HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Lewes on 27 June 2019

PRESENT:

Councillor Colin Belsey (Chair), Councillors Phil Boorman, Angharad Davies, Ruth O'Keeffe, Sarah Osborne, Peter Pragnell and Alan Shuttleworth (all East Sussex County Council); Councillor Johnny Denis (Lewes District Council), Councillor Amanda Morris (Eastbourne Borough Council), Councillor Mike Turner (Hastings Borough Council), Councillor Bob Bowdler (Wealden District Council) and Jennifer Twist (SpeakUp)

WITNESSES:

Adam Doyle, Chief Executive Officer, Sussex and East Surrey Clinical Commissioning Groups (CCGs)

Jessica Britton, Managing Director, Eastbourne, Hailsham and Seaford CCG / Hastings and Rother CCG

Ashley Scarff, Director of Commissioning and Deputy Chief Officer, High Weald Lewes Havens CCG

Colin Simmons, 111 Programme Director (Sussex), NHS Coastal West Sussex CCG

Aileen Phillip, Workforce Project Manager, Integrated Urgent Care (IUC) Transformation Programme, South East Coast Ambulance NHS Foundation Trust (SECAmb)

Dr Adrian Bull, Chief Executive, East Sussex Healthcare NHS Trust

LEAD OFFICER:

Harvey Winder, Democratic Services Officer

1. MINUTES OF THE MEETING HELD ON 28 MARCH 2019

1.1 The Committee RESOLVED to agree the minutes of the meeting on 28 March 2019.

2. APOLOGIES FOR ABSENCE

2.1 Apologies for absence were received from:

- Cllr Mary Barnes
- Cllr Johanna Howell (Substituted by Cllr Bob Bowdler)
- Geraldine Des Moulins

3. DISCLOSURES OF INTERESTS

3.1 There were no disclosures of interest.

4. URGENT ITEMS

4.1 There were no urgent items.

5. CLINICAL COMMISSIONING GROUPS (CCGS) FINANCIAL AND GOVERNANCE PLANS

5.1. The Committee considered a report and presentation on the financial plans of the three East Sussex Clinical Commissioning Groups (CCGs) for 19/20 and the proposal to merge into a single East Sussex CCG from April 2020. The Committee then asked the witnesses present a number of questions.

5.2. The Committee asked what Brighton & Hove CCG (BHCCG) was doing differently compared to the other CCGs in Sussex and East Surrey in order to achieve a 'green' rating on both the finance and leadership ratings given by NHS England (NHSE) to CCGs.

5.3. Adam Doyle, Chief Executive Officer, Sussex and East Surrey CCGs, explained that three years ago BHCCG was rated red by NHSE and was in financial difficulties. It was the first CCG he was appointed to as Accountable Officer in Sussex, and required a full change of governance, a refresh of its leadership team, and the development of a plan to deliver financial balance. Since then, the CCG has had a track record of achieving and sustaining its financial and leadership goals.

5.4. Mr Doyle added that all other CCGs in the Sussex and East Surrey Sustainability and Transformation Partnership (STP) had subsequently fallen into financial difficulties. Since taking over as the chief officer at each CCG in turn, he has enacted the operational principles applied to BHCCG and is confident that they are all improving and are closer to achieving financial targets than they were last year.

5.5. The Committee asked how local representation will be maintained on the proposed East Sussex CCG Governing Body.

5.6. Adam Doyle explained that the three CCG Governing Bodies are being asked for indicative approval of the merger during June and July. Discussions with local representatives will then take place over the summer about the constitution of a new East Sussex CCG, including how local representation will feature in the membership of its Governing Body. The current working view, which will be subject to this engagement process, is that GP members of the Governing Body will represent populations of about 100,000 residents. He added that, in order to safeguard localism within the larger organisation, each GP Governing Body member will need to have an infrastructure around them to ensure they can be made aware of and represent local views at governing body meetings.

5.7. The Committee questioned whether the additional infrastructure needed to support governing body members representing larger areas would not cancel out any potential savings from merging the three CCGs; and whether there was scope for voluntary organisations to provide this information.

5.8. Adam Doyle explained that running the eight statutory CCG Governing Bodies (across the whole STP) has a cost to it. He said he believed that the right operating model can be developed that will both meet the required 20% back office saving and provide the appropriate level of support the people on the new CCG governing bodies would need.

5.9. He said that this will be aided by the new Primary Care Networks (PCNs), which are required under the NHS Long Term Plan. PCNs will be in a position to gather information from their patients at a local level and feed it back it to the East Sussex CCG, and discussions are due to take place with the new Clinical Directors of the PCNs to discuss how this might be achieved. This was in addition to the existing Patient Participation Groups (PPGs), many of which are quite active and will need to be utilised by the proposed East Sussex CCG.

5.10. The Committee asked how the cost of any redundancies from the CCGs – required as a result of the 20% savings mandated by NHSE – would be covered.

5.11. Adam Doyle said that savings were predominantly coming from senior level management. The remainder would come from the infrastructure savings achieved from consolidating the governing bodies, and a process of considering which vacancies to recruit to was also in effect. He considered this to be the right approach to take to safeguard hard-working staff and enable them to continue to do their work.

5.12. He said he was not yet at the stage to declare to staff that there would be no redundancies, but this would become clearer after all eight CCG governing bodies had made a decision on their consolidation. Mr Doyle added that staff would be engaged over the summer about the proposed CCG model.

5.13. The Committee asked what the effect would be on health services from the 20% reduction in back office funding, and how confident the CCGs were that the reorganisation could be delivered.

5.14. Adam Doyle clarified that he had two budgets – one used to fund individual providers to deliver healthcare services, and a separate budget to run the CCGs. The 20% savings would come from the second budget and not from healthcare services. He was confident that the reorganisation of the CCGs could be delivered by April 2020.

5.15. The Committee asked what number of employees the 20% back office savings represented.

5.16. Adam Doyle said that it was difficult to calculate how many employees 20% would comprise as everyone was paid different amounts. It was more easily represented as a saving of just under £5m from a £40m budget across the eight CCGs. He reiterated that this figure could be reached with the smallest number of affected people by focussing on the senior management, who are more highly paid. Mr Doyle acknowledged that this decision was being taken with the requirement in mind of needing to discharge statutory functions effectively; he pointed to the improvements in the NHS England ratings as evidence that this approach was working but said it would remain under regular review.

5.17. The Committee asked how the CCG Governing Body will take into account the small areas of deprivation that exist across the county.

5.18. Adam Doyle said he believed that the best way to manage health inequalities was to manage them in the communities where those inequalities existed. The model of integrated care being developed – which he clarified did not yet exist as a finalised plan – should improve services to people in deprived areas, as it involved partner NHS and local authorities developing

preventative services and community-based care. He added that the organisational changes to the CCGs would help to enable the development of this integrated model of care.

5.19. The Committee asked how patients in the north of the county who tend to use Maidstone and Tunbridge Wells NHS Trust (MTW) services would be affected by changing services in East Sussex.

5.20. Adam Doyle explained that it is clear the health and social care integration plans in East Sussex do not include plans to change services based in Pembury Hospital in Kent that are used by patients in East Sussex. The CCG governing bodies have requested to receive assurance that patients within Sussex who use services in Kent, Surrey and Hampshire (which are areas that border the Sussex STP) will receive the same level of service as patients using services within the Sussex border. Early discussions are happening with Kent CCGs about ensuring this is the case.

5.21. The Committee asked how voluntary groups would be able to participate in the development of the CCG merger plans.

5.22. Adam Doyle explained that he was meeting with his leadership team to finalise the engagement plans for the wider stakeholder group, which would include the voluntary sector.

5.23. The Committee asked when the CCGs would be able to achieve financial balance without the need for Commissioner Sustainability Funding (CSF).

5.24. Adam Doyle said that all eights CCGs are improving their current financial position and he believed that the significant improvement of 2018/19 will be maintained again this year. He explained that the NHS financial position is in a state of flux and that the current financial framework for commissioners – where if a CCG meets an agreed financial target additional, non-recurrent CSF money is awarded to enable it to break even – is expected to be very different for 20/21. If this non-recurrent money is provided recurrently from 20/21 as part of the CCGs' allocated funds, he argued, it would be possible to demonstrate that the CCGs are achieving recurrent financial balance. He said that the financial framework details for 20/21 are expected to be announced in the Autumn.

5.25. The Committee asked whether continued local authority savings would affect the ability to develop out of hospital care, and whether once the CCGs have achieved a sustainable financial position they will have the resources to help subsidise the Adult Social Care Department (ASC) of ESCC.

5.26. Jessica Britton, Managing Director, Eastbourne, Hailsham and Seaford CCG (EHS CCG) & Hastings and Rother CCG (HR CCG) explained that there is a strong partnership in East Sussex across the CCGs, NHS providers and East Sussex County Council (ESCC), which put them in a better place to plan together. The response to the NHS Long Term Plan required from each area will provide a mechanism to understand the organisations' budgets and how best to use them together for best effect.

5.27. Adam Doyle said that it is quite clear based on its legal framework what services the NHS is responsible for delivering. He argued, therefore, that it would not be appropriate for the NHS to prop-up the ASC budget, which he considered a separate budget and one that has been denuded over quite some time. The solution, therefore, was at a national level and the NHS

should lobby alongside local government for additional funding for adult social care. He added that the NHS does, however, have a duty to deliver population healthcare, so there should be the ability to integrate well with the local authority to commission services that keep people healthy over the long term.

5.28. Adrian Bull added that East Sussex Healthcare NHS Trust (ESHT) now has strong operational integration with ESCC that will continue to be developed, for example, there are now mixed teams of social workers and district nurses managed by a single manager. In addition, the Better Care Fund (BCF), which is jointly managed by the CCGs and ESCC, dedicates quite considerable NHS resources into a common fund for use by ESCC and the CCGs. He added that ESHT is aware of ESCC's financial challenges and how they impact on joint care, such as through the closure of the intermediate care beds at Firwood House.

5.29. Ashley Scarff, Director of Commissioning Operations, High Weald Lewes Havens CCG (HWLH CCG), explained that CCGs recognise the importance of working in partnership with ESCC to avoid people arriving in A&E unnecessarily. This includes developing support packages of care for people living in care homes to reduce the likelihood of them needing hospital care in an unplanned way, and the continued development of preventative care. Adrian Bull pointed out that these initiatives have successfully reduced A&E attendances from care homes, particularly in HWLH area, whilst attendances from all other sources were increasing.

5.30. The Committee queried whether any of the pipeline Quality, Improvement, Productivity and Performance (QIPP) schemes have yet been identified and whether they would be implemented by the end of the financial year.

5.31. Jessica Britton clarified that the named QIPP plans were those that were in place and being actively delivered. Pipelines schemes, on the other hand, were either a QIPP scheme very close to moving into being delivered; or an emerging plan that does not yet have a finalised assessment of quality and financial impact attached to it and is therefore not yet agreed to move towards delivery. Adam Doyle added there will always be a pipeline of plans being generated that may then be delivered in future years to ensure the CCG remains on a stable financial footing.

5.32. HOSC asked whether QIPP savings in the area of prescribing can continue to be delivered year on year despite significant savings being made there in 18/19.

5.33. Jessica Britton said this is one of the areas where the CCGs are confident they can continue to deliver savings. Commissioning pharmacists continue to visit care homes, GP practices and work with hospital teams to ensure support and training is in place to undertake good medicine reviews and instil best practice in prescribing, resulting in better outcomes for patients and more cost-effective use of drugs. Given that national benchmarks for prescribing costs per number of population show East Sussex as doing well but able to do better, there is still room for improvement.

5.34. The Committee asked what impact assessments have been done on the prescribing costs increasing due to Brexit.

5.35. Adrian Bull said that there is a national NHS programme of preparation for Brexit. EHST has been fully involved locally through the appointment of one of its executive directors to a regional committee looking at risks to the supply of medicine. One of the key central messages

of the committee is that individual NHS organisations should not stockpile medicines, as this creates a crisis of its own making rather than addressing the issues at hand.

5.36. **The Committee asked whether reducing unwarranted reduction in hip and knee surgery would result in rationing surgery that individuals might need**.

5.37. Ashley Scarff explained that this QIPP saving plan involves adapting the Musculoskeletal (MSK) pathway to enable a relatively small number of people to consider informed options around alternatives to surgery, such as pain management, and rheumatology and physiotherapy support. This is based on data on patients' experience of hip and knee surgery that showed that with the benefit of hindsight a number of patients who had received surgery would have preferred to have done something different.

5.38. Adrian Bull added that the aim was not to prevent people who need surgery from having it, but to provide conservative management to those who will respond well to it and who would otherwise had surgery and put themselves at risk or face a disappointing outcome. He confirmed that the MSK pathway is still designed to ensure that where a patient meets the criteria for a surgical intervention it is offered to them, and the pathway changes will be subject to audit. Dr Bull said that some delays do occur for elective MSK surgery and that this needed to be improved.

5.39. The Committee RESOLVED to request:

1) A future report in November including governance arrangements for the new CCG; the role of PCNs; and financial plans for 20/21, including how central funding is expected to be allocated from 20/21; and

2) That the engagement plans for the CCG merger are circulated by email for information.

6. URGENT CARE - OUT OF HOURS HOME VISITING SERVICE PROCUREMENT

6.1. The Committee considered a report on the procurement of a Sussex-wide Out of Hours (OOH) Home Visiting Service. The Committee then asked the witnesses present a number of questions.

6.2. The Committee asked why the OOH Home Visiting Service was being procured separately to the new NHS 111 service.

6.3. Colin Simmons, Integrated Urgent Care Programme Director, Coastal West Sussex CCG, explained that the procurement that was paused last Summer had been for a Sussex-wide NHS 111 service. He said he could not go into all the reasons why it was stopped, due to procurement confidentiality, but it did include an OOH Home Visiting Service. The reason for the changes included:

- the proposed NHS 111 service now includes Kent, where there is a different home visiting arrangement in place; and

- separating out the service and commissioning a shorter contract for the Home Visiting Service allows testing of what model of home visiting works best with the new NHS 111 service.

6.4. The Committee asked whether there was a risk that recruitment to the service would interfere with attempts to recruit to other emerging urgent care services.

6.5. Colin Simmons agreed workforce recruitment and retention was an issue but was also an issue across the whole of the NHS. To tackle this issue, the OOH home visiting service will have a mix of clinical skill sets – whereas the current service is predominantly GP-based – enabling patients to see paramedics, or advanced nurse practitioners in certain circumstances. Plans are also being developed to use the workforce in the most flexible, constructive way, for example, establishing whether clinicians in the NHS 111 Clinical Assessment Service (CAS) could work for a different provider, i.e., the provider of the Home Visiting Service, to enable the clinician to vary their workload in a way that suits them.

6.6. The Committee asked how the CCGs can ensure that providers deliver on any promises to provide the workforce set out in the service specification.

6.7. Colin Simmons explained that part of the role of all commissioning organisations is to hold providers to account to deliver on their promises, but CCGs can also encourage providers to work together to help ease workforce issues.

6.8. The Committee asked how the service might overcome the issue of a shortage of GPs

6.9. Colin Simmons explained that the shortage of GPs would be overcome in part by developing a multidisciplinary team including paramedics, advanced nurse practitioners and GPs. Whilst GPs will still be required for certain clinical interventions, these other staff could help support the GPs' workload. It will also be necessary to develop ways of making the service seem more attractive to prospective GP, given the traditional issues with OOH services appearing unattractive employment opportunities.

6.10. The Committee asked about how oversight of this potentially complex urgent care system could be ensured.

6.11. Colin Simmons explained that the CCGs' role in ensuring different providers work together across the urgent care system will involve being clear about the expected outcomes of the new integrated urgent care system, as well as looking at the clinical governance arrangements for handing patients from the care of one provider to another are safe for patients.

6.12. The Committee asked how access to summary care records could be shared between the ICT systems of NHS 111 and the OOH Home Visiting Service

6.13. Colin Simmons explained that call-handlers for NHS 111 can currently access summary care records. In future the 111-CAS clinicians, if they need to look at further details, will be able to view full patient records, although they will require a patient's consent. There are a multitude of different ICT systems in use by the different urgent care providers and the current interim 111 contract for 19/20 involves testing out how these can best be linked together.

6.14. The Committee asked when new innovations are introduced how it can be ensured they work correctly

6.15. Colin Simmons agreed it was important to ensure new technology, such as video calling instead of face-to-face appointments, is used to help improve services for patients, but it also needs to be understood they will not be appropriate for all situations. Patients will also need to be made aware of such technologies and be comfortable using them, and some clinicians will also need to see the benefits demonstrated to them. he believed that there needs to be stakeholder engagement and plans to pilot some of these technologies.

6.16. The Committee asked whether the procurement timeline was short and whether there was confidence there were providers able to take on the service.

6.17. Colin Simmons agreed it was a tight timeline but the mobilisation period of three months was not considerable due to the size of the service. The 111-CAS, on the other hand, had an eight month mobilisation period in recognition of its size. Nine providers showed interest in the OOH Home Visiting Service during an engagement event, suggesting there is interest in the market to provide the service.

6.18. The Committee asked what will happens to patients assessed by the CAS

6.19. Colin Simmons explained that the 111-CAS will consider a patient's need over the phone and, if necessary, assign an appropriate time period in which the OOH Home Visiting Service will need to visit them. This will be either two, four or six hours. 111 will pass the referral on to the OOH Home Visiting Service with the response time indicated and the OOH service's target will be to respond within that time. 111 will then carry out comfort calling every so often during that period to check if the patient is ok and their needs have not changed.

6.20. The Committee RESOLVED to note the report.

7. EAR, NOSE AND THROAT (ENT) SERVICES RECONFIGURATION - UPDATE

7.1. The Committee considered a report providing an update on the progress of the implementation of the reconfiguration of Ear, Nose and Throat Services (ENT) provided by ESHT. The Committee then asked the witnesses present a number of questions.

7.2. The Committee asked for an update on any success with the recruitment of clinicians and whether consultants have sufficient time allocated to training junior doctors.

7.3. Dr Bull explained that the trust currently has an overall 10% vacancy rate compared to a national average of 16%. The turnover was 9.5% compared to an average of 15-16%. He added that there were variations around those numbers and difficulties remain recruiting to specialities, which included ENT. To help improve recruitment in ENT the two joint consultant posts are being advertised in conjunction with Brighton & Sussex University Hospital NHS Trust (BSUH). This will enable consultants to have access to both the tertiary work that goes on in Brighton and the district general work at Eastbourne District General Hospital (EDGH).

7.4. Adrian Bull said there is no doubt that the reputation of the trust is much better. As a result, he was mostly shortlisting two or three applicants for most advertised consultant specialities, except in those few areas where there were shortages, and a new generation of young consultants was beginning to develop at the trust. He added that many consultants were attracted to district general work generally, and East Sussex specifically, and not all wanted to go work in a tertiary centre and its associated academic pressures. Some, though, enjoyed exposure to both, and the relationship with BSUH and Kings College NHS Trust helps to attract those seeking this balance. ESHT also continues to support the medical schools at the University of Brighton and the emerging one in Kent.

7.5. The Committee asked for clarification whether the addition of an adult surgery list at Conquest Hospital didn't run against the proposal to centralise the service at EDGH

7.6. Dr Adrian Bull clarified that the original purpose of the reconfiguration was to centralise adult ENT surgery at EDGH, not the entire ENT service. The final configuration has adult inpatient surgery centralised at EDGH but with a monthly day list retained at Conquest Hospital. This was at the request of ENT surgeons who wanted to ensure that the theatre teams had the opportunity to practice the skill set required for ENT surgery so that in the event of an emergency procedure there was sufficient knowledge and resources in place. Dr Bull said it was possible to accommodate this additional day list and still address the issues of ENT medical staffing being over stretched over two sites because the previous planned surgery lists at Conquest included patients who needed an overnight stay at the Conquest, meaning that ENT doctors then had to travel from the EDGH inpatient ward to see them the next day.

7.7. Adrian Bull added that the paediatric list at the Conquest, on the other hand, was for children who needed to stay overnight following more complex surgery, such as for sleep apnoea, at the paediatric ward at that hospital site.

7.8. The Committee asked for confirmation whether the ENT staff were on board with the proposals

7.9. Adrian Bull confirmed that ENT staff supported the proposals. He said that early on some nursing staff had thought there were going to be no services available, but this was resolved quickly once they understood what the proposals were going to mean for them. The consultants are also all now supportive following their concerns about emergency care. he added that they are of the view that all ENT paediatric patients should, in the long term, be seen in a tertiary centre. This is not currently a national requirement, however, and they are satisfied that the current configuration is sufficiently safe.

7.10. The Committee RESOLVED to request that the Trust's performance reviews of ENT are circulated by email for information.

8. HOSC FUTURE WORK PROGRAMME

8.1 The Committee considered its work programme and the minutes of a joint HOSC working group meeting with Brighton & Sussex University Hospital NHS Trust (BSUH).

8.2 The Committee RESOLVED to:

1) note the work programme subject to removing the NHS Long Term Plan item and adding it as the subject of an away day to discuss potential future scrutiny subjects;

2) request a briefing providing the details of dentistry services in East Sussex is circulated by email.

The meeting ended at 11.53 am.

Councillor Colin Belsey
Chair