HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee (HOSC) held at County Hall, Lewes on 20 June 2013

PRESENT:

Councillor Ensor (Chairman), Councillors Carstairs, Pragnell, Standley, St Pierre and Wincott (all East Sussex County Council); Councillor Ungar (Eastbourne Borough Council); Councillor Poole (Hastings Borough Council); Councillor Phillips (Wealden District Council); Councillor Davies (Rother District Council)

WITNESSES:

Hastings and Rother Clinical Commissioning Group (CCG)
Dr Greg Wilcox, Chief Clinical Officer
Catherine Ashton, Associate Director of Strategy

Eastbourne, Hailsham and Seaford CCG
Dr Martin Writer, Chair
Dr Matthew Jackson, Chief Clinical Officer (Designate)
Catherine Ashton, Associate Director of Strategy

High Weald, Lewes, Havens CCG
Dr Elizabeth Gill, Clinical Chair
Frank Sims, Chief Operating Officer

NHS England, Surrey and Sussex Area Team
Pennie Ford, Director of Operations and Delivery

Brighton and Sussex University Hospitals NHS Trust (BSUH)
Matthew Kershaw, Chief Executive
Duane Passman, Director of 3Ts
Nikki Luffingham, Chief Operating Officer
Elma Still, Associate Director of Quality

East Sussex Healthcare NHS Trust (ESHT)
Darren Grayson, Chief Executive
Dr Amanda Harrison, Director of Strategy
Dr Andy Slater, Medical Director (Strategy)
Lindsey Stevens, Head of Midwifery

LEAD OFFICER: Claire Lee, Scrutiny Lead Officer

1. CHAIRMAN'S BUSINESS

1.1 The Chairman paid tribute to the work of Councillor Rupert Simmons as the previous Chairman of HOSC.

2. APOLOGIES

2.1 Councillor O'Keeffe (Vice-Chairman), Councillor Merry (Lewes District Council), Ms Julie Eason and Mr David Burke (voluntary sector representatives)

3. MINUTES

3.1 RESOLVED to confirm as a correct record the minutes of the meeting held on 21 March 2013.

4. DISCLOSURE OF INTERESTS

4.1 Councillor Pragnell declared a personal, non-prejudicial interest as a recent user of ESHT's cardiology service.

4.2 Councillor Wincott declared a personal, non-prejudicial interest as a registered patient at Dr Wilcox's GP practice.

5. REPORTS

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

6. THE NEW NHS COMMISSIONING LANDSCAPE

6.1 The Committee considered a report by the Assistant Chief Executive which set out changes to commissioning structures in the NHS which came into effect in April 2013.

6.2 Representatives of the three East Sussex Clinical Commissioning Groups (CCGs) and NHS England, Surrey and Sussex Area Team (as listed above) delivered presentations outlining their organisations' role, structure and priorities.

6.3 The CCG representatives responded to questions from the Committee covering the following issues:

6.4 **Influence of GPs**
Dr Wilcox indicated that he views the establishment of CCGs as an opportunity for GPs to be at the heart of commissioning decisions, particularly in the context of significant challenges facing the NHS. Dr Gill advised the Committee that GPs' primary concern would be quality and safety, with a focus on meeting National Institute of Health and Care Excellence (NICE) guidance and addressing unwarranted variations in care and outcomes.

6.5 **Budgets and variations in service**
Dr Wilcox explained that CCG allocations are set by a national formula but that individual CCGs agree their own Quality, Innovation, Productivity and Prevention (QIPP) plans, giving these plans better clinical ownership and local focus than in the past. It is the responsibility of each CCG to make the best use of their resources to meet the needs of their population and, as these needs will vary between areas, the services commissioned will also vary, in order to be responsive. Dr Wilcox advised the Committee that there is natural and

appropriate variation between different doctors, GP practices or hospitals and it is therefore a myth that all provide an identical service in the first instant.

6.6 **Cross-border working**

Dr Gill suggested that the CCGs' predecessor Primary Care Trusts had tended to focus attention on East Sussex Healthcare NHS Trust (ESHT) and spent less time working with other acute providers based outside the county. As residents of Lewes, High Weald, Havens area primarily use out of county hospitals the CCG is able to focus on these providers and has joined their networks. The CCG is also working with their neighbours and on links from out of county hospitals to local services such as Adult Social Care.

6.7 **A&E pressures**

With regard to pressure on Accident and Emergency (A&E) departments, Dr Jackson advised that the CCG approach would be to improve the quality of care rather than restrict access. He indicated that CCGs are reviewing the whole urgent care pathway and developing commissioning plans to provide an appropriate response to needs. A side effect of these plans should be a reduction in unnecessary A&E attendances as other responses become more available.

Dr Gill highlighted the need to work with the Ambulance Service in relation to patients they do not convey to hospital. GPs expect to receive referrals from the Ambulance Service and will undertake home visits where required. Dr Gill also described the role of paramedic practitioners in providing helpful information to GPs on the patient's needs.

6.8 **Conflicts of interest**

Dr Writer acknowledged that, as providers of services, GPs have an inherent conflict of interest and this is recognised. As a result, GP and other primary care services are commissioned by the NHS England Area Team. Dr Writer assured the Committee that CCGs are mindful of the role of GPs who sit on governing bodies and that, where a decision will affect an individual, they do not take part in the process. CCG decisions are also made in public to aid transparency.

6.9 **Children/early intervention**

The CCG representatives assured HOSC that the needs of children and families are reflected in CCG business plans and fall within the high level priorities which were presented.

6.10 **Community cardiology**

With regard to the Eastbourne, Hailsham and Seaford CCG target to increase from 0 to 60% the proportion of patients referred to community cardiology with heart failure having a personalised care plan, Dr Jackson confirmed that he viewed this as achievable. The level of new diagnoses is approximately 8 per month and there is a GP with a special interest in cardiology in place.

6.11 Pennie Ford of the NHS England Surrey and Sussex Area Team responded to questions covering the following areas:

6.12 **Primary care access**

Ms Ford confirmed that the Area Team would look at the achievement of primary care access targets through contract monitoring and any issues would be addressed through a combination of joint working with CCGs and GPs, coupled with sanctions where appropriate. She also highlighted that CCGs have a role in improving primary care quality despite the fact that they do not commission primary care services.

6.13 **Quality Surveillance Groups**
Ms Ford explained that these groups are designed to support sharing of information between partners and identification of quality concerns at an early stage. She advised that they will use a combination of hard data and soft intelligence which will be triangulated to identify potential concerns which can then be further investigated.

6.14 **Financial challenges**
Ms Ford confirmed that there are real financial challenges for many CCGs in the Surrey and Sussex area which need to be addressed through working across the whole healthcare system. The Area Team, in its commissioning role, is working with CCGs on developing improved patient pathways. In its assurance role the Area Team is providing support and challenge to CCGs as required and can bring in external support where necessary.

6.15 RESOLVED:
(1) Note the plans of new NHS commissioning organisations and to scrutinise specific issues in more detail through the Committee's ongoing work programme.

7. <u>BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS TRUST – SERVICE PRESSURES AND 3TS (TEACHING, TRAUMA AND TERTIARY CARE) PROGRAMME</u>

7.1 The Committee considered a report by the Assistant Chief Executive which set out the Trust's response to recent service pressures, particularly in the A&E department of the Royal Sussex County Hospital, Brighton. The report also provided an update on the progress of the 3Ts programme.

7.2 Matthew Kershaw, Chief Executive, Duane Passman, Director of 3Ts, Nikki Luffingham, Chief Operating Officer and Elma Still, Associate Director of Quality from BSUH, together with Dr Elizabeth Gill, Clinical Chair and Frank Sims, Chief Operating Officer of High Weald, Lewes, Havens CCG, attended to discuss the reports with the Committee.

7.3 In relation to the recent pressures, Mr Kershaw explained that the Trust had initially been focusing on actions it could take within the hospital but is now beginning to work with partners on wider system issues such as delayed transfers of care. Further support is being sought from the Emergency Care Intensive Support Team (ECIST) for this phase of work. Mr Kershaw also explained that issues raised in a recent Care Quality Commission (CQC) report focused on processes within the A&E department. The majority of these issues were already being addressed though the existing action plan and the Trust is reporting on progress to CQC. Mr Kershaw expressed confidence that CQC would see an improvement when they re-inspect the service.

7.4 Dr Gill confirmed that High Weald, Lewes, Havens CCG is working closely with the Trust and Brighton and Hove City CCG to address the issues and is pleased with progress. Mr Sims explained that the CCGs are taking forward work in two areas: firstly, to implement a number of ECIST recommendations which can be applied to other settings to prevent admissions; and, secondly, to differentiate the issues for residents of each CCG area and put in place appropriate alternative services.

7.5 The following areas were covered in response to questions from the Committee:

7.6 **Four hour target**

Ms Luffingham clarified that the national four hour A&E standard relates to the time from the patient arriving at reception to when they leave the department. Mr Kershaw advised that the Trust views it as a maximum and aims to see patients more quickly, but the recent pressures had caused performance to dip below acceptable levels. Mr Kershaw assured the Committee that ambulance staff are not asked to delay bringing patients into the department in order to delay the time from which the four hours is measured. However, he explained that, during times of peak activity, ambulances may be waiting to hand over patients due to the physical limitations of space within and immediately outside the department.

7.7 **Triage/assessment**

When asked whether the Trust takes a team based approach to triaging patients in the emergency department, Mr Kershaw confirmed that this is the case and both doctors and nurses are involved. Historically the system was based on assessing and streaming patients and this is now being reviewed in order to remove steps in the process which don't solve the patient's issues. A 'see and treat' approach is now being used where possible, and patients are only streamed into an appropriate pathway if their problem cannot be managed immediately. This frees up staff to focus on more complex cases.

Ms Luffingham added that another measure used for A&E performance is the proportion of patients assessed by a clinician within 15 minutes. In the 'majors' stream this assessment is by a doctor and in the 'minors' stream it is often nurse-led.

7.8 **Night time discharges**

HOSC raised concerns about vulnerable people being discharged from A&E at night without access to transport. Mr Kershaw indicated that he would be happy to review any specific cases. He highlighted the dilemma that patients should not be admitted to hospital purely due to travel problems, but agreed that patients' individual circumstances should be given attention to ensure any available support is accessed.

7.9 **Ward rounds**

Mr Kershaw explained that when the Trust had been under severe pressure patients had been admitted to available beds all over the hospital rather than necessarily in the specialist ward for their condition. This meant that sometimes doctors were taking the whole day to review all their dispersed patients. The action plan currently being implemented has altered ward round times to ensure that all discharge reviews are taking place in the morning and all patients are reviewed by a senior clinician. This is designed (alongside other measures) to support morning discharges which will free up space to enable new patients to be admitted to the correct wards.

In addition, ECIST had found the A&E department to be over-admitting patients, prompting the Trust to bring the Rapid Discharge Team into the department to identify patients who could return home with support, thus reducing admissions and pressure on beds.

7.10 The following issues arose in response to questions on the 3Ts programme:

7.11 **Decanting process**

Mr Passman assured the Committee that plans for decanting services to other locations during building works were clinically led and clinicians will be fully involved in implementation to ensure quality and safety are maintained. Trust health and safety staff are also involved in undertaking risk assessments and

there are both internal and external checks which must be passed before moves proceed. A lead-in time has been built into the schedule which will enable staff to familiarise themselves with new environments before seeing patients there.

7.12 **Access**
Mr Passman informed HOSC that the new development includes 300 new parking spaces which will be for patients only. The current 508 parking spaces are shared between patients and staff, although staff with BN1, 2 or 3 postcodes cannot obtain a permit (without good reason) and are expected to use alternative transport.

7.13 **Funding approval**
Mr Kershaw advised that the Treasury is currently undertaking final checks on the financial elements of the Trust's plans and detailed discussions are underway with both the Treasury and NHS Trust Development Authority with regard to sustainability. A final decision on the c£420m scheme is expected in the autumn and Mr Kershaw expected this to be positive, given that the need for the redevelopment is unquestioned locally and nationally.

7.14 **Staff recruitment**
Mr Passman assured HOSC that any additional clinical staff required as part of the 3Ts programme would be primarily for specialist tertiary services not provided by other local Trusts. There is therefore unlikely to be any impact on other Trust's ability to recruit skilled staff as a result of BSUH's plans.

7.15 RESOLVED:
(1) To request that the Trust continues to keep HOSC updated on key milestones in the 3Ts programme.
(2) To further explore system pressure issues in September 2013 as part of the scheduled agenda item on urgent care.

8. <u>EAST SUSSEX HEALTHCARE TRUST (ESHT) CLINICAL STRATEGY</u>

8.1 The Committee considered a report by the Assistant Chief Executive which included an update from East Sussex Healthcare NHS Trust (ESHT) on progress with implementing reconfiguration of stroke, orthopaedic and general surgery services and temporary changes to the configuration of the Trust's maternity and paediatric services. The report also included an update from the East Sussex Clinical Commissioning Groups (CCGs) on the development of future commissioning plans for maternity and paediatric services.

8.2 Darren Grayson, Chief Executive, Dr Amanda Harrison, Director of Strategy, Dr Andy Slater, Medical Director (Strategy) and Lindsey Stevens, Head of Midwifery responded to questions covering the following areas:

<u>Stroke, general surgery and orthopaedics</u>

8.3 **Full Business Case (FBC)**
Mr Grayson confirmed that the Trust is currently in discussion with the NHS Trust Development Authority (TDA) regarding further work needed on the FBC for the capital funding needed to fully implement the Clinical Strategy. Because further work is needed, the FBC is not being considered by the Trust Board in June as planned. Mr Grayson highlighted that the TDA had come into existence on 1 April 2013, had only recently published its guidance on FBCs, and it had therefore not been possible to engage with them earlier. When challenged on whether the issues could have been foreseen, Mr Grayson argued that the TDA's regime is

very different to the predecessor Strategic Health Authority process and that, given the TDA only recently agreed their procedures, it would not have been possible to anticipate the additional requirements which now apply.

8.4 **Access to capital funds**

HOSC questioned whether the Trust's previous assurances to the Committee that there would be reasonable access to capital funds had been accurate in light of the new developments. Mr Grayson indicated that the case for obtaining capital remained strong and there had been positive dialogue with the TDA which recognised the benefits of the planned reconfiguration, the significance of the Clinical Strategy to the Trust's modernisation, plus the financial benefits. The additional requirements relate to the more complex approval process, and additional detail on estates implications, rather than the strength of the case.

Mr Grayson clarified that the capital application covers the £30m funding required for the whole Clinical Strategy, not just the portion needed for the three areas of agreed reconfiguration, and that it is now apparent that an application of this level would need consideration by the TDA Board.

8.5 **FBC content**

Mr Grayson emphasised that the FBC is not designed to gain approval for the service changes as the decision to reconfigure the services has already been taken. It aims to flesh out the detail of the changes and being specific about the benefits of change and how these will be evaluated.

8.6 **Staff morale**

When asked about the impact of the FBC delay on staff morale, Mr Grayson acknowledged that there had been anxiety amongst affected staff both on a professional level and as local patients themselves. He argued that the best way to address this is to move forward with implementation which would provide certainty.

8.7 **Interim service change**

Mr Grayson indicated that the Trust is looking to make initial service changes to deliver clinical benefits whilst the FBC process which will deliver the capital programme to support the full implementation of the changes was developed. This would address the clinical pressures which are driving the reconfiguration. The intention is to make these changes before the winter peak period.

Dr Slater gave more detail on the interim plans as follows:

- General surgery – clinical pathways are agreed and it is anticipated that the reconfiguration can be implemented on an interim basis in October by creating a safe clinical environment for patients which the service can move into. The redesign of the associated environment for staff and behind the scenes facilities cannot be achieved until the full capital funding is agreed.
- Stroke – there is a pressing need to improve stroke services and provide the enhanced clinical service planned. It is anticipated that reconfiguration on an interim basis can be achieved in July with an appropriate patient care environment. Again, it will be redesign of staff areas and associated facilities which will be on hold pending the release of capital funds.
- Orthopaedics – no interim plans. Current configuration will continue for now.

Dr Slater clarified that the necessary beds, clinical areas and theatre slots would be available under the interim arrangements. In addition, he confirmed that a second CT scanner would be in place at Eastbourne hospital before stroke services are reconfigured.

8.8 **Public communication**

Dr Harrison advised that the Trust would be communicating with patients and the public before changes are made and afterwards, once there is evidence of the benefits to share. In relation to stroke specifically, there will need to be a clear message that patients will be taken directly to the right place for their condition and the Trust will look to raise awareness of the FAST (Face, Arm, Speech, Time to call 999) test for stroke symptoms. Mr Grayson added that the public consultation process during 2012 had been as comprehensive as possible and that the Trust would work with the Clinical Commissioning Groups (CCGs) on ongoing communications and engagement. This will not involve leafleting all homes as this would be too costly.

<u>Maternity and paediatrics</u>

8.9 Mr Grayson highlighted the following key points regarding the temporary reconfiguration of consultant-led maternity and inpatient paediatric services which was implemented in May:

- ESHT had not wanted to be in a position of having to make temporary changes. The situation had arisen, in Mr Grayson's view, due to a failure of the previous attempt to reconfigure services in 2007/8.
- The Trust wants to work with the CCGs to develop long term plans as soon as possible and there is much work to do on this over the coming months.
- There are some outstanding concerns relating to the temporary arrangements raised by paediatricians at Eastbourne hospital and the Trust is working with them to address these.

8.10 **Issues raised by paediatricians**

Dr Slater clarified that there is acceptance amongst the Trust's paediatricians that the Special Care Baby Unit (SCBU) service had to be reconfigured alongside the consolidated single consultant-led maternity unit. There has been more debate, particularly amongst the Eastbourne based paediatricians, over whether it was also necessary to reconfigure the inpatient paediatric service. He stated that the Trust's position was to do what is safest and the Royal College of Paediatrics and Child Health (RCPCH) had indicated that middle grade doctor staffing issues were likely to worsen rather than improve. On this basis, it was felt that consolidating the inpatient service on a temporary basis at the same time as the consolidation of maternity and SCBU services would be safest.

Dr Slater advised that the policies in place for the reconfigured service have been based on those in use at other Trusts with a similar model, and they have been reviewed for safety by external clinicians. He explained that main concern of the Eastbourne paediatricians relates to paediatric cover for the emergency department outside the opening hours of the Short Stay Paediatric Assessment Unit (SSPAU). The advice to ESHT, in line with arrangements at other Trusts, has been that consultant input is not required where there is no inpatient paediatric service on site. However, the Trust has adopted transitional arrangements which provide an increased level of support to the emergency department and midwife-led maternity unit in Eastbourne out of hours, whilst the new configuration beds in and staff gain additional confidence and skills.

In summary, Dr Slater stated that there is general agreement to a single inpatient unit from the paediatricians at both sites - the debate is about the arrangements needed to support this.

8.11 **External review**

The HOSC Chairman advised that the Committee had referred the paediatricians' concerns to the Care Quality Commission (CQC). Mr Grayson confirmed that the Trust is in constant contact with CQC and that he had recently spoken with the Commission's regional lead. CQC had met with the Eastbourne paediatricians to discuss the issues they had raised and would be reflecting on this – as yet there is no indication of them taking further action.

Dr Slater is also in ongoing correspondence with the paediatricians at Eastbourne and the Trust has invited the RCPCH to review the policies in place, which will take place in late July. Mr Grayson highlighted the value of this external perspective as there may be a difference of opinion between the Eastbourne paediatricians and the rest of the consultant body.

8.12 **Midwife-led unit (MLU)**

When asked how usage of the Eastbourne MLU has been managed, Ms Stevens explained that antenatal risk assessment is embedded in the pathway and has built on experience from the Crowborough Birthing Unit and home births. She reported that the experience over the first seven weeks had been very positive and there had been no issues with inappropriate births. There had been a relatively high rate of transfers of women in labour to the Conquest Hospital but this is indicative of midwives taking a very cautious approach in the early days. Ms Stevens expected this transfer rate to reduce as midwives gain in confidence. The 35 women who had given birth at the MLU to date were reported to be very happy with their care.

8.13 **Births transferring to Brighton**

Ms Stevens indicated that the Trust had been aware that women in Seaford would be likely to choose Brighton over the Conquest Hospital when the changes were made and there has been evidence of this occurring as expected. Likewise, women in the north west of the ESHT catchment area may choose to use Pembury hospital, although little change has been noted there. Midwives are encouraging low risk women from Seaford to try the MLU.

8.14 **Travel implications**

Ms Stevens advised the Committee that antenatal inpatients are rare nowadays, so long term visiting for families is unlikely to be necessary. Post-natally, the Trust is considering 24 hour visitor access at the Conquest Hospital unit to maximise convenience for families, but further checks are required before making a decision on this. Dr Harrison indicated that the Trust Board considered the travel impact for women and families and took this into account when making their decision to implement the temporary reconfiguration. These issues will need to be re-examined as part of the development of plans for the longer term.

8.15 **Future configuration**

Mr Grayson emphasised that the temporary arrangements do not prejudice a decision about the long term future of the services, which will be taken by the CCGs working with NHS England, patients, the Trust and the County Council. He indicated that the Trust Board decision had been influenced by changes since the previous review of maternity services in 2007/8, such as increased complexity of the caseload.

8.16 RESOLVED:

(1) To express disappointment with the delay to full implementation of stroke, general surgery and orthopaedic service reconfiguration, given the Committee's support for these changes in December 2012.

(2) To request that the HOSC Clinical Strategy Task Group continues to provide close scrutiny of the implementation of changes to stroke, general surgery and orthopaedics.
(3) To request that the Task Group expands its role to incorporate the development of longer term proposals for maternity and paediatrics.
(4) To request a further progress report in September 2013.

9. DEMENTIA SERVICE REDESIGN

9.1 The Committee considered a report by the Assistant Chief Executive which outlined a planned review of dementia assessment beds by the Clinical Commissioning Groups (CCGs).

9.2 Catherine Ashton, Associate Director of Strategy for Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CGC and Dr Matthew Jackson, Chief Clinical Officer (Designate) for the former responded to questions:

9.3 **Occupancy**
Ms Ashton explained that the overall occupancy across both dementia assessment wards over the past year was 54% but that usage levels will vary at different times. She confirmed that peaks and troughs in activity would be examined during the review.

9.4 **Review scope**
Ms Ashton confirmed that the cost-effectiveness of different options would be looked at as part of the review. The usage of the units across each of the CCG areas and the needs of each area would also be examined.

9.5 **Respite**
Ms Ashton explained that respite care is provided in different settings, and so does not form part of this review. However, respite provision is part of the wider picture.

9.6 **Early diagnosis**
Dr Jackson explained that the assessment beds are primarily used by undiagnosed patients when a crisis arises. The CCGs are focusing on improving early diagnosis of dementia which should prevent crises occurring in this way and thereby reduce demands for these beds in future.

9.7 RESOLVED:
(1) To support the planned review of dementia assessment beds.
(2) To support the proposed approach to public engagement.
(3) To confirm that options 3 and 4 listed in appendix 1 would constitute a substantial variation to services requiring consultation with the Committee.
(4) To re-establish the HOSC Mental Health Task Group (comprising Cllrs Carstairs, Pragnell and Standley) to consider the outcomes of the review in more detail and to review any proposals for substantial change, including the process and outcomes of any public consultation.
(5) To request a report back from the Task Group in September 2013

10. WORK PROGRAMME

10.1 RESOLVED to note and update the Work Programme.

The Chairman declared the meeting closed at 1.22pm