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NOTICE OF MEETING

MEETING	**JOINT HEALTH SCRUTINY COMMITTEE - HINCHINGBROOKE HOSPITAL**
DATE:	**MONDAY 2 APRIL 2007**
TIME:	**10.30 am**
VENUE:	**PATHFINDER HOUSE, HUNTINGDON**

AGENDA

PAGE NO

1. Welcome and Apologies

2. Declarations of Interest

3. Minutes of the Meeting held on 16 March 2007 **1 - 16**

4. Election of Vice Chairman

5. Consideration of Further Evidence

- Finances
- Risks and how these are addressed
- Nature and impact of changes
- Shifting activity from the hospital to the community setting and the interface with social care services
- Transport and access to services

6. Update and Discussion of Consultation Process

7. Next Steps and Requests for Further Information

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Scrutiny Committee

HINCHINGBROOKE HOSPITAL JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

16th March 2007

Action

1. WELCOME AND APOLOGIES

Councillor Male in the Chair welcomed everyone to the meeting and noted the apologies received.

2. DECLARATIONS OF INTEREST

No declarations of interest were made.

3. MINUTES OF PREVIOUS MEETING – 28th February 2007

Difficulties in circulating the minutes had resulted in members not having the opportunity to read them thoroughly. The Committee therefore decided to defer consideration of the minutes until the next meeting on 2nd April.

4. DETAILED EXAMINATION OF PROPOSALS IN RELATION TO:

- **Finances**
- **Risks and how these are addressed**
- **Nature and impact of changes**
- **Implementation plans and timescales**

At its meeting on 28th February, the Committee had raised a number of questions and sought information from Cambridgeshire Primary Care Trust (PCT) and Hinchingbrooke Health Care NHS Trust (HHCT). Replies to these requests had been circulated to the Committee, but too short a time before the meeting to allow members to read and consider them in detail. The Chairman asked that in future all parties should produce their written information well in advance of a meeting.

It was decided to ask officers from the PCT, from Hinchingbrooke, and from the Strategic Health Authority (SHA) to introduce each question and answer. The document "Key Questions/Requests for Further Information" is attached to the signed copy of these minutes, with each question numbered consecutively for ease of reference; **the written answers are background to the points noted in these minutes**. The lead officers from each body answering the questions were:

- **Darren Leech**, Project Director (Hinchingbrooke HCT)
- **Matthew Smith**, Assistant Director, Commissioning (PCT)
- **Simon Wood**, Interim Programme Director for Service Reconfiguration (SHA)

Referral rates

Question 1) Backup evidence and clarification of the figures of a 40.7% higher than average England level of inpatient elective referrals and 33.8% higher level of new outpatient activity.
Question 2) What catchment areas were used in producing these figures?
Question 3) Is it based on actual population or weighted population?
Question 4) What is the evidence the figures are accurate and up to date?

Noting that the figures of activity at Hinchingbrooke related to the weighted population of the old Huntingdonshire PCT, members suggested possible reasons:

1. Huntingdonshire was particularly unhealthy
2. Huntingdonshire residents were hypochondriacs
3. GPs were referring patients more readily than elsewhere
4. more preventative work was being carried out in Huntingdonshire than elsewhere.

In answer to members' questions, Simon Wood (SHA) explained that

- to reduce the present 140% elective admission rate to the national 100% would require a reduction of 29% of the present total figure
- a reduction of 25% would still leave the rate a little above the national average
- reducing the number of Huntingdonshire referrals would have a minimally small impact – about 0.1 or 0.2% – on the national average number of referrals (he offered to provide the figure) SHA
- the PCT in its proposals for Hinchingbrooke was not aiming to achieve the national average, but to provide good clinical care for the local population, having made its own assessment of what was deliverable and achievable.

Noting that the most recent figures available had been used for the present report, members asked for the year to which each of the different sets of figures related, as some were for 2005/06, and others more recent. HHCT

Question 5) How do they compare to referral patterns from other parts of Cambridgeshire and from surrounding areas that use Hinchingbrooke?
Question 6) How do they link to information in 'Looking to the Future: Technical Analysis'?

Simon Wood (SHA) clarified that

- the figures for referral patterns given in answering this question related, for each PCT area, to admission rates for residents in that area to any hospital
- the 140.7% elective admission rate for Huntingdonshire PCT was the rate for the area's residents, not the rate for Hinchingbrooke patients
- the proposed reduction of 25% on this figure related to a reduction in elective admissions for residents of Huntingdonshire, regardless of which hospital they were attending.

- it was not possible to say with absolute certainty what the hospital's catchment areas or admission rates were for elective and for emergency admissions; the definite admission rates available were those classified by PCT area.

Members stated that it would be helpful to have some understanding of where Hinchingbrooke's patients came from, including those referred from beyond Huntingdonshire, and asked for a breakdown of the patients by area of origin, expressed both as number and as percentage of patients. HHCT/ SHA

In clarification of the weighted population, Simon Wood said that

- this figure took into account an allowance for the level of need and the age of the population.
- the weighted population figure was probably less than the numerical population because Huntingdonshire was an area of comparatively low need.

Members asked for the actual population figures used in comparing Huntingdonshire with the other areas in the answers. SHA

Looking at the comparison of Huntingdonshire PCT with surrounding areas, members noted that 40% deviation was the highest figure for all of the previous East of England PCTs. They asked what the standard deviation of the data was, and whether 40% was an exceptional number for the East of England (or indeed for the UK, if known). SHA

Members queried whether account had been taken of the expected increase in population in Huntingdonshire; it was commented that if a member was not being told by residents that they had to wait a long time for a hospital appointment, all was well, but if residents were having to wait, then there was a problem. Simon Wood said that the 25% reduction in activity was the aim for next year, and that Hinchingbrooke had built assumptions about future growth into its planning looking 3 – 4 years ahead.

Noting that efforts had been made to reduce hospital waiting lists in general in the past four years, members asked whether this had been a factor in the high admission rates for Hinchingbrooke. Simon Wood said that they had considered this, and concluded that, although Hinchingbrooke was a bit ahead of some other hospitals in reducing its waiting lists, this had not been a major factor in the figures. In view of a later comment by Chris Banks, Chief Executive of the PCT, that the hospital had been doing a lot of work to clear waiting lists, the Committee asked for clarification as to whether this activity had been a factor in the hospital's admission rate. PCT

Members expressed concern that some patients might be overlooked in the effort to cut back referrals. Dr Boon Lin, the hospital's Medical Director, said that HHCT was working closely with GP colleagues, and speciality groups were looking at pathways to ensure patients were treated in the appropriate place, a way of working which was already in place for gynaecology and cancer patients. He assured members that clinicians would continue to make referrals in accordance with the patient's clinical need.

<u>Question 7)</u> Breakdown of levels of referrals/over-referrals by type of activity/condition.

Looking at the table included in answer 7, members asked that the figures in the table be compared with the range, e.g. of 2 standard deviations either side of average, if possible. HHCT/ SHA

Members challenged the implicit assumption that carrying out treatment at a GP surgery rather than in hospital would always reduce costs and improve patient care. It was explained that

- one reason for carrying out minor procedures in hospital had in the past been the limitations imposed by the financial systems then in place for reimbursing GPs for the work
- these systems had now changed
- the tariffs now set for payment for treatment were greater for hospital-based work than for the same work carried out in a primary care setting
- a community-based facility had far lower running costs than a consultant-led unit in a large building with high overheads.

In answer to their concerns that the move to transfer treatment from hospital to primary care was finance-driven, not patient-driven, members were assured that

- the changes were being led and driven by the GPs themselves
- on present proposals, GPs would be treating patients whom they would in the past have referred to hospital.
- GPs must always work within their clinical competence
- previously there had not been any alternative to hospital, whereas now, community-based facilities were being developed and GPs were receiving additional training.

Dr Lin (HHCT) gave the example of the treatment of heavy menstrual periods, something for which much could be done in a community setting, but for which there had been no infrastructure. Locality clinics had now been established, where women could now be seen and receive the most commonly used treatment.

Members summed up the key question as whether it would be better to be treated in the GP's surgery than in hospital. They asked for a detailed analysis of why it was cheaper to treat a patient in a GP's surgery rather than in hospital, given that equipment, doctor's time, overheads, and dressings would all still be required. PCT/SHA

Members also expressed concern about the location of and access to these clinics, and about the availability of GP time to carry out additional work. Matthew Smith (PCT)

- acknowledged the importance of transport
- said that work on transport arrangements would be undertaken with patient groups
- stressed that patient choice was a key element – there would be locality clinics and GP clinics, and hospital clinics would still continue
- explained that GPs with a Special Interest (GPSIs) would not be restricted to working in one place but could for example hold clinics in each of the four market towns.

Members suggested that most people were more concerned about the quality of their treatment than about the setting in which it was delivered, and queried how much money would be saved if the hospital clinics were still to continue and GPSIs were to be working in more than one setting, requiring further equipment and premises. PCT/SHA

In response to members' comment that in parts of the area served by Hinchingbrooke, it was already difficult to get an appointment with a GP, Matthew Smith said that PCT

- the question of GP core capacity was very important
- there were national targets for availability, and regular monitoring
- it was important to get the basics working well – as they already were in most practices – before attempting to extend a practice's activity.

Matthew Smith reminded members that, in addition to expanding GPs' work, there were also proposals that other health professionals, such as consultants, physiotherapists and specialist nurses, should work outside the hospital setting. He pointed out that it was cheaper to pay a consultant to work in the community because the overheads (costs for building and support services) were lower.

Members queried how much could be saved by moving services from the hospital setting, and whether these cheaper services would still be adequate. Simon Wood (SHA) explained that SHA

- there was a difference between the cost of a service and the charge to the PCT.
- On the current system, the PCT paid the standard national tariff (which took account of hospital overheads) for services received by a patient in hospital
- if the PCT could arrange for those services to be delivered locally, it could arrange locally for the cost of provision, which would reflect the lower overheads of a GP or of a consultant working in the community compared to hospital overheads
- the proposals covered both the PCT's intention to provide care locally and the hospital's intention to reduce management costs
- these together would ensure savings for the PCT and a viable hospital at Hinchingbrooke, with reduced income balanced by reduced costs.

Asked whether consultants would lose a lot of time travelling to outlying clinics, Dr Lin explained that many consultants were already working elsewhere. Travel time was built into the timetable, and wherever possible, a consultant would spend a whole day in one location.

The Chairman suggested that the Committee could start to put forward tentative conclusions to enable others to comment on them. He summed up the discussion so far into the tentative conclusion that the Committee was not convinced that transferring services to GPs would be viable because of considerations of:

1. cost
2. capacity of GPs to carry out the work
3. transfer of the necessary clinical skills to GPs
4. travel – practical implications for patients.

A former member of the Hinchingbrooke Patient and Public Involvement (PPI) Forum in the audience said that there were clinical governance issues about service delivery and the frequency with which a practitioner carried out a particular procedure. She pointed out that it was not just a matter of finance – patients wanted to see the person best able to do the job in hand.

Commenting on the Committee's tentative conclusions, Dr Lin said that from a clinical governance point of view, quality was maintained by GPSIs coming in to the hospital once a month to run a clinic alongside the hospital specialist in their special interest field.

Question 8) Evidence for why the additional referrals are happening, for each type of activity, e.g. are GP practices over-referring, and if so, why, and is it a general issue or related to particular practices?

Noting that almost all Huntingdonshire GP practices had a high rate of hospital referral compared with GPs elsewhere in Cambridgeshire, the Committee requested referral figures for the 23 Huntingdonshire GP practices by practice. PCT

Question 9) How are the proposed reductions in activity at Hinchingbrooke split between people using non-hospital alternatives, and people receiving hospital services from other hospitals (including the private/non NHS sector)?

In answer to members' questions, Matthew Smith (PCT) said that the types of elective work under consideration for transfer to the private sector were diagnostic procedures, general surgery, neurology and orthopaedics. Commenting that the non-elective admission rate for Huntingdonshire PCT was at the national average level, members asked whether it was proposed to reduce absolute numbers of admissions to the hospital; Matthew Smith replied that it was to develop excellent alternatives to hospital admission.

Darren Leech (HHCT) said that there was good admission avoidance work being done in the community with frequent users of hospitals, giving the example of a respiratory nurse already working proactively in the community with older patients who had airway problems. He expressed the hope that these proposals might allow the PCT to develop the paediatric equivalent in order also to avoid admissions for children with ongoing respiratory problems. He offered to provide the Committee with other examples of such work. HHCT

Financial issues and viability

Question 10) A risk analysis is needed of the changes proposed in Option 2.
Question 11) What are the implications of any delays in implementation or in achieving the required savings in the timescale? What is the alternative (or plan B)? Under what circumstances/at what stage would Option 2 be considered unviable?
Question 12) Detailed evidence for the financial viability for the different aspects of Option 2 etc.

Darren Leech (HHCT) said that there was no alternative being proposed to Option 2, whose significant risks were already known. He offered to put

together a paper in depth on the risks of Option 2 in time for the Committee's next meeting. The Chairman requested that it be made available a few days before the meeting. HHCT

Asked by members what the point of the consultation was if there was only one option under consideration, Simon Wood (SHA) said that

- it would have been disingenuous to put forward non-viable options
- having examined four options, only Option 2 was believed to be viable
- there was no Plan B
- Plan B would have been the nuclear option of having nothing at the Hinchingbrooke site and dispersing the activity to other hospitals
- this was not being suggested, and was not practical because the capacity did not exist elsewhere to take up all of Hinchingbrooke's work

The Committee noted that there was no option on the table to close Hinchingbrooke.

The Committee agreed that a small group of members should meet with representatives of PCT, SHA and HHCT within the next week to identify the financial information that the Committee required in response to these and other related financial questions, so that the information could be supplied in time for the Committee's next meeting on 2nd April.

Darren Leech explained that there were outline budgets and plans for Option 2, but the hospital did not yet have details of what the PCT would be commissioning. Members said that they were not seeking a detailed budget for the hospital, but would like to see a business plan, to include how equilibrium in the HHCT budget would be achieved. HHCT

Question 13) What is being done/planned to reduce hospital overheads?

Darren Leech (HHCT) said that

- the disposal of the back of the hospital site would reduce the level of capital charges which the hospital had to pay
- reduced activity levels would reduce the size of workforce required to deliver services (workforce plans were covered in later answers).

Rachel Harrison, an assistant director of finance within the NHS, explained that capital charges were the cost of using capital – interest was charged on capital borrowed to acquire an asset, and depreciation of the asset was a capital charge, which was paid to the Department of Health (DoH) and had to be accounted for in the accounts. If an asset was decommissioned, there was then no need to pay the capital charge.

In answer to their questions about plans to sell off part of the site, members noted that

- by comparison with other hospitals, Hinchingbrooke occupied a large area for its bed stock
- there was a considerable gap between the Medical and Rehabilitation Services (MARS) and the main hospital
- the plan was to draw a line behind the main hospital and sell off land and buildings beyond that line, moving the medical wards to the front of the hospital for clinical reasons

- moving the medical wards would eliminate a 500-metre journey for the resuscitation team, and for trolleys with patients and meals
- because new operating techniques had reduced operation times, there was already unused theatre space, some of which had already been put to other uses; it was more economical to use fewer theatres more intensively
- the hope was that the profits from the sale could be used to help repay the historic debt, but the DoH was about to issue new rules on the use of capital receipts, which would dictate HHCT's freedom to use the receipts to fund the deficit.

Asked where workshops and the facilities department fitted in to the plan to dispose of part of the site, Darren Leech offered to provide a map of the site showing demarcation between different areas of buildings. These included the residences (not all of which were being used by Hinchingbrooke staff), the Ambulance Trust building (the Ambulance Service had already said it was happy to move along the road), and the goods receipt and workshop area (these would have to be provided elsewhere if their land was sold). HHCT

Members expressed concern that relocation of people and services could involve considerable capital expenditure. Darren Leech replied that the intention was to relocate by making use of existing buildings and fabric.

Question 14) A cost benefit analysis of each of the changes etc.

In response to their question about how one option could be recommended without the cost benefit of each option being known, members noted that a high-level analysis had already been completed. Darren Leech (HHCT) offered to provide the detailed cost-benefit analysis behind the summary table of options at page 7 of the Summary Consultation Document HHCT

Question 15) Why retaining maternity services at Hinchingbrooke, rather than commissioning them from elsewhere, would cost the PCT an extra £1.1m.
Question 16) What are the costs of the different options for maternity care?

Darren Leech referred members to the separate paper on maternity services for Huntingdonshire. He explained that Hinchingbrooke currently had a £2. 1 million deficit on women's services; it was proposed to deal with it by:

- reducing the insurance premium by running the Special Care Baby Unit (SCBU) as a level 1 unit, caring for babies who needed a lower level of care than was provided at the present level 2 SCBU
- providing some of the service in the community, e.g. by establishing midwife clinics (already used in other areas) instead of visiting mothers routinely in their homes, and by reconfiguring community midwifery teams
- restructuring staffing patterns to fit with the requirements of the European Working Time Directive and with the recommendations of the Royal College of Obstetricians and Gynaecologists
- increasing income by encouraging mothers from other parts of Cambridgeshire (in particular Cambourne and Northstowe) to give birth at Hinchingbrooke.

Members noted that

- neither Addenbrooke's nor Peterborough had the capacity to take on additional births at present
- Peterborough could not expand provision overnight
- Addenbrooke's was already close to the number of births (6,000) for which insurers would require the expensive option of a consultant presence round the clock (5,534 babies were delivered there last year)
- some Huntingdonshire women would need to go to Addenbrooke's because they needed specialised services not available in Huntingdon
- increasing the overall number of births at Hinchingbrooke would increase the hospital's income.

Members expressed concern that the downgrading of the SCBU might increase the risk to babies needing level 2 care, who would need to be transferred to Addenbrooke's. Dr Lin (HHCT) explained that

- wherever clinically possible, babies likely to need high levels of care were identified in advance, either during pregnancy or (in the case of unexpected very premature births) in labour
- already, very sick and very premature babies were treated at Addenbrooke's rather than Hinchingbrooke
- a very good neonatal transport system was already in place
- the proposal to downgrade the SCBU and deliver more low-risk women at Hinchingbrooke was still under discussion with the clinical network.

Responding to members' comment that Cambourne women perceived Addenbrooke's to be the hospital of choice, Dr Lin said that from May, Hinchingbrooke would have a midwifery presence in Cambourne, and midwives from Addenbrooke's would be withdrawn. Cambourne GPs were very supportive of Hinchingbrooke's plans to increase the number of low-risk births at the hospital.

Dr Lin summarised Hinchingbrooke's preference for maternity services as to leave maternity provision in place, and to increase capacity.

Question 17) Workforce plans, for different disciplines, including reductions, redundancy costs, redeployment, staff development/training to take up new/different roles, recruitment and retention strategies etc.

Darren Leech (HHCT) outlined the workforce plans, pointing out that the usual turnover in staff was more than 1 in 10. The aim was to match staff to the reduced activity, maintaining flexibility of staffing by use of short-term contracts.

Members expressed concern that there must be unease and uncertainty amongst the existing long-term staff, and asked what consultation had been undertaken with the trades unions, and what the effect on pensions would be for redeployed staff. Darren Leech said that

- nurses had been assured that it was HHCT's intention to honour existing long-term contracts, though this may be by offering suitable alternative employment if their original work was no longer there (e.g. the theatre nurse whose theatre list disappears)

- the redeployment may require retraining and preceptorship for staff
- redundancy would be used only as a very last resort
- the effect of using short-term contracts would be monitored over time
- the impact on members of staff who were foreign nationals would be no different from that on any other staff member
- since the Cambridge News had announced the hospital's closure last autumn, the staff had simply been anxious to have the situation resolved
- the Trust Staff Council embraced all the trades unions, which had been consulted via the Council
- non-union staff member had also been briefed; a fully-documented record of all who attended briefings had been maintained
- it was his understanding that, where an employee's grade and pay were adversely affected, terms and conditions were protected for four years, with special provisions for pensions.

Offered copies of relevant HR policies, the Chairman requested a half-page summary of HR policy on protection of terms & conditions of employment, and effect on pension, in relation to redeployed employees. HHCT

Members asked where the reductions in staff were expected to take effect. Karen Charman, Director of Human Resources and Communications at HHCT, offered to share with the Committee more detail of what areas were involved, but not in the public arena because of the risk that people affected could identify themselves. HHCT

The question of training costs for staff transferred to the community was raised by a member of the audience. Janet Dullaghan, Chief Operations Officer for the provider side of the PCT, said that she would be responsible for the community staff in Huntingdonshire. Training would be provided as necessary; the budget for next year was being set and would include an element for training. Asked by members whether all the costs of training had been included in Option 2, Darren Leech suggested that this could be talked through at the sub-group meeting in the following week. HHCT

Question 18) What evidence is there that Hinchingbrooke will attract patients from other parts of Cambridgeshire and from surrounding areas especially Bedfordshire and Peterborough etc?

Darren Leech (HHCT) pointed out that there had been a steady increase since April 2006 in the number of patients attending Hinchingbrooke from beyond the Cambridgeshire PCT area. HHCT wished to make itself the provider of choice. He gave the example of discussions with Bedfordshire, where there was no surgeon with a foot and ankle special interest; dozens, probably hundreds, of foot and ankle patients from Bedfordshire had now attended Hinchingbrooke.

Members asked that numbers, as well as percentages, be supplied for the graph showing new attendances from outside Cambridgeshire PCT, and indeed for reports in general. HHCT

Asked what services were being offered to residents on the Norfolk border, Darren Leech said that in principle all services were available. HHCT had

started to discuss with GPs north of Wisbech what services it could offer. Because of limited orthopaedic capacity in Norfolk, some Norfolk PCT patients were now receiving orthopaedic treatment at Hinchingbrooke.

Members expressed concern at what might appear to be a strategy to take patients from surrounding providers, but were reassured that this was not a core component of the proposals. However, it was necessary to allow capacity for population growth.

Question 19) What evidence is there that Hinchingbrooke, especially the treatment centre, will work to sufficient capacity to be economically viable etc?

Members noted that the Treatment Centre was an integral part of the hospital, with the same members of staff working in both Treatment Centre and main hospital. It was therefore difficult to separate them; they should be considered as a whole.

Dissolution

Question 20) A financial cost/benefit analysis of the proposed dissolution – including a breakdown of any extra costs, and anticipated savings in management/back office costs.
Question 21) How is it envisaged the new arrangements would work in practice? What options are being considered in terms of who would take over management, and on what terms?
Question 22) How would the views and needs of local residents on future provision of services at Hinchingbrooke be taken into account in the new management arrangements?

Simon Wood (SHA) stated that it was not yet known who would take over the management of the former HHCT, but he suspected it might be another foundation trust. No such arrangement had yet been finalised nationally, but negotiations were under way for a foundation trust to take over a hospital trust in the west of England; this would be in place before the time came to consider dissolving the Hinchingbrooke trust.

Sue Smith, Chairman of the HHCT Board, said that the first task was to secure the future of clinical services at Hinchingbrooke. Only once these had been assured would attention turn to governance, by which time a new governing organisation would have no opportunity to cherry-pick services. If the hospital structure had by then become too small to warrant separate governance, HHCT with the help of the SHA would formulate proposals, which would then be the subject of separate consultation.

Members asked why another foundation trust would want to take over management of Hinchingbrooke, and what the interim arrangements would be between dissolution of the present trust and the new one taking over. Sue Smith replied that

- Hinchingbrooke would become an attractive proposition once it had attained financial viability and sustainability
- Hinchingbrooke would bring income and patients to another trust and add to its catchment area

- the present Board would remain in place throughout the changes proposed in the current consultation
- there would be no void between any old and new managements.

On the question of staff savings in a combined organisation, members noted that the present Board posts which would disappear in a new organisation had been included in the overall total of 200 jobs to be shed.

In response to concerns about how the takeover of one NHS trust by another would work, members noted that a paper on the subject had recently been produced by Monitor, the independent body which authorised and regulated NHS foundation trusts. The process outlined would be very demanding on both organisations, which would both be required to appear before Monitor. Chris Banks, Chief Executive of the PCT, said that the unprecedented proposal for one trust to take over another in the west of England would be watched closely.

Northstowe

Question 23) How do proposals tie in to the implications of the future development of Northstowe, especially as this may be larger than anticipated?
Question 24) Where in the medium to longer term will the size of Northstowe affect where services are provided?

Chris Banks (PCT) said that Northstowe provided an opportunity in that there would be an increased demand for services, and funding for those services. Its population was likely to consist predominantly of young adults who would require maternity and paediatric services.

The point was made that there was some evidence that the demography in new housing included numbers of older people (the report *Bridge to the Future*, drawn up by the Milton Keynes and South Midlands sub-regional SHA). Chris Banks said that he been judging largely by the experience of Peterborough Development Corporation in the 1970s, but the issue was complex. The PCT would be able to accommodate Northstowe's growth.

On the question of hospital utilisation and capacity, Chris Banks said that there was overcapacity at the moment, given plans to increase community provision and to enable older residents to remain in their own homes for longer. He could not predict what would happen over the next 10 – 15 years, but assured the Committee that the PCT was working on a strategy to develop services to meet Northstowe's needs as they developed.

Members expressed concern that the reduction of Hinchingbrooke might be followed by the need to expand it again, particularly as plans to dispose of part of the site could make it too small to meet future needs. The Chairman asked for some indication of how the PCT's strategy for Hinchingbrooke was likely to work in relation to the expected growth in Cambridgeshire's population. SHA/PCT

Historic debt

Question 25) How will the hospital's historic debt be dealt with?
Question 26) What are the terms of the loan from the Strategic Health Authority, and what are the implications of having to pay it back?

Simon Wood (SHA) explained that discussions with the DoH on the historic debt were continuing. Because they had not yet reached a conclusion, he was unable to supply any further information at this stage. The SHA would need to tackle the historic deficit, but had still to determine how this would be done.

5. UPDATE AND DISCUSSION OF CONSULTATION PROCESS

Chris Banks, Chief Executive of the PCT, informed the Committee that 14,000 copies of the summary consultation document and 1,400 of the full document had now been distributed, and seven public meetings organised. He repeated the PCT's offer to attend meetings of community groups, and stated that the PCT would be seeking external scrutiny of the consultation process.

In answer to questions, Chris Banks explained that people had been asked to book in advance to attend the public meetings, but this was to enable the PCT to gauge the likely size of audience, and people could still turn up unannounced. Quality assurance measures were in place to test how well the whole publicity process was working. A representative of the Patient Partnership Group (for patients from Addenbrooke's, Papworth and Hinchingbrooke hospitals who were affected by cancer) said her members had not received information about the meetings despite their contact details being known; Chris Banks offered to discuss this with her after the meeting.

Members suggested that County and District Councils be asked to publicise consultation events on their websites, and that Bedfordshire be supplied with consultation documents for each of its libraries.

6. SHIFTING ACTIVITY FROM THE HOSPITAL TO THE COMMUNITY SETTING, AND THE INTERFACE WITH SOCIAL CARE SERVICES

Mark Howe, Head of Adults Client Side for Cambridgeshire County Council attended the meeting to comment on the proposals on behalf of the County Council and Adult Social Care. He presented the apologies of the Director of Adult Support Services, Claire Bruin, who was prevented by illness from attending the meeting.

Having looked at the consultation document, Mark Howe reported that it contained nothing that did not fit in with the existing interface of co-operation between County Council and PCT. There was an established strategic working relationship and structure in which providers and commissioners for health and for adult social services already worked together, and the Hinchingbrooke proposals should be viewed in that context. He welcomed the move to develop and provide services as close to the user as possible, because that fitted with the existing strategy.

Mark Howe went on to say that the details of the proposals required close examination for how they would translate into operational service delivery. He used the example of the Short-term Assistance and Rehabilitation Team (START) operating in Cambridge and South Cambridgeshire, which he said had averted the need for 502 people be admitted to hospital by identifying their needs and providing them with appropriate community-based care. Mark Howe said that if there were to be a similar shift in provision of care in Huntingdonshire, that would have a considerable effect on the demography of those using the service structure.

Mark Howe said that the questions to be asked were

- what mechanisms would be in place to monitor outcomes for services
- what the delivery arrangements would be to maintain users' independence in the community and quality of life
- what would be the user s' and the carers' experience of the services provided.

Subject to these matters, he supported the direction of travel of the consultation proposals.

A PCT representative, speaking on behalf of Sharron Cozens, PCT Lead for Adult Services, stressed that the adult social care strategy was a joint strategy of PCT and County Council, with services users at its heart. Further development was required to enhance care teams and to increase admission avoidance work.

Mark Howe was joined by Janet Dullaghan, Chief Operations Officer for the provider side of the PCT, in responding to members' questions and comments. In the course of discussion, members noted that:

- there would be clear challenges to ensure that PCT and County Council between them had sufficient resources to meet service users' needs
- keeping people out of hospital would avoid charges for social care waiters ("bed-blockers"), and so increase funds for community care
- the demographic challenge of an aging population required review of service delivery to vulnerable residents
- more efficient and effective ways of working would be sought, with an element of invest to transform
- the cost of providing the necessary care would be met through the usual pooled budget resources; there was a £2.5 million investment in primary health care included in the proposals
- the cost implication of the proposals for the County Council were not yet known
- there would be challenges associated with ensuring that there would be sufficient resources in terms of public and private sector carers to meet the needs of those requiring long-term care – some care packages required up to two people visiting five times a day
- START had been a flagship of integrated therapeutic, social and community care
- the PCT was making efforts to make employment as a carer attractive by offering a variety of short-term and permanent contracts, including some with flexible hours and some for term-time only working.

Members commented that the County Council's budget would be unable to afford any additional care costs. Cambridgeshire was unique amongst UK local authorities in sharing adult care provision with the PCT. This arrangement carried both opportunities and risks, because the Council was assessed on the quality of provision of adult social care services, half of which it had no responsibility for. Councillor Eells commented that Norfolk County Council also had a very restricted budget; there was some joint commissioning of adult social services in Norfolk. Chris Banks (PCT) assured members that the consultation proposals were not premised on offloading the costs of care onto the local authorities, but were intended to achieve a viable future for Hinchingbrooke.

Darren Leech (HHCT) said that the hospital performed well in most key indicators, but did have the highest rate of delayed discharge in the whole of Eastern England. Speaking from the Hospital's point of view, he welcomed the prospect of improved care in the community.

Looking at possible increased transport costs for patients attending for treatment at community-based facilities rather than at Hinchingbrooke, members asked whether there would be additional arrangements for assistance with these costs. They were told that existing arrangements for assistance would continue – patients who were eligible for help with travel costs on income grounds would receive the same help to access more local facilities, and those unable to use public transport would still be helped. Members pointed out that it was unreasonable to expect, for example, a Somersham patient travelling to the GP dermatology clinic in Buckden to make the journey by public transport, as it took three hours in each direction.

The Committee identified the following concerns as requiring answers at its next meeting:

- the funding implications for the County Council's budget of the move to primary care — CCC
- whether the £2.5 million extra funding for transfer of care to from the secondary to the primary sector was all available to be spent on community care — PCT
- the County Council's view on the viability of moving to more care being provided at the primary care level — CCC
- whether both County Council and PCT had considered how the plans related to transport provision (particularly present bus services) and the impact of the proposals on transport links. — CCC/PCT

7. NEXT STEPS AND REQUESTS FOR FURTHER INFORMATION

The Committee resolved to set up a sub-group to meet informally with representatives of HHCT and the PCT to look at the financial and risk assessment background to the proposals. In view of the need to hold this meeting quickly, it was agreed that membership of the sub-group would be open to all members of the Committee depending on their availability.

In discussion with Jane Belman, Health Scrutiny Co-ordinator for Cambridgeshire County Council, the Committee identified the following items for inclusion at its next meeting, which was likely to be extended from a half to a full day:

- feedback from Cambridgeshire Social Services
- GP perspective on the proposals
- impact on travel / public transport
- evidence from Hinchingbrooke PPI Forum (if it wished to give it)

The Committee had previously identified that the Ambulance Trust should be invited to contribute its perspective.

Jane Belman was asked to provide information on demographic factors, and to identify tentative conclusions and areas of uncertainty, in preparation for the Committee's **next meeting on Monday 2nd April.** J Belman

The Chairman thanked all participants for their contributions to the meeting.

Members of the Committee in attendance:
Councillors J Cunningham and S Male (in the chair) (Bedfordshire County Council), Councillors P Downes, M Smith and L Wilson (Cambridgeshire County Council), Councillor J Eells (Norfolk County Council), Mr N Roberts (Cambridgeshire PCT PPI Forum) and Dr A Owen-Smith (Hinchingbrooke PPI Forum)

Apologies:
Councillor A Carter (Bedfordshire County Council), Councillors G Heathcock and K Reynolds (Cambridgeshire County Council), Councillors Y Lowndes, B Rush and K Sharpe (Peterborough City Council)

Time: *10.30am. – 3.30pm*
Place: *Pathfinder House, Huntingdon*