HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Lewes on 30 June 2016

PRESENT:

Councillors Colin Belsey (Chair), Councillors Ruth O'Keeffe, Frank Carstairs, Angharad Davies, Alan Shuttleworth, Bob Standley and Tania Charman (all East Sussex County Council); Councillors Janet Coles (Eastbourne Borough Council), Councillor Mike Turner (Hastings Borough Council), Sam Adeniji (Lewes District Council) Bridget George (Rother District Council) and Jo Bentley (Wealden District Council); Julie Eason and Jennifer Twist (Speak Up)

WITNESSES:

High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG)

Wendy Carberry, Chief Officer
Alan Beasley, Chief Financial Officer
Sally Smith, Director of Delivery

Eastbourne, Hailsham and Seaford Clinical Commissioning Group (EHS CCG) / Hastings and Rother Clinical Commissioning Group (HR CCG)

Jessica Britton, Chief Operating Officer
Graham Griffiths, Director of Performance and Delivery

South East Coast Ambulance NHS Foundation Trust (SECAmb)

Geraint Davies, Acting Chief Executive
Tim Fellows, Operational Manager

East Sussex Healthcare NHS Trust (ESHT)

Dr Adrian Bull, Chief Executive
Jenny Darwood, General Manager Urgent Care

Coperforma

Michael Clayton, Managing Director

Brighton & Sussex University Hospital NHS Trust (BSUH)

Andrew Stenton, Interim Director of Operations - Unscheduled Care
Dr Steve Holmberg, Medical Director

Healthwatch East Sussex

Julie Fitzgerald, Chief Executive

LEAD OFFICER:

Claire Lee, Senior Democratic Services Adviser

1. MINUTES OF THE MEETING HELD ON 24 MARCH 2016

1.1 The Committee agreed the minutes as a correct record of the meeting held on 24 March 2016.

2. APOLOGIES FOR ABSENCE

2.1. Cllr Joanna Howell gave her apologies (Cllr Jo Bentley substituted).

3. DISCLOSURES OF INTERESTS

3.1. Cllr Mike Turner declared a personal interest because he intended to refer throughout the meeting to a document titled *Emergency Ambulance Services in England* written by his son Nick Turner on behalf of the NHS Support Federation.

3.2. Cllr Jo Bentley declared a personal interest as someone who had received a service from Coperforma.

3.3. Cllr Ruth O'Keeffe declared a personal interest as an active member of Healthwatch East Sussex.

4. URGENT ITEMS

4.1. There were no urgent items.

5. PATIENT TRANSPORT SERVICE

5.1. The Committee considered a report by the Assistant Chief Executive, East Sussex County Council, on the performance of the Patient Transport Service (PTS) in Sussex following a change of provider on 1 April 2016.

5.2. High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG) and Coperforma apologised unreservedly for the failures of the PTS since 1 April, and promised to look at the learning from the independent incident review.

5.3. Michael Clayton, Managing Director of Coperforma, updated HOSC regarding a meeting on 29 June following the news that VM Langford (a provider of ambulances for the PTS) had gone into administration. At the meeting Coperforma met with staff-side representatives and local management to assure staff that, whatever happened to VM Langfords, their pay, staff benefits, and pension contributions for June would be funded by Coperforma. All staff would also be able to take employment with designated Coperforma ambulance providers in the area that would protect their terms and conditions. Staff-side representatives were comfortable with the proposed changes and staff were appreciative.

5.4. HOSC expressed concern at the performance of the PTS over recent weeks and more than one HOSC member spoke about the effect the PTS had on local residents who had contacted them directly with their experiences of the service.

5.5. The Committee asked the witnesses from HWLH CCG, Coperforma and South East Coast Ambulance Service NHS Foundation Trust (SECAmb) a number of questions relating to the Patient Transport Service.

The tendering process and due diligence by CCGs

5.6. HOSC queried the extent to which HWLH CCG had carried out due diligence on Coperforma, and asked whether the CCG was concerned that there was only one formal tender. The Committee also asked whether the CCG had considered the concerns of the GMB trade union about the tendering process.

5.7. Alan Beasley, Chief Finance Officer, HWLH CCG, said that although Coperforma was the only organisation that submitted a final tender, the CCGs had looked into why the two other organisations which were invited to tender did not ultimately submit a bid. The feedback from SECAmb was that the Trust could not provide a substantive bid within the financial envelope that was offered. Arriva Transport Ltd. responded that it did not have the capacity to submit a tender in line with the timescale required.

5.8. Alan Beasley did not take the view that the issues with the performance of the contract since 1 April were due to the funding provided by the CCGs for providing the PTS. He said that Coperforma did not express concerns about the funding offer during the tendering process.

5.9. Alan Beasley assured the Committee that, although only one tender was submitted, the same process was followed as if there had been multiple submissions, for example, the same financial evaluations and due diligence.

5.10. Alan Beasley said that HWLH CGG did review the capacity and capability of Coperforma and in turn Coperforma reviewed the capacity and capability of its subcontractors. Assurance was given by Coperforma for each main subcontractor, alongside HWLH CCG's own high level financial viability checks, which allowed the CCG to be able to embed them within the contract. Because VM Langfords was a going concern when it went into receivership, the finances may not have been the focus of the problems at that company.

5.11. Alan Beasley added that the independent investigation into the PTS transition will look at the due diligence the CCGs undertook and he recommended that HOSC wait to consider the conclusions of that review.

5.12. Wendy Carberry, Chief Officer, HWLH CCG, said that content of the GMB letter was reviewed at a programme board meeting against the assurance process that was in place and decisions were made at the programme board accordingly. She confirmed that there was a response to the letter by the CCGs.

Use of subcontractors

5.13. HOSC asked why the CCG did not see any inherent risk in the proposed structure of commissioning a managed service provider (Coperforma) that would then subcontract the patient transport provision to other providers.

5.14. Alan Beasley said that the previous PTS contract with SECAmb involved around 20% of journeys being undertaken by private sector vehicles. The issues since 1 April were system wide and to say that they were wholly due to the subcontractors was not a fair statement. The independent investigation has looked at all areas and was unlikely to conclude that fault lay entirely with the subcontractors.

5.15. Michael Clayton said that the contract involved 18 subcontractors to allow flexibility and resilience in the service. This meant that although Coperforma did not predict the failure of VM

Langford, the broad range of providers allowed Coperforma to put the work and staff onto other providers to avoid the receivership having a detrimental effect on the service.

Due diligence by Coperforma

5.16. HOSC asked the extent to which Coperforma had conducted due diligence on its subcontractors and how it could be sure that more subcontractors would not go into receivership like V M Langfords.

5.17. Michael Clayton said that Coperforma's Clinical Assurance Team puts all potential subcontractors through a quality assessment review that looks at the company and its directors, its attitude to continuous improvement and its willingness to work in an open and transparent way. The review also includes an inspection of the vehicles, crews, and crew training records.

5.18. Michael Clayton said that Coperforma undertook detailed financial analysis of VM Langfords. The organisation had been working successfully with Coperforma for five years. A reinvestigation by Coperforma was triggered by the arrival of new management following an aggressive takeover of the company. It became clear during mid-May that Coperforma had concerns about the new management and their ability to deliver on promises to grow the company. A contingency plan was then put in place for the 70 staff who would potentially be affected, which has now been successfully implemented. Mr Clayton said that it was unlikely that the other providers would go into receivership in the same way as VM Langford, as its receivership has raised concerns about aggressive takeovers for companies that were growing well and is likely to put off other providers from following suit.

SECAmb decisions and changes to the contract

5.19. HOSC asked why SECAmb gave notice on the previous contract and whether its decision not to bid for the new contract should have concerned HWLH CCG.

5.20. Alan Beasley clarified that the contract was coming to the end of its original term and SECAmb was entitled not to continue with the contract under its existing terms and conditions. He assured HOSC that the contract was not redesigned as a cost saving measure. The financial envelope offered was the same as the previous contract and no additional activity was added. However, there were more challenging performance indicators than in the previous contract meaning that the new provider would be expected to achieve higher standards for the same amount of money. Wendy Carberry added that HWLH CCG had benchmarked what CCGs spent on PTS contracts and the Sussex contract was mid-range.

5.21. Alan Beasley confirmed that there is a continual growth in the number of people using PTS. The Patient Transport Bureau operated a 'paper-driven' service, so there was an expectation that Coperforma's use of an ICT-driven service would absorb the impact of this growth in demand over the coming five years.

5.22. Geraint Davies, Acting Chief Executive, SECAmb, explained that the contract was extended for a year beyond its original end date, enabling the CCG to develop a revised service specification and commission the new service. Mr Davies added that SECAmb did raise some concerns about the standards the CCGs were requesting, and the costs associated with those standards, which were fed back to the CCGs.

5.23. Geraint Davies explained that SECAmb did not wish to bid for the contract to be the managed service provider, i.e. the provider that manages subcontractors that in turn provide the patient transport – in effect a "booking agency". SECAmb did, however, consider taking on the role of one of the subcontractors providing the transport, as this is the Trust's core business. Once the managed service provider contract was awarded to Coperforma, SECAmb entered discussions with them as a potential subcontractor, but concluded that the terms were not commercially viable for the Trust.

5.24. Geraint Davies clarified that the equivalent of the managed service provider for the previous PTS was the Patient Transport Bureau – managed by the CCGs – and SECAmb was a service provider directly commissioned by the CCGs, rather than subcontracted by the Patient Transport Bureau.

Responsibility for the decision

5.25. HOSC asked who was responsible for the decision to award Coperforma with the contract.

5.26. Wendy Carberry said that the decision about awarding the contract to Coperforma was made by a programme board with representatives of all seven Sussex CCGs that was then ratified by each CCG Governing Body. There was no one person responsible for the decision. The procurement process was coordinated by HWLH CCG and the decision making process was through the programme board.

5.27. HOSC questioned whether spreading the responsibility for designing and awarding the contract across multiple CCGs through the programme board had led to failures in the process.

5.28. Alan Beasley explained that the skill sets of the predecessor Primary Care Trusts have been spread out over seven CCGs. The ability to draw skills from other organisations onto the project team was very important for this project and the difficulty in co-ordinating staff from seven CCGs was compensated by the access gained to the skilled staff within those CCGs.

Learning from previous contracts

5.29. HOSC asked whether HWLH CCG had taken lessons from the previous PTS contract into account when drafting the PTS contract.

5.30. Alan Beasley said that an EU procurement process had to be followed as the contract was over a certain value, and HWLH CCG used external procurement specialists to assist with the process. However, there were lessons that were learned from the previous contract because a significant part of the engagement process with stakeholders involved seeking feedback on the existing service. This feedback was then taken on board for the new PTS contract, for example, the timeliness of the previous service informed the performance indicators of the new contract.

Mobilisation and transition arrangements

5.31. HOSC queried the robustness of the transitional arrangements; in particular arrangements to ensure the most vulnerable people were safeguarded.

5.32. Sally Smith, HWLH CCG, said that as part of the procurement process, Coperforma provided a detailed mobilisation plan that covered all of the areas to be addressed during the transition. For example, TUPE arrangements for transport and support staff transferring from SECAmb, and booking staff transferring from the Patient Transport Bureau; and the technology and ICT around the new service provision and online booking function. The CCG project team agreed the plan. The project team was reporting to the programme board which included directors from all seven CCGs and Coperforma during the transition period.

5.33. Sally Smith said that during the transition period, HWLH CCG held joint meetings with SECAmb, the other CCGs, Patient Transport Bureau and Coperforma to go through all of the stages of the transition plan and assure the organisations that they were on track and completing all of the necessary actions for a successful transition. Clearly there had been failings in this process as it was not delivering in the way that the CCGs had wished it to, but they were waiting for the independent review for an objective perspective on the transition.

5.34. Michael Clayton said that Coperforma had put in place an overlay team to train staff transferring to Coperforma (and new staff) on the new computer systems and the more customer focussed role. He said that not all staff did choose to transfer, leading to a shortfall, and some staff who did transfer decided it was not for them and took employment elsewhere. The overlay team provided Coperforma with resilience to cover that shortfall.

5.35. Michael Clayton said that the data Coperforma was provided with did not allow it to drill down sufficiently to anticipate peaks in demand, and some of those peaks had left Coperforma short of transport at certain points during the day. Coperforma introduced an additional 29 shifts from the end of May to the beginning of June to deal with these peaks in demand, which drove the improvement in performance. By the end of July and beginning of August there will be a further 84 shifts coming on stream which is more than is needed to hit the performance indicators in the contract. This excess number of shifts was a risk contingency designed to help Coperforma manage the risk during the winter months, which were expected to see increased demand on patient transport due to increased travel times and greater health issues.

The purpose of an independent review

5.36. HOSC questioned the value and purpose of the independent review.

5.37. Alan Beasley said that the he believed the review to be of value. He explained that the investigation was mandatory because it was a “level 3” investigation that formed part of the serious incident process. Furthermore, the review will result in a ‘lessons learned’ document which would be of value in informing future procurements.

Financial penalties for failure to meet performance indicators

5.38. HOSC asked whether there was a clause in the contract that meant Coperforma would receive financial penalties for failing to meet required performance standards, and whether there was a clause for terminating the contract.

5.39. Wendy Carberry explained that HWLH CCG was using the remedial action plan as well as utilising the levers within the standard NHS contract to improve the performance of Coperforma to where it should be. However, contingency plans are also being looked at.

5.40. Alan Beasley confirmed that there are financial penalties built into the NHS standard contract that would apply for failure to meet targets.

Performance of Coperforma and the reliability of performance data

5.41. HOSC welcomed the apparent improvement in Coperforma’s performance but questioned how long it would take to reach the full expected standard, and how accurate the data supporting the improvement was.

5.42. Alan Beasley said that the CCGs had agreed an eight week remedial action plan on Coperforma that lasted until the end of June. It was anticipated that by the end of the first week of July, Coperforma would be close to hitting the performance indicators in the contract. He said, however, that HWLH CCG now had to consider the impact of the VM Langford receivership – which took place during the remedial action plan period – on the trajectory for improvement and whether there is justification to extend the remedial action plan for one week to mitigate its impact.

5.43. Alan Beasley said that looking beyond the data it was ultimately people being let down by the service which was unacceptable. He explained that there were 1,000 patient journeys per day, so even if Coperforma was achieving its 95% on time standard then that would be 50 people per day who did not receive the service that they deserved. A key concern for the CCG is that too often the same patients are being affected by delays on multiple occasions.

5.44. Alan Beasley said that HLWH CCG is working to improve the analysis of performance data. Coperforma had been open in providing the data and it appeared that the data matched the company's claims regarding performance – both when it improved and when there were issues. The CCG was comfortable that the data presented also reflected qualitative feedback on Coperforma's performance.

Driver standards and deployment

5.45. HOSC had heard concerns about a number of patients not being picked up at their designated time by the PTS, particularly early in the morning; alleged driver behaviour, particularly for patients who felt nauseous during the drive; and the requirement that volunteer drivers had to purchase smart phones capable of running a mobile worker application.

5.46. Michael Clayton made the following points in response:

- There are 56 volunteer staff and 230 full time employed staff.
- early morning transport work is pre-allocated (not allocated on the day) and the issues relating to early morning transportation were being rectified by additional training and earlier shift starts for the earlier journeys.
- he was particularly concerned at the lack of vomit bowls as this was a requirement and he would look into that particular incident.
- the London congestion charge was paid for by subcontractors (or reimbursed) and that they should be informing their staff of that fact.
- one of the reasons for providing a mobile worker application to the drivers was that it has built in satnav. Some volunteer drivers had raised concerns about having to buy a smart phone, but many of the drivers who now use the application like it. The application also allows Coperforma to know driver locations, identify any delays, and is a more effective way of protecting patient identifiable data than paper print outs.

5.47. The Committee RESOLVED to:

1) Request a further update on the Patient Transport Service at the 29 September 2016 meeting.
2) Request comparative data between the current and previous patient transport service contract on:
    a. The unit cost per patient journey
    b. Drivers' caseloads, e.g., the number of journeys or miles travelled per driver
    c. Management charges
    d. Quality targets
3) Request a copy of the CCG's response to the GMB letter

6. HOSPITAL HANDOVER

6.1. The Committee considered a report by the Assistant Chief Executive on the extent of delays in handover of patients from ambulances to hospital emergency departments, how handover is managed, and actions in place to address this issue.

6.2. East Sussex Healthcare NHS Trust (ESHT), Brighton & Sussex University Hospital NHS Trust (BSUH) and South East Coast Ambulance Service NHS Foundation Trust (SECAmb) provided presentations on their role in the hospital handover process.

6.3. HOSC asked the witnesses from the three Trusts a number of questions.

Impact on ambulance services

6.4. HOSC asked when SECAmb would reach a critical point in terms of handover delays.

6.5. Geraint Davies said that SECAmb was already at a tipping point and there were regularly days where there were 'planned wipeouts' (i.e. no ambulances available to respond to new calls). These occurrences did not necessarily fit a pattern.

6.6. Tim Fellows, Operational Manager, SECAmb, said that the delays in hospital handover meant that most ambulances were having to travel from one of the three hospitals in Brighton, Eastbourne and Hastings to respond to emergency calls, making response times more lengthy. If hospital handover times could be improved then ambulances could be redistributed strategically across a wider geographic area so that there would always be an ambulance close to most residents. He clarified that patients, in the main, had not been suffering any harm as the response times were still good and the quality of care remained high.

Causes of handover delays

6.7. Dr Adrian Bull, Chief Executive, ESHT, said that hospital handover was not an issue just for the A&E department, or even the hospital, but the health system as a whole. The delays in hospital handover were a symptom of a wider problem that was also affecting ESHT's 4 hour and 12 hour A&E waiting time targets.

6.8. Dr Bull accepted that hospital handover times were unacceptable but made the point that it was dangerous when considering a system–wide issue to focus on just one parameter and try to fix it at all costs. He said that handovers were taking so long because busy staff were attending to patients who need care elsewhere; a patient waiting in an ambulance with paramedics may be safe whilst another patient may arrive at A&E in urgent need of care. Focusing exclusively on handover would have knock-on effects elsewhere. It was a complex interdependent problem with a lot of competing issues that need resolving,

Actions to reduce handover times

6.9. HOSC asked what actions are being taken to reduce handover times, in particular the recruitment of staff, and what the timescales for these actions having an effect would be.

6.10. Geraint Davies said that the main issue for SECAmb was for acute trusts to get the appropriate capacity at A&E departments to enable ambulance crews to handover patients in a timely way. He recognised the pressure this put on acute trusts, which was why the ambulance and acute trusts needed to work in partnership to get a realistic system in place. He said that it would be a significant challenge to reduce handover times to the level that they were in April 2013.

6.11. Dr Bull said that the A&E departments at Eastbourne District General Hospital (EDGH) and Conquest Hospital required greater capacity. The Trust has the funds to provide this

capacity, but is unable to recruit sufficient staff at present. Due to the need for continual cover of the department the Trust is forced to rely on agency staff, costing more than if they were able to recruit the five additional permanent staff needed.

6.12. Jenny Darwood, General Manager – Urgent Care, ESHT, said that there was a recruitment and retention issue at ESHT. There are vacancies in all medical levels in the Trust, including middle grade and consultant level. The Trust was actively trying to attract staff to work in East Sussex, for example, by offering incentive payments and developing training packages for new staff, including for specialist doctors to work towards becoming consultants. Dr Bull reminded HOSC that escalating pay to attract consultants could have a knock on effect of forcing other NHS organisations to increase their offer to this limited pool of staff; competition for agency staff had already caused their cost to increase significantly.

6.13. Dr Bull said that there were other ways of improving capacity through the system and ESHT was working to analyse the potential impact of such improvements. For example, the Trust had commissioned an expert team to match surges in demand to the allocation of staff. ESHT was also working with NHS Elect to review the allocation of capacity on both hospital sites to urgent and elective care.

6.14. Dr Bull said that ESHT is working fully and collaboratively with social services at the discharge end of the process to create capacity; CCGs and primary care at the other end to see if demand for hospital care can be reduced; and with neighbouring hospitals and the ambulance trust when patients enter the system.

6.15. Dr Bull recognised that in situations like that caused by the delays in hospital handovers that relationships can become fraught between ambulance and hospital staff. He was committed to ensuring that professional courtesy was maintained at all times so that the patient was not caught in the middle.

6.16. Andrew Stenton, Interim Director of Operations - Unscheduled Care, BSUH, echoed the difficulty of recruiting to some medical roles. As the Royal Sussex County Hospital (RSCH) is a major trauma centre it has 24 hour consultant cover which helps in many ways – but there is a shortage of junior doctors and, in particular, nursing roles which was also a national problem. He said that BSUH had the funding to fill these roles but, like ESHT, was relying on agency and bank staff due to difficulties recruiting permanent staff. The Trust has various strategies, such as recruiting from abroad, to reduce these staffing issues but it was difficult to put a timescale on when they may be resolved because it was a national problem.

6.17. Dr Steve Holmberg, Medical Director, BSUH, said that there were not enough doctors in training grades to fill the vacancies nationally in some specialities. He agreed that increasing pay offers was not the solution to attracting staff; it was more effective to improve the job offer, for example, by offering career development.

6.18. Andrew Stenton said that BSUH used escalation protocols to bring in clinical staff from other areas to the A&E department– such as staff on training, or carrying out non-clinical roles on that particular day – to assist in managing peaks. Direct patient care takes priority during times of considerable pressure.

6.19. Tim Fellows said that a lot of good work was going on in the county, for example, developing specialist assessment pathways at the Conquest Surgical Assessment Unit where ambulance clinicians can admit patients directly. The fractured neck of femur pathway at the Princess Royal Hospital takes pressure off A&E by allowing patients to be admitted directly to the right place quickly. Paramedics are also focused on non-conveyance where appropriate, i.e., avoiding hospital admissions. The stroke centre at Eastbourne DGH and the major trauma centre at Royal Sussex County Hospital were also effective.

Leadership

6.20. Given that this issue cuts across several organisations, HOSC queried whether there is one person taking the lead on co-ordinating efforts to reduce hospital handover times.

6.21. Dr Bull said that he was taking the lead on, and was accountable for, reducing hospital handover times at ESHT, and he was ensuring that the Trust was doing everything it needed to. He also considered that he was responsible for ensuring ESHT worked with partner organisations on the issue.

6.22. Andrew Stenton clarified that there was no one person responsible for co-ordinating system wide responses to hospital handover delays. There is a statutory group – the System Resilience Group – which brings together all NHS bodies in community, acute, and ambulance services - that looks at this and other issues on a monthly basis. The group is held accountable by the wider NHS for delivery on these areas.

Current waiting times

6.23. HOSC asked what the current waiting time is at acute hospitals for handover.

6.24. Geraint Davies said that a deal was being negotiated through the System Resilience Group to set a realistic target of 30 minutes for handover, as the national target of 15 minutes would be too challenging for the system. This would be accompanied by a realistic trajectory to achieve 30 minute handover times. NHS organisations go into escalation procedures when a patient breaches a 45 minute handover time. This is so that organisations can understand what the delay means for the patient and the system as a whole.

6.25. Geraint Davies said that the only hospital in the Trust's area performing well was Medway Hospital, which was also the only hospital where handover times had fallen over the past two years. This had been achieved by redesigning the A&E Department and assigning dedicated handover nurses. He said it was an example of good practice but could not necessarily be replicated elsewhere due to individual circumstances; in particular that Medway NHS Trust had put these processes in place because it had been in special measures.

6.26. Andrew Stenton said that Princes Royal Hospital in Haywards Heath had shorter handover times than the RSCH due to the different type of care the hospitals provided and the volume of patients that they dealt with; there was a great deal more pressure at RSCH than at the Princes Royal.

6.27. Jenny Darwood said that the 4 hour window for seeing patients in A&E started when patients arrived in an ambulance so ESHT had no incentive not to take over their care.

National picture

6.28. HOSC asked whether the 60% increase in handover hours was similar to the national level, and asked how it had impacted on patients.

6.29. Geraint Davies said that the South East area covered by SECAmb was an outlier in the top quartile and always has been. Some hospitals stood in the top 5 or top 10 nationally for handover delays.

6.30. Dr Bull said that there had been no data to suggest there was any adverse effect on patient outcomes so far. ESHT has a system for reporting and investigating any incident where harm had occurred to a patient and there were no such incidents where hospital handover delays had been the cause.

6.31. The Committee RESOLVED to:

1) request a report in December 2016 on the work led by the System Resilience Group and Urgent Care Network to improve the wider urgent care system and reduce handover delays;

2) request additional data from SECAmb on:

    a. Comparative hospital handover times nationwide; and

    b. The number of planned wipeouts over recent years and whether there are spikes in demand.

7. SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST (SECAMB) UPDATE

7.1. The Committee considered a report by the Assistant Chief Executive providing an update on a number of developments in relation to SECAmb's services.

7.2. HOSC asked a number of questions in relation to these developments.

Patient triage and patient safety

7.3. HOSC raised concerns about the safety of SECAmb's 'hear and treat' and 'see and treat' policies; the effect on patient safety of the use of non-paramedic staff on ambulances; and the reasons for a disparity between the number of incidents recorded by SECAmb and NHS England.

7.4. Geraint Davies said that neither SECAmb nor any other ambulance trust in the country has an all paramedic workforce. There is a skill mix in the organisation comprising paramedics, technicians, and emergency care support workers.

7.5. Geraint Davies said it was a challenge for SECAmb to ensure that when a call comes into the organisation it is triaged properly. The hear and treat policy involves putting clinicians into control rooms so that calls can be reviewed by clinical staff. This ensures that calls are triaged correctly and responded to in the most appropriate way. The see and treat policy involves ensuring that the right crew with the right skill mix is present for the clinical need of the patients, maximising the opportunity to provide the necessary care in situ and reducing the need to convey to other services. The triage system used by SECAmb is a national system that is quite risk averse. As part of the ambulance triage programme, SECAmb is working with partner organisations to understand how to adapt the triage system to effectively manage patients in a manner that is as safe as possible.

7.6. Mr Davies added that nationally the Ambulance Response Programme had been set up to look at how best to ensure ambulance trusts hear and treat and see and treat effectively – there are five ambulance trusts involved in the pilot and if successful it will be rolled out across England in the autumn. The programme should allow ambulance trusts more time to triage patients up front and then re-categorise calls.

7.7. Geraint Davies said that when a 'Serious Incident' (including a death related to an incident) occurs, SECAmb investigates it, learns lessons, and changes its pathways accordingly.

SECAmb culture

7.8. HOSC asked about the bullying culture and staff morale issues identified by the Care Quality Commission (CQC) in a letter to SECAmb following its recent inspection and what the senior management team would be doing to address these concerns.

7.9. Geraint Davies said that he would remain as Acting Chief Executive until a new Chief Executive was recruited, which was estimated to be in 4-6 months – he said he would not apply for that role himself. He said that his remit as Acting Chief Executive would be to: stabilise the organisation; ensure that there are plans in place to address the recommendations of the external review into the red 3 triage pilot; and plans to deliver performance improvements over the next few months. Geraint Davies said that he would achieve this using his own experience of building cultural change alongside that of external NHS consultants who would be brought into SECAmb. The challenge over the next two years would be to move away from being a hierarchical organisation to one where staff were engaged and empowered, and senior leadership was open and transparent. He said the organisation had become more open, staff were consulted on proposed changes, and their views were sought on how improvements could be made.

7.10. Tim Fellows said that culture varied between organisations and also within large organisations such as SECAmb; he said that there were cultural issues in the wider SECAmb that he did not recognise in East Sussex. He said that organisations can always do more to improve.

7.11. Geraint Davies assured HOSC that SECAmb's senior management had been aware that bullying and harassment culture was a major issue in the organisation prior to the CQC inspection, and this had been included in a presentation of all of SECAmb's challenges made to the CQC. He said that senior managers had been made aware of this issue as a result of the outcomes of staff surveys.

7.12. Geraint Davies said that, in regards to poor staff morale leading to poor patient care, patient satisfaction surveys had indicated that patients considered that they were receiving good care, but he recognised the limitations of such surveys and the importance of staff morale.

7.13. The Committee RESOLVED to:

1) request a further update from SECAmb in September 2016 to include findings of the triage scheme patient impact report and the full CQC report (if available).

2) request further details of the Trust's workforce skills mix.

3) arrange a visit to the Lewes Emergency Operations Centre for HOSC Members.

8. BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST (BSUH) CARE QUALITY COMMISSION (CQC) UPDATE

8.1. The Committee considered a report by the Assistant Chief Executive which provided an update on recent CQC activity in relation to Brighton & Sussex University Hospitals NHS Trust (BSUH).

8.2. Dr Steve Holmberg, Medical Director, provided HOSC with a presentation.

8.3. HOSC agreed that it was clear there were significant issues with BSUH, but until the full CQC inspection report had been released, the Committee did not know enough to comment fully. It was particularly important that HOSC understood the details as BSUH was both a regional referral centre and a teaching hospital.

8.4. HOSC asked whether the waiting times for outpatient appointments at BSUH, in particular neurology, had improved.

8.5. Dr Holmberg said that BSUH has a real problem with the timeliness of offering treatments, which includes outpatient appointments, and that is highlighted in the CQC notice to the Trust. BSUH had not understood the scale of the problem but a lot of work has been done over recent months to analyse this and measures will be put in place to improve the issue over time. He said that BSUH is working with its Clinical Commissioning Groups (CCGs) to access additional capacity where there are insufficient staff or facilities to enable a rapid enough improvement by the Trust alone.

8.6. Dr Holmberg also referred to ongoing operational difficulties with the Trust's booking hub. BSUH was beginning to deliver significant improvements in performance but it was a journey that was not yet completed.

8.7. With regard to neurology, Dr Holmberg said that there was triage in place early on in the patient referral process which aims to mitigate risk to patients. To some extent, neurology is a victim of its own success due to a number of referrals to the service outside of its natural catchment area because it is seen as a good service. This meant that not all patients could be seen in a timely manner.

8.8. The Committee RESOLVED to:

1) Agree to co-ordinate ongoing scrutiny of BSUH's CQC report with neighbouring Health Overview and Scrutiny Committees;

2) Request a report on the outcome of BSUH's CQC inspection on 29 September; and

3) Circulate the CQC report electronically as soon as it is published.

9. EAST SUSSEX HEALTHCARE NHS TRUST (ESHT) QUALITY IMPROVEMENT PLAN (QIP)

9.1. The Committee considered a report by the Assistant Chief Executive which included a response from ESHT to HOSC's report on the Trust's Quality Improvement Plan (QIP).

9.2. Julie Fitzgerald, Chief Executive, Healthwatch, provided a summary of Healthwatch's work with ESHT in relation to the QIP. HOSC thanked Healthwatch for their involvement in the process.

9.3. HOSC asked further questions in relation to specific areas identified as a concern in the Care Quality Commission (CQC) report.

Patient records

9.4. HOSC asked for an update on funding for the digital tagging system for patient records, and the progress of the records storage site at Apex Way.

9.5. Dr Adrian Bull, Chief Executive, confirmed that the digital tagging system was in place and as a consequence the number of missing patient records at outpatient appointments had fallen significantly. The move to Apex Way had begun following extensive consultation with affected staff and the performance of the new system was being carefully tracked. A formal opening of Apex Way was due to take place on 12 July 2016.

Patient involvement

9.6. HOSC asked what ESHT was doing to ensure patients were involved in the quality improvement process.

9.7. Dr Bull said that ESHT involved patients in service design well in an ad-hoc manner but agreed that the Trust needed to do more to ensure patient involvement in its service design at all levels as a matter of course. He said that ESHT will develop a well thought through plan to achieve this. He used the example of the work ESHT had undertaken with Healthwatch, including a recent mock inspection in preparation for the next CQC visit, that was very helpful to illustrate effective patient involvement.

Maternity services

9.8. HOSC asked for an update on the capital works proposed as part of the reconfiguration of maternity services in 2014, and asked whether it would affect the decision to single-site consultant-led services at the Conquest Hospital.

9.9. Dr Bull said that the capital improvement spend in 2013/14 for maternity services was just over £100,000 at Eastbourne District General Hospital (EDGH). In the 2017/18 capital programme there is a further £130,000 planned to improve the environmental surroundings of the midwife-led unit. ESHT has limited capital funds and there is a list of proposed capital projects which total greater than the £45m annual capital budget. Included in this list is the significant and substantial rebuilding of the maternity unit at EDGH, but this cannot be accommodated in the current capital programme because of other urgent works which take priority. ESHT is planning to create a business case for further external capital funding to enable the Trust to carry out more of its proposed capital projects.

9.10. Dr Bull clarified that ESHT has no plans at present to bring consultant-led maternity services to back to EDGH, but the Trust would continue to listen to the concerns of the residents it serves.

Seven day working

9.11. HOSC asked ESHT to clarify its seven day working plans, including how it planned to work with other hospitals and whether the Trust was planning to hire more non-clinical staff.

9.12. Dr Bull said that ESHT works as part of a wider network to deliver some specialist services, for example, the provision of immediate response for people with heart attacks. This does not mean ESHT will rely on other Trusts to provide core services on a seven day basis. He agreed that the NHS should work towards a full seven day service but the stated objective of the NHS at the moment is to ensure that there are a certain number of standards which apply seven days a week, for example consultant-led reviews of admitted patients and access to diagnostic tests. ESHT must reach these standards by 2020 with certain milestones in between. A senior consultant –led group has been set-up to ensure that ESHT complies with these milestones. A consultant-led medical round is a cornerstone of good medical care in hospital, and at the moment ESHT is not comprehensively achieving this. Dr Bull has set a challenge to his senior medical staff to achieve this.

9.13. Dr Bull said that there is real value in introducing non-clinical staff because it enables clinicians to reduce time spent on non-clinical tasks, for example, freeing up ward matrons to lead nurses by providing administrative support for documentation.

Patient satisfaction and performance

9.14. HOSC asked about the value of patient satisfaction as a measure of a trust's performance.

9.15. Julie Fitzgerald said that patient surveys formed a very important part of a wider understanding of a trust's performance, but should be triangulated with other sources of information, such as the findings of independent inspectors with the ability to gather evidence and present it to the correct authorities. For example, Healthwatch East Sussex performed joint enter and view visits with Healthwatch Brighton at Brighton and Sussex University Hospitals NHS Trust and sent this information to the CQC and the local Quality Surveillance Group.

9.16. Dr Bull said that ESHT was not providing perfect care to all patients across its services. He said he will sign the majority of complaint response letters and compliment response letters in the future. This was because it was important for senior leaders to understand the experience of patients. Dr Bull said ESHT needs to continually measure its performance by looking at patient feedback, waiting times, infection rates, staff morale – which is currently a mixed picture – and patients' individual experiences. He suggested that it was important to avoid a cycle of self-reinforcing bad news at the Trust – he will continue to promote the good things that happen in the organisation so that staff recognise achievements and are encouraged to flag good and bad events without a fear of reprisal.

9.17. Julie Fitzgerald said that Healthwatch commissions the Independent Complaints Advocacy Service. There had been more referrals recently but when Healthwatch drilled down into these figures it was found that more staff were referring patients to the Service. This indicated that staff were recognising that learning from complaints was a useful tool for improving performance.

Stroke standards and consultant referrals

9.18. HOSC asked for clarification with regard to stroke standards and the process for consultant to consultant referrals

9.19. Dr Bull said that, as far as he was aware, the standards at the hyper acute stroke unit were being met. He acknowledged an issue with consultant to consultant referrals which ESHT is currently discussing with Clinical Commissioning Groups.

Infection control

9.20. HOSC asked whether there were sufficient infection control measures in place at the hospital entrances.

9.21. Dr Adrian Bull said that the entrances of both EDGH and Conquest Hospital were due to be redesigned to be more accessible, efficient, and pleasant to patients and the public.

Medical bed capacity

9.22. HOSC queried the Trust's strategy to increase medical bed capacity in order to reduce the use of surgical beds for medical cases.

9.23. Dr Bull said that ESHT's strategy was being vetted by NHS Elect. The strategy set out the allocation of bed space between medicine, surgery, planned and urgent care. NHS Elect has indicated that the balance is wrong and a reallocation will be necessary. ESHT will need to protect the elective bed space at the same time as providing space for urgent admissions – this includes active work with Adult Social Care to manage patient discharge. There is a specific action plan both in terms of re-designation of areas of the hospital and much more focus on the flow of patients through the hospital and into the wider system.

9.24. The Committee RESOLVED to:

1) request a further report providing an update on the performance and development of the Trust's maternity services.

10. SUSSEX AND EAST SURREY SUSTAINABILITY AND TRANSFORMATION PLAN

10.1 The Committee considered a report by the Assistant Chief Executive about the purpose and process of developing a Sustainability and Transformation Plan for Sussex and East Surrey.

10.2 The Committee RESOLVED to request a further update in December 2016 focusing on the implications for East Sussex.

11. HOSC FUTURE WORK PROGRAMME

11.1 The Committee RESOLVED to note the work programme.

The meeting ended at 2:10pm.

Councillor Colin Belsey
Chair