HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Lewes on 28 June 2018

PRESENT:

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

WITNESSES:

Eastbourne, Hailsham and Seaford Clinical Commissioning Group (CCG) / Hastings and Rother CCG
Jessica Britton, Chief Operating Officer
Mark Angus, Urgent Care System Improvement Director

High Weald Lewes Havens CCG
Ashley Scarff, Director of Commissioning and Deputy Chief Officer
Hugo Luck, Deputy Director of Primary and Community Care

East Sussex Healthcare NHS Trust
Dr Adrian Bull, Chief Executive
Vikki Carruth, Director of Nursing

LEAD OFFICER:

Claire Lee, Senior Democratic Services Adviser

1. MINUTES OF THE MEETING HELD ON 29 MARCH 2018

1.1 The minutes of the meeting held on 29 March 2018 were agreed as a correct record.

2. APOLOGIES FOR ABSENCE

2.1 Apologies for absence were received from Cllr Janet Coles.

3. DISCLOSURES OF INTERESTS

3.1 There were no disclosures of interest.

4. URGENT ITEMS

4.1 There were no urgent items.

5. EAST SUSSEX HEALTHCARE NHS TRUST: CARE QUALITY COMMISSION INSPECTION REPORT

5.1. The Committee considered a report on the recent Care Quality Commission (CQC) Inspection Report on East Sussex Healthcare NHS Trust (ESHT) and an update on the Trust's work to improve End of Life Care (EOLC).

5.2. Dr Adrian Bull, Chief Executive, ESHT, and Vikki Carruth, Director of Nursing, ESHT, introduced the report and answered the following questions from the Committee.

Making financial savings without compromising quality and safety performance

5.3. Dr Bull said that the trust has had troubled finances for a number of years and had a deficit of £48m prior to his arrival in mid-2016. The underlying financial position was worse than that at the time, however, and was being enhanced by one or two one-off in-year contributions. A report by Dame Ruth Carnall in 2016 said that the finances were on a rapidly deteriorating trajectory and were heading towards a deficit of more than £60m. The Trust has arrested this deterioration and the deficit for 2017/18 was £54m, with plans for a deficit of £45m for 2018/19.

5.4. Dr Adrian Bull said that the Trust's aim is to maintain quality and safety improvements made over the last two years whilst reducing its financial deficit. He was clear that whilst ESHT would work to tackle financial issues, the trust would not do so by making short-term cost saving measures that would imperil quality and safety. He clarified that it was not the case that financial improvements were being ignored in order to improve quality and safety.

5.5. Dr Bull explained that a range of initiatives have been undertaken to achieve this financial position, for example, significantly improving financial reporting, and allowing devolved responsibility for budgets to the service level, rather than top down corporate budget planning. Dr Bull explained that every financial initiative the trust develops goes through a formal quality improvement assessment process to ensure that the initiative will not have an adverse effect on clinical performance. Large areas of financial inefficiency that still need to be addressed include agency staff, drug costs and length of stay of patients.

5.6. Dr Bull said that many of the trust's initiatives to improve quality will also deliver financial savings because poor quality care costs money, for example, unnecessary lengths of stay, avoidable readmissions, and extra treatments for preventable infections. He explained how two years ago the length of stay for emergency care was over 6 days but is now 4.6 days. This meant that despite the significant increase in admissions over the past two years, the total number of bed days has fallen and the trust has been able to reduce the number of beds it is running, thus saving money.

Exiting Financial Special Measures

5.7. Dr Bull said that it is less clear how the trust can emerge from financial special measures compared to quality special measures. This is in part because the latter happens as the result of a CQC recommendation whereas there is no equivalent for financial special measures. He believed that the NHS Improvement (NHSI) team will take a subjective view that the trust can come out of special measures once it has fulfilled a number of criteria, for example, having a satisfactory plan to get to a financial break-even position; demonstrating an ability to deliver this plan; and instilling confidence that the plan will be achieved without NHSI oversight. He said that

he felt NHSI is now more sensitive to the risk of driving trusts into a difficult quality position through focussing entirely on financial improvement.

5.8. Dr Bull explained how a five-year plan is being developed with the Clinical Commissioning Groups (CCGs) and NHSI that will enable the trust to break even in three years' time. If this plan is adopted then the earliest that the Trust can come out of special measures is 12 months' time. He cautioned that the scale of the task should not be underestimated and is something the system has tried to address for more than 10 years.

Sustainability and Transformation Fund

5.9. Dr Bull explained that the Sustainability and Transformation Fund (SFT) was additional government funding of £2.5bn introduced into the system a few years ago that NHSI opted to hold back from trusts to incentivise them to achieve their control total. ESHT has been in negotiations with NHSI over its target control total, for example, the control total for 2017/18 was a £35m deficit. If the Trust had hit that deficit – which it did not – it would have triggered £13m of SFT funding that would have reduced the net deficit to £22m. Furthermore, ESHT ended up last year with a significant cash flow problem in attempting to achieve this accelerated deficit reduction plan. The control total for 2018/19 is a £21m deficit and will trigger £15m of STF funding if reached. NHSI now accept that this is an unrealistic trajectory for the Trust but argue that it is beyond their powers to adjust it. Dr Bull said therefore that for now STF is out of reach for the trust. The five-year plan would bring back the possibility of receiving it in future years, however, and is based on a more achievable trajectory that will avoid the cashflow problem of last year. He clarified that the trust is funded in cash up to the control total deficit and beyond that point the trust must use its reserves. ESHT's reserves are now negative and a low interest rate reserve loan is used instead, which does not harm the trust's year to year operational performance.

Collaborative financial planning

5.10. Dr Adrian Bull said that all of the ESBT Alliance organisations have their own financial pressures and are separately regulated, meaning that sometimes organisations can be tempted to look inwards to solve their own problems. He said that ESHT was consciously working to maintain its focus on the wider system and will continue to attend joint financial meetings, such as the Financial Recovery Board, to discuss financial pressures on each organisation in the ESBT system and the impact changes one makes will have on the others, for example, work is being commissioned to look at the impact on the savings East Sussex County Council is making to its preventative Adult Social Care services. The trust is also working with partner organisations to plan for winter pressures and ensure the system has the necessary resource to meet the extra demand.

Date of publication of CQC action plan

5.11. Dr Adrian Bull said that an action plan developed in response to the CQC's 'must do' and 'should do' recommendations has to be submitted to the CQC. This is a public document and will be completed shortly and then published. In addition, the Trust's Quality Account will be published imminently and will include quality priorities along with the plans of how to achieve them. There is also a 2020 strategy document that is publically available and will be made published at the same time as the Quality Account.

A&E performance at Eastbourne DGH and Conquest Hospital

5.12. Dr Bull explained that the A&E services at Conquest Hospital and Eastbourne District General Hospital (EDGH) had both significantly improved over the past 18 months, for example, performance against the A&E 4 hour wait time averaged around 70% across both sites 18 months ago and the trust was in the bottom 20 trusts in England, whereas over the past 6 months the performance has risen to 90% and is in the top 20 trusts in the country. The increase in waiting time performance has been similar at both sites, with both A&E Departments at various times performing slightly better than the other.

5.13. Dr Bull clarified that the specific reason why EDGH A&E Department remained as requires improvement and the Conquest Hospital was rated good was due to an issue with the reception and admin team at EDGH being short staffed, under pressure and getting too few breaks. This had been identified by the CQC as the only 'must do' action and the Trust was working now to rectify it. He said he was disappointed that this had happened as it was an issue that the trust had previously recognised at both sites and action had been taken to address it, however, it appeared that only Conquest Hospital had implemented the actions. In addition to this 'must do' action, the CQC had also identified that mental health care in A&E was worse at the EDGH, but Dr Bull was confident that this was due to a one-off incident during the inspection and standards were common across both sites. Dr Bull added that there is a change in leadership happening at EDGH (unrelated to the inspection findings) and this is being taken as an opportunity to unify leadership of emergency care across the two sites and focus on improving standards. He said that staff at the EDGH had been disappointed that they had not received a good rating.

Triaging at A&E

5.14. Vikki Carruth explained that the system in place at A&E aims to triage a patient once immediately upon their arrival. This is to ensure that if they need immediate treatment they are directed to 'majors' and otherwise are asked to take a seat in the waiting area. Dr Bull said that in the last 12 months nurse rounds have been introduced at the A&E waiting areas to ensure that all patients who are waiting are not forgotten or left in discomfort. Ms Carruth said that she believed the system was efficient but that some patients may be confused by the triage process, so the trust plans to put up signage to explain visually the journey through A&E.

Effect of CQC rating on recruitment

5.15. Dr Adrian Bull said that there is no doubt that two years ago ESHT was finding it difficult to recruit because it was rated inadequate, was in special measures for quality, and had a poor reputation. However, he believed that the current CQC rating of requires improvement would not affect recruitment as around two thirds of trusts have the same rating. In addition, recent improvements to the trust's reputation have helped with recruitment in a number of areas, for example, every trainee midwife who recently graduated has been recruited to the trust; and a recent consultant advertisement received three high quality applications whereas before they often received none. However there is still a national shortage of certain roles, for example, consultants in haematology, that makes recruitment an ongoing challenge.

Bullying and harassment

5.16. Dr Bull assured the Committee that the trust has taken explicit measures on bullying and harassment. As a result of these measures some very senior people have changed their behaviour noticeably, which staff have commented is evidence that the trust is taking the issue seriously. He said that specific interventions were made in two speciality departments that had difficult reputations and unhappy staff. The interventions included replacing some of the leadership, and taking actions to address interpersonal issues. Both departments have now achieved cultural improvements that have been remarkable, leading to them receiving national accreditation this year. In addition, the NHS Staff Survey last year showed that the Trust was one of the most improved for engagement with its staff.

Expanding new roles

5.17. Dr Bull said that both the matron's assistant and junior doctor's assistant roles have been successful and valuable to the trust and the trust is seeking to expand these roles. Dr Bull and Vikki Carruth outlined some additional roles and training opportunities that have been introduced, or are in the process of being introduced:

- Physician's associates, which is a role that assists medical staff and is widely used in the United States;
- Surgical care practitioners;
- A new training role for healthcare assistants to allow them to become associate practitioners, just beneath the level of registered nurse; and
- clinical orderlies to support clinical staff on wards and departments.

5.18. Vikki Carruth added that much work had been done to improve retention of existing staff, for example, a range of initiatives were in place around improving staff wellbeing and resilience, including the use of Schwartz rounds. Flexible working is also being introduced for a number of staff who are older and in physical roles, providing them with shorter or different shifts.

Reconfiguration of stroke services at EDGH

5.19. Dr Adrian Bull said that the two wards currently designated as stroke units at the EDGH are not all taken up by stroke patients. The proposed reconfiguration of beds will enable the more effective concentration of stroke patients on a single ward with all staff on the ward trained to care for stroke patients. He said he did not see it as a downscaling of the stroke service.

5.20. Dr Bull said that the changes to stroke wards are part of a wider review of the 750 beds in ESHT that will reduce the overall number across both sites of approximately 75-80 – with the option to open them again during winter – that is being driven in part due to the reduced length of stay of patients at the trust in recent years. The review also involves a rebalancing between medicine and surgery beds that will result in relatively more medical beds. This is because in previous years it has increasingly become necessary to move medical patients into surgery beds during busy periods, which is not good practice.

End of Life Care for children and young people

5.21. Vikki Carruth explained that there are several co-ordinating groups set-up to manage EOLC for children and young people of which she is a member, for example, an EOLC steering

group that includes colleagues from paediatrics and community services; and a steering group for children with complex needs that are likely to cause life limiting illnesses. These groups demonstrate the Trust's commitment to providing the best possible care for children and young people, particularly during the complex time of transitioning to adult care services. She said that EOLC for children and young people is more difficult and specialist, and less understood and well developed as a whole than it is for older people who are more likely to be facing the end of their life. There are also more ethical discussions for EOLC in younger people than older people, particularly around issues such as resuscitation.

Response to Gosport Hospital report

5.22. Vikki Carruth confirmed that Graseby pumps were not used in ESHT and had not been for eight years. Ms Carruth said that whilst she did not believe that ESHT had any of the problems Gosport Hospital had around syringe driver usage, prescription dosages, or whistleblowing policies, as highlighted in the recent report, she nevertheless thought that the Trust should review that this was the case. An assurance report will be provided to the ESHT Board for consideration in the near future.

EOLC rating

5.23. Vikki Carruth said she was confident that the EOLC service will receive a rating of good from the CQC on re-inspection with some areas highlighted as outstanding. She was disappointed that the service was not re-inspected but that did not detract from the improvements that had been made. Whilst acknowledging it was not perfect, the concerns around the EOLC service were not about the level of care the service provides but around the fact that there is not a systemic practice of documenting discussions with patients and relatives about EOLC arrangements, which the service is working to rectify. In addition, the National EOLC Collaborative Team visited ESHT in May 2018 and has said it wishes to share some examples of EOLC care at the Trust as best practice around the country.

Seven Day Specialist Palliative Care Team (SPCT)

5.24. Jessica Britton said that she would inform the Committee by email about the progress of the SPCT business case.

5.25. The Committee RESOLVED to:

1) note the report;

2) request a copy of ESHT Action Plan;

3) request an email about the progress of the SPCT business case.

6. URGENT CARE

6.1. The Committee considered a report providing an update on the redesign of the urgent care system as part of both the Connecting 4 You and East Sussex Better Together programmes, and the pause of the NHS 111 procurement process.

6.2. Ashley Scarff, Director of Commissioning Operations, HWLH CCG; Hugo Luck, Deputy Director of Primary and Community Care, HWLH CCG; Jessica Britton Chief Operating Officer, EHS/HR CCG; and Mark Angus, Urgent Care System Improvement Director, EHS/HR CCG; introduced the report and answered the following questions from the Committee.

Continuation of existing NHS 111 contract

6.3. Mark Angus said that the CCGs are about to enter discussions with current NHS 111 providers to ensure continuity of service beyond the end of the current contract in April 2019. He is confident that continuity of service can be achieved.

NHS 111 procurement process

6.4. Mark Angus said that the CCGs are intending to do further engagement with the market and see whether there are any learning opportunities from other NHS 111 system plans being developed elsewhere in the country. This will help to ensure there is a positive response from providers to the procurement process when it is reinitiated. He said it was important to reflect that the decision to pause the procurement process was not an indication of a flawed procurement process and this view is supported by NHS England.

6.5. Jessica Britton said that the redesign of Urgent Treatment Centres (UTCs) in the East Sussex Better Together (ESBT) area of East Sussex is on pause until the impact of the pause in NHS 111 procurement can be determined. She did not anticipate that it would impact the plans significantly but it was necessary to ensure that the new specification UTCs will be deliverable within the revised timescales. Ms Britton said that further update on the effect on UTCs would be presented at the next HOSC meeting.

Lewes Victoria Hospital

6.6. Hugo Luck confirmed that the Lewes Health Hub and Lewes Victoria Hospital (LVH) UTC would not be duplicating services as the two services will be integrated together into a single urgent care system. He explained that the three GP practices that have combined to create the Lewes Health Hub will treat patients with long term conditions at the Health Hub (or in the individual practices prior to the completion of the Hub) and patients requesting urgent care will be asked to go to the UTC at the LVH where some of the Lewes GPs will be present, along with emergency nurse practitioners (ENPs). Mr Luck illustrated this separation by explaining that a patient may ring their GP practice with an urgent care need and be directed to go to the LVH instead, or they may book an appointment at the UTC online, or via NHS 111. The triaging of patients at the UTC will be undertaken by a doctor and around 50 patients a day who would otherwise have seen their GP at a practice will see an ENP instead, which will be more suitable for their needs, and conversely 20% of current minor injury unit (MIU) patients at the LVH will see a GP instead due to their medical need. The model also makes use of the extended access to primary care currently being procured as the UTC will offer evening and weekend GP cover.

6.7. Hugo Luck explained that the current Minor Injuries Unit (MIU) at Lewes Victoria Hospital already had a diagnostic and X ray capability and that the main difference between it and the planned UTC would be the medical oversight provided by GPs, which will enable the treatment of a much wider range of illnesses.

6.8. Hugo Luck said that the model will require additional staffing but the current MIU that is run by Sussex Community NHS Foundation Trust (SCFT) has a low vacancy rate. Existing staff have been trained up over the past two years as part of an earlier re-procurement of community services that involved training up MIUs, which now aligns with NHS England's urgent care requirements.

6.9. Hugo Luck said that the LVH building has an underutilised ward that, subject to the confirmation of the business case, will be converted into three consultation wings. The building tender will go out in July and building work will begin in September. As the care model, staff and funding are in place, subject to this building work being delayed, the UTC will be in operation by December 2018. A full communications plan with patients will also be undertaken at a suitable time.

Other UTCs

6.10. Hugo Luck said that there is a Sussex and East Surrey Sustainability and Transformation Partnership (STP) review of UTC locations that is determining where other UTCs may be required. There is a clear need for a UTC at Brighton, Eastbourne and Hastings but it is more difficult to determine in other areas, for example, a UTC at Uckfield would be only 8-9 miles from the A&E at Princess Royal in Haywards Heath and so could be duplicating the service. He said that HWLH CCG was committed to maintaining the MIU presence where possible at the sites in Crowborough and Uckfield.

6.11. Jessica Britton confirmed that there were no plans in the ESBT area to have UTCs outside of Hastings and Eastbourne but other urgent care improvements would be put in place such as primary care extended access.

Reduction in preventative ASC services

6.12. Ashley Scarff said that ongoing savings to Adult Social Care preventative services require more than ever closer working with the voluntary sector organisations that play a part in the urgent care system, which starts at the preventative stage. HLWH CCG will look to maximise opportunities as much as it can within the resources available to make sure that initiatives that are the bedrock of the urgent care strategy are not disrupted.

6.13. Jessica Britton agreed and said that ESBT is predicated on how to best treat people outside of a hospital setting through investing in primary and community services and working with the voluntary and community sector. ESBT has a community resilience programme that is shared with HWLH CCG and both CCG areas are currently procuring extended primary care access, which is a preventative service in so far as it can help ensure people are treated early in a primary care setting, reducing the need for hospital admissions.

Effect of CCG savings

6.14. Jessica Britton said that the CCGs are looking at financial recovery programmes to stabilise in-year finances and become solvent over the next three to five years. The plans – some of which have been discussed by the CCGs at Governing boards – will comprise a number of things. The ESBT CCGs are looking at a £18m saving for 2018/19 – 3% of the total allocation, which is totally achievable and the CCGs are confident that they can deliver it. Ms Britton said that there are currently no proposals for savings across services commissioned by

the CCGs and that any savings that would result in service changes would be the subject of public consultation.

6.15. The strategy for improving the primary care estate includes a number of projects and proposals from individual practices that are considered by the CCGs as part of a planning cycle. The necessity of each project will continue to be reviewed and assessed as normal. Currently there are no proposals to stop any building works, but future works will need to take account of the need for achieving sustainable financial recovery within the CCGs.

6.16. The Committee RESOLVED to:

1) note the report;

2) agree to suspend the work of the HOSC sub-group considering Urgent Treatment Centre proposals in the East Sussex Better Together area, pending re-submission of the proposals in the autumn; and

3) request a further report on the progress of urgent care redesign in September 2018.

7. HOSC FUTURE WORK PROGRAMME

7.1 The Committee considered its work programme.

7.2 The Committee RESOLVED to:

1) agree the work programme;

2) agree that the Chair writes a letter to the relevant CCGs requesting more detailed information about the reasons for the NHS 111 procurement delay;

3) request a report to be circulated by email on the progress of improving cancer care services in East Sussex;

4) agree to nominate Cllr Bowdler as a member of the HOSC working group for Sussex Partnership NHS Foundation Trust (SPFT);

5) request a briefing on post-natal mental health care in East Sussex; and

6) raise the issue of mental health waiting times at the next HOSC working group for SPFT.

The meeting ended at 12.10pm

Councillor Colin Belsey
Chair