HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Lewes on 27 September 2018

PRESENT:

Councillors Colin Belsey (Chair), Councillors Bob Bowdler, Angharad Davies, Sarah Osborne and Alan Shuttleworth (all East Sussex County Council); Councillors Barnes (Rother District Council), Councillor Janet Coles (Eastbourne Borough Council), Councillor Mike Turner (Hastings Borough Council), Councillor Johanna Howell (Wealden District Council) and Geraldine Des Moulins (SpeakUp)

WITNESSES:

Samantha Williams, Assistant Director, Planning, Performance and Engagement, East Sussex County Council
Dr Adrian Bull, Chief Executive, East Sussex Healthcare NHS Trust
Jessica Britton, Managing Director , Eastbourne, Hailsham and Seaford Clinical Commissioning Group (CCG) / Hastings and Rother CCG
Mark Angus, Urgent Care System Improvement Director, Eastbourne, Hailsham and Seaford CCG / Hastings and Rother CCG
Ashley Scarff, Director of Commissioning and Deputy Chief Officer, High Weald Lewes Havens CCG
Hugo Luck, Associate Director of Operations, High Weald Lewes Havens CCG

LEAD OFFICER:

Claire Lee, Senior Democratic Services Adviser

8. MINUTES OF THE MEETING HELD ON 28 JUNE 2018

8.1 The minutes of the meeting held on 28 June 2018 were agreed as a correct record.

9. APOLOGIES FOR ABSENCE

9.1 Apologies for absence were received from Cllrs Boorman, Earl and Murray; and Jennifer Twist.

9.2 The Committee wished Cllr Earl a swift recovery from his illness.

10. DISCLOSURES OF INTERESTS

10.1 There were no disclosures of interest.

11. URGENT ITEMS

11.1 There were no urgent items.

12. NHS SUSTAINABILITY

12.1. The Committee considered a report about the financial and clinical sustainability of the NHS in East Sussex including the Financial Recovery Plans (FRP) of the three Clinical Commissioning Groups (CCGs); the progress of the Sussex and East Surrey Sustainability and Transformation Partnership (STP); and the Clinically Effective Commissioning (CEC) workstream of the STP.

12.2. Dr Adrian Bull, Chief Executive, East Sussex Healthcare NHS Trust (ESHT); Jessica Britton, Managing Director, Eastbourne, Hailsham and Seaford CCG (EHS CCG)/ Hastings and Rother CCG (HR CCG); Ashley Scarff, Director of Commissioning and Deputy Chief Officer, High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG); and Samantha Williams, Assistant Director of Planning, Performance and Engagement, East Sussex County Council (ESCC); provided answers to a number of questions from HOSC.

Financial Recovery Plans (FRP) of the CCGs

Details of savings plans

12.3. Ashley Scarff explained that the C4Y FRP involved delivering £9.2m of savings in order to reach a deficit control total of £10.7m. If this target is reached the CCG will receive £10.7m of Commissioning Sustainability Funding (CSF) that will mean it ends the year without a deficit. The FRP comprises a mixture of short and long term savings plans, for example, a major MSK redesign a number of years ago now delivers cumulative savings of £1.25m per year, which is identified in the FRP. Short term savings are to be made from discretionary spend such as overheads and corporate costs that can be stopped more swiftly and that do not have an impact on patient care, for example, vacancy freezes in CCG offices.

12.4. Jessica Britton explained that the East Sussex Better Together (ESBT) CCGs' FRP includes the delivery of £18m of Quality, Improvement, Productivity and Prevention (QIPP) schemes in order to contribute to reaching a combined deficit control total of £32m across both CCGs. As with the C4Y FRP, achieving this deficit control total will result in a CSF payment of £32m. The QIPP programme includes 18 schemes, some of which aim to improve the organisational efficiency of the CCGs; some of which involve reviewing contracts to ensure they are cost effective; and some of which involve the development of new services or pathways that are more cost effective, for example, pharmacists supporting GP practices and community health services to ensure people are given the right medications; and the High Intensity User Service that involves community-based services providing pro-active care to high users of hospital services to reduce instances of them reaching a crisis point and presenting in A&E, which is a more costly outcome to the health system. In addition the CCGs are working to ensure all other spend is contained within current budgets.

Unmitigated risk in FRP

12.5. Ashley Scarff said that HWLH CCG has identified savings schemes for all but a few hundred thousand of the target £9.2m savings in its 2018/19 FRP. These identified savings, however, are on a spectrum from assured delivery at one end to savings that are at a high risk of delivery in 2018/19, or are in an early stage of development, at the other end.

12.6. The CCG has identified £2.3m of savings categorised as at high risk of delivery and is carrying out further work to reduce these risks. This includes close management of individual saving schemes to avoid slippage, and 'over programming', i.e., identifying more savings opportunities than are required to be made in-year. This is in recognition that not all savings proposal ideas when worked up into more detailed plans will realise the same level of savings as originally estimated.

12.7. Ashley Scarff said that if the CCG does not achieve these savings it will not receive its CSF and would start the 19/20 financial year in deficit. This deficit would then continue to accumulate each year and raise the savings target required by NHS England (NHSE) to address it, resulting in a compromise to the CCG's ability to invest proactively in new community-based service redesign that are key to future financial sustainability and effective patient care.

Impact of local authority savings

12.8. Ashley Scarff confirmed that the CCGs had taken into account the impact of ongoing savings by ESCC and other local authorities to preventative social care services. The CCG is working closely with the local authority through the Connecting 4 You (C4Y) partnership board to understand the impact of the savings as much as possible and how to mitigate the impact of them. Sam Williams added that ESCC is making an 8% reduction in Adult Social Care Department (ASC) assessment capacity but is making no savings to its community care budget, therefore prioritising patient flow and ensuring that community care packages are protected.

Impact of savings on community budget

12.9. Ashley Scarff said that the CCG is going to great lengths to protect the community budget, as making savings from that budget would run the risk of significantly greater spend elsewhere in the system. He said that there is a fixed contract to provide community services with Sussex Community Foundation NHS Trust (SCFT). Therefore, any identified savings in the community budget would be coming from efficiencies to the ways in which services are provided, for example, better purchasing of supplies and consumables, reducing duplication of services, or implementing recommendations of the Government's 'Getting it Right First Time' initiative. He added that some small savings have also come from suspending community pilots such as the supplementary community transport scheme in the Havens area in order to enable the CCG to focus on protecting its core primary, acute and community services.

Impact of savings on place-based plans

12.10. Ashley Scarff said that a key goal of the C4Y and East Sussex Better Together (ESBT) place-based plans is to design and deliver innovative and transformative community services that integrate health and care locally and are delivered in the most cost effective setting. This leads to a reduction in demand in more costly parts of the health system, in particular, hospital services. Dr Adrian Bull said that the Joint Community Rehabilitation (JCR) teams are an example of successful community-based services that have been established throughout the county to reduce pressure (and therefore cost) on hospital care. The JCR provides joint health and social care assessments of patients to determine their social care reablement or medical rehabilitation needs to enable them to return quickly from hospital with appropriate care packages.

12.11. Ashley Scarff explained that these new integrated services were put in place at an additional cost with the expectation that they would deliver savings in future years by reducing demand for hospital care. However, cash restraints this year are such that return on investment from innovations needs to be achieved in-year in order for the CCGs to stabilise their systems, and the ability to implement long term investments is much more difficult.

12.12. Dr Bull explained that some of the momentum of the integration of organisations within ESBT has been lost this year due to the substantial financial pressures, although there remains a number of ongoing projects to improve integration amongst the ESBT Alliance members, for example, improving the ICT infrastructure to enable social care, primary care and ESHT employees to use common ICT systems.

Role of regulators

12.13. Ashley Scarff explained that NHS England is well aware of the financial challenges facing the East Sussex CCGs and this is reflected in the deficit control totals that recognise the CCGs will not be able to deliver a balanced budget this year. The CSF monies will also help to put the CCGs in a much better place next year. He confirmed HWLH CCG is on target to hit its deficit control total of £9.7m and Jessica Britton confirmed that both ESBT Alliance CCGs are on target to hit their combined deficit control total target of £32m.

12.14. Dr Adrian Bull said that NHSE and NHS Improvement (NHSI) have appointed a single regulator for the ESBT Alliance healthcare system that is reducing the tensions between the bodies through the development of an integrated three-year financial improvement plan.

12.15. Dr Bull explained that both NHSI and the trust agree that improving the effectiveness of care to patients will reduce the need to perform more costly medical interventions, and so help to restore the trust to financial balance. There is an ongoing debate, however, about the rate at which the trust can deliver financial improvement whilst still maintaining the significant improvements that have been made to quality and operational performance of the trust.

ESHT's financial deficit

12.16. Dr Adrian Bull said that two years ago ESHT's finances were running at a monthly deficit of £5.9m, with an independent report estimating it was on course for a £60m annual deficit. The deficit has since been reduced to £3.2m per month and the Trust is currently only slightly off track for meeting its planned deficit of £44.9m, although Dr Bull said he is confident it can be reached. NHSI has set a control total of £35m.

12.17. Dr Bull said that the Trust's planned deficit of £45m for 2018/19 is made up of four chunks that the Trust believes it can address over the next 24-36 months:

- £11-13m of Provider Sustainability Funding money. The Trust must reach its control total of £21m deficit in the current year to receive this money from NHSI, which for 18/19 will be out of reach but may not be in future years.

- £9m shortfall in income, based on PWC analysis. Receiving this money will depend on agreeing with the CCGs and regulators that the activity the Trust carries out is appropriately funded, or that the trust carries out less activity in the future, as the trust

was not previously accurately describing the work it was doing and receiving the appropriate income for it.

- £15-20m efficiency and workforce improvements. Dr Bull said this is an achievable target of 5% of turnover, e.g., it could be achieved in part by reducing the £30m annual expenditure on more costly temporary staff through recruitment of permanent staff. This has been achieved in some areas, e.g., both A&E Departments are now fully staffed whereas three years ago only 1/3 of doctors were permanent.

- Additional costs associated with running two medium sized hospitals spread across the county.

Patient and clinical engagement with proposed savings

12.18. Ashley Scarff explained that HWLH CCG would not want to undertake any savings that would have an adverse or unfavourable impact on patients. He said that all of the savings proposals go through a robust assessment process including Quality Impact Assessments and Equality Impact Assessments, so all clinical colleagues within the CCGs would be fully aware of any potential impacts on patients.

12.19. Jessica Britton explained that the ESBT CCGs have involved patients and clinicians in the development all of their plans. This includes recruiting a number of 'care pathways experts with experience', e.g., people with lived experience of diabetes are helping with the re-design of the diabetes pathway (which is planned to deliver £54k savings in 2018/19). The CCGs will also assess the impact of proposals on patients before proceeding with implementing them through Quality Impact Assessments, Equality Impact Assessments and Health Inequality Impact Assessments.

Continuing Health Care Budget and Personal health budgets

12.20. Jessica Britton explained that the CCGs are reviewing a number of individual Continuing Health Care (CHC) packages that have been in place for several years and may no longer be suitable to meet the patient's needs. The review process involves working with patients and families who have a number of services in place to streamline those services into a package of care that is most suitable to them, and meets the guidance CCGs are required to follow. Ms Britton confirmed that there had been no appeals from individuals against this process as it did not involve imposing a certain package of care, or removing care from a patient. Sam Williams added that the fact there had been no appeals is testament to the suitability of the approach taken to reviewing CHC plans. Jessica Britton confirmed that Personal Health Budgets are sometimes used to help provide community health care for some people, discussions are undertaken with the patient and family about how best to meet the person's needs.

Risk of hard Brexit on costs

12.21. Ashley Scarff explained that the effect of Brexit is currently unknown, however, there could be a potential economic impact, for example, on the cost of supplies and availability of staff. If this was to happen there would be limited ability locally to insulate against the effect as it would be a national issue affecting the whole country.

Discharge process

12.22. Dr Adrian Bull confirmed that both the medical and therapy teams must assess a patient as medically fit for discharge before they will be discharged. Readmission rates of patients are monitored closely to ensure that patients are not discharged with a medical condition and readmitted shortly afterwards. Conversely, anyone who is medically fit for discharge but remains in a hospital bed are at risk, for example, of losing muscle tone and bone density, being exposed to cross infection and losing packages of care in their home. Dr Bull said it is necessary, therefore, to strike a balance of when to discharge patients. A policy has been developed with ESCC over the last few months to ensure that patients who are refusing discharge in the hope of securing their particular preference for a residential or nursing placement are moved from a hospital bed to a more appropriate location.

Preparedness for Winter period

12.23. Dr Bull explained that the reduced lengths of stay over the last two years has enabled the Trust to set aside a number of beds during periods of normal pressure and open them in the three or four months of the winter period. There is also an enhanced winter period funding agreed with CCGs to allow the Trust to respond to the increase in demand during winter.

Sussex and East Surrey Sustainability and Transformation Partnership (STP)

Formal merging of CCGs within the STP

12.24. Ashley Scarff confirmed that there are no plans for formal CCG mergers and the current priority is to work collectively under a single Chief Accountable Officer. The CCGs' relationship, however, is continually evolving and if there is a self-evident advantage of going down the route of formally merging then it would be explored. He explained that funding for merger activities all come from the existing resource of the constituent CCGs.

Continuation of local decision making

12.25. Ashley Scarff confirmed that the increasingly close collaboration of CCGs within the STP would not result in the loss of local clinical influence or leadership, as the individual CCG Boards remain the sovereign commissioning decision making bodies within the STP.

12.26. Jessica Britton confirmed that individual place-based plans would continue, following the appointment of Adam Doyle as Chief Officer of all 8 CCGs, as they can ensure the continued integration of health and social care within local authority areas.

Advantages of commissioning at STP level

12.27. Jessica Britton explained that the STP will benefit individual CCGs by simplifying the system of commissioning some NHS trust providers, for example, mental health services across the STP area could be commissioned once from Sussex Partnership NHS Foundation Trust rather than individually by each CCG, ensuring consistency in service and the financial benefits of economies of scale.

Clinically Effective Commissioning (CEC)

Identifying further CEC proposals that may require wider consultation

12.28. Ashley Scarff explained that as part of 'tranche 3' the Clinically Effective Commissioning (CEC) programme will explore changing the CCGs' policies towards procedures if there is currently inconsistency in how treatments are offered. He said that this process will be handled very sensitively and reiterated that no decisions about the preferred way forward with services has yet been made. Identifying procedures in tranche 3 of the CEC programme has been in progress for a number of months but there is not yet a timeline for when they can be shared publicly, as there would need to be a consensus from clinicians working on the programme about what can be feasibly delivered. It may also be the case that engagement for tranche 3 could be carried out on a procedure-by-procedure basis rather than of the whole tranche 3 in one go. Jessica Britton added that there is a patient engagement group being established to ensure patients are involved in the development of these tranche 3 policies.

Implementing Tranches 0-2

12.29. Ashley Scarff explained that the CCGs are in the process of implementing tranches 0-2. This involves providing electronic versions of policy changes to clinicians who work face-to-face with patients and who would be using the amended policies for guidance on referring patients for the procedures identified in tranches 0-2. He added that some CCGs have the correct policies in place already, particularly those in Tranches 0 and 1, so the process of rolling them out will involve few changes.

12.30. Ashley Scarff said that each procedure in tranches 0-2 included a quality impact assessment that was considered by CCG governing bodies at the same time as the amended procedure polices. He said that these were considered at public governing body meetings so should be available online.

12.31. Jessica Britton clarified that tranches 0-2 are not a list of procedures that are no longer available. Instead, the tranches are a list of procedures that have had their policies for referring patients revised based on national clinical evidence and expertise, and in order to ensure consistency. This means they may not be the most appropriate course of treatment for many people. Jessica Britton agreed that the CCGs will need to consider how best to convey this message and ensure the public did not just see them as a list of cuts. She added that tranche 3 will involve a much greater conversation with local people as they are developed.

Impact on patient choice of CEC proposals

12.32. In a response to a question about a patient's right to choose where they receive care, Ashley Scarff provided assurance that patient choice is written into the NHS Constitution and that there is nothing within CEC that would affect a patient's choice to access services in London or further afield. He said there are clear rules set out in the legislation covering Payment by Results (PBR) tariffs that give patients the right to access services covered under PBR outside of their CCG area that their local CCG must pay for.

12.33. Ashley Scarff said that feedback indicates patients like to receive healthcare locally and as a result CCGs aim to commission healthcare locally where it is safe to do so. He added that the CCGs feel it important that GPs refer people locally as it benefits local healthcare providers and the local economy, and is best for a patient's experience. However, if the patient chooses to receive care elsewhere it is enshrined in the NHS Constitution that they can do so.

12.34. The Committee RESOLVED to:

1) request a further update on the ESBT Alliance's Financial Recovery Plan at the next meeting;

2) request that the proposed savings include the total budget of each service area to indicate the extent of their impact;

3) invite the new CCG Chief Accountable Officer, Adam Doyle, and the System Improvement Director of the ESBT area to attend the next meeting;

4) request that the specific savings proposals for HWLH CCG be circulated by email; and

5) request figures for the uptake amongst patients of Personal Health Budgets.

13. URGENT CARE

13.1. The Committee considered a report providing an update on the progress of the NHS 111 re-procurement; the Urgent Treatment Centres (UTCs) redesign in Eastbourne and Hastings; and the progress of the roll out of Primary Care Extended Access across East Sussex.

13.2. The Committee considered reports on these areas from Ashley Scarff, Director of Commissioning Operations, HWLH CCG; Hugo Luck, Deputy Director of Primary and Community Care, HWLH CCG; Jessica Britton**,** Managing Director for ESBT CCGs; and Mark Angus, Urgent Care System Improvement Director for ESBT CCGs.

NHS 111

Revised model of service

13.3. Ashley Scarff explained that the existing NHS 111 service has huge demand on it that has in many ways outstripped the planned activity of the service. The new service will be based on increasing clinical engagement with patients over the phone via a clinical assessment service (CAS) that will help to reduce the number of onward referrals to A&E and GP practices.

13.4. Mark Angus explained that over the past year a greater understanding has developed of what an integrated urgent care system should look like. This has helped commissioners articulate to the market more clearly what is wanted from an NHS 111 service and has helped providers develop a greater understanding of what is required for delivering a successful service. There has also been improvement in the detail of key performance indicators required of the new service model. Ashley Scarff confirmed NHSE has oversight of the procurement process and approves of it.

Penalties for not hitting national deadline

13.5. Mark Angus clarified that the new NHS 111 service will be in place by April 2020 but CCGs are due to have delivered the nine mandatory NHS urgent care outcomes by March 2019. Work is ongoing to ensure that the current providers are able to deliver those outcomes to patients by March next year.

Urgent Treatment Centres (UTCs)

Viability of UTC and walk-in centre

13.6. Mark Angus explained that two main factors will be taken into consideration when designing options for the proposed UTC service:

- The majority of people who access current walk-in centres do so because they find access to GP practices both in and out of hours difficult. To assist with this, the CCGs' primary care extended access service will provide out of hour's access to GPs at five hubs in the Eastbourne area and four in the Hastings area from 1 October.

- The CCGs estimate that 7% of patients using the Hastings walk-in centre and 16% of people using the Eastbourne walk-in centre would benefit from the additional services of a UTC.

13.7. Mark Angus explained that feedback, including feedback around the viability of a primary care hub at Hastings Station Plaza, has been used to identify different potential options for the UTCs. The next step is to do due diligence to test the financial and clinical viability of the different options in the next few weeks before returning to HOSC in due course with final proposals.

Location of UTC at Conquest Hospital

13.8. Dr Bull confirmed that the additional area within the Conquest A&E is for the Primary Care Streaming Service – which is still in early days of development – and may be converted to a UTC at a future date.

Primary Care Extended Access

GP role

13.9. Hugo Luck confirmed that it is the responsibility of the CCGs to commission the primary care extended access service not for GP practices to agree amongst themselves how to provide it, although they could agree to do so. A GP practice's core hours are stipulated in their General Medical Contract and primary care extended access falls outside of this agreement.

Location of hubs

13.10. Hugo Luck said that the primary care hubs in the High Weald Lewes Havens area will be either GP practices or minor injury units. One hub will be in Lewes, one is likely to be in Crowborough, and one in likely to be in Uckfield. The Uckfield hub will provide GP out of hours on a Sunday, which will only be at one location due to the difficulty in recruiting workforce on that day, and the lack of patient demand on Sundays in other pilots elsewhere in the country.

Advertising

13.11. Hugo Luck explained that publicity for primary care extended access will be largely limited to within GP practices or when on the phone to NHS 111 to ensure it is clear it is an improvement or extension of the existing GP practice service and not a separate, new service.

Staffing the primary care hubs

13.12. Hugo Luck explained that the hubs will be staffed by:

- existing GPs as an extension of their service;
- the provider's range of own bank staff; and
- paramedics overseen by GPs from the provider's partnership with South East Coast Ambulance NHS Foundation Trust (SECAmb).

13.13. The Committee RESOLVED to:

1) resume the work of the HOSC sub-group considering UTCs proposals in the ESBT area;

2) request an update on the potential options for the UTCs in the ESBT area at the next meeting; and

3) request confirmation of the location of the extended access hubs in each CCG area.

14. WORK PROGRAMME

14.1 The Committee considered its work programme and RESOLVED to:

1) add a report to the November meeting to agree the terms of reference for a Joint HOSC to consider potential future Clinically Effective Commissioning (CEC) proposals;

2) request the policy for prevention of smoking within the hospital boundary at ESHT is circulated to the Committee by email.

The meeting ended at 1.20 pm.

Councillor Colin Belsey
Chair