**BRIGHTON & HOVE CITY COUNCIL**

**HEALTH OVERVIEW & SCRUTINY COMMITTEE**

**4.00pm 10 JULY 2024**

**COUNCIL CHAMBER, HOVE TOWN HALL**

**MINUTES**

**Present**: Councillor Fowler (Chair)

**Also in attendance**: Councillor Baghoth, Evans, Hill, Galvin, Mackey, O'Quinn and Theobald

**Other Members present**: Geoffrey Bowden (Healthwatch Brighton & Hove), Mo Marsh (Older People's Council), Nora Mzaoui (CVS representative)

## PART ONE

### 1 PROCEDURAL BUSINESS

36(a) **Substitutes and apologies**

36.1 Cllr Theobald attended as substitute for Cllr Hogan.

36.2 Apologies were received from the Youth Council.

36(b) **Declarations of interest**

36.3 There were none.

36(c) **Exclusion of the press and public**

36.4 RESOLVED – that the press and public be not excluded from the meeting.

### 2 MINUTES

2.1 The Chair informed members that, following the April HOSC meeting she had contacted the Chief Executive of University Hospitals Sussex NHS Foundation Trust (UHSx) seeking a clarification of some remarks he had made at the meeting. Dr Findlay responded, apologising for inadvertently misleading the committee when he had stated that the Royal College of Surgeons was always invited to participate in the recruitment of surgical consultants. Dr Findlay believed this to be the case, but had subsequently learnt that the Royal College had been invited to participate in some, but not all recruitments. Whilst NHS Foundation Trusts are not required to involve the Royal

Colleges in recruitment, they will be invited to participate in all future recruitment. There is a note in the minutes explaining this correction.

**2.2** **RESOLVED -** the minutes of the 10th April 2024 committee meeting be approved as an accurate record.

## 3 CHAIR'S COMMUNICATIONS

3.1 The Chair gave the following communications:

I'd like to welcome everyone to the Health Overview & Scrutiny Committee. We have some new members and some members who have been with us for a while, or who are returning after some time away from the committee.

The council has recently adopted a new governance system, including 2 new Overview & Scrutiny committees, people and place, which will focus on council services, including adult social care and council-run Public Health. The HOSC will continue to hold local NHS services to account for the planning and delivery of service to local residents. However, where there's a significant cross-over between NHS services and council care or public health, as in today's item on A&E pressures, the HOSC will continue to work with council departments as well as NHS partners.

As we're not a new committee, we are not starting from scratch, and we have a number of legacy issues which we are committed to scrutinising, including the performance of local NHS providers and the provision of trans healthcare. However, there will be an opportunity for members to help shape the HOSC work plan going forward, and I will be asking officers to arrange an informal work planning meeting to which all members, including our co-optees will be invited to contribute.

## 4 PUBLIC INVOLVEMENT

4.1 There were no public involvement items.

## 5 MEMBER INVOLVEMENT

5.1 There were no member involvement items.

## 6 LIVER DISEASE AND PALLIATIVE CARE

6.1 This item was presented by Jo Harvey-Barringer. Dr George Findlay (University Hospitals Sussex NHS Foundation Trust [UHSx] Chief Executive); Professor Catherine Urch (UHSx Chief Medical Officer); Dr Andrew Heeps (UHSx Chief Operating Officer and Deputy Chief Executive) and Peter Lane (RSCH Hospital Director) joined the meeting remotely. Ms Harvey-Barringer had asked to address the committee on her experiences of the care provided to her wife, Joanne, after she was diagnosed with liver disease; and on problems she had encountered accessing palliative care for her partner in the last months of her life.

6.2 Ms Harvey-Barringer outlined the progress of her wife's care, from initial diagnosis to her eventual death. Ms Harvey-Barringer described a number of instances where aspects of care, communication, or the attitude of staff were of an unacceptable standard. In particular, many aspects of hospital care did not allow Joanne the dignity and respect she was due; and although community palliative support was excellent, there was insufficient hospital-based support.

6.3 The Chair thanked Ms Harvey-Barringer for addressing the committee, noting that it must take a lot of courage to speak in public about such distressing experiences.

6.4 Professor Catherine Urch (UHSx Chief Medical Officer) told the committee that Ms Harvey-Barringer has raised a number of important points and thanked her for sharing her testimony. Professor Urch offered to meet with Ms Harvey-Barringer to discuss what the Trust can do to change. Dr George Findlay (UHSx Chief Executive) reiterated that the Trust was happy to follow up on all of the issues that Ms Harvey-Barringer had raised.

6.5 Cllr Wilkinson noted that patients with liver disease often require extensive palliative care. He asked that the committee focus on local provision of palliative and end of life care at a future meeting.

6.6 Geoffrey Bowden (Healthwatch Brighton & Hove) told members that he used to help run the GB Association for the Study of the Liver, and was acutely aware of the important role palliative care plays in liver disease. Mr Bowden also noted that Healthwatch Brighton & Hove deals with numerous issues relating to dignity and respect. He offered to meet with Ms Harvey-Barringer to discuss how Healthwatch might assist her.

6.7 Mo Marsh (Older People's Council) supported calls for palliative/end of life care to be scrutinised by the committee.

6.8 Cllr Galvin asked whether early primary care diagnosis may have helped Joanne. Ms Harvey-Barringer responded that as far as she was aware, the GP had done everything they should: prior to her diagnosis Joanne had been receiving regular liver function tests due to some thyroid issues.

6.9 Cllr Evans told members that no one should face discrimination because of perceptions that their illness may have been partly caused by their own behaviour. She echoed calls for the committee to scrutinise palliative/end of life care.

6.10 Cllr Baghoth noted that it was sometimes the case that patients make a choice not to receive much information about their condition. Ms Harvey-Barringer responded that this was not the case with Joanne; although Joanne was sometimes forgetful because of her illness, she did want information, and Ms Harvey-Barringer helped her by leaving lists of questions with her. However, this did not lead to improved communication with hospital staff.

6.11 The Chair thanked Ms Harvey-Barringer for her attendance at the meeting and noted that the support officer would make introductions to Professor Urch and Mr Bowden so they could follow-up with Ms Harvey-Barringer outside the meeting. The Chair also read out a statement from the Sussex Integrated Care Board:

**ICB statement on Palliative Care**
The NHS Sussex Palliative and End of Life Care (PEoLC) commissioning team would like to thank Jo Harvey Barringer for raising concerns regarding the care her late wife Joanne received following a diagnosis of cirrhosis of the liver. We are sorry that your experience of care did not live up to the high quality we would wish for people across Sussex.

The palliative and end of life care services that NHS Sussex commission are intended for all people to access irrespective of diagnosis and are not commissioned solely for those with a cancer diagnosis. We are therefore saddened to hear that Joanne's non-cancer diagnosis appears to have been a barrier to her receiving that high quality of end of life care we strive for.

We continually work to improve the care that the population of Sussex receive at the end of their life, and consciously work in a way that is inclusive of those with non-cancer as well as cancer diagnoses. For example, by working together we have now been able to launch a Pan Sussex Standard Operating Procedure (signed up to by all providers) with a full suite of supporting documentation to deliver safer and more consistent PEoLC (palliative & end of life care) medication for adults with any condition being cared for in the community.

Looking forward we are working to implement a Sussex-wide all hours PEoLC (palliative & end of life care) co-ordination hub. The introduction of this hub should enable the experience of those being cared for in the community to be of a significantly higher standard than Jo has described regarding her late wife's care. It will be a part of the work being developed within in the formation of Integrated Community Teams (ICT) in Sussex. The initial focus of ICT Development will on be about improving care and support for those with complex needs. Many of those with PEoLC (palliative & end of life care) needs will be included in that first cohort so NHS Sussex is confident that this will improve the care for that sector of our population.

**To provide further detail of the way in which we have been working to improve the provision of PEoLC** (palliative & end of life care) **care.**
The NHS Sussex PEoLC (palliative & end of life care) team co-ordinates a Pan Sussex PEoLC (palliative & end of life care) Programme Oversight Group, which convenes every 2 months, with stakeholders across the whole Integrated Care System represented. This group looks at PEoLC (palliative & end of life care) provision for people of all ages with the aim of identifying ways to improve service provision.

The group developed a Sussex PEoLC (palliative & end of life care) strategic action plan to reflect a number of workstreams being undertaken which in addition to those already highlighted include:

- The introduction of the ReSPECT process (**Re**commended **S**ummary **P**lan for **E**mergency **C**are and **T**reatment) to facilitate the creation ReSPECT plans to reflect patient's wishes for the care they receive when they have health crises and cannot express their views in those crisis situations. This supports patients to receive the level of care they wish for in their preferred place of care.

- Input into service specification for the Frailty and End of Life Care Locally Commissioned Service to improve identification of those who are likely to be in the last year of life in the Primary Care setting, allowing for anticipatory care planning conversations to take place in a timely fashion to support the delivery of the right care in the right place.
- Co-ordination of an education programme, funded by NHS Sussex, and delivered by Hospice colleagues to support the whole Sussex workforce involved in the care of those with PEoLC (palliative & end of life care) needs, including for staff working in the social care sector.

These agreed workstreams are our starting ambition to achieve our collective aim in Sussex 'to continue to make the last stage of a person's life as good as possible, through working together confidently, honestly, and consistently to help each individual and the people important to them'. We acknowledge there is still work to be done and all feedback on experiences, negative as well as positive, is considered as we reflect and work together to improve care for people at the end of their life.

6.12 Members agreed that palliative/end of life care should be added to the committee work programme, and that scrutiny of this issue would be informed by the work that Healthwatch Brighton & Hove has already undertaken.

## 7 ROYAL SUSSEX COUNTY HOSPITAL A&E PRESSURES

7.1 The Chair told members that this item arose from a letter to the last HOSC by Cllrs De Oliveira and Burden, expressing concerns about conditions at the Royal Sussex A&E. The committee did explore some of these issues with Dr Findlay, CE of University Hospitals Sussex, at the last meeting, but members were keen to have a dedicated item at the following meeting. Members also agreed that a future item should have a whole health & care system focus, recognising that A&E is not just about the hospital trust.

7.2 The item was presented by Claudia Griffith, NHS Sussex Chief Delivery Officer. Ms Griffith was joined by Dr George Findlay, UHSx Chief Executive; Dr Andy Heeps, UHSx Chief Operating Officer and Deputy CEO; Professor Katy Urch, UHSx Chief Medical Officer; Peter Lane, UHSx Hospital Director for the Royal Sussex County Hospital; John Child, Chief Operating Officer, Sussex Partnership NHS Foundation Trust; Steve Hook, BHCC Interim Corporate Director (Health & Adult Social Care), Housing, Care & Wellbeing; and by Chloe Rogers, Sussex Community NHS Foundation Trust, Area Director (Brighton & Hove).

7.3 Ms Griffith told the committee that the Royal Sussex County Hospital (RSCH) A&E department faces significant pressures and that the local health and care system works together to meet these challenges. RSCH A&E is a busy department, with 270-300 patients per day. The site is also very constrained, which makes managing these patient numbers complex. There are high levels of attendance from people living locally, from

people in deprived communities, and from students and younger people. There are particular challenges in meeting the statutory 4 and 12 hour waiting time targets and in terms of patient experience.

7.4 In the long term, there is a plan to re-build the RSCH emergency department., and NHS capital funding is reserved for this. In the short term, system partners are taking a number of measures to mitigate pressures. These include:

- The Urgent Treatment Centre situated next to A&E
- The use of virtual wards
- Funding for additional GP appointments
- Better use of community pharmacy capacity
- The Brighton walk-in centre
- Better liaison with and support for care homes
- Outreach work with the local nighttime economy
- Additional support for the most vulnerable groups (e.g. homeless and rough sleepers via Arch GP practice)
- A focus on high intensity (repeat) users, with services supporting those who attend A&E most frequently
- Additional primary care appointments can be offered to people presenting at A&E
- A homeless team operates in A&E providing support to homeless and rough sleeping patients.

7.5 Chloe Rogers informed members of services that Sussex Community NHS Foundation Trust (SCFT) is involved in. These include:

- An Emergency Community Response Team (around 200 referrals per month). The team is meeting national 2 hour targets and is able to handle increasingly complex cases
- SCFT works closely with ambulance services, attending in response to calls in situations where they can offer a better treatment option than an ambulance call-out
- Virtual wards – these offer an alternative to hospital admission for some patients
- Admission prevention – there is a team at A&E meeting patients from ambulances and providing care instead of admission where appropriate.

7.6 Dr George Findlay informed the committee that UHSx is focused on the 4 hour wait target; there has been improvement, but there is still some way to go. Similarly, waits associated with ambulance handovers have improved, but more work is needed. Although the number of people presenting at A&E has remained fairly stable, we are seeing a higher proportion of people who require hospital admission.

7.7 Peter Lane told members that other measures being taken to mitigate A&E pressures include:

- The use of a continuous flow model to make flow through the RSCH as efficient as possible
- The introduction of a surgical assessment unit
- Development of a pharmacy first programme
- Regular staff huddles to better manage flow
- A focus on reducing the time it takes for patients in critical care to be transferred to a ward environment.

7.8 Ms Griffith outlines some measures being used to streamline discharge processes. These include:

- Working in partnership with VCS organisations which offer a 'settle' service to help patients immediately following discharge
- A transfer of care hub – a multi-disciplinary team which focuses on discharge arrangements for more complex patients
- Maximising the use of community bed capacity
- A team which supports patients once they have returned home.

7.9 John Child told members that:

- Patients whose discharge from acute mental health beds is delayed due to waiting for supported accommodation, nursing placements and packages of care (patients clinically ready for discharge) is the root cause of people waiting at A&E for admittance to an acute mental health bed.
- Sussex Partnership NHS Foundation Trust (SPFT) is working with system partners to address this issue: e.g. via the Sussex Mental Health and Housing Programme.
- There are many more initiatives ongoing, including improving the urgent and emergency mental health care pathway, focusing on admission avoidance through enhanced community services, the Sussex Mental Health Helpline, and remodelling the SPFT crisis and home treatment teams
- There is no single initiative that will resolve the long standing challenges rather a series of planned improvements across urgent, acute and community mental health services with each having an incremental impact.
- Whilst the pressures remain there have been improvements- the number of patients assessed as needing hospital admission each month has reduced over the last 18 months, the number of patients waiting and the length of time waiting have also improved since highs in autumn 2023

7.10 Steve Hook told the committee that A&E is part of a much larger system, with flow through and out of the hospital a critical factor in managing A&E capacity.

- There are two hospital social work teams, one focusing on acute beds and the other on step-down beds
- Around 200 people are supported at any one time
- The Sussex system is challenged, but there is a major focus on discharge and this is having an impact – currently there are around 20 patients in RSCH who are medically fit for discharge but awaiting a care package; this is down from an average of around 30 at Easter
- There is a focus on improving pathways into step-down beds and into the Discharge to Assess initiative (where patients receive care assessments once they have returned home)
- There has been an increase in in-house reablement beds at Craven Vale
- Adult social care works closely with SCFT to prevent admissions, with around 1500 patients seen in the last year. The team helps divert lots of activity from the RSCH emergency department.

7.11 Cllr Evans noted that the Secretary of State for Health had recently described the NHS as 'broken'. Cllr Evans stated that we know that the problems with A&E locally are being repeated across the country, and, although it is good to hear about effective initiatives,

we should not pretend that the system is functioning well. Dr Findlay replied that he challenged the notion that the NHS was broken: there are significant problems across the country and patient experience is often not great, but staff are working very hard and the great majority of patients continue to receive good care. Patient feedback from the RSCH emergency department is over 80% positive.

7.12 In response to a question from Cllr Wilkinson on rates of people presenting at RSCH A&E with mental health problems compared to other parts of the country, John Child agreed to provide a written response.

7.13 In response to a question from Cllr Wilkinson on the success to date of the Mental Health Urgent & Emergency Care Improvement Plan, Mr Child told members that the situation at RSCH has improved, but significant challenges remain. There are smaller numbers of patients waiting for a mental health bed, but some people are waiting far longer than they should.

7.14 Mo Marsh told the committee that care in RSCH A&E is excellent, but that communication between hospital departments and primary care is often poor; that patient experience is often not good, particularly in terms of waiting times; much more work is needed on patient records; and a more holistic approach to care is required. Ms Griffith responded, acknowledging that there can be a disconnect between services. However, this is being addressed via the Integrated Care Team (ITC) programme. Digital patient records are being improved also, although there is still a long way to go.

7.15 The Chair noted that she had heard about a number of GP appointments being cancelled. Ms Griffith responded that she was happy to follow up on this outside the meeting.

7.16 In response to a question about disruption to the hospital when the Emergency Department is reconfigured, Dr Findlay responded that the Trust is well-used to managing complex building projects on the RSCH site.

7.17 In response to a question from Cllr Baghoth on why there are such long waits at RSCH A&E when the numbers of people attending are not unusually high, Dr Findlay responded that there are not more people attending, but their care needs are increasing and they do take longer to treat. However, the main issue is flow through the site rather than demand. The system needs to work together to tackle delays in discharge and to reduce average length of stay.

7.18 Geoffrey Bowden noted that the NHS treats around 1.7 million people a day, with an increasingly older population and greater deprivation and with a third less beds than 25 years ago. The NHS is not broken, but staff are doing an amazing job to continue to deliver services despite these challenges.

7.19 In response to a query raised by Cllr Evans about hospital staff not always volunteering their names, Dr Findlay responded that all staff should be wearing ID (this is regularly checked), and that staff are encouraged to use their names when talking to patients.

7.20 In response to a question from Cllr Hill on the Red Cross homeless support service, Ms Griffith told the committee that the system works with the Red Cross to evaluate people

with a homeless/rough sleeping background to ensure they are offered wrap-around care so as to mitigate the risk of an escalation of their health problems.

7.21 In answer to a question from Cllr Hill on the processes to recruit surgical consultants, Dr Findlay confirmed that processes have been refreshed and the Royal Colleges are being invited to all panels, although they are not always able to attend, and there is no requirement for them to be involved in recruitment.

7.22 The Chair thanked everyone attending for their contributions.

## 8 WINTER PERFORMANCE 2023-24

8.1 This item was presented by Claudia Griffith, NHS Sussex Chief Delivery Officer. Ms Griffith told the committee that a report on local health and care system planning for winter 2023-24 had been presented to the Brighton & Hove Health & Wellbeing Board in November 2023, and that the report before members today was to follow up on this. The health and care system plans every year for additional pressures over the winter period, particularly in terms of the demand for hospital services. The aim is to mitigate risk, especially in terms of risk to the most vulnerable people and communities. Steps taken over the past winter included a mix of demand management, admission avoidance and flow improvement measures:

- Additional capacity for the 111 phone service (there were still some capacity problems and more work with the provider, South East Coast Ambulance NHS Foundation Trust, is needed to address these going forward)
- 27,000 more GP appointments (67% of these face to face)
- 98% of community pharmacies signed up to the pharmacy first initiative which empowered pharmacies to treat and prescribe for certain conditions
- There was generally good vaccination take-up
- A single point of access for hospital admissions avoidance services helped coordination, especially with support to care homes
- There was expanded virtual ward capacity, with 192 virtual beds made available. However, benchmarking shows this is a relatively under-used service with room to expand
- There was reduced attendance at hospital A&E by people seeking help for mental health issues
- Length of stay in community beds was reduced
- There was successful falls prevention work led by the city council
- There was effective workforce support, with lower levels of sickness than in the previous year
- Industrial action had a significant impact, but there was also excellent partnership working to support the acute sector and minimise the negative impact on patients.
- Learning for future years includes the need to focus more on supporting the most vulnerable people; and on further simplifying urgent care pathways in order to divert patients from A&E.

8.2 Cllr Wilkinson asked for details of winter plan actions that had not been fully met due to resource constraints. Ms Griffith agreed to provide a written response.

8.3 Cllr Hill asked for details of any regional evaluation of the effectiveness of virtual wards. Ms Griffith agreed to pick this up with regional colleagues.

**8.4 RESOLVED –** that the report be noted.

The meeting concluded at 7:15pm

Signed Chair

Dated this day of