Brighton & Hove City Council

Health Overview & Scrutiny Committee

Title:	**Health Overview & Scrutiny Committee**
Date:	**15 July 2020**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall**
Members:	**Councillors:** Deane (Chair), O'Quinn (Group Spokesperson), McNair (Group Spokesperson), Barnett, Brennan, Grimshaw, Hills, Lewry, Osborne and Powell **Co-opted Members:** Zac Capewell (Youth Council), Caroline Ridley (Community Sector Representative), Fran McCabe (Healthwatch), Colin Vincent (Older People's Council)
Contact:	**Giles Rossington** Senior Policy, Partnerships & Scrutiny Officer 01273 295514 giles.rossington@brighton-hove.gov.uk

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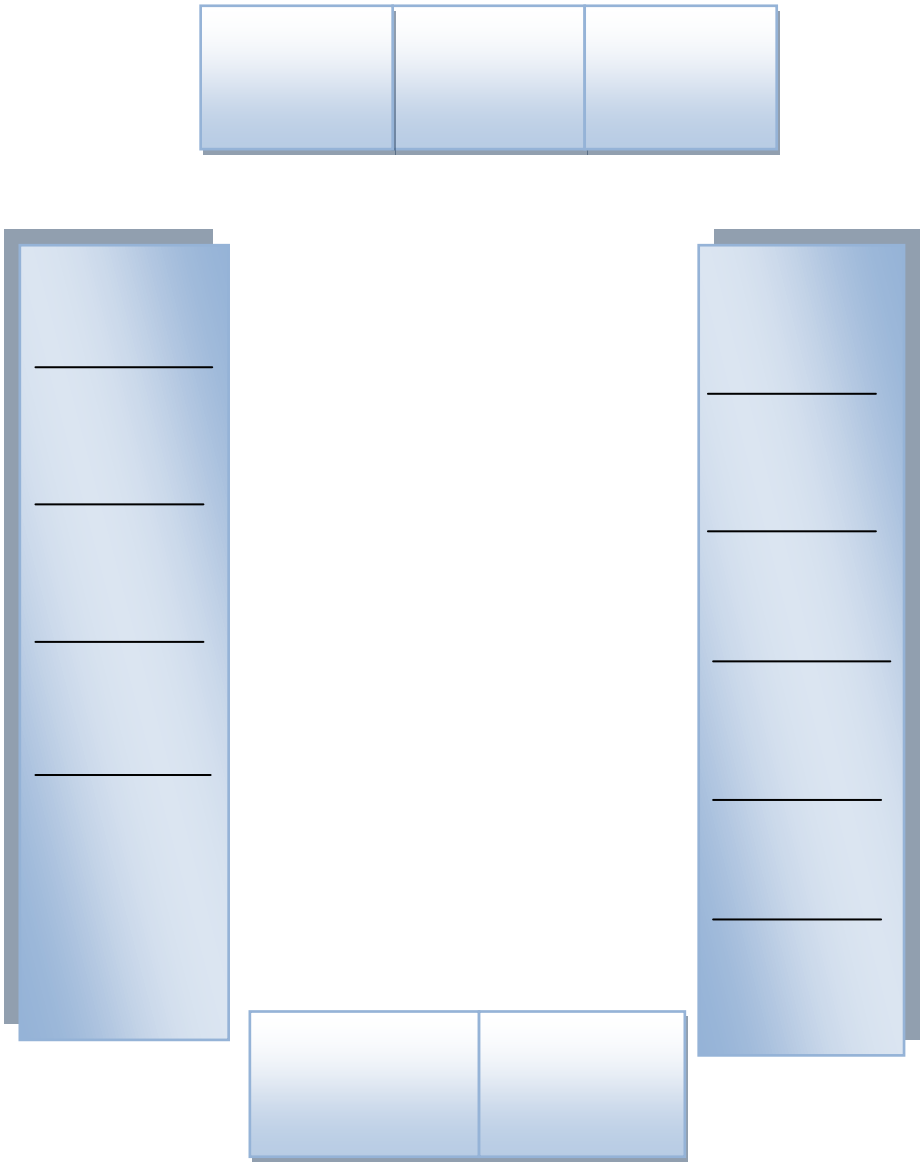
Democratic Services: Health Overview & Scrutiny Committee



AGENDA

PART ONE **Page**

1 PROCEDURAL BUSINESS

(a) **Declaration of Substitutes:** Where Councillors are unable to attend a meeting, a substitute Member from the same Political Group may attend, speak and vote in their place for that meeting.

(b) **Declarations of Interest:**

(a) Disclosable pecuniary interests;
(b) Any other interests required to be registered under the local code;
(c) Any other general interest as a result of which a decision on the matter might reasonably be regarded as affecting you or a partner more than a majority of other people or businesses in the ward/s affected by the decision.

In each case, you need to declare:
(i) the item on the agenda the interest relates to;
(ii) the nature of the interest; and
(iii) whether it is a disclosable pecuniary interest or some other interest.

If unsure, Members should seek advice from the committee lawyer or administrator preferably before the meeting.

(c) **Exclusion of Press and Public:** To consider whether, in view of the nature of the business to be transacted, or the nature of the proceedings, the press and public should be excluded from the meeting when any of the following items are under consideration.

NOTE: *Any item appearing in Part Two of the Agenda states in its heading the category under which the information disclosed in the report is exempt from disclosure and therefore not available to the public.*

A list and description of the exempt categories is available for public inspection at Brighton and Hove Town Halls and on-line in the Constitution at part 7.1.

2 MINUTES **7 - 18**

To consider the minutes of the previous Health Overview & Scrutiny Committee meeting held on 22 January 2020, (copy attached).

3 CHAIR'S COMMUNICATIONS

4 PUBLIC INVOLVEMENT 19 - 22

To consider the following items raised by members of the public:

(a) **Petitions:** To receive any petitions presented by members of the public to the full Council or to the meeting itself;
(b) **Written Questions:** To receive any questions submitted by the due date of 12noon on the 10 July 2020.
(c) **Deputations:** To receive any deputations submitted by the due date of 12 noon on the 10 July 2020.

5 MEMBER INVOLVEMENT

To consider the following matters raised by Members:

(a) **Petitions:** To receive any petitions submitted to the full Council or to the meeting itself.
(b) **Written Questions:** A list of written questions submitted by Members has been included in the agenda papers (copy attached).
(c) **Letters:** To consider any letters submitted by Members.
(d) **Notices of Motion:** To consider any Notices of Motion.

6 PRESENTATION FROM HEALTHWATCH BRIGHTON & HOVE ON THE COVID 19 CRISIS 23 - 34

Presentation from the Chief Executive of Healthwtach Brighton & Hove on Healthwatch activities and patient experience during the Covid crisis (slides attached).

7 PRESENTATION FROM BRIGHTON & HOVE CLINICAL COMMISSIONING GROUP (CCG) AND BHCC HEALTH & ADULT SOCIAL CARE (HASC) ON THE COVID 19 CRISIS

(verbal presentation)

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OVERVIEW & SCRUTINY COMMITTEE

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Date of Publication - Tuesday, 7 July 2020

BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00pm 22 JANUARY 2020

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Deane (Chair)

Also in attendance: Councillor Barnett, Evans, Grimshaw, Hills, McNair, O'Quinn, Powell and Hugh-Jones

Other Members present: Fran McCabe (Healthwatch), Colin Vincent (Older People's Council)

PART ONE

22 APOLOGIES AND DECLARATIONS OF INTEREST

22.1 There were apologies from the Brighton & Hove Youth Council and from Caroline Ridley, Community & Voluntary sector representative.

22.2 Cllr Siriol Hugh-Jones attended as substitute for Cllr Tom Druitt.

22.3 There were no declarations of interest.

22.4 It was agreed that the press & public should not be excluded from the meeting.

23 MINUTES

23.1 RESOLVED – that the minutes of the 16 October 2019 meeting be agreed.

24 CHAIRS COMMUNICATIONS

24.1 The Chair explained that the local response to the NHS Long Term Plan (LTP), the Sussex Health & Care Plan, was currently being finalised and could therefore not be discussed at this meeting. The definitive plan will be considered at the 18 March 2020, whilst the slot at the current meeting would be used to explore the general principles underpinning the LTP.

24.2 Cllr Barnett informed committee members that she and Cllr Grimshaw had recently visited Lindridge Nursing home to look at the home's rehabilitation beds. She was pleased to report that she thought that provision is excellent: care was of a very high standard; re-ablement was being offered; the food was very well presented. The

dementia beds were also excellent, and in general lots of thought had gone in to making residents feel at home. Cllr Barnett now felt reassured that the closure of the intermediate beds at Knoll House would not have a detrimental impact on rehabilitation. Cllr Grimshaw agreed that the home was really impressive.

25 PUBLIC INVOLVEMENT

25(A) Janet Sang:

25.1 Ms Sang asked the following question:

"My understanding is that each Integrated Care Provider-Partnership central to the Long Term Plan will commission health and social care, and will have a contractually-capped budget based on per capita funding. If that is the case, two issues arise.

Firstly what concerns does HOSC have about the care of those not registered in participating GP practices?

Secondly, what will happen should the needs of the population exceed what can be provided within that budget?

If my understanding is not correct, please explain what is the funding and provision model enshrined in the Long Term Plan."

25.2 The Chair responded:

"I've asked the CCG about this matter and they have informed me that the NHS LTP does not in fact prescribe that commissioning organisations will use a capitated payments model when contracting with an ICP. In fact, there is no prescribed form for the way that partnerships are developed locally outside of ensuring that whatever is delivered is fit for purpose in addressing health inequalities. The focus is on developing programmes for change against some of the identified priority areas and being effective in the way partners in the Brighton and Hove health and care system work together. Any decision made about how partnership working develops will be based upon how best to deliver these programmes; how outcomes can most effectively be improved for the population as a whole; and how this can be done within the funds made available across health and social care.

Your question raises important points about future contract models. I don't believe that we can answer them now but they will become relevant as local thinking about the way organisations work formally as partners develops and we will certainly use them to inform our scrutiny.

We are clear, however, that any model which is developed in Brighton and Hove will need to be based upon providing health and care for the whole population and will include those who are "normally resident" as well as those who are registered with a GP."

25.3 Ms Sang asked a supplementary question:

"Risk and reward sharing is a key feature of the policy agenda for Accountable Care Organisations in the US and Integrated Care Systems in England. The Integrated Care Systems/Partnerships already rolled out by NHS England appear to adopt mainly a model of risk/reward or "gain/loss sharing" which offers a financial reward to limit health care.

What are HOSC's views on this culture of "managing" health-care demand for financial gain, and on its relation to the fundamental values of the NHS?"

25.4 The Chair thanked Ms Sang for her supplementary question. She agreed that any move to a model that rewarded health providers for under-treating patients would be troubling. Future scrutiny of the Long Term Plan will consider this issue.

25(B) Judith Anston

25.5 Ms Anston asked the following question:

"In B&H we have 1 GP for every 2,526 residents. This is one of the worst ratios in the country, the national average being 1 GP to 1,780 patients. (March 2019 figures, from FOI provided by B&H CCG)

Does the Long Term Plan address the need for more GPs in the city? Fewer surgeries is making it harder for some communities to access appointments, and access to less qualified staff is propping up provision: is the Long Term Plan undermining primary care?"

25.6 The Chair responded:

"Thank you for your question.

We are not yet in a position to say precisely what the Sussex Health & Care Plan, the local response to the NHS Long Term Plan, contains. The Sussex Plan should be published soon and the HOSC will seek to scrutinise it in some detail, starting at our March meeting.

I do share your concerns about city GP services, as I'm sure do other committee members, and the HOSC will look closely at what the Sussex Health & Care Plan has to say about developing city provision.

I recognise that there are valid concerns about access. GP practices are not evenly spread across the city, with a particular scarcity of provision in East Brighton and in Hangleton. This is a long-term issue, but has been exacerbated by recent Practice closures and mergers. Whilst it is important to recognise that larger practices can offer real benefits to patients as well as offering a sustainable business model, the question of access is an important one and something that the HOSC will focus on when it scrutinises plans for primary care in the city.

The HOSC will also want to focus on the use of a wider range of clinical professionals by GP practices. This can have real advantages, perhaps particularly in terms of patients being able to access really expert pharmaceutical advice or physiotherapy

services from their GP practices. It also needs to be recognised that there is a national shortage of GPs and that there is no easy fix. However, it is crucial that the quality of care provided by GP practices is maintained and improved going forward, and the HOSC will certainly want assurance that any plans to diversify practice staff-mix have a robust evidence-base and are closely monitored to ensure that quality does not fall."

25.7 Ms Anston did not have a supplementary question, but did wish to note that most patients choose to register with their nearest GP as they value proximity of other issues. Any move to a model with fewer GP practices will therefore run counter to what patients want from GP services.

25(C) Valerie Mainstone

25.8 Ms Mainstone asked the following question:

"It is recognised that there has been a dramatic increase in the number of people who are struggling with their mental health: an increase due, at least in part, to the politics of austerity. It is worth recalling Aneurin Bevan's question "Why is it that in times of economic crisis the working class is made to bow its knee to the needs of capital?"

The funding of our Child Mental Services is the lowest in Western Europe. Up to 70%of those sleeping in our streets suffered a traumatic childhood, necessitating their being received into the care of the Local Authority.

The British Medical Association states that mental health workers are overworked, demoralised, and forced to deliver a compromised service. How will the Long Term Plan improve mental health services in Brighton, Hove and Portslade?"

25.9 The Chair responded:

"I do agree that mental health services are very important, and that they have not historically received all the attention they should. This is a national problem, but a particular issue locally: Brighton & Hove has worryingly high levels of people with mental health conditions, including young people. This is reflected in local suicide and self-harm rates.

The HOSC will certainly be looking to see what the local response to the NHS LTP is proposing to do to improve mental health services for city residents and to improve preventative services so that fewer people develop problems in the first place. We will expect to see really ambitious planning backed with a level of funding that recognises that high needs in the city.

We have also got a report on the recent Sussex-wide review of young people mental health services coming to this committee in March. Again, I would expect to see robust planning to improve services for children and young people, including better and timelier access into services."

25(D) Pat Kehoe

25.10 Ms Kehoe asked the following question:

"Is HOSC concerned that the recent raising of treatment thresholds and rationing of services is preparing the way to provide restricted budgets for Integrated Care Partnerships, irrespective of the care that is actually needed?"

25.11 The Chair responded:

"It is clear that there is considerable local concern about NHS plans to limit access to particular medical procedures, whether this is about ceasing to use particular treatments, limiting or delaying access to treatments, or raising the threshold for referral.

It does need to be recognized that there may be good reasons for these actions: as our understanding of medicine increases, we may find that some treatments are ineffective or even damaging or that they benefit only a proportion of patients. The NHS does need to regularly review the clinical basis for what it does and to act on the latest evidence.

The NHS Clinically Effective Commissioning programme, which is what I think the question is referring to, has been presented by NHS commissioners as just this type of review of the evidence base to ensure that all procedures are based on the best possible clinical evidence and not as an attempt to save money or to restrict spending in preparation for ICPs or any other change.

I do recognize that there are valid concerns about whether this type of initiative is clinically rather than financially led. I am confident that the evidence base for many of the Clinically Effective Commissioning changes was compelling, but I will ask CCG colleagues to provide the HOSC with some more information, set out in terms that are accessible for lay people, about some of the tranche 2 decisions that have caused local concern, specifically changes to the thresholds or treatment pathways for some orthopaedic surgery. This will be reported at a HOSC meeting later this year."

25.13 Ms Kehoe asked a supplementary question, enquiring when tranche 3 of the Clinically Effective Commissioning Programme would be published. The Chair responded that no date has as yet been communicated to the HOSC. Tranche 3 is on the work programme and will be scrutinised as soon as possible.

25(E) Liz Williamson

25.12 Ms Williamson asked the following question:

"In a recent meeting of the full council, concern was expressed about the democratic deficit which was illustrated by the CCG outvoting the elected members on the HWB on the fundamental issue of the Long Term Plan and Integrated Care. One Member went as far as to say it was simply a rubber stamping exercise.

This meeting followed a recent report on the Population Health Check in Brighton and Hove which revealed a lamentable 1.8% of the population were consulted. This statistic is even more concerning since the population is expected to increase by a further 6% by 2026.

This democratic deficit experienced by both Council members and the local citizens of Brighton and Hove could be addressed in the form of a people's or citizen's commission on health and social care which would be under-pinned by the political will and support of the Council and which would provide Council Members with detailed information that would inform the decision making processes. Will the HOSC propose this more progressive and meaningful consultation drawing on the expertise of a wider group of people in Brighton and Hove with the knowledge and experience of health and social care?"

*Office of National Statistics estimate for population was 287,200 in 2016 with an estimated rise of 6% until 2026 reaching 304,300.

25.13 The Chair responded:

"I would be happy to discuss ways for the HOSC to engage with a people's commission on health and social care. For clarity though, I think it's important to note that the council has a very limited budget for engagement across many areas. I'm therefore not in a position to promise any kind of financial or administrative support.

I would be happy to arrange a meeting with you to further discuss your plans."

25.14 Ms Williamson asked that, if the HOSC is unable to establish a health commission, it should refer the matter to Full Council.

25(F) Linda Miller

25.15 Ms Miller asked the following question:

"Our local hospital is very short of staff. From the figures supplied by BSUH it appears we currently need 512 more nurses and 43 more consultants.

How does the CCG's Sussex Health and Care Plan address the shortfall of staff at our local hospital? Will the CCG's long term planning result in a sufficient number of nurses and doctors to serve our population? How can our local healthcare service improve if there isn't the staff to provide it?"

25.16 The Chair responded:

"Thank you for your question.

I share your concern at the very high number of medical and nursing vacancies at BSUH and would further note that vacancy levels at the Trust and at other local NHS trusts have been worryingly high for a long time. The local health and care system has long-standing issues with the recruitment and retention of staff, something that has been acknowledged by system leaders.

We will wait and see what impact Brexit has on the local NHS workforce situation, but nationally there has been a very significant fall in nursing applications from Europe following the Brexit decision.

I would also like to note the negative impact that the decision to end nursing bursaries has had. Political groups on the Council unanimously supported the partial reintroduction of bursaries last year.

We don't yet know the content of the Sussex Health & Care Plan, but I think you are quite right to identify workforce as a key element in any improvement planning. The HOSC will certainly seek assurances that the Plan addresses these longstanding issues of recruitment and retention as well as the allied performance issues that mean local people often have to wait much longer than they should for both emergency and planned healthcare, with Brighton & Hove residents currently having to wait longer than anyone else in England for planned operations. We know that the 3Ts development at the Royal Sussex Hospital will help with some of these performance issues, but the system clearly needs to find some effective workforce solutions also.

This is something that I hope NHS colleagues can begin addressing at today's meeting when we have a presentation on the NHS Long Term Plan – I have forwarded your question to them. It is also definitely an area we will address at the March HOSC meeting when we will begin scrutinising the definitive Sussex Health & Care Plan"

25.17 As a supplementary question Ms Miller asked what the HOSC would do if members were not satisfied with the workforce measures set out in the Sussex Health & Care Plan. The Chair assured her that this issue would be robustly pursued by the HOSC.

26 MEMBER INVOLVEMENT

26.1 There were no member questions.

27 HEALTHWATCH BRIGHTON & HOVE ANNUAL REPORT 2018-19

27.1 This item was introduced by David Liley, Chief Executive of Healthwatch Brighton & Hove (HW).

27.2 Mr Liley introduced the HW annual report. In the past year HW has:

- Sat on a number of bodies and committees
- Focused on service reviews and service 'audits'
- Begun measuring the impact of HW projects by looking at what percentage of HW recommendations are implemented (this is now around 75% from around 30% in HW's first year of operation)
- Continued to do good work despite reduced funding, in large part due to the dedication of volunteers. Coping with reduced funding is a challenge, but HW recognises that this is a period of austerity and that many local HW organisations have seen deeper cuts to their budgets.
- Made a number of recommendations to health and care commissioners and providers, but would particularly point to its work in improving the environment in A&E and in care homes.

27.3 In response to a question from Cllr McNair on the challenges of recruiting volunteers, Mr Liley told members that volunteer numbers vary from year to year. HW is actively seeking to broaden its recruitment, working with city universities and voluntary organisations, advertising opportunities, and reaching out to GP practice Patient Participation Groups (PPGs).

27.4 In answer to a query on provider resistance to HW conducting 'enter & view' visits, Mr Liley noted that there has been surprisingly little resistance. HW does have statutory powers to enter & view but has never had to use these powers.

27.5 Mr Liley told the committee that the quality of food provided in hospital settings remains a concern: everyone in the system wants hospital food to improve, and BSUH does have a positive history of responding to HW recommendations, so it is hoped that more progress will be made.

27.6 In response to a question from Cllr Powell on the provision of lockers for in-patients at the Royal Sussex County Hospital, Mr Liley was unable to provide details of the relevant HW report at the meeting, but agreed to provide a written response.

27.7 In answer to questions from Cllr O'Quinn on HW's work on oral health in care homes, Mr Liley told members that HW has not yet re-visited homes so it is unclear to what degree its recommendations have been implemented. The Care Quality Commission (CQC) is aware of HW's work on this issue, and indeed uses it as an example of best practice, so this is something that the CQC may itself pick up during future inspections.

27.8 Mr Liley told the committee that many local HW organisations conduct multiple visits to care homes. However, this is not necessarily an effective use of resources; the HW Brighton & Hove approach is to share intelligence with the CQC and with commissioners and to undertake targeted interventions where specific concerns have been raised.

27.9 Mr Liley told members of the excellent work undertaken by Young Healthwatch, with support from the YMCA; highlighting a forthcoming report on sexual health services and the work that Young Healthwatch has done to make safeguarding information more accessible to young people.

27.10 In response to a question from Cllr Knight on mapping inequalities, Mr Liley told members that HW does undertake diversity and equalities impacts on all projects, but there is more that could be done here. However, HW has limited resources.

27.11 In answer to a question from Cllr Grimshaw on HW 'Listening Labs', Mr Liley told members that these tend to be held around specific issues and may be in advice centres, YMCA centres, or delivered on the street. Mr Liley agreed to send Cllr Grimshaw more information on this.

27.12 Cllr McNair noted the high user satisfaction with city GP services. Mr Liley remarked that the latest GP survey results show even stronger satisfaction despite significant issues, particularly in terms of access.

27.13 In response to a question from Cllr Powell about HW links with the community & voluntary sector (CVS), Mr Liley told members that HW was very well-linked with the local CVS and also with HW organisations across Sussex. Mr Liley also suggested that the HOSC might wish to look at how effective BHCC and NHS engagement is with 'hard to reach' communities. Cllr Powell agreed, noting that it might also be useful to look at the accessibility of some hospital settings.

27.14 In answer to a query from Colin Vincent as to whether HW had ever escalated local issues to Healthwatch England or to the Secretary of State for Health, Mr Liley confirmed that some issues had been escalated: e.g. Sussex Patient Transport Services and Personal Independence Payments.

27.15 The Chair asked which issues HW would advise the HOSC to scrutinise, and Mr Liley suggested the following:

- GP practice sustainability and the sustainability of the Primary Care Network (PCN) model;
- Acute healthcare performance against national targets
- Complaints & Advocacy (e.g. how to make the system less complex)
- Unregulated (i.e. not regulated by the CQC) social care services: e.g. high support housing;
- Equalities and engagement
- End of life care.

28 THE SUSSEX HEALTH & CARE PLAN - LOCAL RESPONSE TO THE NHS LONG TERM PLAN

28.1 This item was introduced by Ashley Scarff, CCG Director of Partnerships and Commissioning, and by Lola Banjoko, CCG Managing Director (South). Ms Banjoko noted that the local response to the NHS Long Term Plan (LTP), the Sussex Health & Care Plan (SHCP), is a system response, involving all local NHS Trusts and commissioners, but also local authorities and the community & voluntary sector (CVS).

28.2 The key objectives of the SHCP are:

- To reduce health inequalities.
- To improve outcomes.
- To be person-centred.
- To accurately reflect local need – the local plan is informed by the Joint Strategic Needs Assessment and the Brighton & Hove Joint Health & Wellbeing Strategy (JHWS). The main areas of SCHP focus, cancer, multiple long term conditions, children & young people, and mental health, are also the main issues facing Brighton & Hove as identified by the JHWS.
- Better utilising local assets, including CVS capacity, via social prescribing.
- More joined-up working (e.g. the local homeless care pathway).
- Better use of workforce (e.g. reducing duplicated visits to care homes)
- Using data and digital to underpin improvement (e.g. South East Coast Ambulance Trust should be able to access people's care plans/end of life plans when responding to emergency calls.

- Delivering a shared vision with partners working positively together.
- To deliver as much care as possible via 'neighbourhoods', with 30-50,000 populations. These represent the smallest unit that can realistically sustain a range of community and primary health services, care services and services linked to the wider determinants of health such as housing. Neighbourhoods represent the fundamental planning block for both the SHCP and the JHWS.
- To deliver primary health services via a Primary Care Network (PCN) for each Neighbourhood. PCNs will help support GP Practice resilience, a key issue given intense workforce pressures currently being experienced. They will also collectively provide services such as physiotherapy and social prescribing, advancing the LTP's preventative agenda and transferring activity away from the acute sector.
- To develop the Sussex Health & Care Partnership on a Sussex-wide footprint, reflecting the fact that all local NHS Trusts work across local authority areas. The Sussex Health & Care Partnership will bring commissioners and providers of health and care together to plan services, spread good practice and work together to improve delivery.

28.3 Mr Scarff noted that the LTP introduces no new organisations or entities. This is about existing organisations working together in different ways.

28.4 In response to a question from Cllr Hugh-Jones, Ms Banjoko confirmed that all city GP practices have chosen to join a PCN. The LTP does not mandate the consolidation of GP practices, although practices within a PCN might opt for consolidation if it increased their sustainability.

28.5 In answer to a query from Cllr Hugh-Jones on data integration, Ms Banjoko acknowledged that the NHS had a patchy history with major IT projects. However, lessons have been learnt from past experiences and the technology to enable data sharing has improved in recent years. The initial focus will be on the integration of summary acre records.

28.6 In response to a question from Cllr Hugh-Jones on whether plans to ensure that any LTP changes requiring additional patient journeys would be supported by sustainable and affordable travel options, Ms Banjoko responded that this would be explored in individual service change planning. It should however be noted that the 3Ts development at the Royal Sussex will enable the repatriation of some specialist services to the city, reducing patient and family journeys.

28.7 In answer to a query from Cllr Hugh-Jones about LTP engagement, Mr Scarff informed members that previous engagement exercises such as "Our health, our care, our future" had informed the local response to the LTP. More engagement is planned, and there will be specific engagement and consultation relating to implementation of any service changes.

28.8 In response to a question from Cllr McNair on whether the LTP would entail the redistribution of primary care assets across the city, Ms Banjoko told the committee that this would be up to GP practices. Mr Scarff added that PCNs may seek to differentiate between patients who require generic GP services and those who need continuity of care from a named GP in order to ensure that finite resources are deployed as effectively as possible.

28.9 In response to a question on whether the ability to book Urgent Treatment Centre (UTC) appointments was yet in place, Ms Banjoko promised to provide a written response.

28.10 In answer to a query from Cllr Hills on membership of the Integrated Care System (ICS) Executive Group, Mr Scarff confirmed that the Chief Officers of NHS providers and commissioners would be invited, as would local authority Directors of Adult Social Care (DASS). There would also be support from the medical and clinical directors of the member organisations. Mr Scarff stressed that the ICS would have no delegated authority to make decisions, with accountability retained by member organisations. There is no elected member representation on the ICS, with Health & Wellbeing Boards expected to be the key vehicle for democratic accountability.

28.11 Cllr Knight commented that she was unconvinced by the term 'neighbourhoods': areas of 30-50,000 people are catchment areas rather than homogenous communities. She also noted that the language used to explain some of this information was unclear. Mr Scarff noted that 'neighbourhood' is a term being used by the NHS nationally. Whilst accepting Cllr Knight's point, he stressed that 'neighbourhoods' present a more granular scale for commissioning than is typically the case; it would not be possible to deliver sustainable service provision at a smaller scale.

28.12 Cllr Powell asked questions about the steps taken or planned to ensure that there was engagement with a wide range of city communities representing people with protected characteristics. Ms Banjoko assured members that equalities issues were being taken very seriously. Engagement materials will be made available in (easy to read) print, braille and sign forms; engagement events will be accessible; there will be dedicated events for certain groups (e.g. people with a learning disability); the CCG will work closely with community & voluntary sector groups when planning engagement; the CCG will work with public health to ensure they have accurate data on people with protected characteristics; the CCG will actively use its staff networks to support engagement with specific groups (e.g. involving BAME staff in engagement with BAME communities).

28.13 In response to a question from Fran McCabe on engagement with the private sector, Ms Banjoko told members that the local private sector is essentially domiciliary care and residential care: there are no significant local private healthcare providers. There will be engagement at a neighbourhood level: e.g. linking hospital gerontologists to local residential care homes in order to reduce unnecessary hospital admissions. Mr Scarff added that it was more challenging to engage with domiciliary care providers, but this is something the system is committed to doing. There is also a commitment to engage effectively with carers, including support via the Better Care Fund.

28.14

29 OSC DRAFT WORK PLAN/SCRUTINY UPDATE

The meeting concluded at Time Not Specified

Signed Chair

Dated this day of

HOSC Public Questions 15 July 2020

1 Dr Yok Chang

"It seems that HOSC has not met because NHS bodies have been charged with the following tasks, but were not ready with responses yet:

- An evaluation of the local Covid response across the health and care system.
- An explanation of the changes made to NHS services in recent months made under urgency powers (i.e. service changes that in normal circumstances would have required consultation with HOSCs).
- Plans for recovery across the local health and care system – i.e. returning services to 'normal' including dealing with the backlog of elective procedures etc."

Please would you clarify what service changes were made under the corona crisis and are these changes permanent or reversible if now open to scrutiny."

(This Q has been submitted as a written question and will receive a written response which will be included in the minute of the meeting.)

2 Janet Strang

"At the beginning of the current pandemic, local MP Peter Kyle was expressing dismay at the vulnerability of patients and staff in care homes. At the same time, the GMB trade union was reporting that at the Royal Sussex County Hospital, BAME staff were being bullied, discriminated against, and pressured to work without adequate PPE.

"Does the HOSC share my concern about the high proportion of BAME deaths due to Covid-19, and if so, will the HOSC invite a senior officer to appear at its next meeting to provide the relevant statistics for Brighton & Hove?"

3 Valerie Mainstone

"The founding ethos of the NHS was that it would provide healthcare for everyone, free at the point of need. Now, voluntary organisations such as Medact, and Docs Not Cops, are extremely concerned about migrants who are unwilling to access NHS services, for fear of being charged sums of money that they cannot afford, and/or of being deported if NHS staff report them to the Home Office.

"Does this HOSC deplore the fact that current rules deter some people from seeking NHS help during the pandemic, and agree that NHS services throughout the country should be free and available to all at the point of need, regardless of ethnicity/nationality/immigration status?"

4 Madeleine Dickens

“Various Government initiatives to deal with Covid- 19 have proved tragically ineffectual. Net result one of the highest death tolls. One such failing was the guidance issued that “**negative tests are not required prior to transfers / admissions into the care home”,** contributing to a public health disaster.
HOSC members are no doubt extremely concerned about the Government failure to liaise and share intelligence with Local Authorities which has exacerbated the crisis.
With so many unnecessary deaths and grieving families across the city, will members call on the Full Council to convene public enquiry into this issue to ensure concerns and questions can be answered and guidance developed to avoid any re-occurrence?"

5 Chris Tredgold

'Care Home residents have been the most severely affected by Covid-19 - accounting for over 40% of England’s high death rate.
Age and undiagnosed infected patients discharged from hospital have been causes of this - but so have a lack of testing and adequate PPE.
Testing is at last planned - weekly for the staff, monthly for the residents.
Homes and Local authorities need the results quickly.
How will the HOSC ensure that all staff and residents in Care Homes receive clear test results and that all staff have access to adequate PPE?'

6 Ken Kirk

Does the HOSC share my concern that the government’s Test and Trace system run by Deloitte, see the answer to a parliamentary question, does not require Deloitte to pass positive cases to local authorities. Do you agree that the HOSC should require B&H director of public health to its meeting to ensure scrutiny of his planned response to a possible second Covid wave?

https://www.theyworkforyou.com/wrans/?id=2020-05-19.48980.h

Stella Creasey MP: To ask the Secretary of State for Health and Social Care, whether the contract with Deloitte for covid-19 testing requires that company to report positive cases to Public Health England and to local authorities.

Nadine Dorries (Minister of State): As an existing professional services provider to the public sector, Deloitte’s expertise is being used to supplement in-house resource to deliver significant programmes of work, which currently includes the national response to COVID-19. The contract with Deloitte does not require the company to report positive cases to Public Health England and local authorities.


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HOSC – COVID Restore and Recovery

COVID - 19
The impact on Brighton and Hove

COVID-19 Impact on B&H

healthwatch Brighton and Hove

As at 2 July:

- 764 confirmed cases of COVID 19 B&H (19% of all deaths in the city since lockdown have involved COVID)
- 2,679 West Sussex (612 deaths, 17% of all deaths)
- 1,476 East Sussex (345 deaths, 15% of all deaths)

152 COVID 19 deaths in Sussex 144 registered by BSUH, 619 across Sussex

Deaths in B&H have mirrored the national trend with a peak in deaths related to COVID-19 in April 2020, followed by a downward trend thereafter.

A second peak in deaths appeared in May, again mirroring the national trend.

The rise in recorded deaths in Brighton and Hove related to COVID-19 grew more slowly than the national trend.

Currently, the number of additional deaths related to COVID-19 now appears to be very low in our city.

In addition, the South East had the second lowest mortality rate of deaths involving COVID-19 between March and May.

COVID-19 Impact on B&H

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The R number (reproduction number) - not available for Brighton and Hove.

- As at 2 July, South East region R number is within the average range for all regions in the UK (0.7-0.9),
- The current growth rate of daily new infections (-5 to -1). This data suggests that transmission of COVID is steadily declining in the region.

Numbers of confirmed cases

- The city has a rate of 263 cases per 100,000 people compared with 436 per 100,000 for England and 368 per 100,000 for the South East.
- We are ranked 134 out of 150 local authorities in England (where 1 is the highest rate).
- Currently the rate of new cases is now much lower compared to April and May which is good news.
- When looking at the cumulative number of cases per 100,000 of the population Brighton and Hove has a lower level than the national Local Authority median. This indicates that overall levels of confirmed cases in our city have remained lower than the median since reporting began.

Care homes

- nearly 40% of all care homes in Brighton and Hove have reported outbreaks of the coronavirus.
- At 42% the South East has the fourth lowest level of care homes affected by COVID-19 out of nine national regions (highest 54.2% London, lowest is 29.5% South West).

The response to COVID 19

NHS = National Hospital Service ?

Was enough attention given to community vulnerability at the start of the outbreak?

Healthwatch - response

healthwatch Brighton and Hove

Projects suspended

- Home Care quality reviews
- Hospital quality reviews
- LD experiences in Care Homes, with Speakout, for CQC
- 24hrs in A&E Sussex wide (and all other enter & view)

Replacement projects

- COVID bulletins and health & social care guidance
- Escalation of issues to system leaders
- Hospital Discharge Wellbeing [Hops project]
- Cancer webinar
- Care Homes Family Forums
- Mental Health Sector Connector Forums
- Restore and Recovery – connecting PPI engagement across Sussex

Business as usual

- Working from home
- Taking on new challenges
- Patients help and info line

Issues escalated

healthwatch Brighton and Hove

- Access to GP services – phone only, problems getting an answer, issues for deaf community
- Incoherent and uncoordinated response to some issues e.g. B12 injections
- PPE availability inside and outside hospitals
- Vulnerability of Care Home residents and staff, agency staff, hospital and end of life care
- Community healthcare – absence of dental care, slow to establish emergency dental centres, confusion over access to services, absence of advice, podiatry
- Water and sanitation for 'Van dwellers'
- Support and advice for people with direct payments, personal budgets
- Home care vulnerabilities – PPE and care packages that ended or declined
- Repeat prescriptions
- Access to GP's for migrants with no papers – 'Safe GP's'
- Patient transport services – inadequate advice for patients
- Democratic deficit – HWB's and HOSC postponed, CQC inspections stepped down, NHS complaints suspended

Response to issues escalated

- High levels of public and patient confidence
- ‘War time spirit’ – make do and mend

- Prompt responses from City Council, CCG and NHS
- Close co-operation high level access to NHS leaders, first time Healthwatch was recognised as the official voice for Patients and the Public
- Dedicated link between the NHS/CCG and Healthwatch in B&H and Sussex wide
- B&H City Council – we worked through Community Works and cell system, less formal but probably just as effective as NHS liaison
- BHCC recognition for the Healthwatch response, endorsement of our bulletins, support for new projects, maintained our income

Current and future challenges

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What services will be re-designed and how?

Can the Public and Patient voice inform Restore and Recovery?

Co-production and experts with lived experience

Current and future challenges

Community services - health and social care safe access

Re-setting GP services, including people with no digital access and 20% who want face to face consultations

Vulnerable communities - socio economic disadvantage, BAME, people with disabilities

Dental Services - slow recovery, people feel abandoned, clear timetable and plan required

Current and future challenges

Patient transport services - recommission in 2020/21 provides an opportunity to learn from COVID and improve the service

Emotional and mental health - planning for surge in demand is in hand across children, adults, older people services

Hospital outpatients - massive waiting lists, already long before COVID, backlog may take years to resolve, a tragedy for cancer patients and others whose condition may shift from operable to inoperable on a waiting list