HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at Council Chamber, County Hall, Lewes on 22 May 2015

PRESENT:

East Sussex County Council Members
Councillors Michael Ensor (Chair), Ruth O'Keeffe (Vice-Chair), Frank Carstairs, Peter Pragnell, Alan Shuttleworth, Bob Standley and Michael Wincott

District and Borough Council Members
Councillors John Ungar (Eastbourne Borough Council), Sue Beaney (Hastings Borough Council), Bridget George (Rother District Council), and Sam Adeniji (Lewes District Council)

Voluntary Sector Representatives
Julie Eason (SpeakUp)
Jennifer Twist (SpeakUp)

ALSO PRESENT:

Care Quality Commission
Tim Cooper, Head of Hospital Inspections
Terri Salt, Inspection Manager
Alan Thorne, Head of Hospital Inspection, South East

East Sussex Healthcare NHS Trust
Darren Grayson, Chief Executive
Stuart Welling, Chair
Dr Amanda Harrison, Director of Strategic Development and Assurance
Alice Webster, Director of Nursing
Dr Andy Slater, Medical Director
Jenny Crowe, Head of Midwifery
Imelda Donnellan, General Surgery Consultant and Clinical Lead for the Surgical Clinical Unit
Nicky Roberts, Consultant

Eastbourne, Hailsham and Seaford Clinical Commissioning Group (CCG) / Hastings and Rother CCG
Dr Martin Writer, Chair
Jessica Britton, Associate Director of Strategy and Governance
Allison Cannon, Chief Nurse

High Weald Lewes Havens CCG
Wendy Carberry, Chief Officer
Dr David Roche, Area Chair

Trust Development Authority
Julie Blumgart, Clinical Quality Director
Suzanne Cliffe, Portfolio Director (Acting)
David Robertson, Business Director

Healthwatch
Julie Fitzgerald, Director

Senior Democratic Services Advisor (ESCC)
Giles Rossington

1. APOLOGIES FOR ABSENCE

1.1. Apologies for absence were received from Councillor Angharad Davies (substitute Councillor Peter Pragnell).

1.2. **Councillor Michael Ensor:** there have been several changes to the Committee's membership following the annual council meetings of East Sussex County Council (ESCC) and the district and borough councils, although so far only two of the five district and borough councils have held their annual council meetings and so confirmed their HOSC representative.

1.3. We warmly welcomes the following new members:

- Councillor Angharad Davies as an ESCC member (replacing Councillor Peter Pragnell);
- Councillor Sam Adeniji as the Lewes District Council representative (replacing Councillor Jackie Harrison-Hicks);
- Councillor Bridget George as the Rother District Council representative designate until formal confirmation at the 27 May 2015 Rother Annual Council meeting (replacing Councillor Angharad Davies);
- The yet to be confirmed Wealden District Council member, who will be confirmed after 27 May 2015 Wealden Annual Council meeting.

1.4. We warmly welcome the continued membership of:

- Councillor Sue Beaney as the Hastings Borough Council representative;
- Councillor John Ungar as the representative designate of Eastbourne Borough Council until formal confirmation at the 27 May 2015 Annual Council meeting.

1.5. We warmly welcome the new HOSC support officer, Giles Rossington.

2. DISCLOSURES OF INTERESTS

2.1. There were none.

3. EAST SUSSEX HEALTHCARE NHS TRUST (ESHT): CARE QUALITY COMMISSION (CQC) QUALITY REPORT

3.1. The Committee considered a report of the Assistant Chief Executive that recommended it consider and comment on the Care Quality Commission (CQC) Quality Report on services provided by East Sussex Healthcare NHS Trust (ESHT).

3.2. **Councillor Michael Ensor:** The CQC report was published on 27 March but – because of the pre-election period – this is the earliest opportunity HOSC has had to meet to discuss and consider the report and its implications.

3.3. The CQC has carried out a follow up inspection of ESHT, but the report has not yet been published and so cannot be discussed at this meeting.

Evidence from the Care Quality Commission (CQC)

3.4. **Tim Cooper:** The Care Quality Commission (CQC) has made a pledge to inspect every acute trust by the end of the 2015/16 financial year. We inspected ESHT (in September 2014) as the inspection regime prioritises high risk trusts, and the Trust was setting off some of our risk triggers.

3.5. We had a team of 52 people for the inspection of ESHT. The Chair of the inspection was a senior doctor from a high profile London hospital who had been their Medical Director for many years and had a high international standing.

3.6. The CQC admits that it got the timing of the inspection process wrong. Due to unforeseen circumstances within the inspection team, and some of our internal processes, the sending of our draft report to ESHT (for checking and factual accuracy) was delayed significantly.

3.7. We met ESHT after it had added comments into the draft report regarding its factual accuracy. The meeting involved senior CQC inspectors and the Trust's Board and was convened to help understand some of the positions we might have misrepresented.

3.8. Some people are concerned that we did not hold a Quality Summit. We took this difficult decision at the very highest level of the organisation because – due to the delay in the submission of the draft report to ESHT – we had decided to carry out an unannounced inspection to update our position on the Trust. This meant that holding a Quality Summit the day before returning to inspect the Trust would not have been helpful.

3.9. Instead of a Quality Summit, The CQC held a meeting with ESHT on 23 March 2015 to discuss their action plan and then began a two-day follow up inspection the next day. The CQC report on the September 2014 inspection was published on the 27 March.

3.10. The CQC recognises that the publication of the report came at the very beginning of purdah, but we felt that the risk of publishing it then was outweighed by the risk of not publishing, for 8-10 weeks, a completed report that contained important information. Nevertheless, the CQC extends its apologies to those who were inconvenienced by the timing of the release of the report.

3.11. There are a number of headlines that can be extracted from the CQC report under each of the five key domains on which the CQC reports: safe, effective, caring, responsive, and well led.

3.12. **Are services safe? –** The CQC saw:

- Significant challenges in incident reporting in surgery due to insufficient staff; staff shortages had resulted in staff prioritising caring for patients over incident reporting.
- Challenges with incident reporting in outpatients and maternity.
- Agency staff – which ESHT relied on in a number of areas – did not have as much access to the incident reporting system as substantive staff. This meant that low or zero harm incidents –which help the Trust develop a learning culture – did not get reported.

- Challenges in maternity and surgery in infection prevention control, particularly around hand washing. Some staff were not following the Trust's policies, including fairly senior members of staff who should have been role models for behaviour.

- Mandatory training was below target, meaning that staff were not maintaining their competencies and skills in key and important areas.

- The condition of patients' medical records was poor and access to them was difficult as they were stored off site. This meant that we saw clinics where patients had only temporary notes that did not contain a patient's full medical record. As this happened so often, it had become normalised and accepted as standard practice in the Trust.

- Poor storage of confidential information that could have made it accessible to members of the public.

3.13. **Are services effective?** – the CQC saw:

- The Trust's own audit showed that 239 policies were out of date, demonstrating that ESHT was not on top of the process of keeping its policies up to date.

- The Summary Hospital Mortality Indicator (SHMI) – the measure of the number of people who die against those who should – was high before we visited and was one of the indicators that triggered our inspection.

- There was a large back log of patients waiting to be seen in a number of services, particularly ophthalmology, meaning that patients did not get treatment on time.

- Vulnerable patients requiring specific considerations under the Mental Capacity Act and Deprivation of Liberty Safeguards were identified by the Trust and well cared for.

3.14. **Are services caring?** – the CQC saw:

- Staff were caring for patients both collectively and individually, and patients reported to us that they were being involved in their care.

3.15. **Are services responsive?** – the CQC saw:

- Challenges around the outpatient redesign, which had been reconfigured in the weeks leading up to our visit. The outpatient reconfiguration had been really badly undertaken and significant tasks that should have been completed in the outpatient redesign had been missed. This resulted in long queues at the outpatient desk; patients getting lost for several hours in the building and being unsure where they were meant to be going; and clinicians unaware that patients were trying to find them.

- There was a higher than expected amount of anxiety from the public and members of staff about sharing their experiences of ESHT. We always have a number of people who want to come and tell us their story and we listen intently to them and take necessary action. During this inspection, many more people wanted to tell us their stories anonymously than we would usually expect. The lengths with which people went to protect their identity before talking to us caused us a significant amount of concern.

- There was a higher than average number of complaints, although the rate of complaints is now falling.

- ESHT's internal audit team described the reconfiguration of services as a sound and robust process and recommended it as good practice. We were concerned about the

anxiety the public expressed towards the reconfiguration and its potential impact on the services that they used.

3.16. **Are services well led?** – the CQC saw:

- A very poor relationship between the Trust Board and staff in the organisation. There was a significant amount of distrust and staff were concerned about their voice being heard.

- A poor understanding of governance and the governance processes from some staff, such as the process by which lessons are learned from incidents.

- Limited assurance of the effectiveness of some quality, risk and governance committees and whether that was impacting on improving care.

- A poor culture across the organisation. When we say "understanding the vision of the organisation", we don't expect all staff to be able to chant the Trust's mantra or recite its policies, but we do expect to staff to see and believe in their individual role in making the Trust a stronger and better place; we felt that this was missing in this organisation.

- A higher than expected number of whistleblowers.

3.17. When we met with the Trust management before our unannounced visit they spoke about making significant progress in some of the areas that I have talked about.

3.18. **Councillor Michael Ensor:** The report highlights areas that are rated 'good'. A week ago I attended the staff award ceremony where a number of key staff had citations of excellence. Therefore, I would wish to continue recognising that staff are working incredibly hard and providing a caring service to the public.

3.19. **Councillor Bob Standley:** It is unfortunate that the report took so long, but you have explained why that was. At the moment we have a damning first CQC report, but how and when will the second CQC inspection in March be reported?

3.20. **Tim Cooper:** The CQC report for the March visit has been written. The report will go through the National Quality Assurance Group (NQAG) process from 4 June. NQAG's role is to ensure that the CQC is consistent in its inspection process across the country. Following the NQAG process, we expect to send the report to ESHT a week later and provide the Trust with 10 days to check its factual accuracy. Our expectation is that a Quality Summit will be held in early July and the report will be published around 3-4 days later. Quality Summits are widely attended by all stakeholders and their purpose is to provide the collective health economy with the opportunity to consider how it will tackle the challenges in the report.

3.21. **Councillor Bob Standley:** When you say that ESHT is facing "challenges", are they not just caused by poor management, particularly from the top? Is poor management something you often find when you do inspections or is ESHT's management worse than normal?

3.22. **Tim Cooper:** An overall rating of 'inadequate' is amongst the lowest ratings that we can give. We rated ESHT 'inadequate' overall and for the 'safe' and 'well-led' domains; this demonstrates the level of concern that we have for the Trust. However, the CQC's role is to provide an accurate diagnosis of the challenges a trust faces. It is for the Trust Development Authority (TDA) to decide whether these challenges are fixable. This is in part because the CQC has to return to the organisations it inspects to see if they have

progressed; if the CQC was involved in helping to deliver the solutions it would highly compromise its ability to evaluate whether the organisation had improved.

3.23. **Julie Eason:** HOSC was told by the CQC two years ago – following its last inspection of ESHT – that the Trust faced systemic problems and was failing in all domains against which it had been rated. It is good to know that the Trust is now rated as 'good' against the 'caring' domain, and this is a testament to the staff working in the Trust. However, the Trust is still failing in most domains, despite action plans put in place following the last inspection. Given that the leadership was rated 'inadequate' and it appears that the issues the Trust faces are systemic, do you feel that there is the capacity in the organisation to turn things round?

3.24. **Tim Cooper:** The CQC as an organisation compared to two years ago is different, having completely revised its model for inspection. That is not to say that there are not parallels between the two inspections, but I would caution against making direct comparisons, because under the previous inspection methodology the CQC either passed or failed an organisation against each domain. Our inspections are now more in-depth and comprehensive and, I think, get to the bottom of some of the real issues.

3.25. The CQC has made comments in the report about management capacity and the Trust's organisational capacity to achieve improvement. Whether you, or the TDA, feel there is sufficient capacity is not for the CQC to say, but we have certainly recognised the gap in what needs to be done and the capacity in the Trust to achieve it.

3.26. **Councillor Ruth O'Keeffe:** Given the amount of concerns that staff appear to have had about coming forward to the CQC, do you think that there are other members of staff who did not come forward?

3.27. **Tim Cooper:** It would be very difficult for me to say that all members of staff who had concerns raised them with us, but there will be some members of staff with concerns who did not come forward – particularly given the desire that those staff who did come forward had to protect their identity. However, the CQC has a sufficient sample size of staff necessary to form a clear picture of the breadth of issues and to reflect the overall feelings of staff.

3.28. The CQC did everything it could to ensure that staff came forward. We gave staff significant opportunities to meet with us; we agreed to meet staff privately offsite if they were nervous about coming forward on hospital grounds; and we also asked the Trust – as we do all for all our inspections – to send out an email to all staff containing a confidential number that they could call us on.

3.29. **Councillor Alan Shuttleworth:** In light of what we have seen and read about the inadequacies at the senior level of leadership (the Chief Executive and the Chairman) including, the lack of vision; the loss of trust between the Board and staff; all the concerns about alleged bullying and other allegations; is it conceivable that the current leadership could turn around the situation?

3.30. **Tim Cooper:** I do not think it is fair for me to comment on whether the leadership is capable of making the necessary changes. The CQC has been accurate in what it has included in the report; it is for others to decide whether the leadership of the organisation is able to take the necessary steps or not. The CQC is absolutely clear that its only role after completing its report is to recommend to the TDA whether or not it thinks that special measures are appropriate. The Chief Inspector of Hospitals, who will make recommendations to the TDA, is waiting for the outcome of the second report before doing so.

3.31. **Julie Eason:** HOSC's role is to challenge and scrutinise the health service and hold it to account. The response from ESHT's senior management to HOSC during previous committee meetings has left me feeling bullied, despite the Committee having the authority to challenge; I can only imagine how staff must feel working for the Trust. Could you give us examples of some of the things that came to light relating to the culture of bullying?

3.32. **Tim Cooper:** I cannot relate any examples off the top of my head, but they are included in the report, and I think that there are a number of people who felt pressured not to raise concerns. We are committed to retaining the anonymity of the whistleblowers who came forward, so it would not be appropriate to refer to individual cases.

3.33. **Councillor John Ungar:** I, like many others, have read this report with horror and shock, but not surprise. This is because, as a HOSC member, I have been concerned about the issues the CQC has raised for a number of years. Thank you for bringing them to light with an evidence base.

3.34. Information is essential for clinical staff to make informed decisions. Did you come across any evidence that poorly maintained medical records were making it difficult for clinicians to diagnose and treat patients?

3.35. **Tim Cooper:** It is fair to say that there was a culture of acceptance in the Trust of the state of the temporary medical records. It is very difficult to make a parallel to individual cases, but the assumption that many of the clinicians working for the CQC made was that if you do not have all of the information on a patient in front of you, it has the potential to impact on the decision that you make.

3.36. I know that the Trust has given some thought and taken some actions regarding what they will do about the way they handle medical records, but at the time of our inspection in September 2014 it was both the quality of the medical records (many were bursting at the seams) and the ease of getting them to the site that was the issue. These problems can be solved, indeed we brought them to the attention of the Trust and within 48 hours some action had been taken. Equally it is fair to say that when you normalise a process that people know is not right, they are put in a difficult position when they try to correct the problem.

3.37. **Councillor Sam Adeniji:** What are the criteria for putting a trust into special measures? If ESHT has made some improvements by the time of the second report and moved from 'inadequate' to 'requires improvement' will the Trust no longer fall into special measures?

3.38. **Tim Cooper:** It is not the role of the CQC to put a trust into special measures, although we may recommend to the TDA that they are. The main trigger for special measures is an 'inadequate' rating in the 'well-led' domain, but the decision is also based on the reasons why a trust's leadership was rated 'inadequate'; the capacity of the trust to move out of special measures quickly; and the challenges that the trust faces.

3.39. Special measures are often viewed by trusts as a badge of shame, but it is a process that is designed to be supportive of trusts that are trying, and struggling, to move out of difficulties. The package of support behind the special measures is designed to help trusts get beyond their current problems and move forwards.

3.40. When the July report is released, the Chief Inspector of Hospitals will make a recommendation to the TDA, but the TDA will take the decision about whether or not to go ahead with special measures.

3.41. **Councillor Frank Carstairs:** The CQC said in its report that the reconfiguration of maternity and paediatric services "has led some of the public to lose confidence that this

service reconfiguration meets their needs. A much higher than expected attended the listening event and contacted us with their concern". In your opinion, were their concerns justified or were they missing the benefits of the reconfiguration?

3.42. **Tim Cooper:** The CQC's role is not to comment on a reconfiguration; that is a democratic decision taken by commissioners in consultation with the local HOSC. The CQC's role is to comment on the services as we see them, we would not comment on whether the reconfiguration was the right decision or not.

3.43. What we do comment on is how services meet the publics' individual needs. Therefore, we would comment on the impact of, rather than the reasons for, the reconfiguration. For example, whether the reasons for a reconfiguration have been widely understood by the public, and whether the way that the reconfiguration has been enacted has left people feeling vulnerable, uncertain, or disengaged form the process.

3.44. The CQC is not commenting on whether the reconfiguration is to the benefit of members of the public, it is commenting on the member of the public's concerns that their questions were not answered and they did not feel engaged during the decision to carry out the reconfiguration. The CQC's concern is that people feel disengaged from the reconfiguration, not that the NHS is embarking on a reconfiguration.

3.45. **Councillor Peter Pragnell:** The CQC report notes that patients' records were not securely stored. Did anything that the CQC saw lead you to believe that the provisions of the Data Protection Act 1998 had been breached?

3.46. **Tim Cooper:** We are absolutely clear of the need to keep medical records confidential. There is a difference between medical records being left out in the open where anyone can see them and medical records being left in a room that is unlocked and unsecured that people could access. The litmus test for whether the Data Protection Act has been breached is whether unauthorised people can access the records easily or not. Certainly, in terms of forming our judgement on our enforcement action – which we are working through at the moment – we are taking due account of all of those issues. I am not sure until we have finished this process, but it is possible that the Data Protection Act was breached.

3.47. **Jennifer Twist:** In my experience working in the voluntary sector, because of the culture at ESHT, patients and carers have had difficulties raising complaints as they are fearful of the impact on the quality of care that they would experience afterwards. Do you feel that this might have had an influence on how many patients came forward to speak with you?

3.48. **Tim Cooper:** This is not the first health economy that has had a reconfiguration that has caused significant anxiety in the community, and is not the first where we have come across community interest groups and save hospital groups that are interested in a particular area. However, the strength of feeling in the community and influence of those interest groups is greater than we expected. This may well be because the population is well organised, has a very clear voice and wants to use it.

3.49. **Councillor Michael Ensor:** We are the health overview and scrutiny committee of the NHS and our role is to observe and scrutinise the NHS from arm's length. We have called for enquiries into a number of aspects of the health service in East Sussex, including acute and community healthcare. We are grateful that the CQC has carried out this "deep dive" into the healthcare system that we have not been able to do due to the nature of our role. Should we have known about these issues before hand, and if not us, who in the NHS should have known?

3.50. **Tim Cooper:** Our new comprehensive inspection process means that we uncover challenges other people have not uncovered. My view is that without repeating the exercise we have done, you would not have achieved this level of detail. However, judging by the views of some HOSC members and looking at the situation retrospectively, the Committee had misgivings about ESHT; so there may have been processes that could have brought those misgivings to light.

3.51. **Councillor Michael Ensor:** HOSC will reflect on its own internal processes and how it conducts its scrutiny role in light of this report. Whatever the outcome, HOSC will be more challenging in its scrutiny of the NHS going forward.

3.52. HOSC is thankful for the CQC report and is looking forward to hearing details about the date of the Quality Summit.

Evidence from East Sussex Healthcare NHS Trust (ESHT)

3.53. **Darren Grayson:** I would like to thank Tim Cooper and his colleagues, particularly for his explanation of the process for the first inspection and the reasons for the delay in providing a draft report to ESHT.

3.54. The number of staff in the room today reflects the strength of feeling in the organisation – not just at leadership level but at all levels – about the process that we have been through, and continue to go through, with the CQC.

3.55. The inspection process began with a presentation to the CQC inspection team by me and the entire executive team. The presentation mentioned the vast majority of issues recorded by the CQC, including those around the perception of bullying and medical record keeping. The one area we were not well prepared on was around medicine management (pharmacy services). The presentation also included what the ESHT leadership team throughout the organisation was doing to address those issues.

3.56. This organisation has a track record of facing up to its issues – whether it was maternity, surgery, orthopaedics, or stroke services – and tackling them.

3.57. The inspection that the CQC did of the Trust in 2010/11 – the most recent inspection prior to September 2014 – resulted in the serving of several enforcement notices and warning notices. The Trust then went through a process of improving the quality of the services it provided that was to the CQC's satisfaction, and more importantly, to the Trust itself. ESHT was inspected eleven times between 2011 and the inspection in September 2014, none of which identified any issues of concern.

3.58. The Trust has a reputation of being honest about its issues, including the perception of a bullying culture – which it has acknowledged and is tackling. The Trust has discussed the perception of bullying at Board level and – most likely – at HOSC more than once, and it is highlighted in the annual staff survey.

3.59. We acknowledge that there is a long way to go, but these are not new issues faced by ESHT. The Trust has faced these issues for many years and some may even date back to previous organisations.

3.60. The CQC raised with us the issue that whistleblowers had come forward during the inspection. They were investigated and their allegations found to be unfounded to the CQC's satisfaction during the inspection.

3.61. Our Quality Improvement Plan (QIP) is led by the doctors, nurses, midwives and others who deliver the services on a day-to-day basis. It would be fair to say that there is a considerable amount of disappointment, anguish, disbelief and anger about the reports,

but we are very clear that our job is to face up to the issues in the report – most of which the Trust already knew about and was working on – and develop plans to tackle the issues and move the Trust on.

3.62. It is perhaps inevitable that there is a focus on the leadership of the Trust, which is fair and to be expected. The Chairman and I, and the rest of the Board, would not want to resile from our accountabilities for the performance of the Trust as a whole. We are absolutely clear that we are on a journey of improvement and have made considerable progress, but there is still a long way to go.

3.63. We have always been honest about these issues and the journey that we are on, both to HOSC and in other forums. We believe that we are taking the right steps; clearly there is a need to focus on making sure that staff, in particular, feel more a part of that journey.

3.64. **Dr Andy Slater:** As a doctor and executive of ESHT, I want to work in an outstanding organisation. ESHT has started a journey to achieve outstanding status, and having now made significant clinical and management changes, I would like to think that the Trust can achieve it.

3.65. A few years ago, the East Sussex Hospitals NHS Trust merged with the community trust to form ESHT; this strategic change was unprecedented for East Sussex. It was initially meant to be a management merger rather than a clinical merger, so since then there have been substantial difficulties creating a coherent service.

3.66. We had, in the past, services that we knew would not meet the demands of a modernising health service, for example, the demands of seven day working and the five year forward plan. The services that we have now are immeasurably more capable of meeting these demands and we are able to see how these services are improving healthcare to our population.

3.67. We underwent a management restructure because we recognised that our existing management structure was not meeting the needs of either our organisation or the population of East Sussex. The restructure took place just prior to the CQC visit – we could have delayed it but we felt that it would have been disingenuous to have done so.

3.68. As an organisation, we recognised that there were areas where we were not performing well. We developed QIPs for these issues that we shared with the CQC prior to their visit.

3.69. We are very grateful to the CQC for highlighting other issues which we were not sighted on, such as pharmacy services (medicine management), and we took steps to remedy these issues during the CQC inspection. When we received the full report, we were able to put together a more coherent plan for remedying these issues that was added to our QIP.

3.70. We have an incredibly dedicated and talented workforce who deliver care, so it would be a shame if the areas rated ‘good’ in the CQC report were not recognised today. I think that it is an incredible tribute to our staff that the care that they deliver was rated ‘good’ and that, within the ‘well led’ domain, it is incredibly heartening that the CQC recognised that management “in the front line” at the ward level works extremely well. We are extending working practices in areas where the management was rated as ‘good’ by the CQC throughout the rest of the organisation.

3.71. It must be recognised that the users of our services are overwhelmingly satisfied with the service that they receive. We have the challenge of communicating actual experiences of patients to the public.

3.72. Our clinical administration review was carried out to ensure that our clinical administration was fit for purpose. However, we made a mistake translating the recommendations of that review to the outpatient service. While it was necessary to implement the recommendations, the way in which it was done was not appropriate; we have taken immediate action to address the issues that the reconfiguration caused.

3.73. We knew that medical record storage was a problem. Many trusts have an electronic solution for patient records, but due to the national failure of the NHS ICT system, we were unable to be in a position where we had electronic records.

3.74. The ability of staff to raise concerns, as highlighted by the CQC, is troubling to me personally and the organisation as a whole. We have very clear policies and procedures about how to raise concerns. As I and other senior officers walk around the organisation we see no difficulty with members of staff raising concerns with us. Where it is possible we will remedy those concerns, and where it is not we will explain why.

3.75. Immediate measures were taken at the time of the CQC inspection to resolve the problems highlighted in pharmacy services.

Councillor Michael Ensor paused the presentation to allow questions from Members.

3.76. **Julie Eason:** HOSC received a report at its last meeting on 26 March (the day before the CQC report) in which we were told everything was improving in maternity and paediatric services and none of the issues in the report were mentioned. Who is responsible for this?

3.77. **Darren Grayson:** Every fact in the report seen by HOSC on 26 March was true and accurate.

3.78. **Julie Eason:** Why was some data for the report to HOSC on 26 March – which was included in earlier reports, and would otherwise have indicated that things were not improving – deliberately not included?

3.79. **Darren Grayson:** I have not seen this information. If it was to be shared with us, we would be glad to compare it to the information that we have been providing. I think that the information we provided last time was accurate and relevant – and the presentation today covering maternity and paediatric services will reflect that.

3.80. **Councillor Ruth O'Keeffe:** Our role as HOSC is to scrutinise the issues and not just commend the achievements of an organisation. You said that you are already working on solutions to the issues highlighted in the CQC report; that the problems were already ingrained over a number of years; and that some of the concerns raised by staff to the CQC were unfounded. Are you comfortable with what seem to be very large problems with the Trust?

3.81. **Darren Grayson:** To clarify, I said that during the inspection some staff raised concerns through the whistleblowing procedure with the CQC. These were investigated by the Trust and found to be unfounded to the CQC's satisfaction. Is that not the case?

3.82. **Tim Cooper (CQC):** A number – but not all – of the whistleblowers who contacted us had made claims that could not be substantiated.

3.83. **Councillor Ruth O'Keeffe:** I am concerned with the sense of ease at which it came across that you knew about the problems identified by the CQC beforehand. I am also concerned that you are saying people had no difficulty raising concerns with senior management, yet many people appear to have been very concerned about raising issues with the CQC. Is it fair to say that ESHT is complacent over the issues it currently faces?

3.84. **Dr Andy Slater:** We absolutely are not complacent about the issues and are enormously concerned that the CQC has identified a group of people within the organisation who feel that they cannot raise concerns. Staff seem happy to raise concerns with senior officers when they are present on the ward as – in my experience – they know it is an avenue for raising concerns. Therefore, we need to ensure that people understand the opportunities and avenues for raising concerns, so that if they do not feel comfortable raising concerns with their line manager, they can raise concerns at a more senior level. We have an independent non-executive director who concerned staff can talk to, as well as other avenues outside of the organisation.

3.85. It is not true that we do not accept the problems facing the Trust. We do have problems, we have recognised that we have those problems, and we have been working towards solutions for them. Solutions to big problems inevitably are more complex and take longer to resolve, for example, medical records. The number of medical records we deal with is enormous and we accept that the necessary investment had not previously been put in place, either in staff to maintain records or facilities in which to keep them. We are now addressing this by securing money for new storage areas and implementing a barcode and radio frequency tag system that will allow us to locate particular notes in a hospital. However, with the millions of notes that we deal with, it takes time to implement these changes.

3.86. **Councillor Michael Wincott:** Staff morale must be incredibly low at the moment. The CQC Report shows that there is good, compassionate care and staff are performing well despite the inadequate staffing levels in some areas. The Director of Nursing is regarded by the CQC very positively, which is good to know.

3.87. Clearly, nursing staff are not the problem; has the Trust Board told the nursing staff that the Trust's 'inadequate' rating it is not their fault? If it is not their fault, whose fault is it? I have been a nurse and I would want the Chief Executive to apologise for the management's failings. The biggest morale boost that Darren Grayson could offer staff is to say "sorry" and offer his resignation.

3.88. **Councillor Sam Adeniji:** The report talks about out-of-date policies, a culture of bullying, ill-conceived or poorly implemented changes, and a lack of clear vision for the organisation. This is not a problem of systems failure but of the management of the organisation – why are the Chief Executive and Chairman not resigning?

3.89. Clearly, there is an issue about staff trusting senior management. To achieve cultural change and to address bullying requires the building of trust, and senior management talking directly to staff is not enough. How do you intend to address bullying without changing management culture?

3.90. What are you doing to improve your relationship with the population that you serve?

3.91. **Councillor Alan Shuttleworth:** There is anger and concern amongst my colleagues, residents and staff. Staff are the lifeblood of the organisation and were rated 'good' by the CQC for the care that they provide. However, the CQC report contains a catalogue of issues around staff relationship with management. What we have seen today is a sense of denial and complacency towards the seriousness of the CQC report and the Trust's endemic problems. I think that the staff are looking to HOSC to address the main issue with the Trust – which I believe is the leadership. The culture of an organisation comes from the leadership, so a successful organisation has to encourage openness and integrity. I echo what my colleagues have already said: if I had seen the report as the leader of ESHT, I would have resigned, and I am surprised you have not done so already.

3.92. **Julie Eason:** It is good to see that Alice Webster is recognised as having the trust of her staff. However, the Chief Executive and Chairman no longer have the trust of this Committee – if they knew the problems were there, they did not tell us. They have not proactively put the issues on the table – the first time I have heard them talk about the bullying culture is this morning. Have the Chief Executive and Chairman tendered their resignations and if not, why not? If they have, why have they not been accepted?

3.93. **Stuart Welling:** The ESHT Board takes the CQC report very seriously – the Board has spent the majority of its time recently considering the CQC report and related issues. The Board is also deeply concerned about the Staff Survey and about any disconnect between the Board and staff. Darren Grayson and I have been trying to address this problem ever since we have been in post. We do not intend to resign. We are determined to continue the job of delivering change at ESHT. Many of the issues identified in the CQC report are operational. However, we do recognise that we need to address the bullying issue and the issue of communications.

3.94. **Darren Grayson:** In response to Julie Eason's point, ESHT brings to HOSC what HOSC asks it to bring: HOSC sets its own work programme and ESHT responds to it – and does so assiduously. Had HOSC asked for the staff survey and how it links to organisational development and bullying/harassment policies, we would have been pleased to bring those to you. If you want us to bring any issue we will bring it – we have never refused to bring an issue.

3.95. We are not in denial – we have tackled issues around maternity, orthopaedics, emergency medicine, stroke, surgery etc. – we have tackled these problems, although much more needs to be done. There have been problems with clinical administration particularly as it relates to outpatients, and we recognise that changes should have been made differently. We are not in denial about this. However we have expertly implemented many massive service changes – this has been recognised by the CQC and independent auditors. I am angry, particularly about the impact of the CQC report on staff who do not recognise their service in what the CQC describes. Clearly, to some extent the CQC is holding up a mirror to the organisation, but I do feel for staff who are upset at the public portrayal of very dedicated workers. In terms of ESHT's 'vision', we were clear with CQC about the financial challenges we face, and about the challenges articulated by the East Sussex Better Together programme, which make the future health landscape very unclear. We are about to set a major deficit budget, along with the majority of acute trusts across England. We have no coherent 5 year vision aligned with that of commissioners – that is plain fact.

3.96. **Councillor Bob Standley:** I am appalled by what I've just heard. ESHT should be coming to HOSC with what the HOSC needs to know, not just providing the HOSC with what it has specifically asked for – the relationship is meant to be that of critical friend

3.97. **Darren Grayson:** That is clearly what I didn't say.

3.98. **Councillor Bob Standley:** That is what I heard and what other members heard.

3.99. **Darren Grayson:** HOSC sets its work programme and ESHT is responsive to that. We provide vast amounts of information in routine reporting – board papers, external reviews etc. But we have taken the HOSC lead in terms of things that the HOSC wishes to look at.

3.100. **Councillor Michael Ensor:** I see where you're heading here. However, your earlier comments succeeded in riling the whole of the HOSC. I can confirm that in the past ESHT has answered questions we have asked, and provided data when we have requested it; but the committee is reacting to your contention that we as lay-people

should always be asking the right questions, and that your duty does not include supporting us to understand issues fully.

3.101. **Councillor Peter Pragnell:** Mr Grayson has said that he's happy to answer any questions, and that the Trust puts lots of information in the public domain; but if HOSC doesn't know about an issue how can we ask about it? Isn't ESHT obliged to tell us about important issues?

3.102. **Councillor Michael Ensor:** We are going round in circles now, and need to progress with the presentation.

Councillor Ensor asked ESHT to resume their presentation.

3.103. **Alice Webster:** ESHT has a comprehensive Quality Improvement Plan (QIP). Part of this is intended to counter any disconnect between 'board and ward' – for example we have executive directors leading key work-streams and these streams are linked in to existing work groups. A key area is incident reporting –for example, temporary workers unable to access systems to raise incidents. We have looked at this and at the data protection issues which impact upon it – part of this work has been completed, including a good deal of staff engagement. We are running a series of open staff forums in May and June for clinical staff and for administrators and support services. We will develop actions following on from this.

3.104. Another key area is around managing the feedback loop – this has come across in a number of different forums and we have been looking at how we feed back to staff when they report incidents – we are now following this up (using IT solutions). We have also looked at our incident-reporting policy and have significantly strengthened training – we have made it clear that if a staff member feels that an incident is important then they need to report it.

3.105. We have also focused on organisational development and communications – there's a work-stream about how we ensure that we know we're responding to incidents rather than assuming that someone else is dealing with them There is also a piece of work around how the organisation communicates, not just vertically but horizontally also – and how we communicate externally. Clearly we haven't been good enough to date and we will change this. We are also developing an ESHT organisational development strategy – this will not sit on a shelf! The strategy will be led from the top, with executive leads for all work-streams.

3.106. In addition, the Trust has a good track record around working with Healthwatch and will continue work to improve our learning from informal as well as formal complaints.

3.107. **Jenny Crowe:** Staff morale dipped after publication of the CQC report, but we are not in the same place now as we were in September when the CQC inspected. In September, the service had only recently completed its reconfiguration and was very much focused on managing this process. The service is very caring and we are determined to improve – and have made some changes already, reflecting on staff and user feedback – e.g. allowing partners to stay overnight when women being induced etc. We have also developed a range of services to support quality e.g. new-born hearing screening. Also, more maternity staff can now provide new born physical examinations enabling timely discharge even when paediatricians are not available. Communication is an issue – we now communicate monthly with all staff and walk the floor along with other senior managers. We are developing our maternity vision: ESHT intends to be both the provider and employer of choice, and we are already seeing staff returning to ESHT – this is a positive sign. In terms of midwifery we are fortunate to have two Midwife-led Units and a good home-birth service – we are working to ensure that women can easily access

information on these services and we intend to host user feedback on our services (via our new Facebook page). We work very closely with the Maternity Liaison Service.

3.108. There have been challenges – we have had vacancies to recruit to, and some issues with long term sick and maternity absences. We are looking at different ways of managing recruitment and staffing – NICE doesn't currently have a toolkit to allow trusts to use its latest guidance for staff planning. We are looking to flexibly recruit over our establishment staffing level to ease temporary sickness/maternity leave issues and will interview a number of staff next week. We have also launched a 'return to practice programme' for returning midwives to encourage back staff who previously worked at the trust.

3.109. **Nicky Roberts:** Since the reconfiguration we have 72 hours of consultant cover on the maternity ward per week. This is a significant advance on the previous position (40 hours). We also currently have a full complement of junior and middle-grade doctors and will shortly recruit to new consultant post. We are well-staffed and providing a safe level of obstetrics.

3.110. In response to Julie Eason's point on HIE: in terms of Serious Incidents (SIs), in the year prior to reconfiguration (Year to May 13) 22 SI; in the year following reconfiguration (May 13-April 14) 10 SI; and 7 in the subsequent year (May 14-April 15). There have been 2 SI since Jan 15, one of which was HIE. The HIE rate will never be 0%, but we have seen a significant reduction in HIE cases since reconfiguration, which is a measure of improved safety.

3.111. **Darren Grayson:** I want to keep on this point because Julie Eason earlier accused me of lying.

3.112. **Julie Eason:** (reads out from an anonymous letter sent to HOSC which describes an ESHT internal meeting post the CQC report: senior managers stated to staff that they believed the CQC report to be procedurally flawed and to give an inaccurate picture of services. However, staff disagreed, arguing that the report was largely accurate.) Is this what happened at the meeting?

3.113. **Jenny Crowe:** We've had a number of staff meetings about the CQC report – not sure which meeting is referred to here. Managers did raise concerns about the way CQC carried out inspections and did raise concerns about findings where we thought that the challenge was not of our recognition. This isn't necessarily to say that the CQC were incorrect, but that we didn't recognise the situation they described.

3.114. **Councillor Michael Ensor**: I want to halt this line of questioning for the moment.

3.115. **Julie Eason:** I'm happy to circulate the anonymous letter and have ESHT come back and respond later.

3.116. **Councillor Ruth O'Keefe:** I want to quote from the CQC report: "the Trust must review the impact of the maternity reconfiguration"; and "the NHS staff survey showed three areas where the Trust was rated worse than expected: one of these was staff who thought that the incident reporting procedure was fair and effective". Also, "staff in maternity were not using the appropriate processes for recording incidents and not appropriately escalating actions." It is on record that I have previously questioned the improvement of maternity services because I haven't seen a significant improvement in the data, particularly given that there have been fewer people using services post-reconfiguration so the rates might actually have been said to have gone up rather than down. I now find the CQC are saying this needs to be reviewed. I now have no confidence in the previous assurances to the HOSC.

3.117. **Jenny Crowe:** The difficulty here is talking about incidents rather than serious incidents – incidents include near misses etc. – events which ought to be reported, but which haven't necessarily impact upon care. A serious incident has very clear guidance about reporting. We do report incidents, but can always improve this and work with staff is ongoing here, particularly in terms of using IT solutions and improving the staff feedback loop. We can do better: we're not perfect, and the general level of incident report does need to be raised, but I can say with confidence that our serious incident reporting is functioning well.

3.118. **Councillor Ruth O'Keefe:** I remain very concerned – the Trust must review the impact of its maternity reconfiguration. I am sceptical about the data used to justify improvement in maternity services.

3.119. **Councillor Michael Ensor:** this meeting is not focused on maternity reconfiguration – we do need to return to this and potentially ask different questions and consider new metrics. Let's re-focus on the CQC report.

3.120. **Cllr Alan Shuttleworth**: I want to focus on the issue of trust – my recollection of maternity reconfiguration scrutiny was that we spoke a lot about incidents and raised just the kind of issues highlighted by the CQC. Given that the CQC has found poor levels of incident-reporting and the potential for this to mean that the trust is not learning from mistakes, I feel that we were given selective information by ESHT – we need to review the impact of maternity reconfiguration.

3.121. **Councillor Michael Ensor**: I now want to move on through the presentation and then bring the Clinical Commissioning Groups (CCGs) and the Trust Development Authority (TDA) in.

3.122. **Imelda Donnellan**: The CQC critiques surgery not just in terms surgical specialities but also in terms of theatre staff, anaesthetic staff, room environments and so on: the entirety of the service across all sites that deliver surgery. We were assessed shortly after the reconfiguration of services: this needs to be born in mind. When inspected we hadn't regained equilibrium following the reconfiguration – some staff were unsettled and some line-management arrangements had not bedded-in.

3.123. The rationale for reconfiguration was to provide a seven day consultant-delivered service and increased consultant anaesthetist presence. CQC didn't mention this major achievement. However a CQC inspection is the ultimate peer review – we do take it really seriously, even though the process was disappointing and demoralising for staff. Clinical leaders have got to pick staff up and work on morale – we have held a number of meetings to try and address this issue.

3.124. How safe are we? We have to look at objective criteria. I am pleased that the CQC acknowledges the time gap between inspection and the publication of the report: it's difficult for staff when there isn't early feedback from the inspection, although we have nonetheless continued to develop services. I won't talk about incident reporting because others have done so and planning is very robust here. The key for me is feeding-back to staff on incident-reporting – this did need bolstering and is now picked up in clinical governance meetings alongside infection control reporting, safeguarding, mental capacity etc. We are looking to introduce a Vital pack system to help pick up the deterioration of patients also. The CQC report highlighted mortality and morbidity reporting – it is important to note that ESHT was aware of this and had a plan already. I hope that this will be referred to in the forthcoming CQC report; it wasn't mentioned in the initial report. Surgery is now well on track in regard to these measures. We also consider and review deaths in low-risk groups, look at quality performance (returns to theatre, complications, complaints etc.) and are up to date with NICE guidance.

3.125. In terms of staffing, we had budgeted for a full establishment of staff, but lacked staff with specialist skills to fill vacant posts, despite an active recruitment programme. Our recruitment drive is now working, particularly in terms of looking outside the South East region. This is a nationwide problem, with no easy solution - going out to Europe or further afield poses its own problems.

3.126. Have changes improved things? The seven day consultant presence has had an impact. Performing operations Out of Hours is typically an indicator of problems (sepsis, haemorrhaging etc.) and should be minimised. I am pleased to say that Out of Hours operations have reduced by 40% following reconfiguration. This means that operations are happening when they should do. When Out of Hours working is required there is now much higher consultant presence. We now have a year's data for high-risk operations: for 229 patients operated on there were 14 predicted deaths due to high risk, but only 4 in fact died. This makes the trust an outlier for good performance – at odds with the CQC findings.

Evidence from the Clinical Commissioning Groups (CCGs), Trust Development Authority (TDA) and Healthwatch East Sussex

3.127. **Councillor Michael Ensor:** we're all very aware of the trust action plan and I don't want to explore it in detail now. I would like to ask the CCGs to comment now. My first question is whether the CQC report findings were news to the CCGs, and secondly what the role of the CCGs is in monitoring the action plan?

3.128. **Jessica Britton:** Just a comment on maternity: it is clear from the reports that the evidence from the CQC inspection further underlines our decision regarding the risks around recruitment and retention of key staff groups. We were always absolutely clear and transparent in our engagement and consultation, and no stone was left unturned in finding the best solution we could for the safest services. HOSC scrutinised this fully throughout the process and since, the data post reconfiguration, particularly in relation to Serious Incidents does indicate that the new configuration is safer.

3.129. CCGs are very much part of one NHS and all parts of the NHS look to commissioning and providing the best and safest services for our population. We know it's vitally important that our local population has confidence in our local services. Our job as CCGs is to commission services that best meet the needs of our population. We do this through Service Level Agreements. We commission activity, and quality, access and safety standards, it is then the provider organisation's job to determine how they organise the daily operational delivery of these services, and this is what the CQC inspected. We were disappointed with the timing of the CQC report publication and the lack of a Quality Summit and therefore welcome the suggestion that CCGs might co-chair, or certainly have greater involvement in, the Quality Summit for the next report when it takes place. Our focus going forward will be on working with all relevant stakeholders to ensure the necessary improvements are made, to monitor the action plan and provide the necessary assurance.

Dr David Roche: CCGs look at a good deal of ESHT data, but not at the CQC's level of detail – we will be able to use the CQC's data to inform future monitoring.

3.130. **Councillor Michael Ensor:** Thank you for this – we will need to revisit whole issue of monitoring. Now for the TDA: what is your role, particularly in terms of monitoring?

3.131. **Judy Blumgardt:** The TDA supports NHS trusts to deliver improvement. We help trusts prepare for the CQC inspection and ensure that staff are supported throughout the inspection process. We also support trusts to understand and respond to their CQC

report via an Quality Improvement Plan (QIP). We have an oversight model in place – we will meet regularly with ESHT to ensure it meets QIP demands and provide additional support as and when needed. Lots of additional support has already been provided. It is clearly important that the QIP actually addresses the CQC report findings. The TDA looks at the performance and delivery of QIP, and also looks at quality. The TDA will ensure that all stakeholders are part of process of monitoring the QIP. We have already held a board to board meeting with ESHT, where the TDA board scrutinised ESHT's capacity to deliver change. We can put additional support in place if required – we are awaiting the findings of the 2nd CQC report for this, and this support offer will be discussed at the Quality Summit.

3.132. **Councillor Michael Ensor:** Healthwatch is an important player here – what is their perspective?

3.133. **Julie Fitzgerald:** We had strong public engagement prior to the inspection, but then entered a longer than anticipated period post-inspection where we couldn't feedback to the public about the inspection process. Adding to the problems, the Quality Summit did not take place, and then the report was published on the eve of election purdah. Again this meant it was not possible to engage properly with the public and Healthwatch regrets it was unable to discharge its responsibilities fully. The CQC is aware of and recognises our concerns here.

3.134. We have recently met with ESHT Chief Executive and Director of Nursing to discuss how to improve ESHT public engagement and communication, particularly around capturing intelligence below formal complaint level. New Healthwatch systems will also capture valuable intelligence. We will also engage with internal ESHT meetings and feedback to the public – we have been doing this over past 18 months, although things haven't hasn't been as much in public as we have liked.

3.135. It is important that there is engagement with the Voluntary & Community sector, with the sector viewed as an asset in terms of engagement. We would also like to see regular discussions between senior ESHT managers and the public.

3.136. **Councillor Michael Ensor:** There is now an opportunity for more questions and to plan how HOSC will monitor this issue going forward. In the first place I propose that we have a special HOSC following the Quality Summit.

3.137. **Councillor John Ungar:** The CCGs commission services and monitor outcomes. Did you pick up high mortality/morbidity rates? And if so did you address this issue? Are you happy with the QIP?

3.138. **Jessica Britton:** CCGs do review, measure and report on mortality and morbidity – this has never been a major outlier (and does vary over time: snapshots don't give the full picture).

3.139. **Alison Cannon:** The CCG has a well-established and robust quality assurance **process**. The CCG meets monthly with the Trust to seek assurance on quality measures and scrutinises all aspects of data from a wide variety of sources for example, data the Trust provides, CQC intelligent monitoring data, staff and patient feedback and surveys, this information is formally reported to our governing bodies. The CCG uses this data to effectively triangulate areas of concern and seeks assurance from the Trust as to how this is being addressed to ensure patient safety and quality. Moving forward the CCG will be strengthening this process by reviewing quality in daily operations. This will be achieved by visiting areas of the Trust using observation, gathering patient and staff feedback to further enhance our existing knowledge of the quality of services provided to patients.

3.140. **Wendy Carberry:** The QIP does focus on the right priorities. We are currently discussing CCG involvement in monitoring this with both the CQC and the TDA.

3.141. **Alice Webster:** It should be noted that QIP formula was agreed at the outset with CCGs and the TDA. It is not something that ESHT has undertaken without consultation.

3.142. **Councillor Bob Standley:** I would like to propose a motion: " that East Sussex HOSC expresses great concern at the findings of the CQC inspection, has limited confidence in the Chair and Chief Executive of the Trust, calls on ESHT to implement the improvement plan as a matter of urgency, and expects ESHT to give regular updates to ensure HOSC members are fully informed of the progress of that improvement plan."

3.143. **Cllr Frank Carstairs:** I second the motion.

3.144. **Julie Eason:** I propose we substitute the word "limited" for "no".

3.145. There was general agreement to this.

3.146. **Councillor Michael Wincott:** I had a similar motion and would like to state that I have absolutely no confidence in the Chair or CE of ESHT.

3.147. **Councillor Peter Pragnell:** I was shocked when I read the CQC report. I would expect the people at the top of an organisation to carry the can for this level of performance. It is unfortunate that the ESHT Chair has left the meeting – because I fail to understand why he and the Chief Executive have not already resigned. I remain convinced at the case of reconfiguration, but I am appalled by this report and am stunned that the leadership has not already resigned.

3.148. **Councillor John Ungar:** HOSC should also acknowledge the good work of hospital staff.

3.149. **Councillor Ruth O'Keefe:** I suggest that we add to Cllr Standley's motion: "whilst recognising the caring qualities of the staff."

3.150. **Councillor Bob Standley:** My motion now reads: "whilst recognising the caring qualities of the staff, that East Sussex HOSC expresses great concern at the findings of the CQC inspection, has no confidence in the Chair and Chief Executive of the Trust, calls on ESHT to implement the improvement plan as a matter of urgency, and expects ESHT to give regular updates to ensure HOSC members are fully informed of the progress of that improvement plan."

3.151. **Councillor Sam Adeniji:** to the CCGs – what happens if a SLA with ESHT isn't met?

3.152. **Wendy Carberry:** There are levers within the contract and we would negotiate to get back on track (e.g. for 18 week performance target).

3.153. **Councillor Ruth O'Keefe:** I wanted a recorded vote, but not all District Council representatives have yet been appointed so I've been advised not to ask for this.

RESOLVED – that the motion be unanimously agreed.

3.154. **Councillor Michael Ensor:** In conclusion, I would like to have a sub-committee to look at the QIP and identify where we want to deep-dive – will then report this back to the16 June HOSC meeting. We will also add a special meeting at end of July. I would like to thank all the NHS organisations who have attended and also members of the public.

The Chairman declared the meeting closed at 1.22 pm