HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Lewes on 24 November 2011

PRESENT:

Councillor Simmons (Chairman), Councillors Howson, O'Keeffe, Pragnell, Rogers and Taylor; Councillor Ungar (Eastbourne Borough Council); Councillor Davies (Rother District Council); Councillor Phillips (Wealden District Council); Mrs Julie Eason, East Sussex Advice Plus, and Mr Maurice Langham, East Sussex Seniors Association

WITNESSES:

East Sussex County Council
Becky Shaw, Chief Executive
Dr Diana Grice, Director of Public Health
Barbara Deacon, Policy Officer

East Sussex Healthcare NHS Trust
Stuart Welling, Chairman
Darren Grayson, Chief Executive
Dr Amanda Harrison, Director of Strategic Development and Assurance
Jane Hentley, Director of Nursing
Dr David Hughes, Medical Director
Jayne Black, Deputy Director of Strategic Development

NHS Sussex
Sarah Blow, Interim Chief Operating Officer (East Sussex)

LEAD OFFICER: Claire Lee, Scrutiny Lead Officer

21. CHAIRMAN'S BUSINESS

21.1 The Chairman informed the Committee that Hastings Borough Council had now indicated that they would not be nominating a HOSC representative for 2011/12 and would consider their position for 2012/13 in due course.

22. APOLOGIES

22.1 Apologies were received from Councillor Heaps, Councillor Merry (Lewes District Council) and Ms Janet Colvert, East Sussex LINk representative.

23. MINUTES

23.1 RESOLVED to confirm as a correct record the minutes of the meeting held on 15 September 2011.

23.2 The Committee noted that following the meeting on 15 September the Chairman had been notified of a correction in relation to minute 15.7. It had been clarified that the commissioning intention in relation to primary angioplasty was to move to a 24/7 service in Hastings. The reference in 15.7 to 'in-hours' provision in Eastbourne and the transfer of patients out of hours to Hastings or Brighton should therefore be disregarded.

24. DISCLOSURE OF INTERESTS

24.1 There were none.

25. REPORTS

25.1 Copies of the reports dealt with in the minutes below are included in the minute book.

26. PUBLIC HEALTH TRANSITION

26.1 The Committee considered a report by the Chief Executive which set out progress with the transition of public health responsibilities to the County Council and Public Health England under national NHS reforms.

26.2 The Chief Executive highlighted the following points by way of introduction:

- The Council aims to maximise the opportunities presented by the changes to public health responsibilities.
- There is significant support and energy amongst partners to take forward the agenda and a widespread recognition that initiatives to keep people healthy represent a wise investment.
- National guidance is awaited in a number of key areas, notably funding arrangements for public health, but this was not preventing progress being made.
- The Council had commissioned an independent review of public health and was awaiting the final report.
- On receipt of the report a proposal would be developed for taking the public health agenda forward in East Sussex and scrutiny input would be welcome.

26.3 The Director of Public Health reiterated the enthusiasm amongst partners and highlighted the important role of district and borough councils in addition to the County Council. She thanked the County Council for welcoming public health staff who had been relocated from NHS Sussex. She also gave a commitment to the development of an action plan in response to the independent review report in order to ensure East Sussex would be in the strongest possible position by April 2013 when local public health responsibilities are expected to formally transfer from the NHS to the County Council.

26.4 The following issues were covered in response to questions from the Committee:

26.5 **Funding**
The Chief Executive confirmed that the government's funding arrangements are not yet clear. Nationally it had been challenging to establish the baseline

amount being spent on public health by primary care trusts due to varying definitions and recording of public health activity. It is expected that shadow local authority allocations for 2012/13 will be announced by the end of 2011 but it is unclear to what extent these will reflect historic spend in local areas or a needs based formula. There had been some indication that levels of deprivation would be reflected in allocations and it was confirmed that the County Council had been raising awareness in government of the impact of population age profile on need. However, the overall resources available for public health are likely to be squeezed due to the broader economic climate.

In East Sussex, NHS Sussex had identified an annual spend of approximately £25m on public health programmes. Once future allocations for the county become clear, the Council would use the same discipline applied to all service areas to ensure a focus on priorities and would provide evidence of this in the public health action plan. The Director of Public Health highlighted that the benefits from investment in public health programmes are often long-term. For example, there is strong evidence that investment in smoking cessation reduces future need for health services but the impact is felt some years later.

26.6 **Availability of public health expertise**

The Director of Public Health assured the Committee that the availability of specialist public health expertise to Clinical Commission Groups (CCGs) and other partner organisations was a key issue being examined by the independent review. She highlighted that the central team is a relatively small resource and it would be important to ensure it is used effectively, along with specialists from Public Health England. The local team had assigned a Public Health Consultant to each CCG to ensure they had access to specialist advice. Effective use of the Joint Strategic Needs Assessment (JSNA) by partners would also be key.

The Chief Executive added that it would be important to develop skills across the local government and partner organisation workforce to enable staff to integrate public health considerations into their work, drawing a parallel with a similar process undertaken in relation to the community safety agenda. In addition, a focus on robust evaluation would be critical in ensuring best use of limited resources as it would inform evidence-based investment in programmes with a demonstrable impact.

26.7 **Cross-county approach**

The Chief Executive acknowledged that pockets of deprivation exist across the county, not just in the urban areas with the highest concentration, and that they are more difficult to identify in rural areas. Effective working across the two tiers of local government would be important in balancing a local and cross-county approach. Good engagement had been received from both Members and officers in all district and borough councils. The Director of Public Health added that public health specialists already worked as part of district level partnerships which provided a good foundation to build on.

The Chief Executive agreed that it would be important to use the JSNA to monitor trends across the county and ensure early identification of developing problems. The Council would need to take a balanced approach between addressing health inequalities in specific areas and population wide health improvement activities. The Director of Public Health added that the recent Marmot report on health inequalities had recommended that public health responses should be proportionate to levels of need.

26.8 **Public engagement and communication**
The Chief Executive indicated that it would be most productive to engage the general public in specific initiatives rather than focusing on the changes to structures and accountabilities for public health. There will be opportunities to make use of new forms of communication such as social media to drive behavioural change. Information for those local stakeholders with an interest in the current organisational changes was being made available via the East Sussex Strategic Partnership website.

26.9 **Health and Wellbeing Board**
The Chief Executive confirmed that the shadow Health and Wellbeing Board was in its early stages of development. The Board had held an initial meeting and its forthcoming second meeting would focus on commissioning priorities. The Board's focus would be on developing a Health and Wellbeing Strategy for East Sussex based on the JSNA.

26.10 RESOLVED to establish a joint Task Group with the Audit and Best Value Scrutiny Committee to provide ongoing scrutiny input to the transition process. Councillors Rogers and Howson agreed to represent HOSC on this group.

27. EAST SUSSEX HEALTHCARE NHS TRUST CLINICAL STRATEGY

27.1 The Committee considered a report by the Assistant Chief Executive which provided an update on the development of the Trust's Strategy.

27.2 Darren Grayson, Chief Executive of the Trust, made the following points to supplement the Trust's written report:

- The draft options identified in the report for each individual Primary Access Point (PAP) would need to be knitted together into combinations which would be operationally practical for each hospital and the Trust as a whole. This process would take into account the critical interdependencies between certain PAPs.
- Acute medicine represents by far the largest service area in terms of the number of patients seen annually.
- The draft assessment criteria outlined in the report reflect a standard range used across health systems. The relative weightings indicated are still in development and are not definitive. The Trust Board would need to make a final decision on this issue.
- NHS Sussex, as the organisation with statutory commissioning responsibility, would be formally responsible for undertaking consultation and decision making, although ESHT would have a pivotal role in the process.

27.3 The following issues were covered in response to questions from the Committee:

27.4 **Maternity options development**
Dr Harrison confirmed that the future role of the Crowborough Birthing Unit would be incorporated into the maternity options. Mr Grayson highlighted the downward trend in usage of the unit and the fact that, should this continue, the service's financial and clinical viability would be called into question. Mr Grayson also assured the Committee that options five and six, which had recently been added in response to requests from stakeholders, would be

developed alongside the four options which had been put forward by the external review team.

27.5 **Older people**

Mr Grayson confirmed that the majority of users of both acute and community health services in East Sussex are older people and that the majority of NHS spend nationally is on this group, notably in the last weeks of people's lives. He reminded the Committee that the Strategic Framework which had been agreed by the Trust Board included the aspiration to become a gold standard provider of care for older people, in recognition of the county's demographic profile. The Trust is already making improvements to key aspects of care, such as privacy, dignity and nutrition, as part of working towards the longer-term strategic aim.

27.6 **Relationships with other providers**

Mr Grayson acknowledged that the Trust increasingly works with other Trusts within clinical networks for a range of service areas. He indicated that the Trust would focus on the areas which would have most benefit to its catchment population, such as acute medicine and emergency care, and recognise its interdependence with Brighton as the regional tertiary centre for more specialist care.

27.7 **Role of commissioners**

Sarah Blow, Interim Chief Operating Officer, NHS Sussex, clarified that the Primary Care Trusts (working as a cluster in NHS Sussex) remained the organisations with statutory responsibility for commissioning until April 2013. From this date, subject to the passage of legislation, commissioning responsibility would transfer to CCGs. However, CCGs had been involved in the Clinical Strategy development process alongside NHS Sussex representatives. Ms Blow added that, although some areas of the strategy were likely to require formal consultation before decisions were made about future configuration, other areas not requiring consultation are also significant for the future sustainability of services and would need to be implemented as soon as possible.

Mr Grayson acknowledged that, ideally, the future strategy for services in East Sussex would be driven by commissioners. However, the Trust was taking the leading role in this instance due to the fact that commissioning arrangements are in transition. He stressed that commissioners had been fully engaged and the strategy would align to commissioning plans.

27.8 **Resourcing of community services**

In response to a question about whether the resourcing of community services adequately reflected the strategy to provide care 'upstream', outside of hospital where possible, Mr Grayson indicated that the strategy did intend to rebalance acute and community provision. He stated that NHS Sussex currently spends approximately 51% of its budget in East Sussex on acute services, in comparison to many other areas of the country where it is in the range of 40-49%, and the intention is to shift the balance towards the community. However, Mr Grayson added that all parts of the NHS are being required to make efficiencies and the Trust's requirement for £100m savings over five years means that all services are being reviewed. Services would be looked at individually to identify the appropriate level of savings, as opposed to a blanket 10% reduction across all areas. Mr Grayson was not aware of any commissioner intention to reduce funding for community services but

advised the Committee that the wider financial context meant that commissioners would not be able to increase their investment in this area.

27.9 **Travel and patient transfers**

Mr Grayson acknowledged the travel challenges in East Sussex and the associated fears expressed by local people about travelling further for healthcare. He emphasised that any strategy or decision to transfer/redirect patients between sites should be judged on whether patients will receive a better service as a result as, ultimately, the patient outcome should be the measure of success. Mr Grayson cited the vascular network model as an example where the proposal to direct certain patients to a specialist centre for emergency or complex surgery was based on evidence that this would improve patient outcomes through improved access to specialist surgeons.

Mr Grayson recognised that the public would view access as their primary criterion for judging options but reminded the Committee that clinicians would view clinical quality/safety as paramount. The Trust Board would need to strike an appropriate balance between different criteria.

27.10 **Consultation and implementation process**

Mr Grayson confirmed that the Trust would support the view that proposals for major service reconfiguration constitute potential substantial change requiring consultation with HOSC and the public. Changes based on redesign of patient pathways or operational efficiencies would not, in the Trust's view, be considered substantial, but Mr Grayson agreed that areas of significant redesign may warrant scrutiny by HOSC outside of a formal consultation process.

With regard to implementation, Dr Harrison confirmed that the Trust's annual integrated business plan for 2012/13 will be informed by the Clinical Strategy work and that the business plan would become increasingly driven by the strategy over time. Ultimately, the annual plan will effectively equate to that year's implementation plan for the Clinical Strategy. Proposed changes requiring consultation would not be implemented prior to the outcome of the consultation and decision making process. However, other changes which would not be subject to consultation would progress to implementation from April 2012 or sooner. Mr Grayson assured the Committee that adequate time would be built into the process for the outcomes of consultation to be fully considered prior to decision making, but he emphasised the need to move the process forward in a timely way given the pressing challenges facing the Trust.

27.11 **Equality Impact Assessments**

Dr Harrison confirmed that Equality Impact Assessments had been undertaken on the models of care for each PAP and assured the Committee that these would be updated through an iterative process to reflect the evolving options. She confirmed that the assessments would be made public and would be used to inform the approach to consultation by ensuring that groups most affected by proposed changes were targeted by consultation activities.

27.12 **Presentation of options**

Mr Grayson confirmed that any consultation document would clearly set out the interdependencies between options and describe the potential trade-offs.

He also assured the Committee that the financial impact and context would be made clear for any options presented for consultation.

27.13 RESOLVED:
(1) To agree that, in principle, elements of options which would require service reconfiguration should be considered to meet the threshold of 'substantial' change, requiring formal consultation with the Committee.
(2) To agree that elements of options requiring significant service redesign may require ongoing scrutiny to ensure desired outcomes are achieved, but are not likely to require formal consultation.
(3) To agree that elements of options requiring efficiency and productivity improvements only should not require formal consultation or ongoing scrutiny.
(4) To request that the Trust continue to work with the Task Group to clarify those proposed changes which constitute reconfiguration (based on their scope, scale and impact) and those which constitute redesign.
(5) To request that the Task Group considers options in more detail as they develop, to identify any elements which would fall outside the above framework due to exceptional circumstances.
(6) To support the proposed Sussex Trauma and Vascular network models due to the evidence that these will improve patient outcomes.

28. EAST SUSSEX HEALTHCARE NHS TRUST – CARE QUALITY COMMISSION INSPECTION

28.1 The Committee considered a report by the Assistant Chief Executive which presented an update on the Trust's progress towards compliance with the requirements of the Care Quality Commission (CQC) following their inspection earlier in 2011.

28.2 Darren Grayson informed the Committee that a further report from CQC, based on a follow-up inspection undertaken in September 2011, was expected to be published shortly. He expected this report to demonstrate substantial progress at all levels of the organisation, but not yet total compliance with all required standards. The Trust Board had also come to this conclusion following a self assessment exercise.

28.3 Jane Hentley presented an overview of the action taken by the Trust to date and her assessment of progress, which included the following points:

- Privacy and dignity had been observed to have improved as evidenced through, for example, hospital walkabouts by senior staff.
- Improvements to documentation were critical to demonstrating compliance with outcome 4 (care and welfare of patients) and outcome 7 (safeguarding) and the Trust is confident that there is evidence of significant improvement.
- The Trust now has a much more robust process in place to monitor its ongoing compliance with CQC standards.
- The Trust wide review of governance, due to be completed shortly, would be important in ensuring the correct framework is in place to identify issues within the organisation.
- A ward review approach has been instigated which has built staff ownership and accountability.
- The Trust's organisational restructure had strengthened leadership and accountability.
- The Trust has an ongoing open and honest dialogue with CQC about the actions being taken and the anticipated timeline for achieving compliance.

28.4 The following issues were covered in response to questions from the Committee:

28.5 **Mental Capacity Act and Deprivation of Liberty Safeguards (DOLS)**
Ms Hentley agreed that these areas were important, particularly given anticipated additions to the Safeguarding Vulnerable Adults legislation to bring the regime in line with that in place for children. The key issues raised by CQC had been a lack of knowledge amongst clinicians and problems with translating theory into practice. The Trust had reviewed both the amount and quality of education and worked closely with Adult Social Care to make improvements. CQC had since commented on the improved level of understanding amongst staff. Dr Hughes added that a Mental Capacity Act clinical champion had been identified and tasked with ensuring appropriate back up from medical teams for nursing staff. He agreed that progress had been made but acknowledged more was needed to achieve compliance.

28.6 **Record keeping**
Ms Hentley described the required improvements to record keeping as being a whole system issue rather than solely dependent on individual practice. However, she assured the Committee that individuals are expected to meet the requirements of their professional practice and face disciplinary action if this was found not to be the case. She added that record keeping was being audited on a weekly basis and improvements had been demonstrated.

Mr Grayson added that CQC had highlighted both good and poor practice within the Trust and had commented on the variability. The approach being taken was low tolerance of poor practice and the provision of practical support where the need for improvement was identified.

28.7 **Dignity in care**
Ms Hentley agreed that the significance of dignity in care was increasingly being recognised. The Trust's work in this area had included clinical practice sessions by senior nursing staff each Thursday where practice could be observed and discussed and information reviewed. She had also worked with colleagues in other Trusts to undertake peer reviews of privacy and dignity. The Trust's recent restructure had enabled a member of staff to be given specific responsibility for monitoring and improving patient experience.

Mr Grayson added that results from patient surveys had been positive, but the Trust also needed to learn from instances of poor experience as identified through complaints or inspections. He had used recent communications to staff as an opportunity to reinforce the importance of kind and compassionate care to patients.

28.8 **Recruitment**
Mr Grayson confirmed that the Trust was now fully staffed to its nursing establishment, with the exception of any vacancies due to normal staff turnover which would be filled quickly.

28.9 **Compliance trajectory**
Ms Hentley explained that the Trust Board would make a further assessment of compliance in January 2012. The aim is to achieve sustained compliance by the end of March 2012 but it is difficult to predict when compliance will be achieved. Mr Grayson confirmed that the Trust was not yet aware of the next

steps CQC would take in relation to the warning notice which had a deadline of 2 September 2011.

28.10 RESOLVED to:
(1) welcome the progress made by the Trust to date and to continue to liaise with the Trust and CQC to monitor progress towards compliance.

29. HOSC ACTIVITY UPDATE

29.1 Individual HOSC Members' activities included:

29.2 **Councillor Rupert Simmons**

- 6 October – attended Public Health stakeholder event on behalf of HOSC.
- October – meetings with NHS Sussex representatives Amanda Fadero, Sarah Blow and Jessica Britton to discuss CCG development and the commissioners' perspective on the East Sussex Healthcare NHS Trust Clinical Strategy.
- 22 November – met with Darren Grayson and Stuart Welling to discuss the Trust's input to today's HOSC meeting.

29.3 **Councillor David Rogers**
Cllr Rogers reported on a meeting of the HOSC Mental Health Task Group on 23 November which had focused on service redesign in dementia services. The Task Group had supported the proposed introduction of a Memory Assessment Service to improve rates of early diagnosis and welcomed the fact that this would be located in community, potentially primary care, settings. The continuation of the carers' breaks service, proposed expansion of the dementia advisor service and introduction of a dementia support service were also welcomed.

Given the challenging financial context and lack of additional resource for dementia services, these developments were being funded through decommissioning four day hospitals across the county. The decision to decommission the day hospital dementia provision from April 2012 was based on an assessment that the service user needs could be better met through social care provision and that the current provision represented poor value for money. The Task Group had supported this decision and gained assurances that all current service users would have an individual review of needs and be supported into alternative provision.

29.4 **Councillor Ruth O'Keeffe**

- Attended training on alcohol awareness for non-professionals which had identified a possible lack of support for families/carers
- Received feedback regarding medical procedures being undertaken during protected mealtimes at Brighton and Sussex University Hospitals Trust

29.5 **Councillor Barry Taylor**

- Attended HOSC visit to food production unit at the Conquest Hospital which had confirmed that the same meals are prepared for both the Conquest and Eastbourne Hospitals using the same process. Special menus for patients with swallowing difficulties had also been demonstrated.

29.6 **Councillor Peter Pragnell**

Cllr Pragnell gave an overview of items discussed at the most recent meetings of the Adult Social Care and Community Safety Scrutiny Committee which had included a recent CQC inspection of Mount Denys residential home, the County Council's response to a national consultation on social care, developments in joint commissioning arrangements with the NHS and progress in the development of reablement services.

29.7 **Julie Eason**

- Worked with Hastings and Rother CCG on a project with the voluntary and community sector.
- Involved with work on fuel poverty.
- Attended stakeholder events on the NHS reforms.

29.8 **Councillor Philip Howson**

- Various activities as a trustee of Age UK Peachaven

29.9 **Councillor Diane Phillips**

- Attended a meeting of the Kent HOSC which included items on A&E admissions, mental health and maternity services.
- Attended the HOSC visit to the food production facility at the Conquest Hospital and had been impressed with the standard of meals.
- Understood that the High Weald Clinical Commissioning Group was progressing in its development.

29.10 **Maurice Langham**

- Involved with the launch of a lunch club by Age Concern Newhaven.

29.11 **Councillor Angharad Davies**

- Attended the food production facility visit.
- Attended a conference on the NHS reforms.
- Attended the September meeting of the East Sussex Stroke Implementation Board which had renewed progress on the stroke strategy which had been subject to some slippage.

29.12 **Councillor John Ungar**

- Welcomed the opportunity presented by the HOSC Clinical Strategy Task Group meetings to explore issues in more detail.
- Involved in a keeping warm, saving money, going green campaign which links to the public health agenda.

The Chairman declared the meeting closed at 1.05pm