BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00pm 10 APRIL 2024

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Fowler (Chair)

Also in attendance: Councillor Baghoth (Deputy Chair), Evans, Hill, Nann, Robins, Wilkinson, O'Quinn, Shanks and Cattell

Other Members present: Geoffrey Bowden (Healthwatch), Theresa Mackey (Older People's Council)

PART ONE

28 APOLOGIES AND DECLARATIONS OF INTEREST

28A Substitutes

28.1 Cllr O'Quinn attended as substitute for Cllr Asaduzzaman
Cllr Cattell attended as substitute for Cllr Baghoth
Cllr Shanks attended as substitute for Cllr McLeay.

28B Declarations of Interest

28.2 There were no declarations of interest.

28C Exclusion of Press & Public

28.3 RESOLVED – that the press & public be not excluded from the meeting.

29 MINUTES

29.1 Members noted that Cllr Asaduzzaman's name had been misspelt in previous minutes. The support officer agreed to correct this.

29.2 RESOLVED – that the minutes of the 31 January 2024 meeting be agreed as an accurate record.

30 CHAIRS COMMUNICATIONS

30.1 The Chair gave the following communications:

Measles is a highly infectious disease which can lead to serious illness.

The measles, mumps, and rubella (MMR) vaccine provides excellent protection against measles, and it is free on the NHS.

To see if your child is up to date with their MMR vaccine, check their red book, or contact your GP practice. If anyone has missed one or both doses of the MMR vaccine, contact your GP practice to book an appointment. It's never too late to catch up on your MMR vaccination.

If you or a family member develops any symptoms of measles, contact your GP by phone. Please do not go to your GP, walk-in centre, or any other healthcare setting without calling ahead, as measles is very infectious.

Visit www.nhs.uk/mmr

31 PUBLIC INVOLVEMENT

31.1 There were no public questions.

32 ITEMS REFERRED FROM COUNCIL

32.1 There were no referrals from Council.

33 MEMBER INVOLVEMENT

33A – letter from Cllrs De Oliveira and Burden: RSCH A&E

33.1 Cllr Tristram Burden presented a letter from Cllr Burden and Cllr De Oliveira concerning conditions at the Royal Sussex county Hospital (RSCH) A&E department.

33.2 Introducing his letter, Cllr Burden told the committee that local residents had been in touch with him and with Cllr De Oliveira to share harrowing experiences of RSCH A&E. Problems included overcrowding; a lack of safe spaces for vulnerable people; the side corridor, which should be a quiet space being used to manage disruptive patients; and people being unable to hear their names being called due to the level of noise in the department. Cllr Burden recognised that there are medium term plans to make significant improvements to the RSCH emergency department, but was concerned that not enough is being done to manage pressures in the short-term.

33.3 The Chair responded: "I'd like to thank Cllrs De Oliveira and Burden for their letter. I'm sure that many of us have first-hand experience of the issues that they raise. We've had the hospital trust at previous HOSC meetings to talk about their capital plans, and it's really good news that almost £50 million has been secured to make improvements to the emergency department. This is a considerable amount of money in the current NHS capital funding context, and shows that the issues at the Royal Sussex are being taken seriously. We also appreciate that the pressures brought to bear in the Hospital Emergency Department are not solely due to emergency medical problems but issues relating to a lack of capacity in other parts of the health and care system, for example in mental health services.

However, these capital improvements won't happen overnight, and the HOSC does need assurance that absolutely everything that can be done to manage problems in the short term is being done. We have the Chief Executive of University Hospitals Sussex, Dr George Findlay, with us today to talk about the recent CQC inspection report on the trust, and I think this presents an opportunity for members to enquire about short term plans for A&E. We will need a dedicated item to explore this issue properly however, and if members agree, I am happy for it to be included on the agenda for the next scrutiny meeting. The hospital trust have said that they would be happy to attend a future meeting and will ensure that A&E leaders and representatives from across the local health and care system, including adult social care, Integrated Care Board commissioners, and other NHS providers, are present to provide operational detail.

33B letter from Cllr Hill: Council governance changes

33.4 Cllr Hill introduced her letter, telling the committee that it was not her intention to discuss the relative merits of cabinet and committee governance, but rather to make the case for a standalone Health Overview & Scrutiny Committee (HOSC). Cllr Hill noted that the proposed new People O&S committee would have a very broad remit and it was difficult to see how the very busy HOSC could be absorbed into a new committee without loss of focus. It was also important to recognise the valuable role played by HOSC's co-opted members. Any new arrangements should ensure that all current co-optees continue to play just as prominent a role.

33.5 The Chair responded "Thank you for your letter. The Council is currently reviewing its arrangements for Overview and Scrutiny in the light of the full Council decision on 28th March to move to a Leader and Cabinet system on 16 May . The proposals include a new Overview and Scrutiny system with two Committees, one dedicated to People and one to Place. The proposals, as I understand them, are for the People Scrutiny Committee to incorporate the HOSC functions. This is something that is done elsewhere and the agenda of the meeting can be divided so as to ensure focus on HOSC issues for a specified part of the agenda. The Council will ensure that the statutory requirements for Health Overview and Scrutiny continue to be met in the implementation of the new arrangements. The proposals have not been finalised and therefore it is not possible to provide further detail at this stage, however, I am keen to hear the views of our current co-optees which I will then be very happy to feed back for consideration as part of the design of the new system."

33.6 Geoffrey Bowden (Healthwatch) noted that Healthwatch England is increasingly looking at housing as a health issue. It would make sense for Healthwatch to be represented on any committees looking at the wider determinants of health in addition to being represented on the HOSC. Mr Bowden also noted that HOSC meetings are typically lengthy; it is evident from this that HOSC has plenty to do as a standalone committee.

33.7 Cllr Shanks noted that HOSC is a body focused on external scrutiny of NHS partners rather than internal scrutiny of council services; it makes little sense to combine these very different functions in a single committee. Also, the Sussex Integrated Care System is still in its infancy and requires close scrutiny.

33.8 Cllr O'Quin agreed that it was important HOSC continued to have a clear external focus. Future arrangements should definitely also include seats for all current HOSC co-optees.

33.9 Cllr Evans concurred that HOSC's status as an external committee should be preserved, as its effectiveness would be otherwise reduced.

33.10 Cllr Hill noted that the majority of councils do operate a standalone HOSC. It would also be helpful for there to be a clearer relationship and referral pathway between the health scrutiny committee and the Health & Wellbeing Board.

33.11 Theresa Mackey (Older Peoples Council) noted that she strongly supported the maintenance of a standalone HOSC.

33.12 The Chair thanked everyone for their contributions.

34 UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST: CQC INSPECTION REPORT (APRIL 2024 HOSC)

34.1 This item was introduced by Dr George Findlay, CEO of University Hospitals Sussex NHS Foundation Trust (UHSx).

34.2 Dr Findlay explained the Care Quality Commission (CQC) inspection process, and the context in which the most recent inspections took place. Points included:

- The recent inspection was of all 4 of the Trust's general hospital sites
- UHSx overall rating is 'requires improvement'. This tallies with the Trust's own assessment
- The CQC inspected in August 2023, but inspection reports were not published until February 2024. This delay is unfortunate, not least because significant improvements have been made in recent months
- The CQC found much good practice across the Trust, particularly in terms of the care provided to patients – the RSCH is rated 'outstanding' in the caring domain
- However, there were also negative findings, including waiting lists being too long; services failing to get some basics right; and a perceived lack of senior leadership visibility
- The CQC has acknowledged that improvements have been made since its inspections and has upgraded some scores accordingly
- All the CQC's 'must-do' actions will be implemented across the Trust (not just in the localities where a particular action is required).

34.3 In terms of specific areas highlighted by the CQC:

- Training and staffing – there have been significant improvements in training and recruitment since the inspections
- Equipment and checking – a daily safety check for key equipment has been instituted. This is reported via the UHSx Safety Dashboard
- Incident reporting – the UHSx rate is now higher than the national average (a high rate is a positive)

- Cancer – UHSx is now outperforming the national averages for cancer treatment
- Document management – the Trust is rolling out a fully electronic system over the next 12-18 months
- Culture – a member of the Executive Leadership Team is focusing on cultural improvement.

34.4 The Chair asked what was being done to make A&E more accessible for people with mental health issues and for the neurodiverse. Dr Findlay replied that the Trust works closely with Sussex Partnership NHS Foundation Trust to support patients who are neurodiverse or who have mental health needs. This includes having a 24 hour 7 day a week mental health liaison service at the RSCH. There is also an enhanced waiting space for people with mental health needs. However, there is no doubt that the mental health crisis pathway needs improving: a hospital emergency department will never be an optimal place for people with mental health problems to present for treatment.

34.5 The Chair asked whether there had been a missed opportunity to reconfigure the RSCH emergency department as part of the 3Ts redevelopment of the RSCH. Dr Findlay responded that emergency department redesign was never within the scope of 3Ts which received funding for the specific purpose of enhancing tertiary, trauma and teaching capacity. The Trust did enter into discussions about whether some of 3Ts phase 2 funding could be allocated to the emergency department, but this was declined, with around £50 million additional NHS capital funding instead allocated for ED improvement.

34.6 The Chair asked why UHSx does not buy beds at Craven Vale to ease discharge pressures. Dr Findlay responded that discharge is a system issue rather than just an issue for the acute trust. UHSx works closely with colleagues in adult social care to try to ensure the timely discharge of patients.

34.7 In response to a question from Cllr Shanks about working with primary care, Dr Findlay agreed that this is a key issue. It is not right to talk about ‘inappropriate attendance’ at A&E as very few people come to A&E without having serious concerns about their health. It is important that people are able to access primary care, and working between the hospital trust and local primary services is now really joined-up. The Trust is working with partners to refresh the Sussex Urgent Care Strategy which will also strengthen links with primary care. In addition, the Urgent Treatment Centre at the RSCH undertakes a really important role in treating and supporting people who do not require A&E.

34.8 Cllr O’Quinn noted that in her experience treatment at the RSCH A&E was consistently good, but waiting for treatment was consistently miserable, with lots of very vulnerable people waiting a long time to be assessed or treated. A&E feels chaotic and overcrowded, and this is not helped by some people using it for seemingly minor things like prescriptions which could be better provided elsewhere. Plans to expand A&E are welcome.

34.9 In response to a question from Cllr O’Quinn about the correct use of antibiotics, Dr Findlay assured members that this is an area of focus for the Trust.

34.10 Cllr O’Quinn asked a question about staff reporting feeling pressured to take on work they do not feel qualified to deliver or in unfamiliar settings. Dr Findlay responded by

stressing that staff are not asked to work beyond their competency. Staff may be asked to move around to cover gaps in service. This is sometimes unavoidable, but the Trust is working to minimise its occurrence and to provide more training so that staff feel comfortable working across a range of environments.

34.11 Cllr Evans asked a question about cancellations of elective procedures. Dr Findlay responded that this is a significant long term problem. Post-operative recovery beds are required for many elective surgical procedures, but when a hospital is under great pressure, these beds may be required for other purposes leading to planned operations being cancelled. Better flow through the hospital is the solution to this issue, and this is principally about reducing delays in the discharge of patients, the most common delay being because patients are waiting for social care packages. There are other factors impacting on elective surgery also, particularly in terms of an increasing demand for emergency procedures and for complex surgery. The Trust is working to increase its theatre productivity and capacity to address these issues.

34.12 Cllr Nann asked whether the problems at UHSx were fundamentally about senior managers not being good enough rather than flaws with systems. Dr Findlay disagreed that there was a problem with the quality of managers at the Trust. There has been recent recruitment of a number of new senior managers and non-executive directors, but many experienced leaders remain in post. The key to improvement is instituting effective processes rather than changing staff, and Dr Findlay is confident that the right leaders are in post, as evidenced by significant improvements across a range of service areas over the past 12 months.

34.13 Cllr Cattell voiced concerns about staff feeling confident that they can safely raise issues, noting that this is a long term problem for the NHS. Dr Findlay responded that this is a major focus at the Trust. Measures being taken include using the datix system to record incidents and commissioning an independent ‘Speak Out’ service, reporting directly to the Chief Executive on a monthly basis. Staff are speaking up and the focus is now on how their input is used: for example, a number of staff have raised concerns about the environment in A&E, but making improvements is not easy given the limitations of the current site.

34.14 In answer to a question from Cllr Hill on colorectal cancer cancellations, Dr Findlay told members that there have been fewer cancellations this year than last, in part due to the recruitment of more staff, in part because there is a ring-fenced colorectal theatre in the Louise Martindale Building. Where procedures have to be postponed, the aim is to reschedule as soon as possible. Both patient and staff feedback has been very positive about the relocation of this service.

34.15 In response to a question from Cllr Hill on staff training in autism, learning disability and in dementia, Dr Findlay told the committee that training is going well with more than 90% of relevant staff receiving this training as part of mandatory safeguarding courses.

34.16 Cllr Robins highlighted a CQC finding that staff do not always feel properly trained or competent to fulfil their roles. Dr Findlay told members that the CQC report reflects what staff have said to the CQC. However, the Trust has a robust onboarding process for all staff, and would never require staff to work beyond their competence. Many staff do feel uncomfortable being asked to work in unfamiliar environments, and whilst the Trust

makes an effort to minimise this, it will sometimes happen. However, staff feeling uncomfortable in an unfamiliar environment is not the same as staff lacking competency.

34.17 In response to a question about meeting statutory waiting targets, Dr Findlay told the committee that strikes have had an impact on waiting times, as the Trust has had to prioritise emergency care. UHSx has been making improvements to waiting times nonetheless, although there is much more work to be done and no one thinks that the current position is good enough. In terms of the 4 hour A&E wait target, performance is currently around 70% (the national standard is 78%). New surgical and medical assessment units will help to improve performance, but the biggest obstacle to improvement remains people being unable to access a bed because of delays in discharge.

34.18 Geoffrey Bowden asked a question about the recruitment of international staff. Dr Findlay replied that the Trust is focused on having as high a percentage of permanent staff as possible. There is a major drive to recruit locally, for example, by working with Higher Education to offer a guaranteed position to people graduating. However, international recruitment is also key to recruiting effectively and the Trust has recruited around 120 international staff in the past year. This is done ethically, with the focus being on recruiting from countries that train more nurses than their own health systems require.

34.19 In response to a question from Cllr Nann on staff being required to work beyond scope, Dr Findlay reiterated that staff are never required to work beyond their competency. If staff feel that this is happening and flag their concerns then this will be addressed immediately.

34.20 Cllr Hill asked a question about surgical consultant recruitment, and whether the Royal Colleges are always involved in recruitment. Dr Findlay responded that The Royal Colleges are invited to take part in all surgical consultant recruitment. However, it's not always possible to find a diary slot that they can do without delaying recruitment to vital posts. The recruitment of surgical consultants is a rigorous process which always involves a Non-Executive Director, the Chief Medical Officer and the CEO/deputy CEO and others, so the process is a robust one whether or not the Royal Colleges accept a specific invitation to participate in a recruitment. The Trust only recruits consultants who are on the specialist register.

Dr Findlay subsequently wrote to the HOSC chair to apologise for inadvertently misleading the committee in the above response as Royal College representatives had not been as routinely invited to attend doctor appointment panels as he understood. This has since been rectified. To note, as a Foundation Trust, UHSussex is not required to do this but the Trust confirmed it appreciates Royal Colleges input and wishes for them to have an opportunity to participate.

34.21 In response to a question from Cllr Shanks on whether the provision of more key worker housing would make recruitment easier at the Trust, Dr Findlay told members that UHSx is a health provider only and that questions about the supply of key worker housing should be addressed to the city council.

34.22 Theresa Mackey enquired why the CQC had reported issues with the Trust collecting staff sickness data. Dr Findlay responded that it was unclear why the CQC stated this as UHSx has robust processes to monitor sickness and is performing relatively well.

34.23 In response to a questions from Ms Mackey on the assurance process for performance improvement, Dr Findlay told members that key metrics are measured daily and reporting via Trust systems in real time.

34.24 The Chair asked a question about late night discharge from hospital. Dr Findlay responded that discharge from in-patient beds should be early in the day. The current median discharge time is 5pm, but there is work ongoing to reduce this and some services now discharge more than 50% of patients by noon each day. Where patients are discharged out of hours, there will be community sector support to help people get settled at home. The process for discharging patients being assessed is somewhat different and these patients will be discharged whenever is appropriate.

34.25 The Chair thanked Dr Findlay for his contributions.

34.26 RESOLVED – that the report be noted.

35 NON-EMERGENCY PATIENT TRANSPORT (NEPTS): CONTRACT AWARD AND MOBILISATION

35.1 This item was introduced by Colin Simmons, NHS Sussex Deputy Director, Commissioning & Transformation; and by Craig Smith, EMED Group CEO.

35.2 Ms Simmons told members that the new Non-Emergency Patient Transport (NEPTS) contract was very different from the previous contract. Changes include:

- A New focus on signposting people who are ineligible for NEPTS to alternative services
- More focus on supporting people with mental health issues, including detained patients
- Support to help providers achieve rapid discharge of patients
- A 12 month mobilisation period for the new contract
- There has been lots of public engagement of the new contract model
- Healthwatch have been involved at all stages of designing the new contract
- The new contract emphasises communication with patients and health providers before and during journeys
- Digital is very important, but it is also important to recognise that digital solutions do not work for everyone.

35.3 Craig Smith introduced EMED:

- EMED is one of the largest NEPTS provider in England, managing more than 1.5 million patient journeys a year
- EMED recently won the Surrey NEPTS contract and this has now gone live. This is going well and will provide useful learning for the mobilisation of the Sussex contract

- EMED is committed to a patient-centred approach and to using metrics that capture success in achieving this
- Mobilisation will need to be handled carefully as the new contract is fundamentally different to what is in place currently.

35.4 Cllr Hill asked whether there were supply chain issues with procuring ambulances. Mr Smith responded that this is not anticipated to be a problem.

35.5 Geoffrey Bowden asked what percentage of the fleet was environmentally sustainable. Mr Smith responded that there will be a rolling replacement process over the 10 years of the contract with a relatively small percentage of electric vehicle at the start of the contract, but increasing over time. There is a premium to purchase electric ambulances, but this is not a simple calculation as it depends on the life of different types of vehicle.

35.6 In response to a question from Cllr O'Quinn on electronic vehicle risks, Mr Smith acknowledged that battery fire was one of a number of risks considered. However, battery longevity is the main risk. Cllr Hill noted that battery fires are more commonly associated with electric scooters, rather than with cars and vans.

35.7 The Chair asked what was being done to ensure that patients were not offered transport on vehicles making multiple picks-up and consequently taking a long time to get people to and from their appointments. Mr Simmons responded that effective journey planning relies on the provider having good data to use to plan journeys. EMED is very experienced in collecting and using this type of data.

35.8 The Chair thanked the presenters for their contribution.

35.9 RESOLVED – that the report be noted.

The meeting concluded at Time Not Specified

Signed Chair

Dated this day of