HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Lewes on 21 September 2017

PRESENT:

Councillors Colin Belsey (Chair), Councillors Phil Boorman, Bob Bowdler, Angharad Davies and Ruth O'Keeffe (all East Sussex County Council); Councillor Janet Coles (Eastbourne Borough Council), Councillor Mike Turner (Hastings Borough Council), Councillor Susan Murray (Lewes District Council), Bridget Hollingsworth (Rother District Council), Councillor Roger Thomas (Wealden District Council), Geraldine Des Moulins (SpeakUp) and Jennifer Twist (SpeakUp)

WITNESSES:

Dr Adrian Bull, Chief Executive, East Sussex Healthcare NHS Trust
Joanne Chadwick-Bell, Chief Operating Officer, East Sussex Healthcare NHS Trust
Jessica Britton, Chief Operating Officer, Eastbourne, Hailsham and Seaford Clinical Commissioning Group (CCG) / Hastings and Rother CCG
Wendy Carberry, Chief Officer, High Weald Lewes Havens CCG
Ashley Scarff, Director of Strategy and Deputy Chief Officer, High Weald Lewes Havens CCG
Mark Angus, Urgent Care System Improvement Director, East Sussex Better Together Alliance
Colin Simmons, 111 Programme Director (Sussex), NHS Coastal West Sussex CCG
Dr Shivam Natarajan, Clinical Lead, Clarity Consulting

LEAD OFFICER:

Claire Lee, Senior Democratic Services Adviser

8. MINUTES OF THE MEETING HELD ON 29 JUNE 2017

8.1 The Committee agreed the minutes of the meeting held on 29 June 2017 as a correct record.

8.2 The Chair thanked Dr Adrian Bull, Chief Executive of East Sussex Healthcare NHS Trust (ESHT), for the tour of the Midwife-Led Unit and Cardiology at Eastbourne District General Hospital (EDGH) and the seminar on the progress of reconfigurations to the Trust's General Surgery and Maternity services.

9. APOLOGIES FOR ABSENCE

9.1 Apologies for absence were received from Cllr Johanna Howell (substitute: Cllr Roger Thomas), Cllr Sarah Osborne, and Cllr Andy Smith.

9.2 The Chair welcomed Geraldine Des Moulins as the new member of HOSC representing the voluntary sector.

10. DISCLOSURES OF INTERESTS

10.1 There were no disclosures of interest.

11. URGENT ITEMS

11.1 There were no urgent items.

12. URGENT CARE

12.1 The Committee considered a report providing an update on developments in urgent care services, including redesign of the urgent care system as part of the East Sussex Better Together (ESBT) programme; and the Sussex-wide redesign and re-procurement of NHS 111.

12.2 Mark Angus, Urgent Care System Improvement Director, East Sussex Better Together; Jessica Britton, Chief Operating Officer for the two ESBT Clinical Commissioning Groups (CCGs); Adrian Bull, Chief Executive, and Joanne Chadwick-Bell, Chief Operating Officer, of East Sussex Healthcare Trust; and Colin Simmons, Programme Director for 111 Transformation, provided answers to questions raised by HOSC Members.

Urgent Care Treatment Centres

12.3. Mark Angus explained that the development of Urgent Care Treatment Centres (UTCs) is a national requirement that is being undertaken locally through the East Sussex Better Together (ESBT) Whole System Urgent Care transformation programme. NHS England (NHSE) requires that detailed urgent care plans are developed by March 2018 and the plans are in place by 1 December 2019.

12.4. Mr Angus said that commissioners within ESBT were currently working out where UTCs will be located based on three potential options:

- co-locating UTCs with the A&E Departments and the new Primary Care Streaming Services at Eastbourne District General Hospital (EDGH) and the Conquest Hospital;

- developing existing walk-in centres to the higher UTC specifications, including diagnostic facilities like an X-ray machine; or

- building new UTCs, although limited access to capital funds makes this option more challenging.

12.5. Jessica Britton said that there will likely be two UTCs in the ESBT area and confirmed that there were no current plans for the development of one in Seaford. She added that in addition to UTCs the transformation programme will include the development of a range of urgent primary and community services available across the ESBT area – including extended opening hours for GP surgeries, and a re-developed Out Of Hours (OOH) GP Service.

Paediatric Urgent Care

12.6. Mark Angus said that the ESBT Whole System Urgent Care transformation programme include provision for paediatric care, but commissioners would need to be confident that any provider would be able to provide the service safely and effectively.

12.7. Joanne Chadwick-Bell added that A&E Departments on both hospital sites have specialist paediatric nurses that can support children with urgent or emergency care need. There are also paediatric units on both sites for children who require more specialist consultant support and there are no plans to change this configuration.

Primary Care Streaming Service

12.8. Joanne Chadwick-Bell said that the Primary Care Streaming Service is due to commence as a pilot from October. ESHT has received a number of CVs from GPs interested in the position and one full-time GP has been appointed so far to the EDGH A&E Department. The Trust is negotiating funding for the role and will be employing GPs directly to help with their indemnity insurance. The service will be divided into shift patterns of four hours at a time to make it easier for GPs to carry out the role part-time if they wish, and ESHT will employ a bank of GPs to help fill the role in a similar way to an out of hours service. The benefits of the service and the level of investment required to run it will be closely monitored over the winter period.

Extended Access Service

12.9. Mark Angus said that there is current pre-market engagement being undertaken to understand the potential to develop extended primary care access services including the potential to establish extended access service hubs, in accordance with the national requirement to extend patients' access to bookable appointments for primary care. He confirmed it would be unlikely that people would see their own GP at these hubs, but the results of public engagement work suggest that people's views on the importance of seeing their own GP is mixed, whilst access to primary care expertise is of key importance.

Ambulatory Care Unit

12.10. Dr Adrian Bull confirmed that a new consultant has been appointed to the Ambulatory Care Unit at the Conquest Hospital who starts in early-October.

Patient Care Plans

12.11. Dr Adrian Bull said that a fully transparent care plan is an aspiration within the NHS and there are many areas where good progress is being made, for example, for people receiving palliative care in the last year of their life there has been a major effort to ensure that the details of those plans are put on the extended summary care record. He explained that all clinicians currently have access to a patient's summary care record but the extended summary care record can only be accessed by certain clinicians mainly in acute settings. There has recently, however, been significant progress in rolling extended summary care records to primary care.

Training for palliative care

12.12. Dr Bull agreed that working with specialised nurses trained in palliative care is important. He said ESHT is working across ESBT area to look at how the patient needs of those 20-30% of palliative care patients requiring care for conditions other than cancer can be met.

The Trust has been in contact with both hospices in East Sussex about doing more to raise awareness and both have indicated that they are open to the idea.

Communication strategy

12.13. Jessica Britton said that under the new urgent care system, patients should be able to call NHS 111 once and be signposted to the right help that they need without needing to find out for themselves where they need to go. Once it is in place, the new 111 service will be promoted to reflect its increased importance as the first point of contact for people requiring urgent care, however, because of this there is no plan to do a major advertising of individual new urgent care services. Joanne Chadwick-Bell added that a communications plan for the winter period is about to be published asking patients to call 111 for all healthcare needs unless it is an emergency.

12.14. Joanne Chadwick-Bell explained that the Primary Care Steaming Service in A&E departments involves the extension of skill sets available at an existing service and are not new services in themselves, and as a result there is no plan to advertise it as a new service.

Capacity, recruitment and retention of urgent care staff

12.15. Mark Angus and Joanne Chadwick-Bell said that GP recruitment it is a significant challenge and area of concern both locally and nationally and explained how the Whole System Urgent Care transformation programme is looking to alleviate the issue:

- a single, better co-ordinated OOH contract rather than the current arrangement of a separate walk-in centre and OOH contract that can lead to both services vying for the same GP workforce;

- exploring the use of technology such as Skype that could allow GPs to provide OOH services remotely;

- using a wider skill set within the workforce, e.g., advanced nurse practitioners with the right training can deal with a number of primary care presentations instead of GPs; and

- incentives to work in a primary care setting, for example, offering joint acute and primary care roles for GPs who want more of a ‘portfolio career’.

12.16. Colin Simmons said that ensuring the OOH workforce has sufficient capacity will require other healthcare workers to be involved in urgent care. He said that many OOH contacts are around requests for repeat prescriptions, so capacity for OOH can be enhanced by developing the 111 service so that when a patient calls 111 they can be asked whether their query is a pharmaceutical one and transferred to their local pharmacist, who can provide the repeat prescription for them.

12.17. Dr Adrian Bull said that workforce recruitment and retention is one of the biggest challenges across ESHT and effects all departments. He agreed that there is merit in exploring the idea of recruiting a senior Associate Consultant to draw in other junior doctors and consultants. He explained that ESHT has had ongoing discussions with Brighton & Sussex Medical School to see how the Trust can better link up with their training programme and improve the academic attraction of ESHT for all clinicians.

NHS 111

Scope of NHS 111 procurement

12.18. Dr Bull explained that the scope of the NHS 111 procurement is for a service that will respond to calls from the public, assess the medical need of the caller, and pass the caller on to the relevant service. Colin Simmons added that under the new procurement model, NHS 111 service will include clinical assessment carried out by clinicians via a Clinical Assessment Service (CAS).

12.19. Dr Bull explained that under the new urgent care system NHS 111 will remain the number to call for urgent medical assessment and will have clinical expertise on site to provide this assessment. On the other hand, Health and Social Care Connect (HSCC) will be there for more complex patients – or a GP on behalf of a patient – to call when they require a mix of clinical and social need, for example, physiotherapy, reablement, district nursing or social care assistance.

Indemnity insurance

12.20. Dr Bull clarified that GPs who are employed by private OOH companies, such as IC24, have different indemnity requirements than if they are employed directly by the NHS. This issue has been recognised and is being rectified through the 111 procurement for those individual who will work within 111 and the CAS. It is also being resolved for GPs due to begin working in the Primary Care Streaming Service by ESHT employing the GPs who work in A&E.

Privacy and electronic patient records

12.21. Jessica Britton said that over the past 4 years the CCGs have been mindful of people's concerns about information sharing and it has been discussed extensively at patient engagement events. The consistent message is that patients want their information to be appropriately shared where it is helpful to meet their treatment needs. This feeds into the development of how to use technology within the boundary of good information governance.

12.22. Dr Adrian Bull said that the 111 re-procurement work has included a survey on patients' attitudes towards the sharing of records. Colin Simmons added that any provider of the NHS 111 service will have to follow the information governance guidelines around data protection, security and audits. Any procurement specification will also make clear who should have access to that data, i.e., clinicians having access to summary care records, rather than all employees being able to access them.

Access to 111

12.23. Joanne Chadwick-Bell said that the 111 call handler will quickly pick up whether the caller does not speak English and will transfer them to a language line. This is a national standard and already available. Access for the deaf community is recognised as a major challenge nationally and NHS England is working with providers on solutions. There are schemes such as signing over Skype that are being trialled by some OOH services.

Call handler career progression

12.24. Colin Simmons confirmed that NHS England's national career blueprints for call handlers will be known before the new 111 provider is appointed. The outline of the national career blueprints – setting out what career progression will look like for a call handler becoming an advanced call handler – will be published early in 2018.

12.25. The Committee RESOLVED to:

1) note the report;

2) consider a further update on urgent care at the June 2018 committee meeting;

3) provide a written update on 111 in January 2018 and a further update in 2 October meeting;

4) request a report on GP access in March 2018; and

5) request confirmation as to the number of GPs to be employed as bank staff for the A&E Primary Care Streaming Service.

13. SUSSEX AND EAST SURREY SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP

13.1 The Committee considered a report providing an update on the most recent developments with the Sussex and East Surrey Sustainability and Transformation Plan (STP).

13.2 Wendy Carberry, Senior Responsible Officer for the STP provided a presentation and answered questions from Members of HOSC.

Effect of STP on Connecting 4 You

13.3. Wendy Carberry said that the CCGs in the Central Sussex and East Surrey Area (CSESA) South plan to merge some back-office functions by April 2018. She confirmed that this will not affect the implementation of High Weald Lewes Havens Clinical Commissioning Group's (HWLH CCG) Connecting 4 You (C4Y) programme – which is the model of care for the HWLH population – or its constituent services such as Communities of Practice, the frailty pathway, and the Golden Ticket dementia pathway. She argued that these services are starting to come together rapidly and the C4Y programme is not as far behind other placed-based plans as it may appear.

CSESA boundary

13.4. Wendy Carberry confirmed that the boundary between CSESA North and South has been fixed. The North will comprise Horsham and Mid Sussex, Crawley and East Surrey CCGs and the South will comprise Brighton & Hove and HWLH CCGs. She said that some functions will be carried out jointly with Brighton & Hove CCG, some with the other CCGs in the CSESA area, and some across the whole STP.

Funding for healthcare

13.5. Wendy Carberry explained that there is no specific extra money that will be provided to deliver the placed-based plans such as C4Y or ESBT. Dr Bull added that the predicted funding gap by 2020 is based on comparing the trend for healthcare funding with the trend for

increasing healthcare needs. The prediction is that the increase in healthcare need is much greater than the expected funding increases but funding itself will not decrease relative to the current levels, so there is no expectation that CCGs will have to reduce spending below current levels. He said that the health and social care organisations must align themselves in such a way as to reduce future demand by using existing resources better. The challenge and tension at the moment, however, is to protect investment in community based care to reduce future demand whilst also addressing significant funding challenges in acute care.

Use of ICT in healthcare

13.6. Dr Adrian Bull said one of the main initiatives across the NHS is to improve the adoption rate of new technologies that help clinicians deliver healthcare. The NHS will increasingly need to support the development of apps and other ICT that will enable patients to take control of their patient records so that expert patients can manage their own conditions, such as diabetes. NHS Digital is encouraging this through an accreditation programme for new healthcare apps, such as those that remind you when to take prescription medicine, which are listed on its website. Dr Bull added that technology can also be used to help detect diseases, for example, a handheld device that has been rolled out to all GP practices in East Sussex to detect atrial fibrillation and is being rolled out elsewhere.

STP Engagement plans

13.7. Jessica Britton clarified that there are no STP plans currently being developed that would require a formal consultation on the grounds that they were a substantial variation to services. ESBT and C4Y programmes have involved local people in engagement and consultation every step of the way, for example, through Shaping Health and Care events and the development of the Health and Wellbeing Stakeholder Group – which will have representation on the ESBT Strategic Commissioning Board from December.

STP ensuring patient choice

13.8. Wendy Carberry confirmed that patient choice is enshrined in the NHS Constitution and would be adhered to during the development of services as part of the STP or the place-based plans in East Sussex.

Impact on STP of NHS England's rating

13.9. Wendy Carberry confirmed that the STP was rated by NHS England "requires greatest improvement". This was in part due to the size and complexity of the STP, significant financial pressures, a number of NHS providers in special measures, and four CCGs in special measures. She said that the STP will be rated on an annual basis and the current rating forms the baseline score.

13.10. Wendy Carberry explained that the STP works closely with NHS Improvement (NHSI) and NHS England (NHSE) and the STP considers that it is on the trajectory to improvement. The STP is in discussions with NHSE about what support it can provide to help overcome the STP's challenges, after which point the STP's Executive Chair role will be appointed to.

13.11. Dr Adrian Bull added that he is confident that the right plans are emerging from the STP but there is a real challenge to make the necessary changes on the scale required to address the current significant financial challenges that already exist across the STP. He said that at the

moment there is no quick solution, but he was confident that the STP will be where it needs to be in the next 3-5 years.

STP Acute Strategy

13.12. Dr Adrian Bull said that it has been agreed that there will be no single overarching strategy for acute care. Instead, acute providers will continue to develop their strategies for the placed-based plans of which they are part, whilst at the same time BSUH will develop a strategy for tertiary care. BSUH will work alongside ESHT and the other providers to ensure that the tertiary strategy complements their place-based strategies. BSUH has committed to develop this tertiary strategy in consultation with partners before Christmas 2017. Dr Bull added that a commitment to joint approach towards elective care has been agreed across the STP but it has not been defined how it will be done yet.

Purpose of STPs

13.13. Dr Adrian Bull that the purpose of STPs is to enable the NHS to meet the healthcare demand of local populations within existing resources. He argued that this can be done by providing better care for patients in the community and avoiding more costly acute admissions. This will also benefit the patient and provide them with better care because it will prevent their condition deteriorating to the point where they need to go to hospital. Describing them as purely money saving exercise is, therefore, overly simplistic.

13.14. The Committee RESOLVED to:

1) note the report;

2) request an update on the STP in either March 2018, or when the Chair considers that it has progressed to the stage where a report would be worthwhile. If a report is not appropriate for March 2018, the reasons why will be provided.

14. CLINICALLY EFFECTIVE COMMISSIONING

14.1 The Committee considered a report providing an update on Clinically Effective Commissioning.

14.2 Ashley Scarff, Deputy Chief Officer and Director of Strategy, High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG); and Dr Shivam Natarajan MS FRCS, Clinical Lead from Clarity Consulting, answered questions from the Committee.

Reason for reviewing procedures with limited clinical effectiveness

14.3. Dr Shivam Natarajan explained that there are approximately 2,500 hip and knee operations in the STP area per year. Out of those, 150 were for revisions of previous operations which means that they were either not done appropriately or properly.

14.4. An initial knee operation costs £5-10k but a revision costs £110k. The Clinically Effective Commissioning (CEC) programme is looking at the first point in the surgical pathway at which these unnecessary revisions can be prevented, which is to ensure that the policies of all CCGs in the STP area are clear about who the appropriate people are who should receive the surgery

and when the appropriate time is in the clinical pathway for them to receive it. This has two benefits: appropriately giving the right person the knee operation will avoid the unnecessary expense of complications, and by having the right people have the surgery additional people who do require the surgery can receive it in a timely manner.

14.5. Dr Natarajan explained that the appropriate thresholds for patients to receive each type of surgery will be set out in STP-wide policies that are in line with the Royal College guidelines and clinical best practice, for example, the current policies for a hysterectomy differ across each CCG, with some saying patients may have one after six months of conservative management and others after 12 months. However, the clinical evidence says there should be three stages/ types of conservative management that should be tried if possible before major surgery. The policy being developed, therefore, says that patients should go through three stages of conservative management before going to surgery. Changing the eligibility for surgery to fit with clinical best practice is not a purely financial exercise but in the interest of good patient care; and may result in more surgeries for some CCGs, or a greater number of surgical procedures for some illnesses.

14.6. Dr Natarajan added that Clinically Effective Commissioning will also tie into other clinical work such as Get it Right First Time and the STP's acute care workstream by highlighting the various avoidable variations in care and eliminating waste. Within the STP only half the surgeons involved with hip and knee replacements are carrying out 30 or more knee or hip operations per year the remaining half are only doing a handful. This variation in quality that this causes should be avoided and is something that could be addressed through this other work, for example, agreeing as part of the acute care workstream to do knee operations in only three major centres of excellence. Ashley Scarff clarified that this process would not result in a limitation in choice but balance choice with quality and better outcomes. Choice is enshrined in the NHS Constitution and the CCGs will uphold that.

Shared Decision Making

14.7. Dr Natrarajan explained that shared decision making has only recently become a formal process within the NHS – although it has been practiced individually by clinicians beforehand. It involves the clinician explaining to the patient the reasons why they should or should not opt for a surgical procedure, for example, the potential complications and the rate at which these complications occur, and the patient's current need for surgery compared to other treatments. This provides patients with the ability to take a judgement based on the positive and negatives of having, or postponing, surgery.

14.8. The policies will also make it clear when during the clinical pathway the shared decision should be made based on national guidelines. This is because it is not always possible to make a shared decision at the primary care stage as the GP may have insufficient knowledge about the illness. In these cases the shared decision may be taken with a specialist clinician following appropriate assessments and investigations.

14.9. Dr Natarajan said that patients will be informed about their rights with regards to shared decision making through a revision of the patient information leaflets.

Procedures chosen for further investigation

14.10. Dr Natarajan said that Clarity Consulting reviewed 150 procedures across the STP area and shortlisted 50 for further investigation across general surgery, eye, musculoskeletal, obstetrics and gynaecology. They were shortlisted as these surgical procedures had a lot of activity that contained the largest variations in the number of surgeries per CCG. Once these 50 procedures have been reviewed it will be rolled out as far as possible across other procedures. Dr Natarajan confirmed that East Sussex CCGs are an outlier in 10 to 15 of these 50 procedures, either because more surgeries are performed here than the STP average, or they are performed at a higher cost than national guidelines recommend.

Accelerated Savings

14.11. Dr Natarajan explained that Accelerated Savings is a piece of work over and above the clinical policy rationalisation work. The Accelerated Savings workstream is looking at other areas of waste within the system, for example, improvement in procurement processes for acquiring knee replacements (prosthesis) where all 8 CCGs procure prostheses from the same few vendors at 8 different prices between £400 and £2,000. This variation in cost does not reflect the variation in clinical outcome, where data shows that the £2,000 prosthesis has poorer results than the £400 one in some studies. Dr Natarajan said that about 50 areas were looked at during August as part of Accelerated Savings and around 10 were identified as areas where improvements could deliver significant benefits across the STP, including procurement optimisation, medicines management and patient transport system inefficiencies. Ashley Scarff clarified that this is the beginning of the process and no decisions have been made yet.

Involvement of CCGs in Clinically Effective Commissioning

14.12. Dr Natarajan explained that there has been a high level of clinical engagement during the CEC project and GPs have been involved at several levels including as CCG Chairs; at four workshops involving multi-disciplinary teams, including GPs; and through a GP engagement exercise where members of the CEC project attended local GP meetings or clinical reference groups to communicate to GPs about the CEC project.

14.13. The Committee RESOLVED to:

1) note the report;

2) request a further update at the March 2018 Committee meeting; and

3) to provide details of the 10 possible areas for improvement to be pursued during 2017/18 as part of the Accelerated Savings process.

15. HOSC FUTURE WORK PROGRAMME

15.1 The Committee considered its work programme and the notes of the three joint HOSC working groups set up to meet with and scrutinise NHS organisations that provide services across multiple local authority areas.

15.2 The Committee RESOLVED to:

1) note the report;

2) note the minutes of the working groups; and

3) add a report on cancer care performance to the 30 November agenda.

The meeting ended at 1.05 pm.

Councillor Colin Belsey
Chair