HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Lewes on 1 December 2016

PRESENT:

Councillors Colin Belsey (Chair), Ruth O'Keeffe, Frank Carstairs, Angharad Davies, Alan Shuttleworth, Bob Standley and Tania Charman (all East Sussex County Council); Councillor Janet Coles (Eastbourne Borough Council), Councillor Mike Turner (Hastings Borough Council), Councillor Johanna Howell (Wealden District Council) and Jennifer Twist (SpeakUp)

WITNESSES:

High Weald Lewes Havens Clinical Commissioning Group

Wendy Carberry, Chief Officer
Alan Beasley, Chief Financial Officer
Ashley Scarff, Head of Commissioning and Strategy
Maninder Singh Dulku, Patient Transport Service Programme Director

Eastbourne, Hailsham and Seaford Clinical Commissioning Group / Hastings and Rother Clinical Commissioning Group

Amanda Philpott, Chief Officer, Eastbourne, Hailsham and Seaford Clinical Commissioning Group/ Hastings and Rother CCG
Dr Mark Barnes, ESBT Clinical Director
Pauline Butterworth, Programme Director for Urgent Care

East Sussex Healthcare NHS Trust

Dr Adrian Bull, Chief Executive

East Sussex County Council

Keith Hinkley, Director of Adult Social Care and Health

LEAD OFFICER:

Claire Lee, Senior Democratic Service Adviser

21. MINUTES OF THE MEETING HELD ON 29 SEPTEMBER 2016

21.1 The Committee agreed the minutes of the meeting held on 29 September 2016.

22. APOLOGIES FOR ABSENCE

22.1 Apologies for absence were received from Cllr Sam Adeniji (Lewes District Council), Cllr Bridget George (Rother District Council) and Julie Eason (Speak Up).

23. DISCLOSURES OF INTERESTS

23.1 There were no disclosures of interest.

24. URGENT ITEMS

24.1 There were no urgent items.

25. SUSSEX AND EAST SURREY SUSTAINABILITY AND TRANSFORMATION PLAN

25.1. The Committee considered a report on the Sussex and East Surrey Sustainability and Transformation Plan (STP).

25.2. Wendy Carberry, Accountable Officer, High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG), and the nominated Senior Responsible Officer (SRO) for the STP, provided the Committee with a presentation. Keith Hinkley, Director of Adult Social Care and Health, East Sussex County Council (ESCC); Amanda Philpott, Chief Officer, Eastbourne, Hailsham and Seaford Clinical Commissioning Group (EHS CCG)/ Hastings and Rother Clinical Commissioning Group (HR CCG); and Dr Adrian Bull, Chief Executive, East Sussex Healthcare NHS Trust (ESHT), were also in attendance.

Place based plans

25.3. Keith Hinkley clarified that, due to the complexity of the STP's footprint, the STP was not a single individual plan but instead comprised three place based plans within its footprint: East Sussex Better Together (ESBT), Central Sussex and East Surrey Alliance (CSESA) (of which the Connecting 4 You (C4Y) programme in HWLH is a part), and Coastal Care. This means that the details of the STP in East Sussex have largely already been set out in ESBT and C4Y and have been through, or are going through, full governance and engagement processes.

Composition of STP Executive and Board, and representation of district and borough councils

25.4. Wendy Carberry explained that the STP Executive comprises 10 Members including a Chair, Senior Responsible Officer, commissioning leads for the three footprints, and specialised commissioning leads (including for community health and mental health). Keith Hinkley, as Commissioning Lead for the East Sussex Better Together programme, is the only local authority representative on the Executive.

25.5. The STP Programme Board comprises 23 representatives, including representatives of each of the four top tier local authorities: Brighton & Hove City Council, East Sussex County Council, West Sussex County Council and Surrey County Council.

25.6. Keith Hinkley explained that although there was no direct district and borough council representation on the STP Board, each of the three place based plans was developed locally by the upper tier local authorities and CCGs in consultation with district and borough councils.

Development of ESBT

25.7. Amanda Philpott said that ESBT formally launched in August 2014. However, planning for an integrated health and social care system had started at an earlier date as a means to address the challenges in the East Sussex health and social care economy which had been unsustainable for a number of years, and is set to become more so with the ageing population, increased healthcare costs, and tightening budgets.

25.8. Keith Hinkley explained that the implementation of ESBT is more advanced than the other place based plans. An integrated Strategic Investment Plan (SIP), commitment to developing an Accountable Care Model, and commitment to a transitional year of Accountable Care during 2017/18, have all been agreed by ESCC, HR CCG and EHS CCG with provider partners. The C4Y programme is expected to develop in a similar way.

Public engagement

25.9. Keith Hinkley said that ESBT is in week 122 of implementation and engagement with the public has been ongoing for two years. The ESBT development process has been open and transparent, with the necessary policy and resource decisions taken through the governance processes of ESCC (Cabinet meetings and the Reconciling Policy, Performance and Resources (RPPR) process) and the CCGs (via the public CCG Governing Body meetings).

25.10. Amanda Philpott outlined some of the ways in which the ESBT programme had been publicised:

- a dedicated ESBT website containing the draft 5-year investment plan, high level outcome measures and meetings of the ESBT Programme Board;
- briefings provided for the local MPs;
- engagement for each of the eight ESBT workstreams, for example, 500 people were involved with the urgent care workstream engagement;
- Healthwatch East Sussex has facilitated public and patient engagement forums;
- staff engagement events have been held; and
- information about ESBT has been included in newsletters such as Your County.

25.11. Amanda Philpott said that because of this commitment to transparency the ESBT element of the STP contains no surprises.

25.12. Keith Hinkley clarified that the STP consultation will take place in 2017 and will use the same communication and engagement mechanisms as the place based plans.

STP-level transformation plans

25.13. Amanda Philpott clarified that whilst the placed-based plans are committed to provide care locally wherever possible, an STP-wide approach will be taken in relation to specialist and tertiary services, such as vascular, stroke and cancer services as these services will continue to need to work in wider clinical networks.

25.14. Wendy Carberry explained that an STP-level approach to workforce is being developed to work with all providers across the STP footprint to develop ways to retain staff within the area and make changes to the workforce in line with the recommendations of the Lord Carter Review of Operational Productivity in NHS providers. Any workforce planning will be done in a consultative way.

25.15. Dr Adrian Bull told the Committee that he is leading the STP-level digital transformation plan. One of its key tenets is to ensure that technology makes it possible for patients to manage their long term conditions and have access to professional advice via phone or other devices, for example, the pilot of a Virtual Fracture Clinic. Rolling out technology will result in increased efficiency that will help organisations provide more for less.

Benefits of STP footprint

25.16. Wendy Carberry argued that the advantage of working across the STP footprint was that it would help acute providers develop sustainable services by integrating more closely with primary and community care; acute providers cannot become sustainable in isolation.

25.17. Keith Hinkley believed that co-terminosity of footprints around existing partnerships would have been preferable, for example, ESBT, and this was argued at the time that the STPs were first put in place by NHS England. However, the wider STP footprint does offer advantages for addressing digital and workforce issues and it has not undermined the place-based plans – which have become the building blocks of the STP.

Use of private providers

25.18. Dr Adrian Bull assured HOSC that that core principles of the NHS – taxpayer funded and free at the point of use – underpin the STP process and there was nothing in the STP plan to suggest that privatisation was the goal of the process. He said that the judicious use of private providers should not be ruled out as they can prove beneficial to the healthcare system in some circumstances, for example, the CCGs commissioned Vanguard to bring in a temporary facility and locum consultants to reduce ESHT's endoscopy waiting times – with less than 1% of patients now waiting more than 6 weeks for diagnosis.

25.19. Amanda Philpott said that CCGs and ESCC are legally obliged as corporate entities to adhere to European procurement law so services developed through ESBT will adhere to that process where required.

Financial situation

25.20. Dr Adrian Bull clarified that the financial deficit anticipated across the health economy by 2020/21 is calculated on the increasing demand and cost for health and social care, not a reduction in resources. This means that the goal of the STP is to make the available resource stretch further, rather than cutting existing resources.

25.21. Dr Bull explained that NHS Improvement (NHSI) has signed off ESHT's financial recovery plan to reduce its deficit to £42m by the end of the financial year (from a £48m deficit in 2015/16). If ESHT achieves this reduction then it will realise £10m of Sustainability and Transformation Funds (STF) held by NHSI, reducing the deficit further to £32m. Dr Bull said that the STF was not related to the STP and it was not a requirement for the Trust to be out of deficit to receive STF support – only that the Trust reaches its agreed deficit target.

Achievements of ESBT and collaborative work in East Sussex

25.22. Dr Adrian Bull said that he has been hugely impressed by the genuine collaboration of colleagues in health and social care across all levels in East Sussex; he thought that the collegiality in East Sussex is second to none.

25.23. Amanda Philpott described a number of schemes developed as part of ESBT that demonstrated collaborative work had been a success, for example, Health and Social Care Connect, Integrated Locality Teams, the review of urgent care, the establishment of frailty practitioners, the use of clinical pharmacists, developing award winning medicine management, a daily operational flow management board (to unblock the system on a daily basis), a scheme to tackle obesity in nursery schools, and the Healthy Hastings and Rother programme to tackle local health inequality.

Winter plans

25.24. Dr Adrian Bull explained that the challenges faced when recruiting staff was mainly around recruiting registered nursing and medical staff. Increasing the capacity to care for people at home means that more healthcare assistants can be used to provide care. These healthcare

assistants are based in the integrated locality teams alongside healthcare professionals and are being given the appropriate training.

25.25. Dr Bull said that the increased community bed capacity would come from a variety of sources including Rye and Bexhill Hospitals, and a contract to reserve beds in nursing homes where patients can be assessed for ongoing care, rather than having to stay in hospital for this assessment; ESHT is also helping St Wilifred and St Michael hospices to increase their hospital flow to community locations and helping St. Wilifred open five additional beds.

25.26. The Committee RESOLVED to:

1) note the report;

2) request a further update at its 23 March 2017 meeting.

26. URGENT CARE REDESIGN

26.1. The Committee considered a report informing it of the work being undertaken to redesign urgent care services in Eastbourne, Hailsham and Seaford and Hastings and Rother as part of the East Sussex Better Together (ESBT) health and social care transformation programme.

GP recruitment and GP sign up to urgent care redesign

26.2. Dr Mark Barnes, ESBT Clinical Director, highlighted the fact that GP shortages were a national issue but the Urgent Care Programme Board is working very hard to make the role of GPs in the Eastbourne, Hailsham and Seaford and Hastings and Rother areas as attractive as possible, for example, by developing a locum bank for GPs so that newly qualified doctors can work in GP surgeries as locums in the hope that it will encourage them to take up the position long term; and offering mixed portfolio careers for young doctors where they are jointly appointed by the CCGs and East Sussex Healthcare NHS Trust (ESHT) so that they split their time between GP surgeries and other clinical areas.

26.3. Dr Barnes explained that the urgent care workstream involves plans to encourage GPs to work together within localities and as part of GP federations in order to ensure that there is consistency within the new urgent care system. However, GP surgeries are independent business and so it can be difficult to enforce changes on their working practices.

26.4. Amanda Philpott said that the extent to which GP practices want to become involved in ESBT wide initiatives and new contracting arrangements will vary. Some GPs will wish to continue as completely independent businesses; others may see benefits to taking up different options.

26.5. Amanda Philpott added that one of the challenges in developing the Accountable Care Model for ESBT will be how to include independent GP services within the model.

Role of Health and Social Care Connect (HSCC) and face to face contact

26.6. Dr Mark Barnes explained that the role of the Health and Social Care Connect (HSCC) within the new urgent care model will be as a consistent triage point for patients. Patients not in need of emergency care will be transferred by 111 to HSCC, where they will be assessed and

potentially referred to the new Urgent Care Integrated Hubs located at the walk-in centres in Eastbourne and Hastings for same day urgent care access. HSCC will be upskilled to include doctors and nurses who will carry out the triage. Patients advised by HSCC to visit the Urgent Care Integrated Hubs will be able to see a clinician within thirty minutes of arriving.

26.7. The two walk-in centres will provide face-to-face contact for patients in Hastings and Eastbourne. There may be potential to develop further face-to-face contact hubs in places such as Hailsham, Seaford and Rye to ensure that advice and assessment is spread across the county.

Role of 111

26.8. Pauline Butterworth, Programme Director for Urgent Care, explained that 111 services will be re-procured to become a call handling service acting as a first point of access for patients. 111 call handlers will then refer patients to either the emergency services or to the local clinical hub. The other current 111 functions – triaging and signposting patients – will be transferred to the local clinical hub, i.e., HSCC. It is anticipated that this meet the needs of patients more appropriately.

26.9. Pauline Butterworth assured HOSC that HSCC would be fully developed as a local clinical hub before the 111 was re-procured as a call handling service to ensure that there were no gaps in service provision.

Outreach

26.10. Dr Mark Barnes agreed that those most deserving of care don't always avail themselves of it. The Whole System Urgent Care programme will include the development of innovative schemes to reach out to homeless people and other vulnerable groups.

Sharing patient details across urgent care services

26.11. Dr Adrian Bull said that Shared Care Records are increasingly used by clinicians, which contain all key information necessary to treat patients, and are often used for a patient arriving in A&E whose full medical notes may be elsewhere. A fundamental part of the STP digital transformation plan involves developing a digital clinical record for a patient where their consent has been given for its use by all clinicians across the healthcare system. This system is already used in palliative care where patients have an end of life care plan that different NHS organisations can access, in particular ambulance services, to ensure that they do not inappropriately interfere with their end of life plans.

26.12. ESHT is about to launch the next phase of its electronic document management (EDM) programme, which involves beginning to move patients on to an electronic patient record system called EMIS. However, the process of digitising and sharing patient records is complex and takes time to reach agreement on the preferred solution, and takes time to implement. The challenge is in convincing people and in the process of migrating data, not in the limits of available technology.

Role of community pharmacies

26.13. Dr Mark Barnes explained that a lot of calls from patients for urgent care relate to concerns they have about their prescriptions, and the Pharmacy Institute has campaigned for

the greater involvement of pharmacies in urgent and emergency care. It is anticipated that one of the roles of the local clinical hub (HSCC) will be to refer patients, where appropriate, to community pharmacists to reduce the pressure on GPs. However, direct redesign of pharmacy services is not possible as commissioning pharmacy services is within the remit of NHS England, not the CCGs.

26.14. Dr Barnes said that clinical input would be needed before prescribing further courses of antibiotics, but pharmacies could conceivably prescribe repeat prescriptions such as blood pressure medication. However, it would be important (under the new urgent care system) that a patient call 111 first and go through the correct triaging process if they wished to have medication re-prescribed.

26.15. The Committee RESOLVED to:

1) note the report; and

2) request a future update in September 2017 once the procurement process for the urgent care service is more developed.

27. PATIENT TRANSPORT SERVICE

27.1. The Committee considered a report providing an update on the Patient Transport Service (PTS) in Sussex.

27.2. Alan Beasley, Chief Finance Officer, High Weald Lewes Havens (HWLH) Clinical Commissioning Group (CCG) updated the Committee on recent developments with the PTS:

- Performance continues to improve according to the statistics, although the data is subject to quality assurance by the CCG's PTS specialist and there remain performance issues to be worked on.

- The sudden closure of Docklands Medical Services (DMS) has had minimal impact on patients as Coperforma has secured alternative capacity.

- Payments were made to all staff of DMS by HLWH CCG in September and October and have been organised for November. They have also been organised for December if required.

- Coperforma wrote to the seven CCGs that commission the PTS to say that it was not economic for the company to continue to provide a PTS in Sussex. Although this communication was unexpected, the CCGs activated their contingency arrangements which involved approaching South Central Ambulance Service to take over the contract. SCAS is rated good by the CQC and has recently been awarded the PTS contract for Surrey.

- HLWH CCG welcomes the six 'areas of improvement' issued by the Care Quality Commission (CQC) following its inspection, and welcomes the CQC's involvement in the transition process.

- The CCGs are undertaking a transparent, phased process of transferring the contract to SCAS that will begin early next year and be complete by 31 March 2017. This process is

based on the recommendations of the independent report by the TIAA into the adequacy of the mobilisation arrangements for the PTS contract.

- Coperforma will continue to deliver the remainder of its contract and is committed to continuing to improve its performance.

- Other subcontractors have expressed concerns to the media about alleged underpayment by Coperforma. HWLH CCG is mediating between the parties and talks are progressing well.

27.3. Alan Beasley and Maninder Dulku, PTS Programme Director, HWLH CCG, gave the following responses to questions from the Committee.

Reason for a 'no fault' termination

27.4. Alan Beasley explained that all CCGs involved in the PTS contract agreed that a managed transfer to SCAS would be in the best interests of patients, and in order to do that it was necessary to declare a 'no fault' termination of the contract. The CCGs looked at the financial costs, impact on patients, and timescales to change the contract without a managed transfer, and agreed that the risk and cost to patients was too high, particularly as the contingency plan with SCAS was already in place.

Recommendations of the independent report

27.5. Alan Beasley said that the TIAA review included a recommendation to hire a patient transport specialist which has been actioned – HWLH CCG has employed Maninder Singh Dulku as the PTS Programme Director. The review also made recommendations regarding managing transfers between providers and the CCG is acting on these by agreeing a phased transfer between Coperforma and SCAS to be completed by 31 March 2017.

Transfer of staff to SCAS

27.6. Alan Beasley informed HOSC that negotiations are underway to transfer staff from Docklands Medical Service to SCAS, and external legal advice was being sought. Further details would be available once negotiations were complete.

Structure of new contract

27.7. Maninder Singh Dulku said that the TIAA report concluded that the previous PTS 'managed service provider' model – one provider managing bookings and separate subcontractors providing patient transport – was not the right one for the service. The new PTS model is tried and tested, involving one provider (SCAS) carrying out both bookings and patient transport. Mr Dulku assured HOSC that due diligence has been undertaken on SCAS capacity and capability, its finances, and its estates, and he was confident that the ambulance trust had the capacity to take on the service despite recently also taking on the Surrey PTS contract.

Transformation plan and continued Coperforma improvement

27.8. Mr Dulku explained that one of the reasons for a phased transfer of the contract was to ensure that Coperforma remain committed to improving the service as they will continue to have a stake in it. HLWH CCG is mindful of the need to have SCAS mobilise whilst keeping Coperforma on board, so regular transformation plan meetings are held between the CCG and the two providers.

27.9. He added that the NHS contract between the CCGs and Coperforma contained performance indicators and penalty clauses; it remained 'business as usual' in terms of

Coperforma needing to meet these performance indicators and HWLH CCG invoking the penalty clauses within the contract if necessary.

Position of South East Coast Ambulance Service NHS Foundation Trust

27.10. Alan Beasley confirmed that South East Coast Ambulance Service NHS Foundation Trust (SECAmb) was committed to improving its core business of emergency transport following its Care Quality Commission (CQC) inspection and had not expressed interest in taking over the PTS contract.

Cost of contract transfer

27.11. Alan Beasley informed HOSC that the cost of the transition from Coperforma to SCAS cannot be disclosed at this stage as it is part of contractual discussions around closing out the contract between the two parties, and is commercially sensitive. Additional costs incurred by other providers, such as hospital trusts for patient transportation, are already deducted from Coperforma's contract.

SCAS's current involvement

27.12. Alan Beasley confirmed that SCAS is not yet providing any of the PTS. The phased transfer was still being agreed, for example, the contract needs to be broken down into blocks and timelines for the phased transfer of these blocks from Coperforma to SCAS agreed.

27.13. The Committee RESOLVED to:

1) note the report

2) request a further update on the progression of the phased transfer at its March meeting – a representative of SCAS to attend.

28. <u>HOSC FUTURE WORK PROGRAMME</u>

28.1 The Committee RESOLVED to agree the work programme.

The meeting ended at 12.31 pm.

Councillor Colin Belsey
Chair