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13 November 2012

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

Thursday 22 November 2012
2 pm
Warspite Room, Council House

Members:
Councillor Mrs Aspinall, Chair
Councillor Monahan, Vice Chair
Councillors Mrs Bowyer, Fox, Gordon, James, Dr. Mahony, Mrs Nicholson, Parker, Jon Taylor and Tuffin.

Members are invited to attend the above meeting to consider the items of business overleaf.

Tracey Lee
Chief Executive

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

AGENDA

PART I – PUBLIC MEETING

1. APOLOGIES

To receive apologies for non-attendance by panel members.

2. DECLARATIONS OF INTEREST

Members will be asked to make any declarations of interest in respect of items on this agenda.

3. CHAIR'S URGENT BUSINESS

To receive reports on business which, in the opinion of the Chair, should be brought forward for urgent consideration.

4. MINUTES (Pages 1 - 22)

The panel will be asked to confirm the minutes of the meetings held on the 13 September and 26 September 2012.

5. TRACKING RESOLUTIONS AND FEEDBACK FROM THE OVERVIEW AND SCRUTINY MANAGEMENT BOARD (Pages 23 - 24)

The panel will monitor the progress of previous resolutions and receive any relevant feedback from the Overview and Scrutiny Management Board.

6. PLYMOUTH NHS HOSPITALS TRUST - CAR PARKING (Pages 25 - 28)

To receive a report on parking facilities at Derriford Hospital.

7. PLYMOUTH HOSPITALS NHS TRUST - REGIONAL PAY UPDATE (Pages 29 - 34)

To receive an update following the panel’s enquiry on the 26 September 2012 into NHS Regional Pay.

8. PLYMOUTH HOSPITALS NHS TRUST - NEVER EVENTS (Pages 35 - 38)

To receive an update on ‘Never Events’ at Derriford Hospital.

9. WORK PROGRAMME (Pages 39 - 40)

The panel will consider its work programme.

10. EXEMPT BUSINESS

To consider passing a resolution under Section 100A (4) of the Local Government Act 1972 to exclude the press and public from the meeting for the following item(s) of business on the grounds that it (they) involve(s) the likely disclosure of exempt information as defined in paragraph(s) of Part 1 of Schedule 12A of the Act, as amended by the Freedom of Information Act 2000

PART II (PRIVATE MEETING)

AGENDA

MEMBERS OF THE PUBLIC TO NOTE
that under the law, the Panel is entitled to consider certain items in private. Members of the public will be asked to leave the meeting when such items are discussed.

NIL.

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Health and Adult Social Care Overview and Scrutiny Panel

Thursday 13 September 2012

PRESENT:

Councillor Mrs Aspinall, in the Chair.
Councillor Monahan, Vice Chair.
Councillors Mrs Bowyer, Fox, Gordon, James, Dr. Mahony, Mrs Nicholson, Parker, Jon Taylor and Tuffin.

Co-opted Representatives: Sue Kelley (Plymouth LINk)

Also in attendance: David Macaulay (Mental Health Services Manager, Plymouth Community Healthcare), Craig McArdle (Commissioning Manager, Plymouth City Council), Councillor Sue McDonald (Cabinet member for Public Health and Adult Social Care), Rob Nelder (Public Health Consultant), Candice Sainsbury (Senior Policy, Performance & Partnership Advisor, Plymouth City Council) and Ross Jago (Democratic Support Officer, Plymouth City Council)

The meeting started at 2 pm and finished at 3.50 pm.

Note: At a future meeting, the committee will consider the accuracy of these draft minutes, so they may be subject to change. Please check the minutes of that meeting to confirm whether these minutes have been amended.

24. DECLARATIONS OF INTEREST

The following declarations of interest were made in accordance with the code of conduct -

Name	**Minute Number and Issue**	**Reason**	**Interest**
Councillor Dr Mahony	All agenda items	Locum General Practitioner	Personal
Councillor J Taylor	31. Special Meeting – Regional Pay	NHS Employee	Personal

25. MINUTES

<u>Agreed</u> the minutes of the meeting held on the 19 July 2012 subject to the following amendments –

(1) Sue Kelley (Local Involvement Network) is added to apologies;

(2) Amend minute 23 (a) to the following – *"there had been concerns regarding Local Involvement Network arrangements due to the national contract specification imposed at the establishment of LINk. It was felt that the powers, held by LINk*

organisations across the country, could have been used more effectively and that there had been a structural problem with too much focus on governance."

26. CHAIR'S URGENT BUSINESS

There were no items of Chair's urgent business.

27. TRACKING RESOLUTIONS AND FEEDBACK FROM THE OVERVIEW AND SCRUTINY MANAGEMENT BOARD

The panel agreed to note their tracking resolutions and add the 'Dementia Challenge' to the work programme.

28. MENTAL HEALTH SERVICES - CAPITAL INVESTMENT IN THE GLENBOURNE UNIT

David MacAulay (Plymouth Community Healthcare (PCH)) introduced a report on planned capital investment into the Glenbourne Acute Psychiatric Unit. It was reported that –

(a) the programme of investment would allow for the re-establishment of a 'place of safety' for those arrested under section 135 and 136 of the Mental Health Act. Assessment of those arrested in Plymouth and the surrounding area had been carried out in police custody suites which was not appropriate for those vulnerable people;

(b) the building redesign of the unit would allow for facilities on site which would enable the management of patients during more challenging psychotic episodes and would help avoid referral to out of area facilities;

(c) the redesign of the accommodation at the Glenbourne Unit would help the service to provide individual bedroom accommodation and single sex wards allowing the achievement of appropriate standards of dignity and privacy;

(d) community and other staff currently placed across the city would be centralised within the unit as part of an integrated management structure;

(e) there would be a reduction in beds from 44 to 36 which was in keeping with the service model of maintaining patients within a community setting where appropriate, and would be supported by an enhancement to community staffing levels.

In response to questions from members of the committee it was reported that –

(f) the graph within the report showed that demand for beds peaked at 40 over the previous two year period. Although the proposal would result in a net reduction of beds to 36, this reduction in capacity would be managed through a better discharge system and enhanced community services. Delayed discharges had accounted for 10 blocked beds;

(g) all staff that were moved into the unit and those staff who would be employed in the extra care areas, would be provided with comprehensive training;

(h) many patients admitted to the unit already had a multi-disciplined community support team working with them, on discharge these services would be

enhanced by home treatment teams;

(i) PCH home treatment teams worked during the weekends, the adult social care out of hours team was also available at the week out of hours services;

(j) patients were only given leave from the unit when staff believed it was appropriate, evidence suggested that the service did not have a “revolving door” where patients returned frequently following discharge;

(k) the redesign was not based on the limitations of the building and the reduction in capacity would be off-set by improved community services.

The panel agreed to recommend that –

(1) Plymouth Community Healthcare return to the panel in 12 months to update on progress;

(2) a report on bed occupancy rates is provided to the panel in April;

(3) a site visit is arranged for members to the Glenbourne Unit, to include a meeting with staff in the home treatment team.

29. **PUBLIC HEALTH TRANSITION**

The panel received an update on the transfer of public health functions into the local authority. It was reported that -

(a) responsibility for key public health functions will transfer from the National Health Service (NHS) to local authorities on 1 April 2013;

(b) a local joint transition plan was in place with key workstreams including Future Public Health Model, Commissioning and Finance, Human Resources, Communications, Risk Management, Intelligence, Core Offer, Health Improvement Team, and Emergency Planning;

(c) key milestones included identification of which NHS Public Health staff to transfer to Local Authority (December 2012) and the final funding formula (December 2012).

In response to questions from the panel it was reported that –

(d) Public Health funding would be ring-fenced for two years, how funding would be allocated remained unclear;

(e) there were various models for the integration of public health into the local authority, all models were being evaluated.

Agreed that –

(1) the Joint Risk Register is made available to the panel;

(2) the public health outcomes framework is distributed by the Democratic Support Officer.

30. **HEALTH AND WELLBEING**

The panel received an update on the progress of the Shadow Health and Wellbeing Board it was reported that –

(a) the Plymouth Health and Wellbeing Board was the key partnership responsible for promoting the health and wellbeing of residents and for the integration of health and social care commissioning;

(b) the Board's focus would be on achieving the best possible health outcomes for children, young people and adults, which would contribute to the wider shared strategic priorities of the city;

(c) the Health and Wellbeing Board would have strategic influence over commissioning decisions across health, public health and social care by reviewing the Joint Strategic Needs Assessment (JSNA) and developing a joint strategy for how these needs can be best addressed;

(d) the Board would hold commissioners to account for their decisions ensuring they are aligned to the Joint health and Wellbeing Strategy. This would include recommendations for joint commissioning and integrating services across health and social care;

(e) the Board would bring together the clinical commissioning group, the community and the local authority to develop a shared understanding of the health and wellbeing needs of the community;

(f) The Shadow Board was operational and would take on its statutory roles from April 2013. Currently the board was assisting in –

- the development Joint Strategic Needs Assessment;
- supporting the establishment of the Local Clinical Commissioning Group;
- overseeing of the transition of Public Health into the local authority;
- overseeing the creation of a Joint Health and Wellbeing Strategy;
- supporting integrated commissioning through the established Joint Commissioning Partnership.

Agreed that Shadow Health and Wellbeing Board minutes would be included on future scrutiny agendas.

31. **SPECIAL MEETING - REGIONAL PAY**

The panel was informed that a special meeting would be held to discuss NHS Regional Pay in the South West. The meeting would take place on the 26 September 2012.

32. WORK PROGRAMME

The panel agreed to approve the work programme, subject to the following additions -

(1) Plymouth NHS Hospitals Trust - Winter Plans (November);

(2) Derriford Hospital Car – Parking for the disabled (November);

(3) Update on Public Health Transition (January);

(4) Dementia Challenge.

33. EXEMPT BUSINESS

There were no items of exempt business.

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Health and Adult Social Care Overview and Scrutiny Panel

Wednesday 26 September 2012

PRESENT:

Councillor Mrs Aspinall, in the Chair.
Councillor Monahan, Vice Chair.
Councillors Mrs Bowyer, Gordon, James, Mrs Nicholson, Parker, Jon Taylor and Tuffin.

Apologies for absence: Councillors Fox and Dr. Mahony.

Also in attendance: Councillor Bent (Torbay Council), Councillor Parsons (Cornwall Council) and Councillor Westlake (Devon County Council).

The meeting started at 10.00 am and finished at 3.00 pm.

Note: At a future meeting, the committee will consider the accuracy of these draft minutes, so they may be subject to change. Please check the minutes of that meeting to confirm whether these minutes have been amended.

34. DECLARATIONS OF INTEREST

The following declarations of interest were made in accordance with the code of conduct -

Name	**Minute Number and Issue**	**Reason**	**Interest**
Councillor J Taylor	Minute No. 36 and 37 SW NHS South West Regional Pay	NHS Employee	Personal
Councillor Parker	Minute No. 36 and 37 SW NHS South West Regional Pay	Member of the National Public Services Committee (GMB)	Personal
Councillor Aspinall	Minute No. 36 and 37 SW NHS South West Regional Pay	Retired Member of the Royal College of Midwives	Personal

35. CHAIR'S URGENT BUSINESS

There were no items of Chair's urgent business.

36. SOUTH WEST PAY, TERMS AND CONDITIONS CONSORTIUM

The panel's lead officer advised the panel that the South West Pay, Terms and Conditions Consortium were unable to send a representative to the meeting. Members were given a short

briefing on the purpose of the consortium and referred to the discussion documents and frequently asked questions contained within the agenda papers.

37. NHS SOUTH WEST REGIONAL PAY - WITNESS SESSION

A. PLYMOUTH HOSPITALS NHS TRUST

The panel heard from Ann James, Chief Executive of Plymouth NHS Hospitals Trust. Ms James reported that –

(a) the Consortium was a group of 20 health trusts identifying opportunities to standardise practice;

(b) the Trust Board and management team were aware of the anxiety and distress caused to staff and had set up a dedicated line to Ms James where staff could raise their concerns;

(c) whatever proposals were made by the consortium, they would need to be approved by the Trust Board;

(d) no decisions would been taken without due consideration of all alternative options;

(e) 63 per cent of the Trust's income was spent on wages which equated to around £230million per year, if there were no changes made to pay, terms and conditions the wage bill would increase by a further £7million in 2013-14;

(f) every work day there was approximately 230 people absent across the Trust which cost in the region of £7million per year, there were many reasons for absence and the Trust worked with staff to address them;

(g) all alternative options to changes to pay, terms and conditions would be explored with decisions being made in an open and transparent manner;

(h) the consortium would continue to meet and would be providing feedback to the Trust on a regular basis, a business case was expected before the end of the calendar year;

(i) Ms James was committed to high quality patient care and would ensure that staff were involved and views taken into account when the Trust made decisions regarding changes to pay, terms and conditions.

In response to questions from the panel it was reported that –

(j) the Trust Board would be advised on possible opportunities for shared services and alternative service delivery in order to

make informed decisions when considering any proposals regarding pay, terms and conditions. Although the Trust experienced a large amount of sickness absence, care needed to be taken on how sickness absence was addressed, particularly in an acute hospital setting;

(k) the Trust was disappointed with staff survey results which put the Trust in the bottom 20 per cent of Trusts with regard to engagement with staff. There was work taking place to address the problem. Although current discussions on pay, terms and conditions may impact on staff morale, the financial situation could not be ignored and all options had to be explored;

(l) all areas of the public sector were dealing with issues of this nature and the Trust Board would take full responsibility for any final decisions made regarding pay, terms and conditions. The Trust was not in a position to choose efficiency savings over changes to pay, terms and conditions and had to explore both;

(m) consistency in pay, terms and conditions would allow for improved recruitment and retention;

(n) the approach would be open and transparent. The Trust was aware of the large contribution they made to the economy of the city and the sub region;

(o) staff were still providing excellent care to all patients, staff were aware of discussions regarding changes to pay , terms and conditions but their priority remained patient care;

(p) there were some services for which the Trust struggled to recruit. A long term plan for recruitment would be developed. There were not any definitive proposals for outsourcing; the current situation was unsettling for staff and the Trust would ensure that staff were being engaged. The Trust did not want to prolong the uncertainty about pay and the future direction of the hospital;

(q) that many clinicians believed that that model of a large acute Trust providing a wide range of services was out dated and needed to change rapidly with more services delivered in the community and the need for hospitals to shrink. The Trust needed to be engaged in that debate. The Health community needed to provide the right service at the right size in the right place and the Hospital would need to carefully consider its future place in the new health system;

(r) the Trust recognised its role in health care in Devon and

Cornwall and would ensure fairness across the 'bigger patch'. No proposals had been put forward by the consortium and when proposals were made the Trust Board would consider the impact on services and staff morale;

(s) all staff across the Trust were included in the consortium's discussions, including managers;

(t) the Trust would be required to make approximate savings of £40 million over two years. The Trust would be reviewing plans in place and arrangements with commissioners;

(u) with regard to national 'Agenda for Change' negotiations the board would need to discuss and express a view on those negotiations. Pay, terms and conditions needed to be sustainable for staff and services.

The panel thanked Ms James for her attendance and contribution.

B. PLYMOUTH UNIVERSITY

Dr Sue Kinsey, Associate Professor in HR Management, reported to the panel that –

(a) the rationale on which regional and local pay systems were seen as a positive change rested on private / public pay comparisons and the crowding out hypothesis. There was very little evidence to support the crowding out hypothesis and a lack of research evidence from private employers;

(b) regional / local pay systems should not be considered when systems were in financial crisis;

(c) private / public sector pay comparisons did not take account of the different occupational markets and the public sector work force profile. Private sector best practice had been advocated without understanding public sector contexts;

(d) there was a wealth of research on performance related pay in the public sector which had shown there had been adverse and unintended consequences;

(e) evidence suggested that where pay bargaining became more fragmented greater inequalities developed across genders, ethnic minorities and between the top and bottom of organisations;

(f) pay changes were deemed a blunt instrument for increasing productivity, sustainable performance required positive working climate and effective and supportive management.

In response to questions from members of the panel, it was reported that –

(g) there was a wealth of research on the 'public sector ethos' and how it had been eroded over a number of years;

(h) consultation did not equal engagement. Top down consultation was often an information giving exercise rather than effective engagement;

(i) pay inequality was at its lowest when national pay and conditions existed;

(j) it was notoriously difficult to put a financial value on an effective, sustainable workforce. It had been difficult to prove that Human Resources interventions resulted in measurable outcomes;

(k) key to the morale of the workforce was a positive psychological contract. Key threats to morale included risks to job security and changes to terms and conditions. Change management theory suggested that effective consultation was key, although this could be seen as 'sugar coating' what was unpalatable;

(l) there was a need to enhance the employees ability to contribute to any organisation. Workers should be engaged in discussions on job descriptions, service redesign and management of absence. Staff should feel to contribute to the best of their ability and enable them to give their best efforts.

The panel thanked Dr Kinsey for her attendance.

C. ROYAL COLLEGE OF MIDWIVES

The panel welcomed John Skewes, Director of Employment Relations and Development at the Royal College of Midwives (RCM). Mr Skewes reported that –

(a) the RCM was involved in the inception of the Agenda for Change (AFC), the NHS pay system. It had replaced a myriad of terms and conditions;

(b) the AFC was based on job evaluation, increasing fairness and removing discrimination. The system was based on a knowledge and skills framework monitored through an appraisal system, however eight years after the instigation only 66 per cent of staff received an appraisal;

(c) efficiency gains would not be achieved, unless system redesign was implemented. The Consortium's approach was 'salami slicing';

(d) pay clearly had a role in the Nicholson challenge of £20bn productivity and efficiency savings across the NHS, however the cost of pay in the South West relatively lower than in the rest of the country;

(e) the Chancellor had asked the pay review bodies to look at the concept of regional pay and the issue of crowding out. 99 per cent of midwives worked in the NHS and were not likely to crowd anyone out;

(f) the Consortium proposals would result in a 15 per cent cut in take home pay, there were already pay cuts in real terms with pension contributions increasing;

(g) the RCM were engaging in a review of the 'Agenda for Change'. NHS employers had engaged with proposals and consultation had shown that members wished to continue to negotiate the 'Agenda for Change'. There were savings which could be made to sickness and unsocial hours payments. the RCM would not negotiate with the Consortium as it was felt that they could not be engaged fully in simultaneous negotiations.

In response to questions from the panel it was reported that –

(h) the impact of NHS regionalised pay on the local economy would be huge;

(i) there was a view that the RCM would not be flexible which was inaccurate as some of Consortium proposals were sound;

(j) a consistent approach to a comprehensive appraisal system was required across the NHS system. Managers needed to be aware of the importance of the appraisal system. Down banding of some posts had already started to take place and savings should be realised over the next few years;

(k) negotiators were close to agreement with regard to the AFC.

The panel thanked Mr Skewes for his attendance.

D. ROYAL COLLEGE OF NURSING

The panel welcomed Helen Hancox, Project Lead for the Campaign Against SW Pay Cartel, Royal College of Nursing (RCN). It was reported that –

(a) South Devon Healthcare had not joined the Consortium. The Trust was highly rated and won a number of awards. The Trust had not joined as it is was not deemed right for patients and not right for staff;

(b) the RCN did not believe that changing the terms and conditions was the answer to the financial challenge. Although it was accepted that services needed to be delivered differently this could be done by addressing procurement and other related activities;

(c) the RCN believed that their members were the easy target. In general Nursing was not a militant profession. Ms Hancox reported never having heard so many members talk about a specific subject;

(d) there were demotivated and demoralised staff throughout the NHS. RCN members on average gave 7 hours a week extra, if forced to work 40 hours a week staff would work to rule;

(e) the Consortium's discussion documents were ill conceived and do not have costing against them;

(f) with regard to levels of sickness it needed to be recognised that nurses typically had higher rates of sickness because of the hours they worked and the type of work they carried out. Shift workers were more unlikely to be unwell and suffer obesity. Women that worked regular night shifts have more prevalent rates of breast cancer;

(g) PHNT did not have a good staff survey results. Although Ms Hancox was reassured by the statements provided by Ms

James, it was requested that the panel note that the trust had 11 of the 38 staff survey indicators in the "worst 20 per cent" category and that attacking terms and conditions would not improve these scores.

In response to questions from the panel, it was reported that –

(h) not all sickness was stress related but working shifts made people ill, clinicians inevitably got unwell because of the environments in which they work;

(i) staff told the RCN that they were demotivated and demoralised. Many staff said if changes to pay and conditions resulted in a staff contracts being terminated before implementation staff would not re-apply;

(j) staff retention and recruitment would be severely hampered by proposals for regional pay. Currently 25 per cent of nurses on the Peninsula were over 55. The recent intake of student nurses at Royal Cornwall Hospital Treliske was only 80 students. Trusts were required to recruit from abroad from countries such as Portugal and the Philippines;

(k) many organisations were seeing a downward shift in the available skill mix;

(l) for some staff the change to pay, terms and conditions would result in work not paying. Many staff would choose to work with agencies as terms were often better. Some Trusts were already spending four times as much on agency staff then previously;

(m) Services provided by Specialist Nurses were being eroded. The RCN believed that specialist nurses would go elsewhere to acheive better remuneration;

(n) there was already a huge reliance on agency staff at the Royal Devon and Exeter Hospital. Temporary agency staff were employed for weeks with accommodation and travel expenses paid. If regionalised pay had the anticipated impact on recruitment and retention this situation would worsen.

The panel thanked Ms Hancox for her attendance.

E. BRITISH MEDICAL ASSOCIATION

The panel welcomed Richard Griffiths, Industrial Relations Manager, British Medical Association (BMA). Mr Griffiths reported that –

(a) the BMA was well aware of the challenges facing the NHS, nationally, regionally and in Trusts locally. It remained the policy of the BMA to resist any erosion of terms and conditions of service. Any proposal which sought to undermine the application of national terms and conditions for doctors in the NHS was rejected as an inappropriate way of attempting to save costs and would not gain support at local or regional level;

(b) any attempt to diminish the terms and conditions currently applicable to medically qualified staff in the SW region would be counter-productive and a dangerous and unnecessary diversion for Trust Managers at a time when the cooperation and commitment of medical staff was an absolute necessity to the success and survival of many Trusts;

(c) whilst Trusts may wish to consider all the options available to them, the BMA strongly recommended that trusts concentrated on identifying operational savings through better management of existing resources rather than make attacks on the terms and conditions of members. It was not the terms and conditions which were the problem, but how they were managed;

(d) the BMA was not prepared to enter into any discussions with Trusts, either individually or collectively, by region or sub region, if proposals were detrimental to nationally agreed terms and conditions;

(e) the BMA would strenuously resist any attempts to undermine nationally negotiated terms and conditions at both local and regional levels;

(f) the BMA was prepared to be and had been actively involved in assisting Trusts to better manage the terms and conditions of medical staff at a local level;

(g) the BMA had seen the “Local Pay Compressor” suggestions of the Consortium in relation to Medical Staff and was struck by the poverty of thought with many of the suggestions amounting to unworkable proposals that had previously been rejected by both the Employers and BMA at national level;

(h) the dangers associated with all of the proposals far outweighed the benefits and the Trusts in the south west

should engage with Medical Staff through the established local negotiating committees to facilitate improved management of existing resources rather than attacking the terms and conditions in an attempt to get changes that simply will not be delivered but may end up being extremely destructive.

In response to question from members of the panel it was reported that –

(i) there would undoubtedly be a negative impact on patients;
(j) the proposals for medical staff would not deliver significant savings. Medical staff needed to be engaged in how to move organisations moved forward and deliver a 'best practice' organisations, those discussing possible proposals clearly had little experience in clinical management;

(k) the process that the consortium had embarked on was tactically inept. All trusts needed to consider the challenges that faced them. The terms and conditions debate had diverted attention away from the important work of service redesign.

The panel thanked Mr Griffiths for his contribution.

F. PLYMOUTH HOSPITALS NHS TRUST JSNC

Suzy Franklin representing the Derriford Hospital Joint Staff Negotiating Committee was welcomed to the meeting. Ms Franklin reported that unions had seen a significant rise in staff approaching them for advice and that it was felt that management were unable or unwilling to engage staff in the issue of regional pay.

In response to questions from the panel Ms Franklin reported that Union members had become aware of the Consortium and developing regional proposals following a Consortium press release. The work of the Consortium had damaged relations between staff and management but the Unions felt reassured that Ms James as the incoming Chief Executive would be working to address this.

The panel thanks Ms Franklin for her contribution to the meeting.

G. PLYMOUTH CHAMBER OF COMMERCE

The panel welcomed Carolyn Giles, representing the Plymouth Chamber of commerce. Carolyn reported that –

(a) there was a need to recognise that the Consortium were not just working on pay changes but that a number of options

were being considered;

(b) the AFC was not affordable and probably never had been. The pay system was out of step locally and the Local Economic Partnership had shown that NHS pay was 8-13 per cent higher than in the private sector;

(c) the NHS had to make changes and one of those options could result in a high level number of redundancies, less pay could be seen as a palatable alternative to no pay;

(d) should there changes to pay, terms and conditions there could be a significant impact on the money spent in the local economy;

(e) there was an excellent calibre of clinical staff working at Derriford. The result of regional pay could mean that more mobile members may not be retained by the Trust;

(f) issues around employee relations were a significant factor. If staff were to engage in industrial action it would have a significant impact on the private sector;

(g) AFC required urgent review and the management of existing term and conditions properly implemented;

(h) if regional pay was implemented it could lead to the loss of approximately £1.2bn from the regional economy.

In response to questions from members of the panel it was reported that –

(i) the implications of the implementation of regional pay in the South West would be felt across all sectors;

(j) it was not necessarily the case that the private sector would be able to fill the gap of job losses. There would be an element of competition through the 'Any Qualified Providers';

(k) any changes would have an impact, whether they are serious or significant depends on what proposals are accepted and implemented. A reduction in pay would undoubtedly have an impact;

(l) any drop in income of public sector workers would damage the income of small business and services. Tough decisions needed to be made.

The panel thanked Carolyn for her contribution to the meeting.

H. RECOMMENDATIONS

Following deliberations based on agenda papers and the testimony of the witnesses who attended the meeting, the panel agreed to recommend –

1. to Plymouth Hospitals NHS Trust (PHNT) that all staff are fully engaged in the consultation of any changes that affect them and their views demonstrably taken into account;

2. that PHNT formally considers the impact of any local pay scheme on the recruitment and retention of staff, particularly those with specialist skills;

3. that PHNT formally considers the impact of any local scheme on the city and sub-regional economy;

4. that the South West Pay, Terms and Conditions Consortium formally seeks the views of other key public sector employers in Plymouth and the sub-region as part of the wider consultation process;

5. that the South West Pay, Terms and Conditions Consortium and PHNT formally considers improved productivity, management and service redesign as an alternative to altering pay and conditions;

6. that PHNT ensures the existing appraisal and supervision arrangements are carried out with 100% of staff;

7. the panel notes the expenditure of seven million pounds on sickness absence within PHNT and requests the trust to produce an effective sickness/absence management strategy;

8. that PHNT formulates and publishes a response to the challenges raised in the staff survey;

9. that PHNT return to a future meeting of the panel to discuss progress against the above recommendations.

38. EXEMPT BUSINESS

There were no items of exempt business.

APPENDIX (Pages 1 - 4)

The case against a local and regional approach to pay, terms and conditions in the NHS

The BMA is opposed to any moves way from national terms and conditions of service for NHS staff. Such moves would have a significant negative impact on the NHS, staff and patients.

A national approach to contract negotiations for NHS staff is both efficient and fair. Any move to local and regional bargaining on pay and other terms and conditions of service (T and Cs) will lead to:

- the shared values and culture of the NHS being undermined
- additional costs through inefficient use of resources
- a demoralised workforce
- recruitment and retention problems
- over-complexity and inefficiency in the NHS labour market
- a reduction in service to patients

Furthermore, this issue is a costly and time consuming distraction from serious attempts to address the huge financial challenges facing the NHS. Rather than focusing resources on short-term measures that will incur additional costs and demoralise the NHS workforce, the emphasis should be on allowing staff and managers to work together on initiatives to improve quality and efficiency of service to patients.

Background

National pay, T and Cs in the NHS
Historically, the NHS' approach to determining pay and other T and Cs has been through regular national negotiations between Government, NHS management and the trade unions. Most recently, national contracts have been negotiated for the various components of the medical and dental workforce, whilst Agenda for Change is the national contract for most non-medical and dental NHS staff. Agenda for Change is the current NHS grading and pay system for all NHS staff, with the exception of doctors, dentists and very senior managers.

The benefits of a national system are clearly outlined in the Handbook to the NHS Constitution for England:

National pay policy for the NHS is designed to provide fair, affordable pay in order to recruit, retain and motivate staff for the benefit of patients and to provide value for money for taxpayers. It also provides a range of flexibilities, such as the opportunity for recruitment and retention premia, to ensure that individual employers have the ability to respond effectively to local circumstances, while retaining a consistent national pay framework that is transparent and ensures equal pay for work of equal value.

However, in the Chancellor's Autumn Statement in November 2011, it was announced that the independent Pay Review Bodies would be asked to consider how public sector pay can be made more responsive to local labour markets. In the health sector this included Agenda for Change staff but not doctors and dentists.

Developments in south west England

In summer 2012, 20 NHS trusts in south west England established themselves as the South West Pay, Terms and Conditions Consortium.

The trusts involved in the consortium are:

- Dorset County Hospital NHS Foundation Trust
- Poole Hospital NHS Foundation Trust
- The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
- Gloucester Hospitals NHS Foundation Trust
- Great Western Hospitals NHS Foundation Trust
- North Bristol NHS Trust
- North Devon Healthcare NHS Trust
- Plymouth Hospitals NHS Trust
- Royal Cornwall Hospitals Trust
- Royal Devon and Exeter NHS Foundation Trust
- Royal United Hospital Bath NHS Trust
- Salisbury NHS Foundation Trust
- Taunton and Somerset NHS Foundation Trust
- University Hospitals Bristol NHS Foundation Trust
- Weston Area Health NHS Foundation Trust
- Yeovil District Hospital NHS Foundation Trust
- 2gether NHS Foundation Trust
- Devon Partnership NHS Trust
- Somerset Partnership NHS Foundation Trust
- Dorset HealthCare NHS Foundation Trust

The consortium is looking to break away from national pay, T and Cs with a view to making substantial savings in order to meet the 'Nicholson Challenge'' of saving the NHS £20 billion by 2015.

The consortium's discussion document Addressing Pay, Terms and Conditions makes it clear that all staff, including medical and dental, are included in the scope of its work.

Proposals include:

- A 5% pay cut for staff earning over £55,000
- Increasing working hours and reducing annual leave
- A 'last resort' of terminating existing contracts and re-employing staff under new terms
- For senior hospital doctors, a reduction in Supporting Professional Activities - protected time to work on non-clinical activities that deliver improvements to quality and efficiency.

The consortium acknowledges that national negotiations are taking place for Agenda for Change staff but claims that progress is too slow, and there is no option but to look at making changes locally or regionally. The consortium will not be producing its business case for its proposals until the beginning of October and it is proposed that discussions in individual trusts will continue until end of 2012 and beyond.

The implications of these developments are considerable, as other regions across England could follow a similar path if definite moves are made to adopt local and regional pay and other T and Cs in the south west.

In August 2012, the BMA and other health unions, including the Royal College of Nursing and UNISON, refused to recognise the consortium, making clear that any talks on the pay and T and Cs for their members should continue under the recognised and well established national machinery.

Why a local and regional approach to pay and T and Cs in the NHS would waste resources

It would be inefficient

- The well-established machinery for national bargaining in the NHS ensures an efficient and cost-effective approach to negotiations on pay and T and Cs
- A model where different parts of the NHS negotiated separately would be wasteful, with duplication of effort, more bureaucracy and greater inefficiency

It would undermine the shared ethos of the NHS

- Staff on different pay and T and Cs in different geographical areas would no longer have the same sense of working for the a singe, integrated service
- It would be unfair and inequitable that staff doing the same job as colleagues elsewhere in the country should be paid less or have different terms of service
- It would be another step towards the fragmentation of the shared values and culture of the NHS, which is already under attack from wider changes to the NHS which seeks to increase the use of 'market forces'

It is short-sighted and undermines the benefits of clinical leadership

- What the consortium is proposing is very short-sighted. For example – one possibility that has been raised is a cut to consultants' Supporting Professional Activities –specially funded time they can devote to initiatives to improve quality. The projects that consultants work on in this time frequently improve productivity and save the NHS money

It could create local recruitment and retention problems

- Regional pay differences could result in migration of doctors to other areas with better pay offers
- Demoralised staff may also choose to leave the NHS or retire early, which would compound local retention difficulties and impact on patient services
- Regional pay will cause additional problems for juniors doctors who during the start of their career rotate regularly between different posts across geographical boundaries – if pay, terms and conditions vary greatly, it will cause unnecessary uncertainty and confusion, and potentially undermine their training
- Hospitals everywhere should be able to recruit and retain high-calibre staff. In a model where pay varies between regions, there is a risk that employers in

some areas would not be able to compete for staff on a level playing field with centres of excellence in big cities because these centres could offer more attractive remuneration. There could well be an impact on patient services if high-calibre staff could not be recruited or retained.

It would demoralise staff and lead to more industrial unrest

- Staff detrimentally affected by any imposed changes to national pay and T and Cs will be angered and demoralised, particularly after recent changes to the NHS pension scheme
- This could lead to a prolonged period of poor industrial relations, which would be a further distraction from the challenges of improving the delivery of care in a context of increasing restrictions on resources

It is unevidenced

- There is no clear evidence that introducing regional pay and T and Cs in the public sector would deliver greater efficiency or long-term savings. Indeed, the £200,000 already spent by the 20 Trusts on setting up the consortium could have been better spent on improving patient services

It could increase regional variations in clinical quality

- Many elements of national contracts for doctors were put in place with clinical quality in mind. Moving away from national contracts could risk greater variations in clinical quality for patients

There could be an impact on local economies beyond the NHS

- Worsening terms and conditions for healthcare staff could have an impact not just on the NHS, but on local economies more widely.

TRACKING RESOLUTIONS

Health and Adult Social Care Overview and Scrutiny Panel

Date / Minute number	Resolution	Explanation / Minute	Action	Progress	Target date
29/07/12 18 (1)	Agreed that the panel receive a progress report in three months which would include a focus on the Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis, Skills analysis and single sex facilities;	This recommendation relates to proposed changes to Mental Health Recovery Pathways.	Request information from Plymouth Community Healthcare	Briefing Circulated – If members require the item to return to panel please inform the Democratic Support Office.	22 November 2012
29/07/12 18 (2)	Agreed that a project plan would be circulated to members.	This recommendation relates to proposed changes to Mental Health Recovery Pathways.	Request information from Plymouth Community Healthcare	Briefing Circulated – If members require the item to return to panel please inform the Democratic Support Office.	22 November 2012
29/07/12	Agreed to receive a further update on the progress of the plan at a future meeting of the panel.	This recommendation relates to the updated Dementia Action Plan.	Further update would be provided to the panel at the January meeting of the panel.	Ongoing	January 2012
13/09/12 28 (1)	Plymouth Community Healthcare return to the panel in 12 months to update on progress;	This recommendation relates to capital investment in the Glenbourne Acute Psychiatric Unit.	Added to work programme		
13/09/12 28 (2)	a report on bed occupancy rates is provided to the panel in April;	This recommendation relates to capital investment in the Glenbourne Acute Psychiatric Unit.			

Date / Minute number	Resolution	Explanation / Minute	Action	Progress	Target date
13/09/12 28 (3)	a site visit is arranged for members to the Glenbourne Unit, to include a meeting with staff in the home treatment team.	This recommendation relates to capital investment in the Glenbourne Acute Psychiatric Unit.		Ongoing	
13/09/12 29 (1)	the Joint Risk Register is made available to the panel;	This recommendation relates to Public Health Transition into the Local Authority.		Completed	22 November 2012
13/09/12 29 (1)	the public health outcomes framework is distributed by the Democratic Support Officer.	This recommendation relates to Public Health Transition into the Local Authority.	Democratic Support to distribute	Complete	
13/09/12 30	that Shadow Health and Wellbeing Board minutes would be included on future scrutiny agendas	This recommendation follows an update on the developing Health and Wellbeing Board	Formal meeting minutes will be attached to all agendas by the Democratic Support Officer	Complete	N/A

Grey = Completed (once completed resolutions have been noted by the panel they will be removed from this document)
Red = Urgent – item not considered at last meeting or requires an urgent response

Plymouth Hospitals NHS
NHS Trust

Report for: Plymouth Health and Adults Overview and Scrutiny Committee

Report Topic: Improvements in Disabled Parking at Derriford Hospital

Report date: For 22nd November 2012

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1. Introduction

Parking their car is often the first experience patients and members of the public have of the hospital. It is therefore very important that the hospital's car parking facilities are appropriate and well managed to ensure visitors are not inconvenienced and are able to find a parking space which is appropriate for their particular needs. This is especially true for disabled drivers who represent a significant number of our car park user base.

The Trust implemented a new parking system in June 2012 which involved the installation of barrier controls, new payment options, the removal of staff from public spaces and improvements to the layout and condition of all car parks.

In planning the new parking arrangements the Trust consulted with two disabled forums; Plymouth Wheelchair Service User Group (PWSUG) and Plymouth Area Disability Action Network (PLYMDAN). The purpose of the consultation was to devise a solution that improved the parking experience for disabled drivers and increased the number of marked disabled bays. The forum recommended that an additional 42 disabled parking spaces be created in car park B behind the barrier control, as this part of the site was deemed to provide the most appropriate access to the Hospital.

However, whilst the hospital was committed to continuing to provide free parking for disabled drivers, it proved impossible to devise a simple means by which large numbers of cars could exit car park B without paying, whilst still being able to police the use of disabled spaces. As a result, the Trust had to revise its plan and installed the additional 42 disabled bays throughout all the non-barrier controlled areas of the site.

It is now clear that this solution does not meet the needs of disabled drivers, particularly those with limited mobility. It is leading to confusion as to which spaces are free and has led to numerous complaints.

2. Current Situation

The Trust has received a great deal of feedback from users of disabled parking facilities which can be summarised as:

- The signage is not good enough to differentiate between which spaces are free and not.
- There are not enough free disabled spaces for the public, causing them to use barrier controlled car parks where they have to pay.

- The new spaces in car park A are not usable by those with limited mobility or in wheelchairs
- Not all of the additional disabled parking bays are of adequate size.
- Members of staff who are disabled badge holders are using public spaces.
- Many of the new spaces are not near the main entrances to the Hospital, thus creating problems for people with limited mobility and those requiring use of a hospital wheelchair.

3. Changes to Improve Parking for Patients and the Public

Further work has been undertaken to identify solutions which better meet the goal of providing more free, full sized parking spaces for disabled badge holders which are near to the main entrance. The preferred solution, which is shown in Annex 1, is to:

- Build 42 new, full sized, level, disabled spaces on the bare land adjacent to car park F.
- Create a fully compliant path from the new spaces to join the existing pavement outside of the main outpatients department.
- Manage these new spaces as 'Patients Only' disabled spaces.
- Provide a wheelchair store in the new car park with 10 coin operated wheelchairs.
- Remove 16 disabled spaces currently in car park A and replace with 32 pay and display spaces.
- Maintain access to any parking space in a non barrier controlled car park by disabled badge holders for free.

4. Consultation

The Trust has sought the views of the 2 key stakeholder forums on this proposed solution and received very positive feedback to date. These comments are however based on drawings and a site visit is currently being organised which will allow group members to view the proposed site and experience the travel distances and gradients first hand. The visit should happen prior to the 22nd November and therefore further feedback can be provided at the meeting itself.

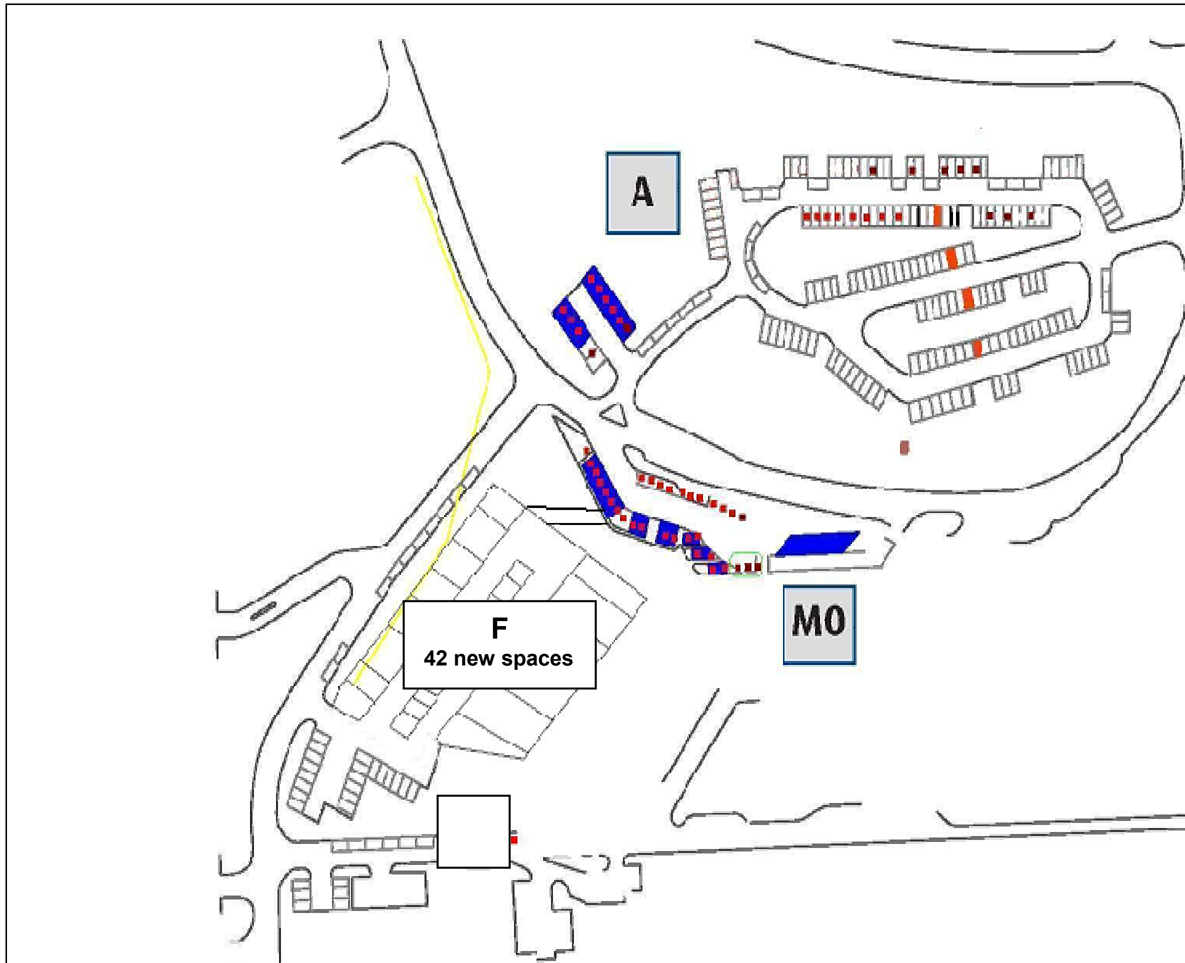
5. Planning Permission and Cost

The cost of this solution will be identified from capital funding sources in 2012/2013

The solution is subject to planning permission by Plymouth City Council, whose officers have offered their support in principle subject to a detailed planning submission.

Following the support of the OSC and receipt of appropriate planning permissions, the new facility will be completed by the end of March 2013.

Annex 1



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Ann James
Chief Executive,
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Democratic Support
Democracy and Governance

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Please ask for: Ross Jago

Date 2 October 2012 My Ref Your Ref

South West Regional Pay, Terms and Conditions Consortium

I am writing to thank you for your attendance at the meeting of the Health and Adult Social Care Overview and Scrutiny Panel on the 26 September 2012.

The meeting was organised in response to a full council motion agreed unanimously by all members of the city council, I have attached a copy for your information.

Although Plymouth City Council had resolved to resist any attempts to introduce local or regional pay schemes it was important that the Health and Adult Social Care Scrutiny Panel heard the rationale behind proposals being developed by the South West Regional Pay Consortium and the impact on patients, staff and the wider Plymouth and sub-regional economy.

Having considered your evidence and that of trade unions, the Plymouth Chamber of Commerce, Plymouth University the panel has made the following recommendations to Plymouth Hospitals NHS Trust Board and the South West Pay, Terms and Conditions Consortium.
The panel would like to reaffirm that Plymouth Hospital NHS Trust remains a key partner in delivering sustainable outcomes for our citizens and has a key role to play in delivering growth and reducing inequalities, particularly in health. I would like to thank you and your staff for a continuing commitment to the scrutiny process and I hope that we can continue with a high level of engagement which will provide quality clinical outcomes for patients.

Councillor Mrs Mary Aspinall
Chair Health and Adult Social Care Overview and Scrutiny Panel.

Plymouth Hospitals **NHS**
NHS Trust

Chief Executive
Level 7, Derriford Hospital, Plymouth, Devon PL6 8DH

Ann James
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Date: 19th October 2012

Councillor Mrs Mary Aspinall
Chair, Health and Adult Social Care Overview and Scrutiny Panel
Plymouth City Council
Civic Centre
PL1 2AA
Plymouth

Dear Mary

SOUTH WEST REGIONAL PAY, TERMS and CONDITIONS CONSORTIUM

Thank you for your letter of 2 October, following my attendance at the Health and Adult Social Care Overview and Scrutiny Panel on the 26th September 2012.

Taking into account that I took up my post as Chief Exectuive one week before appearing before the Overiew and Scrutiny Panel, I was keen to hear the range of views about the issues and potential impact of Plymouth Hospitals Trust's participation in the South West Pay, Terms and Conditions Consortium (the Consortium). I thought that many of the points raised by the panel and by union colleagues were very well made and wish to re-iterate that the Board and I will take all of these comments into consideration, once the Consortium have developed its proposals, which are anticpated to be available towards the end of this year.

I appreciate the panel's recommendations made in your letter, and would like to update you on the issues raised therein, which I have done in the same order as set out in your letter.

(1) *All staff are fully engaged in the consultation of any changes that affect them and their views demonstrably taken into account;*

I have established an open communication link with staff to get their views and allow them to raise their issues directly with me. In this regard, I can confirm that we have received 60 emails, which have all been addressed and have established engagement sessions with all levels of staff over the next eight weeks, to ensure communication is open and staff are fully engaged in terms of this matter.

(2) *PHNT to formally consider the impact of any local pay scheme on the recruitment and retention of staff, particularly those with specialist skills;*

We, like other Trusts, have said previously that once we have proposals to consider, we will conduct a detailed risk assessment which would include the impact on a range of issues, including recruitment and retention.

(3) *PHNT to formally consider the impact of any local scheme on the city and sub-regional economy;*

I wish to re-iterate that as a large, responsible employer, the impact of any of the proposals made by the Consortium will be carefully considered by our Board, while we will obtain the input and feedback from our staff.

(4) *The South West Pay, Terms and Conditions Consortium should formally invite and seek the views of other key public sector employers in Plymouth and the sub-region as part of the wider consultation process;*

Whilst it is unlikely that the Consortium will engage centrally with all the cities and areas within the South West, as it has no legal standing, I am happy to engage with Plymouth City Council on the proposals received and the decision taken by our Board following discussions with our staff.

(5) *The South West Pay, Terms and Conditions Consortium and PHNT to formally consider improved productivity, management and service redesign as an alternative to altering pay and conditions;*

Locally, as a Trust, we are doing this as part of our day to day business, cost savings plans, continuous improvement plans and clinical strategy work.

(6) *PHNT to ensure the existing appraisal and supervision arrangements are carried out with 100% of staff;*

In terms of the Trust HR&OD Strategy an annual target of 90% has been set, as there will always be some staff who are on long-term sick, and based on the statistics of other NHS organisations in England and Wales, whilst we are endeavouring to improve our current rate of 80%, to get this to 100% is unlikely. I am however, happy to report back on progress made, when I return to the Panel in December.

(7) *Given the expenditure of seven million pounds on sickness absence within PHNT, the Trust is requested to produce and publish an effective sickness/absence management strategy;*

I am very pleased to confirm that, since I appeared before the Panel and in line with the Trust's HR&OD Strategy, a Staff Health and Wellbeing Steering Group was formed, consisting of representatives from staff-side and management, including both the nursing and clinical bodies in the Trust, and will pro-actively work towards the development of an effective Employee Health Strategy. Sickness absence management will form part of that work.

(8) *PHNT to formulate and publish a response to the challenges raised in the staff survey;*

We will continue, as in the past, to publish a summary of the survey results, including the key messages, through the work done by the Human Resources and Communications Department.

(9) *PHNT to return to a future meeting of the panel to discuss progress against the above recommendations.*

As indicated during our meeting, I am looking forward to returning to the panel in December to provide an update on the above and any other issues relevant at that time.

I trust the above would be in order and would like to re-iterate my appreciation to the Council for its continued interest as a key partner of this Trust.

I am looking forward to meeting with you in December 2012.

Yours sincerely

Ann James
Chief Executive

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Plymouth Hospitals NHS
NHS Trust

Report for: Plymouth Health and Adults Overview and Scrutiny Committee

Report Topic: Never Event Update Report

Report date: 12.11.2012

Author(s): Alex Mayor, Medical Director
Amelia Brooks, Patient Safety Manager

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1. Background

The Plymouth Health and Adults Overview and Scrutiny Committee (POSC) last received a report on Never Events from Plymouth Hospitals NHS Trust (PHNT) in July 2011.

Since July 2011, PHNT has reported 3 Never Events as below:

Incident Category	Reported Date	Investigation Status
Retained foreign object post procedure	28.09.2012	Ongoing
Wrong site surgery	25.07.2012	Complete
Maladministration of insulin	26.09.2012	Ongoing

The above incidents were escalated as 'Never Events' to NHS Plymouth and the South of England Strategic Health Authority (SWSHA) at the earliest opportunity. All patients and families affected have received a full apology from the Trust.

Where a serious incident (including Never Events) has occurred, a full investigation is conducted to identify all immediate actions required to ensure ongoing safety and potential learning opportunities. Patients and families are asked to participate in this process and will often contribute to the investigation and design of solutions to prevent future incidents. Every never event has an associated safety improvement programme.

The prompt escalation and reporting of these incidents is a good indicator of a strong safety culture at PHNT - we actively encourage all of our staff and patients to report areas of concern because all of these incidents will provide learning so we can continue to improve the safety we provide to patients.

Plymouth Hospitals NHS
NHS Trust

2. Never Event Summary:

Incident Summary:

Retained foreign object post procedure. The patient has received a full apology from the Consultant Surgeon.

Investigation Summary:

The investigation is ongoing at this time and is being led by a senior clinical investigator.

Immediate Actions Taken:

The following actions have already been implemented. Further actions will be added once the investigation is complete.

- Immediate changes to practice implemented within operating theatres to ensure all surgeons and theatre teams are aware of the incident and of the associated risks
- Gall bladder collection bags to be included in the swab count with immediate effect

3. Never Event Summary:

Incident Summary:

Wrong site surgery.

Investigation Summary

The investigation) is complete and has been approved by the South of England Strategic Health Authority.

Immediate Actions Taken:

The following actions have already been implemented.

- Immediate changes to practice implemented within operating theatres to ensure all surgeons and theatre teams are aware of the incident and of the associated risks.
- Immediate changes to practice to ensure that all procedures (excepting specified exclusions) are appropriately marked and that appropriate checks are in place to confirm this.

4. Never Event Summary:

Incident Summary:

Maladministration of insulin.

Investigation Summary

The investigation of this adverse event (Never Event) is being led by a senior clinician and is ongoing at this time.

Immediate Actions Taken:

The following actions have already been implemented. Further actions will be added once the investigation is complete.

- Immediate changes to practice implemented within Emergency Department (ED) to ensure verbal instructions for administration of medicines are not in use – NMC Guidelines reiterated
- Inpatient Diabetes Team have provided immediate support to ED and further education sessions have been booked
- All medical and nursing staff within ED to complete NHS Diabetes Safe Use of Insulin E-learning package
- Apology and explanation given to patient's family and followed up in writing on 28th September 2012
- Insulin e-learning package developed to educate all clinical staff on issues arising from this adverse event

5. Improvement Plans

The investigation and subsequent learning for each Never Event has been incorporated into Trust-wide Patient Safety Improvement Programmes. The Trust has established a Surgical Safety Improvement Programme (led by the Assistant Medical Director) and a Safe Use of Insulin Improvement Programme (led by the Clinical Director for Medicine) to ensure that the recommendations and actions identified through investigation are monitored until point of completion.

The Trust's Safe Care Group (chaired by the Medical Director) currently monitors these improvement programmes on a monthly basis. A monthly report is also provided to the Trust's Safety and Quality Committee and further updates are provided to the Trust Board on a regular basis (last update 9th November 2012).

6. Surgical Safety Checklist Update

PHNT recognises that two of the aforementioned Never Events occurred in a surgical setting and may appear to relate to previously reported incidents. Investigation has identified that the two recent surgical Never Events were not attributable to poor compliance with the Surgical Safety Checklist.

PHNT continues to perform the Surgical Safety Checklist to a very high standard and collects a combination of qualitative and quantitative data to support this and continue to drive improvement. Learning identified by PHNT in this domain has been shared regionally and nationally. The Trust was recently 'highly commended' in the National Patient Safety Awards 2012 for this work.

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Health and Adult Social Care Overview and Scrutiny Panel

Work Programme 2012/13

Topics	J	J	A	S	O	N	D	J	F	M	A	13 /14
Health Integration Programme												
Healthwatch		**19**										
Health and Wellbeing Board / Joint Strategic Needs Assessment (JSNA) / Joint Health and Wellbeing Strategy (JHWBS)				**13**					**28**			
Government Policy Changes (updated as announced)												
Public Health Transition				**13**				**24**				
Joint Priorities												
Alcohol Strategy (Task and Finish)						**X**						
Dementia Strategy		**19**						**24**				
Safeguarding Vulnerable People (review of recommendations)								**24**				
NHS Devon Cluster Primary Care Trust												
NEW Devon, Clinical Commissioning Group (Western Locality)												
Commissioning Intentions						**22**						
Plymouth NHS Hospitals Trust												
Hospital Discharge Process (TBC)												
Winter Planning						**22**						
Car Parking						**22**						
Foundation Trust Business Case (Date TBC by PHNT)												

Topics	J	J	A	S	O	N	D	J	F	M	A	13 /14
Plymouth City Council – Adult Social Care												
Social Care Transformation Programme								**24**				
Plymouth Community Healthcare												
Capital Investment in Glenbourne Unit				**13**							**11**	**X**
Recovery Pathways (Mental Health Service)		**19**				**22**						
Performance Monitoring												
Adult Social Care								**24**				
Quality Accounts											**11**	
Referred by Local Involvement Network												
Services for Gypsies and Travellers (TBC)												