BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00pm 23 JANUARY 2019

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor K Norman (Chair)

Also in attendance: Councillor Allen (Group Spokesperson), Deane, Greenbaum, Morris, Marsh, Hill, Janio and Wealls

Other Members present: Fran McCabe (Healthwatch), Zac Capewell (Youth Council)

PART ONE

21 APOLOGIES AND DECLARATIONS OF INTEREST

21.1 Cllr Janio attended as substitute for Cllr Carol Theobald
Cllr Wealls attended as substitute for Cllr Barnett
Cllr Hill attended as substitute for Cllr Bewick.
Apologies were received from Colin Vincent (Older People's Council Representative) and from Caroline Ridley (Community Sector representative).

21.2 No member declared any interest in matters being considered.

21.3 It was resolved that the press & public should not be excluded from the meeting.

22 MINUTES

21.1 RESOLVED – that the minutes of the 17 October 2018 meeting were agreed as an accurate record.

23 CHAIRS COMMUNICATIONS

23.1 The Chair gave the following communications:

I've got four things to say today:

Firstly, the Care Quality Commission has recently published an inspection report on Brighton & Sussex University Hospitals Trust. I'm delighted to say that this is a really positive report: the Trust has been given an overall rating of good, with several services, including the care provided by staff rated as excellent. The CQC has also recommended that the Trust be taken out of quality and financial special measures.

This really is an extraordinary turnaround, and I'm sure the committee would like to congratulate everyone at BSUH for this achievement. It shouldn't be forgotten that this is a system success also – the CCG, other NHS providers and the council's social care teams have worked effectively together to support the hospital, and I'd like to congratulate them too.

This definitely isn't the end of the story – there are still lots of areas that BSUH needs to improve on, including outpatients, waiting times, and the performance of key services, including cancer. The HOSC will be monitoring work in these areas as well as keeping an eye on the progression of the 3Ts project which will eventually provide much needed additional capacity for hospital emergency services.

Secondly, we've also recently heard that Adam Doyle has had his role as Accountable Officer for CCGs across Sussex made permanent. There is a letter from the CCGs giving more details on this appointment at the back of today's HOSC papers. I'm sure the committee would like to congratulate Adam and wish him all the best in this challenging role.

Thirdly, following the last HOSC meeting I wrote to the Chair of BH CCG asking for more information about the Clinically Effective Commissioning programme. My letter and Dr Supple's response are included for information at the end of today's papers. We discussed the CCG response at the pre-meet for HOSC and it was agreed that it was possible for the CCG to pull together a bit more information about what the procedures in the first tranches of CEC are, what the impact of the changes is and so on. When we receive this additional information it will be circulated to members and included in the papers for the next HOSC meeting.

Finally, there's been some speculation in the local media about the future of the walk-in GP service currently being provided near Brighton Station. We've received some information from the CCG on this which has been circulated to members and will be included in the minute to this meeting. We can discuss this fully at the March HOSC, or people can ask questions now.

23.2 Cllr Morris noted that people using the walk-in centre frequently didn't fill-in the forms as they should, so use of the service may be under-reported.

23.3 Fran McCabe wondered what the future would be for sexual health services currently provided from the walk-in centre.

24 PUBLIC INVOLVEMENT

24.1 There was a Public Question from Ms Linda Miller. Ms Miller asked:

I would like to draw the HOSC's attention to the information provided by the BBC's NHS Tracker about the standard of NHS provision in Brighton and Hove
https://www.bbc.co.uk/news/health-41483322

Patients treated or admitted within four hours of arrival at A&E
October 2018 figures

TARGET
95.0%
YOUR TRUST (BSUH)
80.7%
ENGLAND
89.1%
Brighton & Sussex University Hospitals NHS Trust ranked 113 of 130 trusts

Patients starting cancer treatment within 62 days of urgent GP referral
September 2018 figures
TARGET
85.0%
YOUR TRUST (BSUH)
74.1%
ENGLAND
78.2%
Brighton & Sussex University Hospitals NHS Trust ranked 101 of 131 trusts

Patients having planned operations & care within 18 weeks of referral
September 2018 figures
TARGET
92.0%
YOUR TRUST (BSUH)
80.7%
ENGLAND
86.7%
Brighton & Sussex University Hospitals NHS Trust ranked 106 of 126 trusts

Patients starting mental health therapy within six weeks of referral
Apr - Jun 2018 figures
TARGET
75.0%
YOUR AREA
48.0%
ENGLAND
89.5%
NHS Brighton & Hove ranked 192 of 195 CCG areas

The NHS services provided to Brighton and Hove residents are falling far short of national targets and national averages. Do you agree that disbanding our local HOSC, in favour of a Sussex and Surrey-wide JHOSC, would weaken our ability to oversee and scrutinise, and hopefully improve, what is happening to our local NHS?

24.2 The Chair responded:

There are no proposals to disband the local HOSC in favour of a Sussex and East Surrey-wide Joint HOSC (JHOSC). Local authorities are required by law to appoint a JHOSC in order to scrutinise specific change plans involving the substantial development of a service or a substantial variation in the provision of a service which affect more than one local authority area, which NHS bodies or health service providers

are subject to a requirement to consult with local authorities on. Local authorities have no option other than to join a JHOSC when the conditions requiring one are met.

The requirement applies only where the law requires authorities to appoint a mandatory JHOSC. There is no such requirement to discharge jointly any other health scrutiny functions. Whilst there is a good deal of informal joint working between HOSCs in the region (for example, members from several HOSCs meeting jointly and informally with an NHS provider rather than holding separate meetings), the Council has no plans to combine any of its formal HOSC functions or responsibilities other than those which trigger the requirement to appoint a JHOSC with any other local authority. This explicitly includes the NHS performance issues detailed in your question.

24.3 Ms Miller asked a supplementary question:

"These figures are showing that the current level of funding is not adequate to meet the needs of our local population.

And yet we know that the CCG is having to make £14m of cuts this year, its share of the £50m being cut across the Sussex/Surrey region.

And the proposed Joint HOSC is required because the CCGs are planning Substantial Variations in Service.

What are the Cuts and Substantial Variations in Service that are being planned? When and where will they be published? The public needs to know."

24.4 The Chair agreed to provide a written response to this question. The following text was provided by Brighton & Hove CCG:

The amount of money the CCGs will be receiving from NHS England to pay for health services is going up for next year. However, the increase is not enough to bridge the gap with the ever-increasing rising demand and it is clear that further savings will have to be made during the year to ensure the CCGs do not carry on spending more money than is available.

This may require difficult decisions being made around services that are not deemed to be cost effective or less of a clinical priority when compared to other services that need investment.

The five CCGs of the Central Sussex and East Surrey Commissioning Alliance agreed a financial recovery plan last year with NHS England, which required £50m of savings to be made across the organisations from the total allocation of £1.4bn. This plan was published for the public to read in September and open conversations, information and engagement has taken place with the public, patients and stakeholders around what it means for them. Significant progress has been made to achieve the plan and the CCGs are expected to finish the financial year in a more stable financial footing than they have been in the past.

Due to rising demand, heath services across Sussex and East Surrey currently costs more money than is available. This means that for CCGs to be able to invest in existing

and new services, they have to look at where money can also be saved and then used more effectively.

The Clinically Effective Commissioning (CEC) programme is a Sussex-wide initiative which aims to improve the effectiveness of healthcare services by ensuring that commissioning decisions are consistent, reflect best practice, are in line with the latest clinical evidence and represent the most sensible use of limited resources.

At present there can be differences in the criteria used by local specialists to determine when patients should be referred for tests and treatment. This issue, often referred to as a “postcode lottery”, means some patients are not receiving treatment when they should, purely because of where they live, while others were receiving NHS-funded procedures that offer little or no clinical benefit - including alternative therapies such as aromatherapy, herbal remedies, reflexology and homeopathy.

The aim of the CEC programme is to bring a uniform systematic approach to policy review and implementation across all the CCGs to remove the unwarranted variation that exists and apply sound clinical decision making within mutually agreed policies. This ensures equity of access, improved clinical outcomes, better patient experience and efficient demand and capacity management across the system.

To enable this to happen, all Sussex CCGs have come together as part of the CEC Programme and agreed to take a single approach to identifying, developing and agreeing areas of focus. So far, the seven CCGs across Sussex have adopted a number of standardised polices, covering a range of tests and treatments including tonsillectomies, gallstones and trigger finger. Standardisation has meant minor changes to some CCG policies, or the introduction of policies where they did not exist before.

All of the updates to our clinical policies are evidence-based and built on NICE guidance and best practice to ensure we get the very best outcomes for our patients. The updates are consistent across all seven Sussex CCGs in Sussex and the treatments included are not new, most already had a defined procedure threshold.

The programme is now currently looking at policies where there are more significant differences between existing policies or the need for new policies. This will require and involve rigorous clinical scrutiny and engagement with patients, public, stakeholders and carers.

As well as being more clinically effective for patients, adopting a more standardised approach to clinical policies ensures that NHS funding is being spent more effectively. In some areas this will allow money to be saved which can be invested in other treatments and care that have more clinical benefit to our patients.

The potential savings that can be made from the CEC programme are part of the CCGs’ financial recovery plans. Every CCG in the country has a financial plan that outlines how they will meet their legal obligations around ensuring they are getting best value from taxpayers’ money.

The CCGs are in the early stages of assessing any further potential savings that need to be made and are looking at all areas thoroughly, with clinical insight and scrutiny. We do

not know at this stage if this will require any 'substantial variation' to services. Before any final decisions are made, we will be completing a thorough assessment to help understand how potential decisions may affect people, followed by a period of engagement with local patients, carers and the public. We want to be able to have regular and meaningful dialogue and engagement with the HOSC as these plans for savings develop and believe this can be best done with a Joint HOSC across Sussex. This will allow us to have more consistent conversations, allow discussion to be more thorough, and will allow engagement to be done once in a more timely way.

Additionally, there are other programmes of work that are taking place at regional level which would benefit from having oversight and scrutiny by a Joint HOSC. These may not particularly involve any 'substantial variation' to services but will aim to improve the care of our patients at scale. Currently, these programmes report to the HOSCs and HASC across Sussex and East Surrey at a local level when appropriate, which can cause inconsistency in the discussions around how they can benefit the populations across the region.

25 MEMBER INVOLVEMENT

25.1 There was none.

26 SUSSEX COMMUNITY NHS FOUNDATION TRUST: PLANS TO DEVELOP A COMMUNITY HEALTH HUB ON THE BRIGHTON GENERAL HOSPITAL SITE

26.1 This item was presented by Mike Jennings, SCFT Deputy Chief Executive.

26.2 Mr Jennings explained how the plans for the Brighton General Hospital (BGH) site had progressed, noting that the preferred option retains all patient-services on the site, other than some Brighton & Sussex University Hospital Trust (BSUH) services which are being temporarily provided at the BGH, but will either be moved back to the Royal Sussex County Hospital or provided in a city community setting. Oliver Phillips, BSUH Director of Strategy, confirmed that the two trusts were working closely together to ensure that this transfer is seamless.

26.3 In response to a question on bus access from Cllr Allen, Mr Jennings confirmed that the trust will talk to the bus company about access, specifically including the feasibility of having a bus enter the site to make patient access as simple as possible.

26.4 In answer to a query from Cllr Allen on the future of rough sleeping services, it was explained that there was no intention of moving user-facing services from their central Brighton location at Morley Street. However, some administrative staff would be moved.

26.5 Cllr Marsh noted that local residents had concerns about access for local people if GP services relocate to BGH. The area is very hilly, so that even residents who live only a short distance from the BGH may find accessing it difficult.

26.6 In response to a question from Cllr Greenbaum on staff consultation, members were told that over 80% are in favour of the trust's preferred option for development. Of the 20%

opposed, some prefer a different option or simply do not want to contemplate change. Specific concerns have been raised about traffic congestion, public transport provision and the hilly nature of the BGH site.

26.7 In answer to a question from Fran McCabe about health visitors, the committee was told that the BGH site is not used to provide a patient-facing health visitor service, so patients will not be adversely affected by the plans.

26.8 In response to a query by Cllr Hill as to the ambitions and the financial underpinning of plans, members were informed that the preferred option represents the simplest of the re-designs originally proposed. Any re-design must be wholly funded by disposing of some of the site for housing. SCFT need to secure a reasonable market value for this land to make their plans tenable, but do not need to secure maximum value for everything.

26.9 In answer to a question from the Chair about listed building status, the committee was told that A Block is listed, but that other aspects of the BGH site also have heritage value, including the flint wall curtilage.

26.10 Mr Jennings told members that there will be a mix of market, affordable and key worker housing on the BGH site. However, the precise details of this will have to be negotiated with developers. The Chair noted that he would like to see some extra care housing provision on the site also.

26.11 The Chair thanked Mr Jennings for his presentation and looked forward to future updates.

26.12 RESOLVED – that the report be noted.

27 SOUTH EAST COAST AMBULANCE NHS FOUNDATION TRUST (SECAMB): UPDATE ON QUALITY & PERFORMANCE

27.1 This item was presented by Steve Emerton, SECAmb Director of Strategy and Business Development; Andy Cashman – Regional Operations Manager: WEST; and Helen Wilshaw – Strategy and Partnerships Manager: WEST.

27.2 Mr Emerton told members that SECAmb is on a journey to improvement, and has seen significant advances in the past 12 months. There has been substantial new funding from CCGs following a Trust wide Demand and Capacity review, which has enabled the Trust to invest further in workforce and fleet throughout financial year 1819 to 2021. Performance in the Brighton & Hove City area is good, often meeting all targets set and has historically been so, although SECAmb has sometimes struggled in the wider Brighton and Hove CCG area to meet targets in the more rural parts of its patch.

27.3 Ms Wilshaw told the committee that SECAmb had worked hard with local commissioners and providers via the A&E Delivery Board and sub groups to reduce hospital handover delays and acute hospital conveyance where possible. Hospital handover performance is improving although some significant challenges remain and work is ongoing through a joint operational improvement group to enable continuous improvement. There has also been additional local focus on admission avoidance to

support more patients, where appropriate, in community facilities and at home. Specific focus areas of frailty, homelessness and falls have resulted in support initiatives and targeted resource, such as the 'longest one waiting' vehicle which aims to reduce very long patients waits for the lower acuity incidents at times of significant system pressure. Additional reporting has been developed, on frequent 999 caller nursing and care homes, to establish where further system support is required to reduce 999 calls and avoidable hospital admissions.

27.4 In response to a question from Cllr Marsh on category 3 calls, Mr Cashman explained that calls to 999 and referrals from GPs etc. are classified according to their urgency. Responses to category 3 calls will be slower than to categories 1 and 2, and where appropriate may involve sending a less highly-equipped vehicle.

27.5 In response to a question from Cllr Marsh about the new Make Ready Centre, Mr Cashman explained that this represents the implementation of long term aims. The centre will become operational by March 2020. There will be response posts across Brighton & Hove – not all ambulances will be despatched from the Centre at Falmer. HOSC members are invited to visit the current Brighton Ambulance Station at Elm Grove and then visit the new centre once complete.

27.6 In answer to a query from Cllr Deane about stroke response times, Mr Cashman told members that effective treatment for stroke was about identifying the most urgent cases and getting them to the most appropriate places for diagnosis and treatment. Ambulance response times are one part of this patient treatment journey.

27.7 In response to a question from Cllr Greenbaum about SECAmb involvement in the BHCC Outdoor Events consultation, the SECAmb representatives noted that they were unaware of the consultation. (Following the meeting SECAmb was sent a link to the on-line consultation. BHCC officers responsible for the consultation also explained that their plan has always been to engage fully with key partners, including SECAmb, in the second stage of this consultation. SECAmb have subsequently completed a submission as part of the consultation process.)

27.8 In answer to a question from Ms McCabe on managing falls risks, Mr Emerton told the committee that the Trust works hard to mitigate the risks of patients having to wait for a category 3 ambulance – e.g. by ensuring where possible that the patient is made comfortable and by keeping in touch with patients while they wait so as to be immediately aware of any deterioration. Helen Wilshaw added that it was important to ascertain whether someone was present and able to support the patient; this would be one factor in determining what type of ambulance response was appropriate. There is also further work to be done with care homes; in many instances there is no reason why care home residents need to be left where they fell until an ambulance arrives.

27.9 In response to a question from Cllr Janio on the proportion of unnecessary calls, Mr Cashman replied that this was difficult to estimate as callers may not always be in a good position to understand the seriousness of their condition. Placing more clinicians in call centres and building in more time to assess calls before a response is triggered should reduce the number of inappropriate call-outs. SECAmb also focuses on frequent callers to work out what their conditions are, whether they are receiving the support they

need and works directly with other health and social care colleagues to highlight additional needs.

27.10 In answer to a query from Cllr Greenbaum on the reliability of second-hand ambulances, Mr Emerton explained that the trust does plan for the need to make repairs when buying second-hand fleet. Most repairs are undertaken in-house, unless they are particularly specialist or can be done under warranty.

27.11 In response to a question from Cllr Morris on the categorisation of calls, Mr Cashman explained that this is based on national rules. Categorisation depends on the urgency of the call and also whether the problem is something that can be treated at the scene rather than requiring conveyance to hospital.

27.12 RESOLVED – that the report be noted.

28 NHS 111 PROCUREMENT: JANUARY 2019 UPDATE

28.1 This item was introduced by Colin Simmons, Coastal West Sussex CCG. Mr Simmons explained that the exercise to procure a new Sussex 111 service had been paused while commissioners investigated the potential for procuring a service jointly with Kent CCGs. This is indeed feasible and a redesigned 111 contract will be jointly procured with Kent CCGs.

28.2 Procurement decisions will be taken by a joint committee with delegated powers, rather than independently by each of the CCGs.

28.3 Procuring jointly with Kent presents an opportunity to make significant efficiencies. It is also the case that national requirements for 111 have been recently re-drawn and this required re-visiting the premise of the local contract.

28.4 The plans are now to award a contract in summer 2019, with mobilisation in the autumn.

28.5 In response to questions by Cllr Janio on the contract, Mr Simmons told members that the contract would be for five years with an option to extend for a further two years. There will be penalties if the provider fails to deliver the contracted level of service.

28.6 In answer to a question from Cllr Deane on technology issues, Mr Simmons told the committee that this was a significant aspect of the contract, particularly in terms of ensuring the interoperability of different NHS IT systems.

28.7 In response to a query from Cllr Marsh on transfer arrangements, Mr Simmons assured members that lessons had been learnt from recent procurements; a permanent team will manage the transition from the current provider.

28.8 RESOLVED – that the report be noted.

29 DIRECTOR OF PUBLIC HEALTH: ANNUAL REPORT

29.1 Alistair Hill, Director of Public Health, introduced this item, explaining that this year's DPH report focused on the links between health and the arts. The report uses the format of the 'four wells': starting well, living well, ageing well and dying well. The report's recommendations will be taken forward via the Cultural Framework.

29.2 The Chair congratulated Mr Hill and the Public Health team for the report.

29.3 In response to a question from Fran McCabe on how committed to this agenda the NHS is, Mr Hill replied that there is some CCG-funded arts related work locally, and the NHS Long Term Plan stresses the importance of social prescribing. Sussex Partnership NHS Foundation Trust is also extensively involved in art and culture. However, there is room to do more.

29.4 Cllr Deane noted that she agreed that arts and culture are integral to health and wellbeing, but was concerned that BHCC financial decisions may not support this. Mr Hill responded that the Annual Report seeks to argue the case for the value of investing in the arts.

29.5 RESOLVED – that the report be noted.

30 ESTABLISHING A JOINT HOSC (JHOSC)

30.1 This item was introduced by the scrutiny support officer.

30.2 Cllr Allen stated that he appreciated that BHCC would be required to join a mandated Joint HOSC (JHOSC), although he regretted this necessity. However, he saw no compelling argument to join a voluntary JHOSC, particularly since the May 2019 local elections could well lead to a very different HOSC membership. Victoria Simpson (council lawyer) confirmed that Cllr Allen was correct in saying that the Council would be required to join a mandated JHOSC, but that members have discretion regarding a voluntary JHOSC.

30.3 The Chair stated that he saw no reason not to join the JHOSC now and be fully involved in planning. Cllr Janio concurred, arguing that it was best to be fully involved at the start of the process.

30.4 Cllr Marsh stated that she had concerns about joining now, given the proximity of the local elections. She would therefore vote against. Cllr Morris also told members that he would vote against.

30.5 Cllr Greenbaum stated that she believed that there were good arguments to join now and also to refrain from joining. On balance, she would vote against joining at the present time.

30.6 Members voted on whether or not to accept the report recommendations, and agreed by six votes to two (with one abstention) to reject the recommendations.

30.7 RESOLVED – that the recommendations in the report be not accepted.

31 UPDATE FROM HOSC JOINT WORKING GROUPS

32 HOSC DRAFT WORK PLAN/SCRUTINY UPDATE

33 FOR INFORMATION - CORRESPONDENCE WITH BRIGHTON & HOVE CCG

The meeting concluded at 6:30pm

Signed Chair

Dated this day of