HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Lewes on 30 November 2017

PRESENT:

Councillor Colin Belsey (Chair); Councillors Phil Boorman, Bob Bowdler, Angharad Davies, Ruth O'Keeffe, Sarah Osborne and Andy Smith (all East Sussex County Council); Councillor Janet Coles (Eastbourne Borough Council), Councillor Mike Turner (Hastings Borough Council), Councillor Susan Murray (Lewes District Council), Councillor Johanna Howell (Wealden District Council) and Jennifer Twist (SpeakUp)

WITNESSES:

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

Jessica Britton, Chief Operating Officer

Garry East, Director of Performance and Delivery

Lisa Elliott, Senior Performance and Delivery Manager

High Weald Lewes Havens CCG

Ashley Scarff, Director of Commissioning and Deputy Chief Officer

Sam Tearle, Senior Strategic Planning & Investment Manager

Kim Grosvenor, Dementia Programme Lead

Hugo Luck, Associate Director of Operations

Dr Phil Wallek, GP, School Hill Medical Practice, Lewes

East Sussex Healthcare NHS Trust

Joanne Chadwick-Bell, Chief Operating Officer

Kent and Medway Sustainability and Transformation Plan

Michael Ridgwell, Programme Director,

LEAD OFFICER:

Claire Lee, Senior Democratic Services Officer

16. MINUTES OF THE MEETING HELD ON 21 SEPTEMBER 2017

16.1 The Committee agreed the minutes as a correct record of the meeting held on 21 September.

17. APOLOGIES FOR ABSENCE

17.1 Apologies for absence were received from Cllr Bridget Hollingsworth and Geraldine Des Moulins.

18. DISCLOSURES OF INTERESTS

18.1 There were no disclosures of interest.

19. URGENT ITEMS

19.1 There were no urgent items.

20. CONNECTING 4 YOU UPDATE

20.1. The Committee considered a report providing an update on the Connecting 4 You (C4Y) health and social care transformation programme.

20.2. Ashley Scarff, Director of Commissioning and Deputy Chief Officer, High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG); Dr Phil Wallek, GP, School Hill Medical Practice in Lewes; Hugo Luck, Associate Director of Operations, HWLH CCG; Kim Grosvenor - Senior Programme Manager – Mental Health and Dementia Transformation, HWLH CCG; and Sam Tearle - Senior Strategic Planning & Investment Manager, HWLH CCG, provided a presentation and answered questions from HOSC members.

20.3. Jennifer Twist explained that she represented Speak Up on the C4Y Programme Board and welcomed the involvement of the voluntary sector at all levels of the transformation programme.

Role of Central Sussex and East Surrey Area South

20.4. Ashley Scarff explained that Central Sussex and East Surrey Area (CSESA) South's main purpose is to integrate the constituent CCGs' leadership and governance arrangements in order to increase their capacity and ability to work collectively. He confirmed that it would not replace C4Y as the place-based plan for transforming health and social care in the HWLH area of East Sussex. This is because transformation workstreams will be undertaken at the most appropriate level, and for community and primary care services this will be at C4Y level.

Communities of Practice

20.5. Ashley Scarff elaborated that the four Communities of Practice in HWLH area are broadly analogous to the Integrated Locality Teams that have been developed in the East Sussex Better Together (ESBT) area. Communities of Practice is the name given to integrated services that are provided by East Sussex County Council, Sussex Community NHS Foundation Trust (SCFT) Sussex Partnership NHS Foundation Trust (SPFT), GP practices and the voluntary sector across 4 geographical locations that cover populations of 30-50,000. At this size services can be delivered at a responsive local level whilst still being financially sustainable and the scale is based on national guidelines. He said that within the Communities of Practice

'outer shell' are other services such as the Lewes Health Hub, which is the name given to combined GP-led services within the Lewes Communities of Practice area.

Future priorities of C4Y

20.6. Ashley Scarff said that frailty has been chosen as the main priority of C4Y for 2017/18 as it encompasses a number of elements of out of hospital care, such as falls prevention, proactive care and urgent care. Developing services around how best to support people living with frailty will also help to determine the optimum configuration for the Multispeciality Community Provider (MCP) accountable care system, i.e., how community, primary and social care services ultimately be integrated into a single system in the C4Y area.

GP Streaming service

20.7. Hugo Luck explained the GP Streaming Services at Royal Sussex County Hospital (RSCH), Princess Royal Hospital (PRH) and Tunbridge Wells Hospital (TWH) and provided assurance that it will not take GP capacity from other areas of the healthcare system because:

- IC24 already employed salaried GPs at the RSCH A&E Department as additional clinicians to the Emergency Department. The GP Streaming Service will separate these patients from the rest of the A&E department so patients can be triaged directly to a GP.

- The Streaming Service at PRH has employed GPs who may not want to work in general practice but want to use their GP skills in a different setting. These can be GPs who are semi-retired or have taken a break from working in a GP practice.

Winter Resilience Planning

20.8. Hugo Luck said that in order to help achieve the 85% bed occupancy target over the Christmas period a concerted effort will be undertaken in the week leading up to Christmas to reduce bed occupancy at acute hospitals. The main challenge, however, is the second week of January as admissions begin to rise. Plans are therefore also being developed for this spike in activity, for example, using the additional winter planning money announced in the budget to increase bed capacity by opening additional interim community beds.

Reduction in non-elective admissions

20.9. Hugo Luck explained that most Delayed Transfers of Care (DTOC) are caused by non-elective admissions often via the Emergency Department. He said that the development of the frailty pathway should have a positive effect on the number of non-elective admissions, however, the non-elective admissions data may not prove this causation because a number of other factors can affect admission rates.

Discharge to assess

20.10. Hugo Luck clarified that the new Discharge to Assess process involves discharging patients from hospital with an initial package of care to meet their immediate healthcare needs before the long-term assessment can be carried out in their home. The package of care varies depending on need and is provided for as long as the patient needs it, whether it is a discharge to assess package or a longer term package. The package of care will be regularly assessed depending on the patient's improving or worsening condition. He said that Discharge to Assess is already carried out in Brighton & Hove and has been found to be effective.

20.11. Hugo Luck said that the Continuing Healthcare Team in the HWLH area can provide long-term assessments in a more timely manner in a patient's home than at hospital. This is because all of the hospitals used by HWLH patients are outside of the HWLH area, meaning that it can be quicker for the Team to reach them at their home address than at hospital.

20.12. Joe Chadwick-Bell added that the standard national way of working for hospital trusts always includes an initial assessment of the patient before they leave the hospital whether they are in a ward, A&E Department or acute assessment unit. The patient is assessed by a team comprising a therapist, social worker and nurse, who will assess whether they are safe to leave and what package of care they require. She agreed that long term assessments are better conducted at home as a patient's care need can be determined more accurately when assessed in their home.

Role of family and carer in patient's care

20.13. Hugo Luck said he was confident that, wherever possible, a patient's package of care is discussed with their family as quite often they will have a role in the ongoing care, for example, around medicine management.

20.14. Hugo Luck agreed that a patient's stated needs may be different to their actual needs. He said that the *Let's Get You Home* programme includes a pilot that is working to feed in concerns of the families and views of clinicians, alongside the patient's own stated needs, when carrying out an assessment of a patient.

Dementia Golden Ticket roll-out

20.15. Kim Grosvenor explained that an increasing number of GP practices are improving early diagnosis of dementia in part because the Golden Ticket model provides a more comprehensive and less time consuming dementia service post diagnosis than was previously available. There is still some variability in the pace of roll out of the new model for the service amongst GP practices, although HWLH CCG is not aware of any GP practices that will not consider using the service, and this has been reflected in the phased plan to cover the whole CCG area.

20.16. Kim Grosvenor explained that there is a Golden Ticket training programme for GP practices (next Waves in January and March 2018) and is fully booked. The training will not encompass all GP practices, so alternative methods of ensuring full Golden Ticket coverage may be considered after the training schedule is complete, for example a peripatetic team that rotates around GP practices in the HWLH area. She clarified, however, that since October 2017 everyone in the HWLH area has been getting a comprehensive diagnosis at home and improved diagnostic support regardless whether or not their practice is signed up to the Golden Ticket.

HSCC role in referral Golden Ticket

20.17. Kim Grosvenor confirmed that Health and Social Care Connect (HSCC) is the refer pathway to the Golden Ticket Dementia Guide Service..

Rural access to Golden Ticket

20.18. Kim Grosvenor said that there was good evidence of the Golden Ticket working well in rural areas as the pilot was carried out in Buxted. The Golden Ticket includes free transport for any dementia patient that needs help to access community-based interventions.

Assistance to patients

20.19. Kim Grosvenor explained the Golden Ticket's Guide Service offers emotional advice and support to patients and carers where necessary, for example, where they require assistance with assessments over the phone, or to fill out a lasting power of attorney form.

Number of Dementia patients in HWLH area

20.20. Kim Grosvenor said that the expected number of people identified as having dementia in the HWLH area by the time of the end of the Golden Ticket roll-out in 2019 will be just over 2,000.

Assessments following initial diagnosis

20.21. Dr Phil Wallek explained that patients placed on the Golden Ticket pathway are entitled to a 40 minute review meeting in their GP practice with a dementia specialist within 10 days of diagnosis. This is a holistic conversation that includes discussion of medical needs, quality of life, relationships with family, and support needs.

Blip clinic

20.22. Dr Wallek explained that the 'blip clinic' is available to families or carers of dementia patients on the Golden Ticket pathway. A blip clinic is a 40 minute appointment with a primary care practitioner and secondary care nurse adviser where necessary changes can be made to a patient's care arrangements as soon as issues arise. This is in order to avoid a crisis at a later date necessitating an admission to a more specialised and costly service.

Advertising the Golden Ticket

20.23. Kim Grosvenor said that there is a national campaign based around the strap line "*Worried about your memory? Go to a GP"* that encourages people to seek early diagnosis. There is also information in relation to the Golden Ticket in affiliated GP practices and online.

Proactive diagnosis

20.24. Dr Phil Wallek said that GPs who are part of the Golden Ticket pathway take the opportunity to proactively screen at risk patients for dementia when they attend the GP practice as part of their routine six-monthly or annual appointment, and refer them to the Memory Assessment Service if necessary. This is done using a standardised, nationally validated tool for identifying dementia. He said that referrals to the Memory Assessment Service can still be made where there are concerns by the patient or family but not the GP.

Harder to engage patients

20.25. Kim Grosvenor said that the Golden Ticket includes access to the Respite Service hosted by ESCC that specialises in working with families of patients who are in denial about their symptoms. GP Practices that are part of the Golden Ticket may offer to combine dementia conversations as part of other GP visits, such as for flu jabs, if the families express concern about a patient.

Lewes Health Hub

20.26. Dr Wallek explained that the successful bid for the new Lewes Health Hub included additional funding that has allowed the three GP practices that comprise the Lewes Health Hub partnership to take staff out of frontline work to run six-week projects around service transformation, such as information governance, and prescriptions and chronic disease. This allows new services commissioned by HWLH CCG, such as the Prescription Ordering Service (POS), to be integrated easily into the Lewes Health Hub. Ultimately this means that it will be clear what services will need to be provided in the new Lewes Health Hub building once it has been built. He added that in the meantime staff are utilising the existing space within the three practices, and are planning to utilise space in the Lewes Victoria Hospital as an urgent treatment centre.

Patient Confidentiality

20.27. Dr Wallek said that all patients in Lewes have been notified that all three GP practices will share patient records, but only clinicians and staff directly involved in care of the patient can access them. He added that receptionists will be upskilled over the next year to be *Patient Navigator*s who can direct patients to the most suitable place for them to receive care, which will not necessarily be a GP. This will potentially involve directing the patient to a third sector organisation, so patients will need to be happy to have their medical information shared.

20.28. The Committee RESOLVED to:

1) note the report;

2) request a future update in June 2018 with a focus on the progress of urgent care redesign; and

3) request that recent non-elective admission figures in the HWLH CCG area are provided by email, and request an interpretation of the data is provided.

21. CANCER PERFORMANCE IN EAST SUSSEX

21.1. The Committee considered a report providing an overview of cancer performance in East Sussex.

21.2. Jessica Britton, Chief Operating Officer, EHS/HR CCG; Joe Chadwick-Bell, Chief Operating Officer, East Sussex Healthcare NHS Trust (ESHT); Lisa Elliott, Senior Performance and Delivery Manager, EHS/HR CCG; Garry East, Director of Performance and Delivery, EHS/ HR CCG and Ashley Scarff, Director of Commissioning and Deputy Chief Officer, responded to questions from HOSC members.

2 week initial referral meeting

21.3. Joe Chadwick-Bell explained that, where appropriate, patients will generally receive a diagnostic test before their initial referral meeting with a consultant, rather than this referral meeting being their first point of contact with secondary care. Lisa Elliott said that in the case of suspected lung cancer, for example, a patient would, where possible, not see a consultant until they had been for a CT Scan as it is more useful for the consultant to see the scan to determine next steps. She added that a suspected cancer patient will be fast tracked through diagnostics, indicating they are treated with some urgency.

21.4. Joe Chadwick-Bell said that the aim is for patients to have the first consultant referral meeting within 7 to 8 days rather than the national target of 2 weeks. Lisa Elliott said that if a patient has not heard back from a hospital they can ask their GP to chase the referral status for them, or the patient can do this directly.

Patient Choice

21.5. Joe Chadwick-Bell said that a significant number of the breaches of the 62-day time to treatment target are due to patient choice, i.e., patients choosing not to attend their appointments – sometimes because they forget and sometimes because they choose not to go. There is a specialist nurse whose role is to contact patients to explain the importance of attending the initial referral appointment and this helps to ensure that ESHT meets its 2 week referral time. Some of the very long wait time breaches are due to patients who are very anxious and for them attempts are made at alternative diagnostic methods. Lisa Elliott added that a root-cause analysis is conducted for each 62-day breach to determine the cause of the breach, and a clinical harm review of the patient is also carried out. Joe Chadwick-Bell clarified that a target of 85% of patients being treated within 62 days of diagnosis takes into account the number of

patients who exercise patient choice. The failure to meet that target indicates that there are other reasons beyond patient choice that account for the target not being met.

One-stop consultancy visit

21.6. Joe Chadwick-Bell explained that each cancer pathway has been reviewed in order to determine whether a 'one-stop' diagnostic clinic could be established for patients attending the initial consultancy meeting, enabling them to see all of the necessary specialists in one go, which is established practice in some hospitals. The feasibility of establishing these clinics is determined by clinical best practice and whether it is possible to concentrate specialist clinicians and nurses in one place. The breast cancer pathway is one that is considered suitable for a one-stop diagnostic.

21.7. Garry East added that some 62-Day breaches occur due to people being on the waiting list for hospital services in London, however, when the patients are seen they may then be able to receive a one-stop diagnostic. There is a balance to be struck between seeing patients promptly and being able to provide a full diagnostic when they attend.

Recording stage at time of diagnosis

21.8. Lisa Elliott said that although the staging is generally recorded by the consultant as 1, 2, 3 or 4, it is not always recorded in the right way (correct coding) so that this cannot be easily taken from the electronic system, which explains the low percentage of instances where the cancer stage has been recorded on diagnosis. A considerable piece of work is being undertaken as part of ESHT's Cancer Improvement Plan to ensure that the right code is used to improve the data collection. Jessica Britton added that this was a problem nationally.

Quality of scanners

21.9. Joe Chadwick-Bell said that CT scanners and MRI scanners at EDGH and Conquest Hospital are going to be replaced. The CT scanner in Conquest Hospital is expected to be replaced early in 2018.

Cancer Quality Improvement Programme

21.10. Lisa Elliot explained that the Cancer Quality Improvement Programme is carrying out a number of projects to raise awareness in Hastings and Rother. Jessica Britton added that a large number of community volunteers have been trained to raise awareness about cancer, which is an effective way of raising awareness in some communities that may be less aware of cancer symptoms.

21.11. The Committee RESOLVED to:

1) Note the report;

2) Request a future report on cancer care performance figures either as a committee report or by email;

3) Provide additional detail on the timescales for the programme to standardise the recording of cancer staging at the time of diagnosis; and

4) Request confirmation of whether mobile scanning facilities are able to undertake all types of scan, including those where enhanced detail is required.

22. KENT AND MEDWAY REVIEW OF STROKE SERVICES

22.1. The Committee considered a report providing an overview of the review of stroke services underway in Kent and Medway and to consider the potential implications for East Sussex residents.

22.2. Ashley Scarff, Director of Commissioning and Deputy Chief Officer; and Michael Ridgwell, Programme Director, Kent and Medway Sussex and East Surrey Sustainability and Transformation Plan, responded to questions from HOSC members.

22.3. Michael Ridgwell said that the consultation is likely to include four reconfiguration options, although the details of the options have not yet been finalised. Meeting certain travel times is a requirement for all of the shortlisted options, specifically that a patient – including those outside Kent and Medway – is able to reach the stroke unit within one hour. This travel time analysis is being developed in close collaboration with South East Coast Ambulance NHS Foundation Trust (SECAmb). Access considerations are also being considered by an independent company, particularly for disenfranchised or isolated populations.

Capital investment

22.4. Michael Ridgwell confirmed that all hospitals in the Kent and Medway area will require capital investment in order to make the necessary changes to create 24/7 Hyper Acute Stroke Unit (HASU) with a co-located Acute Stroke Unit (ASU).

Attracting consultants

22.5. Michael Ridgwell said that there are significant issues with attracting stroke consultants to all of the hospital in Kent and Medway, so it is difficult to say which would be the most difficult to attract consultants to. He explained, however, that being able to say that a HASU reconfiguration is underway has resulted in some increase in the ability to recruit staff, including the recruitment of one consultant; this appears to be the case in other areas that have gone through this process. Ashley Scarff added that there is tangible evidence that following the consolidation of stroke services the Royal Sussex County Hospital (RSCH) is now more attractive to medical staff, and it would be reasonable to expect the same across Kent.

Thrombectomy

22.6. Michael Ridgwell said that thrombectomy – the surgical removal of a clot – is a new service commissioned by NHS England that is not yet widely provided by hospitals outside of London. NHS England is, however, recommending that CCGs and trusts begin developing their own thrombectomy centres. He confirmed that each of the four reconfiguration options will include the opportunity for one of the sites to develop as a thrombectomy centre in the future. He added that developing a thrombectomy centre will require a complex process of developing other services that sit alongside a HASU, but it is being given consideration.

RECOMMENDATIONS

The Committee RESOLVED to:

1) note the report;

2) agree that the proposed reconfiguration of stroke services in Kent and Medway is likely to constitute a ‘substantial development or variation’ to services for East Sussex residents requiring formal consultation with HOSC;

3) authorise the Chair, in consultation with the committee, to make arrangements with the other affected HOSCs for the formation of a joint HOSC to respond to the NHS consultation, should this be required before the committee's next meeting.

23. HOSC FUTURE WORK PROGRAMME

23.1 The Committee agreed the work programme subject to the following amendments:

1) defer the Connecting 4 You report from the 29 March to 28 June 2018 meeting;

2) accept the update on the BSUH Stroke Services Review by email in March 2018, and include the update as an appendix to the 29 March 2018 Work Programme item;

3) defer the update on End of Life Care to the 28 June 2018 meeting; and

4) add an item on the quality of maternity services, to include consideration the findings of an Eastbourne Borough Council survey, to the 29 March 2018 meeting.

The meeting ended at 12.35 pm.

Councillor Colin Belsey
Chair