BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00pm 6 SEPTEMBER 2017

COUNCIL CHAMBER, HOVE TOWN HALL, NORTON ROAD, HOVE, BN3 3BQ

MINUTES

Present: Councillor K Norman (Chair)

Also in attendance: Councillors Allen, Greenbaum, Morris, A Norman, Hill, Janio and West

Other Members present: Colin Vincent (Older People's Council), Fran McCabe (Healthwatch), Caroline Ridley (Community & Voluntary Sector)

PART ONE

12 PROCEDURAL BUSINESS

12.1 Apologies were received from Cllr Bewick and from Zac Capewell.

12.2 Cllr Pete West attended as substitute for Cllr Lizzie Deane; Cllr Tony Janio attended as substitute for Cllr Andrew Wealls; Cllr Tracey Hill attended as substitute for Cllr Penny Gilbey.

12.3 There were no declarations of interest.

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

13 MINUTES

13.1 Cllr Allen pointed out that information requested at 2.4 of the minutes (STP expenses to date) had not yet been received. Fran McCabe noted that the HOSC STP working group had also asked for this information, but it had not been forthcoming. The Chair agreed to pursue the matter. [Please note: the information requested has now been received from the CCG and is attached for information at the end of these minutes.]

13.3 RESOLVED – that the minutes of the 28 June 2017 HOSC meeting be approved as an accurate record.

14 CHAIR'S COMMUNICATIONS

14.1 The Chair welcomed everyone to the meeting. The Chair also informed the committee that Item 17: Brighton & Hove Caring Together Update had been deferred until the next meeting at the request of Brighton & Hove Clinical Commissioning Group (CCG).

15 PUBLIC INVOLVEMENT

15.1 There was a public question from Dr Chris Tredgold. Mr Tredgold asked:

"General Practice in Brighton and Hove is becoming unsustainable. 8 practices have closed in the last 2 years. The Ridgeway Surgery in Woodingdean is closing in October. 8 practices are currently not accepting new patients.

Park Crescent surgery is so short staffed that Care UK has been employed to operate a telephone triage system there.

And the STP plans to load more work onto General Practice while GP recruitment falls.

Please can the HOSC say that this situation is not acceptable?"

15.2 The Chair responded:

"Thank you for your question. I'm sure that we are all aware that GP services, both locally and nationally, are under a great deal of pressure and that the situation in Brighton & Hove is very serious.

It certainly isn't the case that nothing is being done here, and later in this meeting, the committee will receive an update on what the NHS in the city is doing to support the sustainability of GP services. Following this presentation, committee members will decide how they want to further pursue the issue of GP sustainability."

15.3 Dr Tredgold then posed a supplementary question, asking the HOSC to agree to ask the CCG to be clear and honest about the further deterioration in local health services (identified by local GPs in a response to a survey) that will occur if more work is transferred from secondary care to General Practice under the Sustainability & Transformation Partnership whilst NHS budgets are being cut.

The Chair responded that the committee would wait and see.

16 MEMBER INVOLVEMENT

16.1 There was none.

17 BRIGHTON & HOVE CARING TOGETHER: UPDATE

17.1 This item was deferred until the next meeting at the request of the CCG.

18 ADULT SOCIAL CARE: FUTURE VISION

18.1 Rob Persey, Executive Director Health & Adult Social Care (HASC), presented on his vision for HASC.

18.2 Mr Persey told members that, on his arrival in 2016, he inherited relatively few issues that caused him serious concern. The most worrying matters were: social care reviews, staff sickness levels, and some issues concerning direct payments (particularly their uptake). Also, the council was and is being stretched by the number of Deprivation of Liberties Safeguarding (DOLS) assessments it is now required to undertake: around 190 per month rather than approximately 130 per annum which had been the figure before the outcome of a court case forced social services departments to change procedures. However, this is a national rather than purely a local problem.

18.3 On a more positive note, Mr Persey inherited a history of positive co-working between social care and the local NHS. This provides a good building-block for further integration. There were also very close working relationships between social care and public health. There has been more work in this direction, and public health is now firmly embedded in everything that social care does.

18.4 Mr Persey also explained his statutory responsibilities as Director of Adult Social Services (DASS); as well as outlining the 3 year directorate plan and HASC's priorities for 2017/18. Health inequalities are a particular priority, as in recent years inequalities have been increasing.

18.5 In response to a question from Colin Vincent on whether a breakdown was available showing how money collected via the social care Council Tax precept has been spent, Mr Persey replied that the precept funding and monies that come via the Better Care Fund (BCF) are ring-fenced to three areas: Adult Social Care (ASC) assessment and delivery; co-working with the NHS on reducing hospital admissions and Delayed Transfers of Care from hospital; and sustaining the ASC provider market. Mr Persey agreed to circulate further information on this.

18.6 Caroline Ridley told the committee that the recently announced tender for supporting Direct Payments is flawed as it demands that potential providers have specific direct experience of this work rather than just being able to demonstrate that they are competent to undertake it. This limits the number of local providers who will be in a position to bid. Mr Persey agreed to look at this issue.

18.7 In answer to a question from Cllr Ann Norman on sickness rates in HASC, Mr Persey told members that social care sickness rates are high everywhere due to the innate stresses of the job. However, BHCC is an outlier in terms of its rates. There are several plans to tackle this. They include running a council-wide wellbeing programme; ensuring staff take proper lunch breaks; encouraging front-line workers to get flu jabs; and the introduction of 'First Care', a new absence reporting system which requires staff to call a helpline rather than their line-manager to report illness. Clinically trained call-handlers are on hand to provide support and advice in addition to registering the absence.

18.8 Cllr Allen made the point that he was eager to see HASC performance reported to HOSC, not dealt with solely at the quarterly joint HOSC/HWB HASC performance workshops. Mr Persey replied that he was happy to bring performance information to HOSC where the data is available (the KPIs for health and social care integration are still being determined). He did not bring performance to this meeting because he had been briefed not to.

However, HASC performance is currently strong. For example, there has been a concerted focus on placements into residential care, where performance has historically been poor. This has been very effective, with the year-end target for reductions already exceeded. Social care reviews remain a real concern, but they are now being processed by priority which should help address the problem.

18.9 Fran McCabe echoed the call for more HASC performance reporting at HOSC, noting that although performance may be reported at other council committees, HOSC co-opted members were unable to scrutinise it there. Ms McCabe also expressed concerns that rising health inequalities might be linked to problems with city GP practices. Mr Persey responded that this was an understandable concern. However, the key factor here was probably the number of GPs working in Brighton & Hove rather than the number of practices, as long as there was a spread across the city. HASC is now working more closely with city GPs: social care has been split into three localities which each align with two of the six city GP clusters.

18.10 In answer to a query from Cllr Janio on the benefits of integration, Mr Persey told members that integration would give the CCG a better understanding of council responsibilities that constitute the broader determinants of health, such as housing and culture. Integration will also help drive a greater focus on prevention. The challenges of integration should not be underestimated, as the council and the NHS are culturally quite different, but this work is very important.

18.11 The Chair thanked Mr Persey for his presentation.

19 GP SUSTAINABILITY

19.1 This item was introduced by Murray King, Interim Associate Director Primary Care, Brighton & Hove CCG. Due to administrative error, the CCG report accompanying this item that should have been tabled at the meeting was not available. There was therefore no report to discuss. The report has subsequently been added to the committee papers on the council's website and circulated to members. Several members noted their dissatisfaction with the absence of a report.

19.2 Mr King told members that there were some local positives: 36 city GP practices are rated 'good' and Brighton & Hove GP Patient Survey results are above average. However, there are also significant problems, particularly in the east of the city where a number of practices are vulnerable.

19.3 Commissioners have developed tools to identify the most vulnerable practices. Four city practices have been identified as being particularly vulnerable, and are receiving additional support. Commissioners are also focusing on single-handed practices due to their inherent vulnerabilities.

19.4 There has also been investment in a telephone service which can augment capacity in practices under pressure. The practices using this service supply a list of their most vulnerable patients who will then *not* be routed to the telephone service. Clinical call-handlers have full access to patient records. In time it is hoped that many call-handlers will be local GPs and practice nurses with a good understanding of the city. The CCG

believes that there is an un-tapped market of local clinicians with the appropriate clinical skills and experience.

19.5 It needs to be recognised, however, that there is a national and indeed an international shortage of GPs and that it is important to think about the skill mix of primary care clinicians – i.e. using physicians' assistants, practice nurses, pharmacists etc. where appropriate and ensuring that GPs only see patients who need to see them.

19.6 Mr King also explained the situation at Ardingly Court, where the practice has effectively decided to split in two. This follows the practice taking on a number of new patients following the recent closure of city GP surgeries run by The Practice Group. The CCG will tender for a new, Whitehawk-based practice, and four of the GPs currently at Ardingly Court will resign in order to bid for the new contract.

19.7 In response to a question from Cllr Morris on practices closing their lists, Mr King told the committee that practices could apply to commissioners to 'cap' (temporarily close) their lists where it was unsafe to register new patients. There are currently five practices with capped lists in the city. This is largely due to practices having to manage the impact of the closure of the Ridgeway surgery and should be a temporary issue. A capped list is not wholly closed; it must still accept some new patients – for example babies born to existing patients on the list.

19.8 The Chair thanked Mr King for his presentation.

20 CLINICALLY EFFECTIVE COMMISSIONING

20.1 This item was introduced by Lola Banjoko, Director of Performance, Planning & Informatics at Brighton & Hove CCG; and by Pippa Ross-Smith, CCG Chief Finance Officer.

20.2 Ms Banjoko told members that the Clinically Effective Commissioning (CEC) initiative is being run across the STP footprint. The focus is on ensuring that planned care decisions reflect current best clinical practice, with unnecessary or low-value interventions identified and eliminated.

20.3 Groups of clinicians from across Sussex and East Surrey will agree on CEC recommendations. However, all decisions about services will be taken by local CCGs, and in theory a CCG could reject CEC recommendations.

20.4 In response to a question from Cllr Greenbaum on referral management, the committee was told that there has been a local system in place for some years to check that GP referrals for treatment are valid and meet the agreed thresholds.

20.5 In answer to a query on CEC public engagement from Fran McCabe, members were informed that there would be engagement on specific service changes, should the changes identified be significant. The timescale for CEC will be determined by the clinicians working on the initiative.

20.6 In response to a question from Cllr Allen as to whether CEC was rationing by another name, members were told that CEC is about ensuring that services are as clinically

effective as possible; it is not about saving money. There are clearly financial challenges that must be addressed, but the system needs to ensure that all activity is clinically justifiable before it can fully tackle financial problems. It is particularly important that everything possible is done to eliminate waste and unnecessary activity so as to minimise the need for changes which might adversely impact upon services.

21 NHS 111 UPDATE

21.1 This item was introduced by Colin Simmons, 111 Programme Director; and Kerry Exley, Coastal CCG.

21.2 Coastal West Sussex CCG is leading the procurement of a new 111 (non-urgent NHS telephone service) contract for Sussex, but all seven Sussex CCGs are responsible for the contract and are actively involved in the project.

21.3 The current contract (with SECAmb) has been extended for 12 months to give sufficient time for a proper re-procurement to be undertaken. This contract is with 17 CCGs across Sussex and Surrey. The new contract will be for five years with an option to extend for a further two years, and will include break clauses. The tender process is expected to begin in January 2018, with a contract award in September 2018 and phased implementation beginning in 2019.

21.4 The Sussex GP Out of Hours (OOH) contract is being re-commissioned together with the 111 contract as it has been recognised that the two services are closely linked, and it is crucial that they are able to work together effectively. This is not always possible currently - for instance, there are IT incompatibilities that mean that patient information can sometimes not be readily accessed or shared. Currently OOH services have some access to records, but 111 has none. Under new arrangements both services should have ready access at least to patient summary care records, and the expectation is that clinicians should be able to access full patient records in read-only mode.

21.5 The new 111 contract will be Sussex-only so as to provide more potential for flexibility should changes to local urgent care systems require a flexing of the contract terms.

21.6 In response to a question from Cllr West on how the new 111 services would better support other NHS services, members were told that a more effective 111 service will relieve pressure on other parts of the NHS by signposting patients to the most suitable service. For example, 111 will have prescribing pharmacists who will be able to issue prescriptions electronically which can be picked up the next day at a local pharmacy. This should reduce pressure on OOH services for repeat prescriptions.

21.7 In answer to a question from Cllr Morris on whether progress would be reported back to the HOSC, Mr Simmons offered to report back both before the tender begins (e.g. December 2017) and also to give an update one year on. Members agreed that this would be helpful.

21.8 In response to a query from Cllr Janio about whether it would be possible to provide a single point of access rather than 111 and 999, members were assured that all calls to 111 are initially assessed to see if they need to be transferred to 999. There is also the facility to transfer less urgent 999 calls to 111.

21.9 In answer to a query on public engagement from Fran McCabe, the committee was informed that it was recognised that good public engagement is key here. A 111 Communications Manager has already been appointed and there will be extensive public and stakeholder engagement as the tender progresses.

21.10 The Chair thanked the presenters.

22 FOR INFORMATION: UPDATE ON THE PROGRESS OF HOSC WORKING GROUPS

23 UPDATED HOSC 2017/18 WORK PROGRAMME

23.1 Fran McCabe suggested that the Healthwatch annual report and the joint Sussex Healthwatch report on Patient Transport Services be included in the committee work programme.

The meeting concluded at 7:05pm

Signed Chair

Dated this day of