BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00PM 21 MARCH 2012

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillors Rufus (Chair); Barnett, Bennett, Follett, Marsh, C Theobald (Deputy Chair), Summers and Pissaridou

Co-opted Members: Hazelgrove (Older People's Council) (Non-Voting Co-Optee), Brown (BH LINk) (Non-Voting Co-Optee)

PART ONE

69. PROCEDURAL BUSINESS

69A Declarations of Substitutes

69.1 Cllr Summers attended as substitute member for Cllr Phillips

Cllr Pissaridou attended as substitute member for Cllr Turton

69B Declarations of Interest

69.2 There were none.

69C Declarations of Party Whip

69.3 There were none.

69D Exclusion of Press and Public

69.4 In accordance with section 100A(4) of the Local Government Act 1972, it was considered whether the press and public should be excluded from the meeting during the consideration of any items contained in the agenda, having regard to the nature of the business to be transacted and the nature of the proceedings and the likelihood as to whether, if members of the press and public were present, there would be disclosure to them of confidential or exempt information as defined in section 100I (1) of the said Act.

69.5 RESOLVED – That the Press and Public be not excluded from the meeting.

70. MINUTES OF THE PREVIOUS MEETING

70.1 RESOLVED – That the minutes of the meeting held on 25 January 2012 be approved and signed by the Chairman.

71. CHAIR'S COMMUNICATIONS

71.1 The Chair informed members that, in response to a request from Brighton & Sussex University Hospitals Trust (BSUHT), he had written a letter to the trust confirming that the HOSC supported the 3T plans to develop the Royal Sussex County Hospital site. Its general support for the programme notwithstanding, the HOSC reserves the right to scrutinise aspects of the development.

72. PUBLIC QUESTIONS

72.1 There were none.

73. NOTICES OF MOTION REFERRED FROM COUNCIL

73.1 There were none.

74. WRITTEN QUESTIONS FROM COUNCILLORS

74.1 There were none.

75. LONG TERM CONDITIONS

75.1 This item was introduced by Jo Matthews, Brighton & Hove Transitional Clinical Commissioning Group (CCG) Commissioner for Long Term Conditions, and by Geraldine Hoban, CCG Chief Operating Officer.

75.2 Members were told that long Term Conditions (LTC) were a CCG priority. Previously services for people had been good in parts, but there was too much variation in the quality and type of services available across the city. In response to this, LTC services were being re-oriented around primary care teams based at the level of clusters of GP practices –3-5 local GP practices with similar demographics in each cluster. Each team would have a broad range of skills, including, but not limited to nursing. Teams will be very closely linked to their GP practices and will regularly discuss admission and discharge information with the relevant GPs. Early feedback on the introduction of this model was largely positive, although there had been some issues with ensuring that team/GP meetings took place as scheduled, and with some unanticipated impacts on other services. It was expected that there would be these types of pressure emerging, and it was always intended that the current year of operation would be used to fine-tune the system in preparation for going to procurement in the following year.

75.3 In response to a question from Cllr Marsh on the definition of LTC, members were told that there was no precise definition, but in essence the term LTC was used locally to identify people who were unable to travel to their GP practices, and who therefore required treatment delivered to their homes.

75.4 In answer to a question from Cllr Marsh on co-working with adult social care (ASC) services, the committee was informed that the LTC initiative has been developed in consultation with ASC. ASC will have a formal role in line-managing carer support managers who will work very closely with the LTC teams.

75.5 In response to a question from Cllr Marsh on the use of care-co-ordinators, members were told that, in some instances service users might choose not to have a care co-ordinator appointed, preferring to co-ordinate their own care, have their carer do so etc.

75.6 In answer to a query from Mr Hazelgrove regarding evaluation of the LTC programme, members were informed that formal evaluation would start in October 2012 and would draw on experiences of service users, GPs, and Sussex Community Trust. As well as soliciting views on the new service, the evaluation would seek to identify measurable improvements in patients' lives, possibly using the well-established methodology of PROMs – Patient Recorded Outcomes Measures.

75.7 In response to a question from Cllr C Theobald about resource implications of this initiative, the committee was told that the introduction of practice-based teams would lead to a small reduction in nursing staff requirement – 3 FTE posts. Other savings would arise from the use of more appropriate staffing – currently, too many service users were supported by inappropriately senior staff (e.g. nurses providing non-nursing services).

75.8 In answer to a question from Cllr Pissaridou regarding how the practice teams would be alerted to patients being admitted to/discharged from hospital, members were told that the hospital activity data would be electronically uploaded onto the Urgent Care Clinical Dashboard every 24 hours and automatically shared with relevant GPs. In addition, the hospital discharge team should liaise directly with GPs for every discharge.

75.9 In response to a query from Mr Brown asking whether the local LTC programme was co-ordinated with national developments and whether it was designed to save money, the committee was told that, locally at least, the programme was driven by the need to improve the quality of services. In terms of co-ordination with national developments, the Brighton & Hove programme pre-dates national moves to improve LTC care. However, the two approaches tally closely, and Brighton & Hove is very much at the forefront of delivering these improvements.

75.10 Mr Brown told members that the LINk had been consulted at every stage of the development of an LTC programme, and LINk concerns had all been addressed. The LINk will continue to monitor the implementation of the programme.

75.11 The Chair thanked Ms Matthews and Ms Hoban for their contributions and requested an update on implementation of the LTC programme in Autumn 2012.

75.12 RESOLVED – That the report be noted and a further updated requested in Autumn 2012.

76. SUSSEX TOGETHER

.1 This item was introduced by Amanda Philpott, Director of Strategy and Provider Development, NHS Sussex. Ms Philpott told members that the NHS spend across Sussex was approximately £2.6 billion per annum. Given that government funding is likely, at best, to flat-line for the foreseeable future, and that health sector inflation, even in the context of a public sector pay freeze, is predicted to run at around 4% pa, some £440 million additional funding would be needed by 2013 to continue to meet increasing population health need through the current configuration of Sussex services. Since this extra money will not be available, the challenge for the local NHS is to make significant efficiencies. In addition, the Foundation Trust (FT) programme should see all NHS provider trusts becoming FTs by 2014. To become an FT a trust must prove that it is financially viable – i.e. capable of making a sustainable annual profit from its activities.

76.2 The process via which these efficiencies will be found is called 'Sussex Together' and will be co-ordinated by NHS Sussex. However, the initiative will be clinically led – by both GP commissioners and provider clinicians – as well as having input from adult social care professionals, services representing the wider determinants of health (e.g. housing) and LINks.

76.3 Sussex Together has initially identified four main priority areas: frail elderly, unscheduled care, planned care and 'other' (focusing particularly on medicine management, paediatrics and maternity). The aim is to establish best practice within Sussex, and then ensure that local services and pathways demonstrate a consistent approach in line with this best practice. It will be for individual Clinical Commissioning Groups (CCGs) to implement this at a local level.

76.4 Thus far, Sussex Together has identified £160 million of potential savings. This is a fairly urgent process, as the more quickly savings can be identified and enacted, the bigger the budgetary impact. Providers have responded very positively to the challenge, even though they compete with one another for custom. A Sussex Clinical Senate has been established, bringing together clinicians from across the county and building on the successes of existing clinical networks.

76.5 Ms Philpott assured members that lessons had been learnt from previous attempts to reconfigure the Sussex health economy, and that there was no agenda to shut hospitals. Hospital trusts recognised that these were difficult financial times and that they had to work together – with each other and with GP commissioners – in order to remain sustainable. The boards of all Sussex NHS trusts are signing up to the principles of Sussex Together.

76.6 In response to a question from Cllr Follett regarding the Sussex Clinical Senate, members were told that it was hoped the Senate would enable provider clinicians to contribute to commissioning decisions at a remove – sharing their knowledge without inappropriately influencing commissioner choices. The Senate would effectively be a continuous clinical summit, and should cost relatively little (most clinicians involved will already be paid for service-planning so will not expect additional reimbursement).

76.7 In answer to a question from Cllr Marsh as to why this type of planning could not be left to CCGs, the committee was told that CCGs were still at a nascent stage of development, and in addition there are benefits from sharing best practice across Sussex. CCGs are at the heart of the Sussex Together initiative.

76.8 In response to a question from Cllr C Theobald on maternity/paediatrics, members were told that this was likely to be a very significant issue going forward, with the need to balance people's reasonable expectations of locally accessible services with a configuration of services that accords with guidance from the Royal Colleges on optimum unit size.

76.9 The Chair thanked Ms Philpott for her contribution and requested a further update in Autumn 2012.

77. IMPLEMENTATION OF THE HEALTH & SOCIAL CARE BILL: UPDATE

77.1 This item was introduced by Terry Parkin, Strategic Director, People.

77.2 Mr Parkin told members that the local Clinical Commissioning Group (CCG) was performing well on all indicators and was well-prepared for the authorisation process. The CCG has successfully resisted some pressure to increase its boundaries beyond that of the city, which is to be welcomed, as the co-terminosity of the CCG and the city council provides significant benefits to the city.

77.3 The city Public Health team have now moved into council premises and are working alongside council commissioners. At a national level, the spilt of responsibilities between Public Health England and local Public Health services is still being worked out, but an indicative budget for local areas has been published and work is underway to match this budget against city needs.

77.4 Plans for a local Health & Wellbeing Board (HWB) have now been approved by Governance Committee, Cabinet and Full Council, having in the process been amended to include greater member-representation. The success of the HWB will depend upon it maintaining a tight focus on high-level outcomes via the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy (as specified in the HWB Terms of Reference agreed by Full Council).

77.5 In terms of Healthwatch (HW), Mr Parkin told members that there was still considerable uncertainty about HW, particularly around children's services. Current plans envisage local HW organisations working closely with a national organisation, Healthwatch England, which will sit within the Care Quality Commission (CQC), the NHS and social care watchdog. However, CQC has no remit to oversee children's services, which fall within the remit of Ofsted, so it is unclear how HW would be able to represent young people's views without recourse to escalating its concerns via Healthwatch England/CQC. This lack of clarity regarding HW's roles is one of the reasons that the local HWB will include a young person from the Brighton & Hove Youth Council, ensuring that local young people have a voice in HWB decisions.

77.6 In response to a question from the Chair on a possible clash of interest with HW taking part in HWB decisions but also potentially scrutinising the implementation of HWB strategies, members were told that the Department of Health had issued guidance on this issue. All the members of the HWB are champions for particular constituencies, so HW is not unique in this respect.

77.7 RESOLVED – That the report be noted.

78. MENTAL HEALTH: ACUTE BEDS

78.1 This item was introduced by Geraldine Hoban, Chief Operating Officer, Brighton & Hove Transitional Clinical Commissioning Group (CCG); Sam Allen, Service Director, Sussex Partnership NHS Foundation Trust (SPFT); and Anne Foster, CCG Lead Commissioner, Mental Health.

78.2 The committee was told that the Clinical Taskforce examining the planned Mill View bed reductions had met twice to agree the set of metrics they would use to determine whether beds should be permanently reduced and to begin to apply these metrics to the data on activity at Mill View. The Clinical Taskforce was being Chaired by Dr Becky Jarvis, CCG Clinical Lead on Mental Health.

78.3 The key metric was the percentage of Brighton & Hove patients seeking admission at Mill View being placed in the hospital, with a target of 95%. SPFT was not currently meeting this target, although it was performing at 92-93%. The Taskforce identified the lack of a local specialist service for Personality Disorder and a paucity of suitable supported housing to accommodate people being discharged from hospital as the key areas that required improvement if the target was to be reached.

78.4 In response to a question from the Chair as to how the 95% target was agreed, members were told that it was not feasible (or desirable) to set a target of 100%; 95% represents a challenging but achievable goal and will ensure that almost all local people receive treatment locally. SPFT would have to show it could attain the target level of services for three consecutive months before the Taskforce would agree to permanent closure of beds. In addition, there were other metrics being considered, looking at bed occupancy rates, user complaints, re-admission rates and seasonal variation.

78.5 In answer to a query from Mr Hazelgrove on the problems associated with supported housing in the city, members were told that there was historically a lack of housing at all levels of support need. There were also wide variations in quality and cost of supported housing across the city and a general lack of ‘move-on’ in the system – e.g. people no longer requiring high levels of support being moved on to lower support housing. A good deal of work has been undertaken in this area, and local providers are confident they can increase capacity.

78.6 The Chair thanked Ms Hoban, Ms Allen and Ms Foster for their contributions, noting that the committee was very happy with the way the process had been handled to date, and would welcome more updates at future meetings.

79. LETTERS TO THE CHAIR

79.1 Members discussed a letter from NHS Sussex alerting the committee to a change in the management of the Sussex Orthopaedic Treatment Centre.

80. ITEMS TO GO FORWARD TO CABINET OR THE RELEVANT CABINET MEMBER MEETING

80.1 There were none.

81. ITEMS TO GO FORWARD TO COUNCIL

81.1 There were none

The meeting concluded at 6.30pm

Signed Chair

Dated this day of