HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Lewes on 28 March 2019

PRESENT:

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

WITNESSES:

James Pavey, Regional Operations Manager, South East Coast Ambulance Foundation NHS Trust
Jayne Phoenix, Deputy Director for Strategy & Business Development, SECAmb
Ray Savage, Strategic Partnerships Manager, SECAmb
Jessica Britton, Managing Director, Eastbourne, Hailsham and Seaford Clinical Commissioning Group (CCG) / Hastings and Rother CCG
Dr Adrian Bull, Chief Executive, East Sussex Healthcare NHS Trust
Jonathan Reid, Director of Finance, East Sussex Healthcare NHS Trust
Ashley Scarff, Director of Commissioning and Deputy Chief Officer, High Weald Lewes Havens CCG
Steph Hood, Communications and Engagement Advisor, Kent and Medway STP

LEAD OFFICER:

Harvey Winder, Democratic Services Officer

23. MINUTES OF THE MEETING HELD ON 29 NOVEMBER

Cllrs Davies and Osborne were present for items 5 and 6.

23.1 The minutes of the meeting held on 29 November were agreed as a correct record.

24. APOLOGIES FOR ABSENCE

24.1 Apologies for absence were received from:

- Cllr Ruth O'Keeffe (substitute: Cllr Charles Clark)
- Cllr Janet Coles
- Jennifer Twist.

25. DISCLOSURES OF INTERESTS

25.1 Cllr Belsey declared a personal interest as an long-time acquaintance of Ray Savage.

26. URGENT ITEMS

26.1 There were no urgent items.

27. NHS FINANCIAL RECOVERY

27.1. The Committee considered a report providing an update on the Clinical Commissioning Groups' (CCG) and East Sussex Healthcare NHS Trust's (ESHT) expected financial outturn for 2018/19 and their future financial plans.

27.2. The Committee received a number of responses to its questions from the witnesses in attendance.

Areas targeted for savings

27.3. Jessica Britton, Managing Director, Eastbourne, Hailsham and Seaford CCG (EHS CCG)/ Hastings and Rother CCG (HR CCG), explained that Quality, Improvement, Productivity and Performance (QIPP) savings made by the CCGs are designed to help improve patient care and at the same time make healthcare more cost effective. Jessica Britton provided some examples of QIPP savings for 18/19:

- a communities pathway programme that involves training community-based staff to treat certain ailments that frail people are often admitted to hospital for that could better be treated in their home, for example, a blocked catheter, or non-injury fall;

- a programme to target and case manage persistent users of A&E (who often use it for non-medical reasons) to keep them out of hospital and better support them at home; and

- a programme to ensure that GPs are referring patients to hospital outpatient appointments appropriately using the best possible clinical evidence to avoid instances of outpatient diagnostics being carried out unnecessarily.

27.4. Jessica Britton added that medicine management is an area that can deliver £3-5m of savings per year whilst also providing a better service for patients through, for example, introducing medicine reviews for patients. QIPP savings have been identified in this area.

27.5. Keith Hinkley, Director of Adult Social Care and Health, East Sussex County Council, said that there is a continued commitment in 19/20 towards a comprehensive programme of integration across community health and social care in East Sussex that will help significantly increase productivity and use the available funding more efficiently by managing people in the community; responding more quickly to people in crisis in their own homes; and facilitating speedier discharge from hospital. A report setting this out will go through the governance process of the CCGs and the Council in the next few months.

27.6. Jonathan Reid, Finance Director, ESHT, said that Cost Improvement Plan (CIP) savings are also aimed at providing a better quality service whilst reducing costs. He said CIP savings include:

- better recruitment, retention, and workforce plans to reduce the reliance on costly agency staff;

- increasing productivity of community staff by rolling out laptops to them, allowing them to do more for less; and

- recruiting a Head of Procurement who looks for the best possible deal for purchasing medical supplies.

Risk assessment of savings plans

27.7. Jessica Britton confirmed that the CCGs QIPP schemes all go through a both an Equality Impact Assessment, and a Quality Impact Assessment that are shared with the governing bodies to help them when taking a decision about a proposed QIPP scheme. All QIPP schemes for 18/19 went through this process as will all those for 19/20.

27.8. Jonathan Reid confirmed that the £18m of Cost Improvement Plan (CIP) savings identified by ESHT for 18/19 were risk assessed and represent the total amount of the potential 'raw savings' that can be made safely from the trust's budget.

Risk of controversial plans

27.9. Jessica Britton said that there are no elements of the CCGs QIPP plans that are likely to be controversial. She said that the proposals for 19/20 would be in a similar vein to those of 18/19. If there were any proposed changes to services, they would be discussed with local residents and the HOSC.

27.10. David Cryer, Chief Finance Officer, Central Sussex and East Surrey Commissioning Alliance, added that although the QIPP savings are challenging, they are made in the context of £930m spend across the three CCGs. Within that scale the savings are more manageable.

27.11. Dr Adrian Bull, Chief Executive, ESHT, said that there are no major, controversial plans included in the trust's 19/20 CIP plans, however, he said it would be rash to assume that any of the Trust's proposed CIP plans would not cause controversy – even those that have the full support of HOSC. He gave the example that some people would consider that assessing a patient's social care needs in an intermediate bed rather than in hospital under the care of a consultant is controversial, despite the evidence that it provides better outcomes for patients. He added that any proposed changes to services would include early notification and discussion with stakeholders, including HOSC.

Receiving central funding for achieving financial targets

27.12. Dr Adrian Bull explained that Provider Sustainability Funding (PSF) is only paid to trusts if they reach a control total deficit set by NHS Improvement. For the last two years that PSF has been available, ESHT has been too far from the control total to receive it. He said that the PSF model is changing and will be phased out within two years. Therefore, during 2019/20 some of the money earmarked for PSF funding will instead be put into increasing the tariff paid to hospital trusts for services they provide, and some will be put into a new Financial Recovery Fund (FRF), which will be paid to providers that agree a control total in the form of one-off in-year funding to help maintain financial sustainability. If the Trust achieves its control total in 19/20 it will receive PSF/FRF monies of £24m, making its net deficit £10m.

27.13. David Cryer explained that Commissioner Sustainability Funding (CSF) was introduced in 2018 to help CCGs achieve their statutory duty to break even. The CCGs in East Sussex received £43m of CSF for 18/19 that has enabled the three CCGs to break even. He said that CSF funding is also being removed and is being replaced through an increased initial funding allocation to CCGs. CSF will be £28m for 19/20 and is contingent on achieving the financial plan each quarter. He said that unfortunately this will still leave the CCGs with a deficit of £3.8m at the end of 19/20, as NHS England adjusted the rules for receiving CSF by limiting it to no more than 4% of turnover.

Allocation of additional NHS funding

27.14. David Cryer confirmed that the East Sussex healthcare system has been allocated a portion of the additional £20bn allocated to the whole NHS up to 2023/24. He confirmed that the CCGs' reduced control total for 19/20 was partly the result of this additional funding.

27.15. Mr Cryer said that the financial planning guidance for CCGs for 19/20 was more prescriptive than in previous years. The guidance requires that a higher percentage of the funding allocation must be spent in community services, mental health services and on the additional funding for the new Primary Care Networks (PCNs). This is a central NHS policy designed to shift resource away from acute care and into support for people in the community. He said that local attempts to focus on community-based care in the past were done in the context of a central NHS policy requiring that resources be spent in acute care to reduce waiting lists, for which much has been done over the past 15 years. He added that the purpose is not to reduce acute spending but constrain demand for it by increasing expenditure in other areas.

27.16. Jonathan Reid said that ESHT will allocate its share of the additional funding to expand the ambulatory care units at both hospitals' A&E departments to operate seven days per week. This is expected to help meet the expected growth in demand for emergency care.

Cost of borrowing

27.17. Jonathan Reid explained that the Trust holds more than £140m of historical debt to the Government with interest rates varying between 1% and 6%, depending on the period the loans were taken out and the national policy on borrowing at the time. The average interest rate is 3.5%. He said that the Government is currently reviewing whether there is a way of rebalancing NHS trusts' debt to give a more sensible set of interest rates and repayment profiles.

Workforce challenges and solutions

27.18. Adrian Bull, Chief Executive, ESHT, said that whilst there is a national shortage in certain clinical and nursing roles that affect all trusts, improvements can still be made locally. ESHT has done so by:

- changing the structure and skill mix of teams that face challenges with recruiting clinical staff by developing roles such as nurse practitioners, therapists, consultant pharmacists, and surgical care practitioners that support or carry out some of the work of middle grade doctors, where clinically appropriate to do so;

- encouraging existing staff to train into new roles, for example, training existing healthcare assistants to become associate practitioners and nurse practitioners;

- recruiting over 120 apprentices across the trust including maintenance, clinical, and corporate teams.

27.19. Dr Bull said that the trust's staff turnover rate has fallen from more than 16% in 2016 to 9.5% (the national rate is 15%); and senior and middle grade doctor positions at both emergency departments are now fully recruited to and all midwife student vacancies have been filled.

Shortage of GPs impacting on trusts

27.20. David Cryer explained that the NHS Long Term Plan has introduced the requirement to develop PCNs in order to enable GPs to share expertise and support each other within a footprint of around 30-50,000 people. PCNs will not solve the GP shortage but will enable practices to alleviate the issue by sharing their resources. It will also enable greater integration with community and social care services based within the footprint of the PCNs.

27.21. Jessica Britton said that PCNs build on work already undertaken in East Sussex to improve primary care capacity in the face of GP shortages, such as encouraging the recruitment at GP practices of paramedic practitioners, pharmacists, and advanced nurse practitioners.

Mergers of the three CCGs in East Sussex

27.22. David Cryer confirmed there was a process of dialogue between the CCGs in the Sussex and East Surrey Sustainability and Transformation Partnership (STP) area. The CCGs' discussions include the creation of CCGs that better align with the local authority boundaries, and whether East Surrey CCG should move into the Surrey Heartlands STP. These changes could result in a Sussex-wide STP with three CCGs – East Sussex, West Sussex and Brighton and Hove CCG. Any decision would be need to be made by each of the CCGs' Governing Bodies and they are expected to do so at their Board meetings during June.

27.23. The Committee RESOLVED to:

1) Request the final outturn for the CCGs for 18/19 be circulated by email; and

2) Request a future report on the finalised QIPP plans for 19/20 and an update on proposals relating to CCG governance arrangements.

28. SOUTH EAST COAST AMBULANCE NHS FOUNDATION TRUST: UPDATE ON QUALITY AND PERFORMANCE

28.1. The Committee considered a report providing an update on the quality and performance of services provided by South East Coast Ambulance NHS Foundation Trust (SECAmb).

28.2. The Committee received a number of responses to its questions from the witnesses in attendance.

Category 3 wait times

28.3. James Pavey, Regional Operations Manager, explained that the Ambulance Response Programme (ARP) Categories are nationally set and are designed to ensure that those patients who are the sickest get the quickest response, but also the most appropriate response and are then conveyed to the most appropriate place of care. This means that during periods of high demand on the service there can be a backlog of less urgent calls (category 3 or 4) which is the result of prioritising the more serious calls and, as identified in the Demand and Capacity review, it is at these times there is insufficient resource to send a response to all calls. He agreed that it is not acceptable that patients triaged to category 3 or 4 have to wait too long and he apologised for the excessive waits that some patients experience, however, he said the additional funding from the Demand and Capacity review would help to address response times in the longer term.

28.4. Mr Pavey explained that there are escalation plans in place for when the backlog of calls reaches a certain level of approximately 70-80 calls across the Kent, Surrey and Sussex region. This occurs when there are more calls than resources, the service is under severe pressure, and there is a high level of patients waiting for an ambulance, including patients who may not need one. It is during these times the trust does quite a bit of 'no sending' to deal with those patients who do not need an ambulance by giving them advice over the phone on other alternative sources of care available to them. He explained that staff will try and give the right advice to these patients over the phone where it appears that they do not need an ambulance, however, sometimes it is difficult to tell what is happening over the phone and it is necessary to dispatch a clinician to visit the patient and determine what care they require.

Falls

28.5. James Pavey explained that falls are initially categorised under Category 3 (response time of 2 hours) provided there are no other serious symptoms such as shortness of breath. The Trust also carries out welfare call backs for patients who are waiting, and their category will be upgraded if they are displaying more serious symptoms.

Hear and treat

28.6. It was explained that only about 60% of patients seen by ambulance crews need to be conveyed to hospital, so it is possible to diagnose and treat some patients over the phone through a process called Hear and Treat. James Pavey explained that Hear and Treat uses a national NHS Pathways programme (the programme used to help diagnose over the phone) and is backed up by clinicians within the control room who can offer advice over the phone. He said that it is a challenge to diagnose over the phone compared to in person, but it is a necessary step to help manage demand by sifting out less urgent calls and directing them to other services where necessary. He added that NHS Pathways is a very safe, risk averse programme and patients are more likely to get seen by an ambulance crew than not when they call 999. People sometimes only dial 999 for advice and when they do call handlers are able to direct them to other suitable services.

Stopping the clock on category 1 calls

28.7. James Pavey confirmed that in the case of a Category 1 call SECAmb does not deploy Community First Responders (CFR) to simply 'stop the clock' on the 7-minute average response time. A CFR's role is to provide vital lifesaving procedures such as defibrillation to a patient until the ambulance crew/paramedics arrive. It is the ambulance crew/paramedic's role to stabilise and convey the patient to hospital. However, appropriately trained and equipped CFR's attendance time is valid under the national standards if the patient does not require conveying. A bystander with a public access defibrillator does not count towards meeting the national standards.

Rural vs Urban response times

28.8. James Pavey clarified that SECAmb is commissioned to deliver a single response time across the whole of Kent, Surrey and Sussex and not different response times in different areas. However, the difference in urban and rural response times was not a new phenomenon, is a national issue, and has no easy answer. Some of the reasons for the discrepancy included:

- the health service was constructed around hospital sites that ambulances convey patients to and they are based in urban centres, meaning that further travel times to hospital sites from rural areas are inevitable. Over the past 20-30 years hospital sites have been concentrated into fewer and fewer larger hospitals;

- SECAmb organises its resources to match concentrations of people, and because the trust receives most of the 115-120 daily calls across the region for category 1 calls in urban areas the trust focuses its resources there; and

- the low number of rural category 1 calls makes their location quite random, meaning it is difficult to allocate resources in rural areas effectively.

28.9. He said that some mitigating actions have been taken, such as installing public defibrillators in public buildings in rural areas and training local volunteers to be CFRs.

28.10. Ashley Scarff added that the HWLH CCG is mindful that its area has the worst response times. The issue is regularly discussed at the CCG's Governing Body and Quality and Safety Committee meetings, and the CCG reviews individual cases to determine what effect the additional travel time may have had on a patient's clinical outcomes.

Demand and Capacity Review

28.11. Jayne Phoenix, Deputy Director for Strategy & Business Development, explained that the Demand and Capacity Review identified the need for additional investment by CCGs in the

trust enable it to meet the ARP response time targets. The trust has developed a detailed transformation programme to ensure that it is able to meet its ARP category targets by Q4 of 20/21 using the additional funding. The achievement of the ARP targets, however, relies on the additional funding helping to deliver a new model of care that involves a number of initiatives including a paramedic recruitment programme; increasing the size of the ambulance fleet – including the recent purchase of 100 new ambulances of which the first few have arrived – and the development of a 'non-emergency' transport fleet to enable the trust to respond to some of the patients waiting longer for an ambulance.

28.12. Jayne Phoenix said that the trust is also piloting different ways to respond to calls involving falls or mental health issues, where it is recognised that alternative pathways to waiting for an ambulance may be more appropriate. In Surrey the trust has been conducting a new pilot involving a non-emergency vehicle with a paramedic and occupational therapist on board responding to falls.

Delivering the recruitment programme

28.13. James Pavey explained that the recruitment programme involves an increase in the percentage of paramedics from about 40% to 70% of the workforce. He agreed that achieving this would be a risk but was necessary. He said that it is possible for people to join the trust in a more junior position, e.g. an Emergency Care Support Worker, and work their way up to a paramedic. Local recruitment for Emergency Care Support Workers in areas like Polegate and Hastings is possible because the positions are on a lower pay scale, and they can be filled because there is still an attractiveness about working in the paramedic profession. He added that it is important to work collaboratively with system partners when developing recruitment plans to avoid losing staff to other organisations.

28.14. Jayne Phoenix added that retention was also important and has improved considerably since 2016. The much better response from staff to the NHS Staff Survey also demonstrated improved staff satisfaction, which is likely to improve retention rates. Initiatives to retain staff include improved career development pathways, and a pilot for staff to rotate within the service (on the road and in the control room) and into primary care.

Hospital Handover times

28.15. James Pavey explained that a delay occurs in a handover of a patient from the paramedics to a hospital A&E department where it takes longer than 15 minutes. Delays are a national issue and significant delays occur across the region SECAmb operates in, although many hospital trusts have made improvements in tackling the issue. This is demonstrated through a 30% year on year improvement during Q3 in terms of hours lost due to hospital handover delays. James Pavey highlighted ESHT as having made dramatic improvements in handover times through working closely with SECAmb, NHS England and NHS Improvement; although not all other hospitals have made as much progress.

28.16. James Pavey explained that a handover involves a handover of clinical information to give the hospital staff a picture of the reasons why the patient was conveyed to the hospital. The hospital may then triage the patient to the appropriate service within the hospital. Dr Adrian Bull added that ESHT does not try to replicate the ambulance team's assessment but does take their information on board in their triage. He said that paramedics may call ahead to triage over the phone and be able to attend the surgical assessment unit or the acute medical unit rather than go straight to A&E and wait for a handover to clinicians there.

28.17. Jayne Phoenix added that all paramedics now have access to a patient's summary care record via iPads, which are issued to all staff. The level of detail is dependent on who put the detail in and can vary a lot, however, it can assist paramedics attending calls where, for

example, a patient may have an end of life care plan in place that includes a 'do not resuscitate' request.

Violence against staff

28.18. James Pavey said that violence against staff is a continuing issue in the NHS and that staff are taught methods of conflict resolution as a means of protection. SECAmb also offers support to staff through a staff welfare and wellbeing hub; records and monitors all incidents of physical and verbal abuse against staff; and will prosecute members of the public who attack staff. Staff also have personal radios to call for help, and body worn cameras may be introduced in the future.

Collaboration with other Trusts

28.19. Jayne Phoenix explained that the main focus of the collaboration with the West Midlands and South Western Ambulance Trusts, will be around improving procurement practices based on the recommendations of the Lord Carter report. She clarified that it is not a plan to merge or to share staffing. It also helps to maintain national resilience by ensuring that the trusts have the same systems so that in an event of a major incident, for example, they can more easily support each other.

28.20. The Committee RESOLVED to:

1) Request further details on the Trust's transformation and delivery programme to be circulated by email; and

2) Request a further report to include details of how SECAmb and hospital trusts are collaborating, including in relation to hospital handover times and the sharing of patient records.

29. KENT AND MEDWAY STROKE REVIEW

29.1. The Committee considered a report about whether the decision of the Joint Committee of Clinical Commissioning Groups in relation to stroke services in Kent and Medway is in the best interest of health services in East Sussex.

29.2. The Committee received a number of responses to its questions from the witnesses in attendance.

Number of patients affected by changes

29.3. Ashley Scarff, Director of Commissioning Operations, HWLH CCG, confirmed that modelling by the CCGs had indicated the total number of patients in East Sussex affected by the planned changes would be approximately 50 per year. These comprise patients who currently use Pembury Hospital in Tunbridge Wells and who would in future use Eastbourne District General Hospital (EDGH).

Additional capacity at the Eastbourne District General Hospital

29.4. Dr Adrian Bull confirmed that ESHT has modelled the likely impact of the additional patients and considers it relatively small compared to the number of patients currently served by the EDGH Hyper Acute Stroke Unit (HASU). He confirmed the additional patients could be accommodated.

Travel Times

29.5. James Pavey explained that SECAmb is effective at identifying whether someone describing their symptoms over the phone (or the symptoms of someone else) is having a stroke. Someone suspected of having a stroke will be placed in a Category 2 response call, which has a target response time of 18 minutes. The ambulance crew will assess the patient on arrival to check that they are having a stroke and they will be then taken to the closest appropriate hospital with a stroke unit. There is a two-hour 'call to needle' time for patients who need to go to a stroke unit and receive thrombolysis (if it is a clot causing the stroke) and SECAmb is confident it can achieve this timescale. He added that strokes are one of the most straightforward conditions to identify clinically, which is a real advantage when determining which hospital to convey a patient to.

29.6. James Pavey confirmed that it will depend on the individual case and will be decided on-scene, but as a general rule an ambulance would convey a patient straight to a HASU first time. An ambulance crew would not take the patient to the nearest hospital in order to have them stabilised before moving them on to a specialist centre. He explained that this was because:

- taking patients to the nearest hospital may add further delays in treatment when transferring them on to a specialist unit; and

- an ambulance crew can manage the straightforward medical needs of a patient with a stroke – such as keeping airways clear – on the way to a specialist unit, so this would not need to be performed at an intermediary hospital.

29.7. He compared the conveyance straight to a HASU as analogous to other medical conditions where it is more important to go to the right place first time such as serious trauma cases where the ambulance will take patients to either the Royal Sussex County Hospital (RSCH) or London hospitals.

29.8. Steph Hood, Comms and Engagement Advisor, added that there is a natural fear about the time taken to get to hospital and, although it is an important factor, the likelihood of good outcomes is more dependent on being on a specialist unit with consultant-led care for the first 72 hours. The model developed in Kent and Medway is designed to be able to deliver this level of care 24/7.

View of the JHOSC members

29.9. In speaking about the views of the East Sussex members of the JHOSC, Cllr Howell explained that she had initially been in favour of the two proposed options that would have ensured that stroke service remained at Pembury Hospital in Tunbridge Wells. However, in light of the evidence that it is important to get patients to the right hospital first time, and evidence that this model had worked elsewhere in Sussex, she urged the Committee to support the decision of the Joint Committee of CCGs.

29.10. The Committee RESOLVED to:

1) Agree that the decision of the Joint Committee of CCGs to reconfigure stroke services in Kent and Medway is in the best interests of health services in East Sussex;

2) Agree to submit the recommendations made by the East Sussex JHOSC members to the CCGs for consideration when implementing the decision; and

3) Request a future update on the implementation of the stroke services reconfiguration.

Cllr Turner abstained from resolution 1.

30. HOSC FUTURE WORK PROGRAMME

30.1 The Committee considered its work programme.

30.2 The Committee RESOLVED to agree the work programme subject to the addition of reports identified during previous items and a report at an appropriate time in relation to the East Sussex response to the NHS Long Term Plan.

The meeting ended at 12.40 pm.

Councillor Colin Belsey
Chair