders who will move into our area.

Q: *Don't understand how the proposed changes to the A&E's in the three hospitals are going to make the system more efficient.*

A: Dr Fenton:
The changes to the A&E's alone won't make the system more efficient; the proposed changes to the out of hospital services, as well as changes to the hospitals, will together make the system more efficient. It's an entire system change to bring about a new way of delivering health services in this area. That is what makes it so complex and difficult.

Dr Howard:
I don't believe the A&E's are broken. The problem is that of provision of services for the big frailty medical group and so much of this sits in the pre hospital community to get resolution there. Without that, everything we are planning, and that's not just A&E; that's also the speciality pathways – without solving that all this will fail because as it is now there are not enough medical beds; it doesn't matter how you divide them or where you put them – when there aren't enough there will be spill over into elective care beds and we will run into the same problem. There are occasions when we do have to admit patients who don't have an acute medical need, because there is no other safe alternative. Not all services run 24/7, 365 days a year so there are still improvements to be made there. It's that big population group that is causing the problem and unfortunately that group is going to grow.

Q: *What happens if you can't take a decision that you all agree on? Will you just override it and go ahead?*

A: Mr Abell:
We will have to look at the feedback from the formal public consultation and ultimately it will be a decision that is made by our clinical commissioning groups.

Dr Howard:
The Clinical Leads are the Senior Consultants, effectively. There are around 6 to 10 Consultants in A&E. The three Clinical Leads from the 3 A&E's are all singing from the same song sheet so would hope it wouldn't come to that.

Q: *Should this not be put back a couple of years to enable changes in primary care to be put in place prior to instigating any changes in the hospitals?*

A: Mr Stidston:
It's a good point, but this is where the two systems need to work as one system. We have to work in tandem on this and it's about taking the steps together and delivering what we need to deliver out of hospital. The challenge is how fast you can go to enable the system to work effectively. It's a complicated system but we have to get it right.

Q: *We are victims of our own success, keeping people alive longer than was the case fifty years or so ago. Specialised convalescent and recovery care appears to be practically non existent, but is very important, along with good catering, and appears to be absent in the healing process.*

A: Dr Howard:
I agree. We constantly have a situation where patients are discharged, only to return to hospital within a very short time frame.

Q: *Is there a mechanism by which you can keep us up to date with developments going forward?*

A: Dr Fenton:
We can't communicate enough. Communication is vital as we gain information which helps inform the process. We do have a communications strategy and a communications lead, a website and do go out to the public. Should you wish us to come back, we would be very happy to do so.

Q: *In what way are you accountable, and to whom?*

A: Mr Abell:
As an executive director of an NHS foundation trust I am

accountable to the board and to the governors of the foundation trust. The governors of the foundation trust are elected by the members of the local community, which is my ultimate accountability through to the governors. I also have accountability to the Secretary of State.

Q: *How can people be assured that there are adequate facilities in the community to care for patients discharged from hospital after suffering from respiratory diseases/COPD and that they are not released too early before adequate care is put in place?*

Dr Fenton:
People are not sent home from hospital unless it's felt appropriate for them. That is a clinical decision. The ability to convalesce appropriately, to provide social care outside the hospital is an issue that we have to deal with and has to be part of this system improvement that we're making.

Dr Howard:
This convalescence problem is not a new one; it's getting worse every year. We see people with big respiratory problems coming back not long after they've been discharged from hospital. We have to be careful to ensure that whatever we're doing in the community has an effect. I've seen several years' worth of winter pressure plans which have not had any effect. There's little evidence out in the community to prevent people coming in and what care they actually need so we need to make sure that's also done properly.

Q: *Have you met with Southend A&E to hear their concerns?*

A: Mr Abell:
I met with some of them yesterday. One of our challenges has been because we've been in a slightly extended purdah period our ability to consult externally has been limited. It is to be hoped that we can build a dialogue upon the conversation started yesterday.

The meeting closed at 9.32 pm.

Chairman .....

Date .....

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