Agenda Item 19

BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00PM 14 JULY 2010

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillors Peltzer Dunn (Chairman); Allen (Deputy Chairman), Barnett, Harmer-Strange, Kitcat, Marsh and Rufus

Co-opted Members: Robert Brown (Brighton & Hove LINk)

PART ONE

1. PROCEDURAL BUSINESS

1A Declarations of Substitutes

1.1 There were none.

1B Declarations of Interest

1.2 Councillor Mo Marsh declared a personal and non-prejudicial interest in Item 12.

1C Declarations of Party Whip

1.3 There were none.

1D Exclusion of Press and Public

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

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

1.6 Apologies were received from Duncan Selbie, Chief Executive of Brighton & Sussex University Hospital Trust; Julian Lee, Chair of Brighton & Sussex University Hospital

Trust; Alan McCarthy, Chair of NHS Brighton & Hove; and Jack Hazelgrove, Representative of the Older People's Council.

2. MINUTES OF THE PREVIOUS MEETING

2.1 Cllr Harmer-Strange noted that the committee had not yet received information promised at the last meeting with regard to data on car parking at the Royal Sussex County Hospital. This will be followed up by officers.

2.2 Members discussed a resolution made at the last meeting to establish a working group to examine NHS Brighton & Hove's Annual Operating Plan. Cllrs Allen, Harmer-Strange and Rufus agreed to sit on the working group.

2.3 RESOLVED – That the minutes of the meeting held on 14 April 2010 be approved and signed by the Chairman.

3. CHAIRMAN'S COMMUNICATIONS

3.1 There were none.

4. PUBLIC QUESTIONS

4.1 There were none.

5. NOTICES OF MOTION REFERRED FROM COUNCIL

5.1 There were none.

6. WRITTEN QUESTIONS FROM COUNCILLORS

6.1 A written question was received from Cllr Kitcat. Beverly Thorp, Associate Director for Women and Children, responded to the question on behalf of Brighton & Sussex Universities Hospital Trust (BSUHT).

6.2 Ms Thorp told members that all wards at the Royal Alex Children's Hospital were currently open, although not every ward was operating at full capacity. The Alex had opened with approximately 50 beds, with the intention being to gradually step up to full capacity (100 beds). Current capacity is 70+ beds, and this is expected to grow as the Alex develops and as the trust is able to repatriate more patients from out-of-county placements. The relocation of children's A&E from the Royal Sussex County (RSCH) site is ongoing, with additional paediatric consultant and nurse posts being recruited.

6.3 In response to a further question from Cllr Kitcat, Ms Thorp informed members that the Alex has provision for 3 Intensive Care (IC) beds, although only one of these is currently operational. There are no immediate plans to bring more IC beds on-line, as the Alex could not readily rota the specialist staff required to run 3 beds without significantly expanding its general services (to the likely detriment of other providers in Sussex). The Alex has, however, concentrated on expanding its resource of High Dependency (HD)

beds, and now has 7 in operation. These beds allow the hospital to cope with a wide range of conditions, although it may always be necessary to send some patients for very specialised care in London hospitals. Amanda Fadero, Chief Executive, NHS Brighton & Hove, added that the Sussex population was not large enough to support a full paediatric IC unit, but that the PCT was committed to developing the Alex as a tertiary resource for the whole of Sussex.

6.4 Robert Brown, LINk representative, informed members that the LINk was eager to promote the Royal Alex, and wanted to encourage BSUHT to invite children into the Alex in advance of elective procedures. Beverly Thorp confirmed that BSUHT had been involved in useful discussions with the LINk on these issues.

6.5 In response to a question from Mr Brown concerning children's cardiac surgery, Ms Thorp told members that there were no plans to perform this surgery in Brighton, but that BSUHT did have arrangements for a consultant cardiologist to visit the Alex to support families with cardiac issues.

6.6 In response to a question from Cllr Rufus regarding the cost implications of running the Alex below capacity, Ms Thorp told members that the Alex was not currently running at a loss. The trust's long term vision was to increase use of the Alex, particularly by moving services for children currently provided at RSCH (e.g. Audiology and ENT) to the Alex, and by promoting the Alex as the Sussex tertiary centre for children's care. Amanda Fadero added that the Alex operating at less than full capacity might be a reflection on recent developments in children's care, particularly in terms of greater emphasis on community-based services. Providing services in the most appropriate settings, even if this entailed under-utilisation of acute beds, should be welcomed.

6.7 Members thanked Ms Thorp for her contribution.

7. DELIVERING OUR VISION FOR THE NHS IN THE REGION IN ECONOMICALLY CHALLENGING TIMES

7.1 This item was presented by Amanda Fadero, Chief Executive, NHS Brighton & Hove. Ms Fadero told members that much of the NHS change required in coming years would be co-ordinated at a local level by NHS Brighton & Hove. However, it made sense to undertake some work across Sussex, with one or other of the Sussex PCTs leading on different work streams. For a number of work streams this would mean that NHS West Sussex was the lead PCT; however, in all instances, NHS Brighton & Hove would remain accountable to local residents.

7.2 The main pan-Sussex areas of priority are:

- Major trauma
- Pathology
- Dementia
- Rehabilitation
- Stroke Care
- Change Management

Details of many of the planned changes and the health 'gains' they may produce for local residents are contained in NHS Brighton & Hove's Annual Operating Plan (AOP). The South East Coast Strategic Health Authority (SHA) has recently issued a 'challenge' to regional PCT AOPs (e.g. questioning whether planned improvements could be made more quickly etc), and NHS Brighton & Hove is currently examining its current AOP and its longer term Strategic Commissioning Plan in light of this challenge.

7.3 In response to a question from Cllr Kitcat on the recently announced plans to phase out Primary Care Trusts (PCTs), Ms Fadero told members that PCTs still had a good deal of work to accomplish, both in terms of continuing to commission high quality services and in terms of ensuring that GP commissioners were adequately prepared to take on commissioning roles. Although the immediate future would see a good deal of integrated working by regional PCTs (e.g. the Sussex Commissioning Unit), most commissioning activity would still take place at a local level.

7.4 Ms Fadero was thanked for her contribution.

8. AD HOC PANEL ON GP-LED HEALTH CENTRE: 1 YEAR UPDATE

8.1 This item was introduced by Juliet Warburton, Head of Primary and Community Care, NHS Brighton & Hove, and by Derek Witt, Care UK General Manager.

8.2 Members were told that the Centre had experienced a very successful first year, and had over-performed in terms of both patient registration and unregistered patient visits to the walk-in centre. Patient satisfaction was also very high. The Centre did have some 'partly achieved' scores in terms of its contract targets, but these were thought to be due to factors relating to the recent opening of the centre (e.g. some records re: patient satisfaction were incomplete, but this was because there were too few patients attending the centre in its first few months of operation to make data collection via the national Patient Survey tenable). NHS Brighton & Hove is confident that these standards will be met in the current year.

8.3 The committee was informed that work was ongoing to gauge what impact the opening of the Centre may have had on local A&E admissions.

8.4 In terms of any negative impact on neighbouring GP practices, members were told that there was no evidence thus far of any such issues.

8.5 In answer to a question relating to 'continuity of care' at the Centre, Mr Witt told members that Care UK employed a permanent team of salaried GPs to staff the Centre, and was therefore confident that continuity of care was good. Ms Warburton added that, if patients were unhappy with the continuity of care provided, this would be flagged up in patient satisfaction surveys – but currently survey data shows no such concern.

8.6 Ms Warburton told members that it had been necessary to sign-post some attendees away from the Centre's walk-in service towards the end of the year, as the Centre had over-performed on this service and more costs would have been incurred by NHS Brighton & Hove had the walk-in service continued to see all patients who presented for treatment. The second year of the contract provides for an increase in walk-in patients, so this problem should not repeat itself. The diversion of patients was closely monitored,

and all patients who required urgent treatment were dealt with promptly. There were no patient complaints arising from the diversion to other services.

8.7 In response to a question on the high number of unregistered patients visiting the Centre who did not reveal the identity of their own GP, Ms Warburton told members that many patients, particularly younger ones, simply did not know who their GP was, although some patients may actively have chosen to visit the Centre rather than their GP (e.g. to discuss issues they would have felt embarrassed to raise with their own doctor). Care UK and the PCT have worked hard to improve data collection in this respect, and results have improved considerably in recent months.

8.8 In reply to a question from the Chairman, Cllr Peltzer Dunn, concerning repeat prescriptions issued by the Centre, Mr Witt explained that the Centre would issue repeat prescriptions to people visiting the city, but would not do so for people already registered with a city GP. There is a degree of trust involved in issuing repeat prescriptions, as visitors who have forgotten their medicines are unlikely to have evidence of their eligibility for prescriptions to hand. However, the Centre will only ever provide a repeat prescription once, so there is limited scope for the system to be abused. When a repeat prescription is issued, this is flagged on the GP practice software system and the patient’s medical records are updated to show that the prescription has been issued

8.9 In response to a question from Cllr Allen about the impact of the Centre on neighbouring GP practices, Ms Warburton told members that there had to date been no negative feedback from local practice managers. The PCT continues to monitor this closely, particularly in terms of patients registering with the Centre (which might have an impact in the medium term had many people previously been registered with neighbouring practices).

8.10 In reply to a question from Mr Robert Brown concerning how the Centre was advertised to Travellers (many of whom seemingly eschew GP services, choosing to present for treatment at A&E), Ms Warburton told members that she would be happy to investigate what more could be done in terms of informing the Traveller community about the facilities offered by the Centre.

8.11 Ms Warburton and Mr Witt were thanked for their contributions.

8.12 RESOLVED – That the report be noted and an update report be requested in 12 months time.

9. SUSSEX ORTHOPAEDIC TREATMENT CENTRE (SOTC)

9.1 This item was introduced by Wendy Carberry, Deputy Director, Contracts, NHS Brighton & Hove and by Pamela Mackie, General Manager, Care UK.

9.2 In response to a question from Mr Robert Brown on Care UK’s criteria for selecting patients, members were told that specialist treatment centres were invariably unable to treat a small number of patients – i.e. those with co-morbidities which meant they could only be safely treated in a large acute hospital environment.

9.3 Cllr Kitcat went on to ask whether this had an adverse impact upon other areas of the local health economy (e.g. upon local acute NHS trusts which will typically pick up the complex co-morbidities inappropriate for treatment at a specialist centre). Amanda Fadero, Chief Executive, NHS Brighton & Hove, responded that it was important to focus on the totality of pathway management across the local health economy rather than on any single element in the pathway. Any financial stresses caused by the existence of the SOTC had to be weighed against the centre's contribution to local elective orthopaedic capacity, and against the local health economy's ability to deliver against the national 18 week waiting time targets (the SOTC is able to process cases more quickly than most general hospital based services). Ms Fadero noted that, although the 18 week targets had now been formally discontinued by the new Government, NHS Brighton & Hove was still committed to commissioning services to an 18 week timetable.

9.4 In answer to a question from Cllr Rufus on how the SOTC was reimbursed for activity, members were told that the SOTC contract, in common with all Independent Sector Treatment Centre (ISTC) contracts, was nationally determined on a principle of 'take and pay' – i.e. that the SOTC was paid a set volume of procedures each year, whether or not it actually undertook all of this activity. Providing Care UK was able to undertake all the activity contractually required of it, the onus was therefore on NHS Brighton & Hove, as lead commissioner for the SOTC, to ensure that there were sufficient referrals into the Centre to achieve value for money from the contract. Amanda Fadero, Interim Chief Executive of NHS Brighton & Hove, added that Care UK had been very flexible in terms of interpreting its contract.

9.5 In response to a query from Cllr Kitcat regarding the difference between the SOTC's contracted activity (paid in full via the SOTC contract) and its actual activity, Ms Mackie agreed that there was a difference here across the year, and that this did translate into additional profit for Care UK. Ms Carberry stressed that this was typically not because the SOTC was unable to operate at full capacity, but because the number of patients seeking orthopaedic surgery varied from month to month, meaning that there were sometimes fewer patients requiring treatment than the contract assumed. Care UK and NHS Brighton & Hove have been working to better control patient referral into the SOTC, and the Quarter 1 performance data for 2010-11 does indicate much better utilisation of theatre capacity at the SOTC.

9.6 Members also had more detailed questions they wished to ask about the SOTC. However, it was agreed that there was little point in asking these questions in the meeting as it was unlikely that there would be answers to hand, and that instead, a list of written questions should be submitted to Care UK and NHS Brighton & Hove at a later date.

9.7 RESOLVED – (1) That the report be noted; (2) That a further monitoring report be requested at a later date; (3) That a list of written questions be submitted to Care UK and NHS Brighton & Hove.

10. BRIGHTON & SUSSEX UNIVERSITY HOSPITALS TRUST: POTENTIAL MERGER WITH QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST, EAST GRINSTEAD

10.1 This item was introduced by Alex Sienkiewicz, Director of Corporate Affairs, Brighton & Sussex University Hospitals Trust (BSUHT).

10.2 Mr Sienkiewicz explained that Queen Victoria Hospital Foundation Trust (QV) had approached BSUHT and asked them to consider a merger. BSUHT had thought about this and was generally in favour of merging, as this would bring benefits to both hospitals and to the people that they serve.

10.3 In answer to a question from Cllr Marsh regarding the process via which a non-Foundation Trust (FT) could merge with an FT, Mr Sienkiewicz told members that BSUHT's FT application had been placed on hold whilst the merger with QV was discussed. If the merger went ahead, then the merged trusts would jointly apply for FT status. The trusts have sounded out Monitor, the Foundation Trust regulator, which has agreed to expedite any such FT request.

10.4 Members were informed that there was a longstanding clinical partnership between BSUHT and QV, and many clinical adjacencies, particularly involving the key '3T' project to develop the Royal Sussex County Hospital as a regional trauma centre (QV's expertise in work such as burns and reconstructive surgery make it an important player in this development). QV also provides general acute services for residents of East Grinstead, and BSUHT is already involved in supporting this work.

10.5 Members thanked Mr Sienkiewicz for his presentation and asked to be kept informed of the progress of the merger plans.

11. BRIGHTON & SUSSEX UNIVERSITY HOSPITALS TRUST EMERGENCY PLANNING

11.1 This item was introduced by Mr Jonathon Andrews, Brighton & Sussex University Hospitals Trust (BSUHT).

11.2 Mr Andrews explained that the trust was extensively engaged in planning for emergencies, as part of its broader business continuity management programme. The trust's resilience in the face of emergency events is assessed by both the Strategic Health Authority and the Care Quality Commission.

11.3 Members thanked Mr Andrews for attending and noted the contents of his update.

12. SOUTH DOWNS HEALTH NHS TRUST: INTEGRATION WITH WEST SUSSEX COMMUNITY SERVICES - UPDATE

12.1 This item was introduced by Andy Painton, Chief Executive, and Andrew Harrington, Director of Operations, South Downs Health NHS Trust (SDH).

12.2 Members were informed that the South East Coast Strategic Health Authority (SHA) was due to consider the final business case for the integration of SDH with West Sussex community services in autumn 2010. However, the two organisations have effectively been integrated for over a year now.

12.3 Integration with East Sussex community services has also been agreed in principle with the East Sussex Primary Care Trusts and with the SHA, although this is subject to a detailed evaluation of the proposals.

12.4 The integrated trust faces major challenges in the coming months, including the need to make very significant savings and the requirement to develop the trust's senior management to best reflect clinical input and to ensure it is capable of the challenges of running a much expanded organisation.

12.5 In response to a question from Cllr Kitcat concerning how a small trust could realistically expect to take on the work of two much larger organisations, Mr Painton told members that it was very important to think of the integration process as the creation of an entirely new organisation rather the take-over of any one organisation by another. The new entity would not be over-centralised, but would maintain the local foci vital to ensure quality community services, whilst centralising those services which benefited from being run centrally (e.g. infection control). Mr Harrington added that it made sense for SDH to be the organisation into which the others were integrated as it already existed as a free-standing legal entity, whilst the community services in both East and West Sussex had formally been part of their respective PCTs, and were therefore not in a position to take on any other organisation.

12.6 In answer to a question from Cllr Allen concerning economies of scale to be achieved by integrating community services across Sussex, Mr Painton told members that there were considerable economies to be realised by integrating SDH with its West Sussex counterpart (approximately £2 million), but relatively minor additional savings from including East Sussex services.

12.7 In response to a question from Mr Robert Brown concern the upgrading of trust estates to make them compatible with the requirements of the Disability Discrimination Act, Mr Painton told members that responsibility lay with the owners of the estates in question: this is principally SDH in Brighton & Hove, but is NHS West Sussex in terms of West Sussex community healthcare buildings.

12.8 In answer to a question from Cllr Allen concerning how the expanded trust would guarantee it maintained a local focus, members were told that this would be guaranteed by the recently unveiled GP commissioning arrangements, which would mean that services for local people were commissioned by GP consortia at a very local level. In addition, Mr Painton pointed out that the nature of community services tended to militate against large scale solutions: whilst it might be sensible to run some services on a county-wide basis, there would simply be no advantage in scaling up the majority of the trust's work.

12.9 Members thanked Mr Painton and Mr Harrington for their input and invited them to return to a future meeting to provide an update on the progress towards integration.

13. BETTER BY DESIGN - UPDATE

13.1 Members considered a letter sent to the HOSC Chairman by Sussex Partnership NHS Foundation Trust and NHS Brighton & Hove. The letter set out progress in terms of the

ongoing initiative to re-design local mental health services. It was agreed that this subject should be considered as a substantive item at a later committee meeting.

14. 2009/2010 HOSC WORK PROGRAMME

14.1 Members discussed the committee work programme.

14.2 It was agreed that two additional items should be considered for the work programme:

(i) implications of the Health White Paper. Members decided that this should be offered to all Councillors rather than just HOSC members, and it was therefore determined that officers should seek to set up a members' seminar with support from NHS Brighton & Hove.

(ii) Annual Report of the Director of Public Health. Members agreed to invite Dr Scanlon to the next (29 September 2010) committee meeting to talk to his recently published annual report.

15. ALCOHOL-RELATED HOSPITAL ADMISSIONS - REFERRAL TO OSC (UPDATE)

15.1 Members received a verbal update on progress in establishing this Select Committee.

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

16.1 There were none.

17. ITEMS TO GO FORWARD TO COUNCIL

17.1 There were none.

The meeting concluded at Time Not Specified

Signed Chair

Dated this day of