HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Lewes on 26 September 2019

PRESENT:

Councillors Colin Belsey (Chair), Councillors Phil Boorman, Angharad Davies, Sarah Osborne, Peter Pragnell and Alan Shuttleworth (all East Sussex County Council); Councillor Mary Barnes (Rother District Council), Councillor Christine Brett (Lewes District Council), Councillor Johanna Howell (Wealden District Council), Councillor Amanda Morris (Eastbourne Borough Council), Councillor Mike Turner (Hastings Borough Council) and Geraldine Des Moulins (SpeakUp)

WITNESSES:

Dr Susan Rae, Urgent Care Clinical Lead and GP, Hastings & Rother Clinical Commissioning Group
Jessica Britton, Managing Director, Eastbourne, Hailsham and Seaford Clinical Commissioning Group (CCG) / Hastings and Rother CCG
Lisa Elliott, Senior Performance and Delivery Manager, Eastbourne Hailsham and Seaford/ Hastings and Rother CCG
Ashley Scarff, Director of Partnerships & Commissioning Integration, High Weald Lewes Havens CCG
Hugo Luck, Associate Director of Operations, High Weald Lewes Havens CCG
Colin Simmons, 111 Programme Director (Sussex), NHS Coastal West Sussex CCG
Ray Savage, Strategic Partnerships Manager, South East Coast Ambulance Foundation NHS Trust
Charles Adler, Paramedic, Integrated Urgent Care Programme Manager, South East Coast Ambulance NHS Foundation Trust

LEAD OFFICER:

Harvey Winder, Democratic Services Officer

9. MINUTES OF THE MEETING HELD ON 27 JUNE

9.1 The Committee agreed the minutes as a correct record of the meeting held on 27 June.

10. APOLOGIES FOR ABSENCE

10.1 There were apologies for absence received from Cllr Ruth O'Keeffe and Jennifer Twist.

11. DISCLOSURES OF INTERESTS

11.1 There were no disclosures of interest.

12. URGENT ITEMS

12.1 There were no urgent items.

13. URGENT CARE IN EAST SUSSEX

13.1. The Committee considered a report providing an update on the procurement of a new NHS 111 service; the development of Urgent Treatment Centres in Eastbourne, Hastings and Lewes; and the future of Eastbourne and Hastings Walk-In Centres. The Committee then asked the witnesses present a number of questions.

NHS 111

13.2. **The Committee asked how many staff would need to be recruited to the new 111-Clinical Assessment Service (CAS); whether this would include new GPs; whether they would be recruited to the cost of GP practices; and whether 111 call handlers may be trained to be able to join the CAS.**

13.3. Colin Simmons explained that the winning bidders, South East Coast Ambulance Service NHS Foundation Trust (SECAmb) and Integrated Care 24 Ltd (IC24), already run between them both existing 111 services and an out of hour GP service, which includes over-the-phone clinical assessments. A gap analysis is now being undertaken to understand what workforce the two providers already have and what is needed for the new service.

13.4. Mr Simmons said that the mobilisation plan for the new 111 service includes developing ways to recruit staff in innovative ways that are attractive to prospective staff but that do not take them from other services. This may include a contract that allows existing GPs to work for the CAS remotely in their own office, rather than physically from a CAS call-centre, whilst still continuing with their traditional GP role. He explained that this proposal will be developed as part of the mobilisation plan, might not be available on day one, and is still subject to full engagement with GPs, however, feedback to date from GPs suggests they are keen to work in different clinical environments and that the CAS could be able to fulfil this desire.

13.5. Charles Adler added that this kind of 'virtual working' is already being established by SECAmb in other areas thanks to the recent availability of new technology. Midwifery calls in Surrey Heartlands for the three hospital sites in the area, for example, are taken in the SECAmb's 999 contact centre at Crawley by midwives working there, rather than on each of the three separate wards. This allows the same number of midwifery staff to have a far greater impact on patient care and allows them to provide additional clinical capacity at the contact centre for non-maternity calls. It also brings together specialities not used to working together and helps enhance their understanding of each other's roles.

13.6. Colin Simmons explained that there is a nationally mandated workforce blueprint for 111 services that includes guidance on supporting the development of non-clinicians' career paths. This is in recognition that the call handler role needed to be made more attractive due to the high turnover rate of staff nationally. SECAmb's 111 call handlers will also be trained to do both 111 and 999 calls to increase the resilience of 999.

13.7. **The Committee asked whether the new service will have access to patient records; and how this will comply with GDPR requirements.**

13.8. Colin Simmons confirmed that the CAS clinical staff will have access to a patient's care record, but not the 111 call handlers. Patients who have more complex needs will speak to the CAS, so clinicians will need access to their records to properly signpost them. Charles Adler added that SECAmb's information governance lead has been closely engaged in the development of the new 111-CAS service.

13.9. **The Committee asked whether there are concerns that patients will not properly articulate their symptoms over the phone.**

13.10. Colin Simmons said that it is recognised that it is not always possible to diagnose everything over the phone, so call handlers and CAS clinicians will signpost to face-to-face services, such as Urgent Treatment Centres (UTCs) or out of hours services, as necessary. Facetime and other video calling services will also be developed over time and will aid in remote diagnosis of patients.

13.11. Charles Adler explained that SECAmb staff do not always need to see a patient's record to make a diagnosis; if a patient has a life-threatening condition it will be clear to either the call-handler or paramedic on scene that they require immediate treatment. In situations where it is less clear, however, access to a patient's summary care record will enable clinicians based in the CAS to better determine what clinical intervention is required for the patient over the phone.

13.12. **The Committee asked how much information a CAS clinician will have on a patient.**

13.13. Colin Simmons said clinicians in the CAS will have access to a patient's summary care record, subject to permission from the patient, that it is produced by their GP practice. 111 call handlers, on the other hand, would only be able to see basic details such as their name and date of birth.

13.14. Charles Adler added that the summary care record is a fairly basic record containing standard subset of data from a patient's primary care record including allergies, medication and the patient's demographic information. In the future, it may be nationally mandated that there are more enhanced patient records available and the CAS may benefit from this greater depth of information. He stressed, however, that it needs to be the right information to the right clinician at the right time and that too much information was not useful. He confirmed that the Summary Care Record could be accessed within both existing 111 services.

13.15. **The Committee asked whether the different digital systems accessing the summary care record would link together**

13.16. Colin Simmons explained that a key part of the mobilisation plan of the new 111-CAS service is to ensure that summary care records will be accessed by the CAS from the main electronic patient record programmes used by GPs, as there are several different options on the market.

13.17. Charles Adler added that historically these programmes had not been designed to join up with each other, or other software used by third parties such as the 111-CAS, however, nationally mandated requirements meant future electronic patient record software would include inter-operability with other systems as standard. He confirmed that the clinicians supporting the

call handlers in the existing 111 service can already access the summary care record, so the new 111 service would be able to as well.

13.18. **The Committee asked how the service would be advertised, whether there would be an engagement plan for hard to reach patients, and how patients from the deaf community would access 111.**

13.19. Colin Simmons said a number of national campaigns for the existing 111 service would begin in October and November. There would then in the new year be further campaigns for the new urgent care service, including the new 111 service. This would be close to the point at which the new service is about to go live so people did not call the existing 111 service expecting to receive the services available under the new service.

13.20. Colin Simmons said that there was a separate plan for engaging with seldom heard groups and a plan for ensuring the service is compliant with British Sign Language requirements, as well as having interpreters in place for people for whom English is not their first language.

13.21. **The Committee asked how patients would be safely triaged through NHS 111 and onto other NHS services.**

13.22. Charles Adler said that 111 has always been a safe 'front door' service into the NHS. When patients call 111 the call handler triages patients using the national NHS Pathways software also used by 999, which determines in the first four questions whether the patient is in, or in imminent risk of, cardiac arrest; safety is therefore inherent in the service. The desire of the system now is to provide 111 and 999 (as SECAmb will provide both services) with a greater depth of clinical expertise. This will mean that once patients have been triaged by 111, they are not required to navigate the health service on their own and can be directly booked into other services such as UTCs.

13.23. Ray Savage added that SECAmb has expanded its medical cover over the last three years. SECAmb now employs paramedic practitioners in the 999 call-centres and clinicians in the 111 contact centre, all of whom have access to summary care records. This ensures improved clinical governance and empowers 111 and 999 call handlers to signpost patients to the right service, which may not always involve sending them an ambulance. He said the new 111-CAS will be building significantly on these services already in place.

13.24. **The Committee asked whether the questions asked by 111 call handlers are appropriate and whether there was a risk following a script made the experience impersonal.**

13.25. Charles Adler agreed that some of the NHS Pathways questions could be frustrating but are determined nationally; SECAmb would not be in a position to use an alternative to NHS Pathways. He added that relying solely on NHS Pathway to triage a patient could make the experience impersonal for them. The new CAS, however, will have a second tier of triage staffed by clinicians, who patients will be able to have more personalised discussions with about the care they need.

13.26. **The Committee asked how the wait times for patients not requiring emergency assistance are determined**

13.27. Charles Adler said that following their call to 111, the wait time for a patient's health intervention will be determined by the service they will have been signposted to from 111, such as an out of hours visit, UTC or GP appointment. The key role of 111-CAS clinicians will be to use their clinical expertise to reassure the patient they have spoken to that they are well enough to wait for their appointment, even if it is the next day.

Urgent Treatment Centres (UTCs)

13.28. **The Committee asked what assurance could be provided that the Lewes UTC timeline would not slip, given the previous delays in the UTC process.**

13.29. Hugo Luck acknowledged that the timeline for the UTC had slipped, but he was confident the 1 April 2020 deadline would be met. He explained that the delays were due to the innovative model being developed to integrate the UTC with the three local GP practices. This had involved bringing together a number of revenue streams, which had now been completed but had taken longer than expected to do so.

13.30. Hugo Luck listed the revenue streams that have been combined to fund the UTC:

- High Weald Lewes Havens CCG's (HWLH CCG) existing General Medical Services contract with the three GP practices;
- the contract with Sussex Community NHS Foundation Trust (SCFT) to run the Minor Injuries Unit (MIU) at Lewes Victoria Hospital,
- the improved access contract with GPs to provide appointments at evenings and weekends;
- new, additional funding from the CCG's resilience budget to employ additional emergency nurse practitioners.

13.31. He explained that the three GP practices between them will provide medical cover at the UTC, as required in the national specifications for UTCs. This will not be funded from an additional revenue stream but from the funding they receive already to provide "same-day care" as part of their General Medical Services contract with the CCG (the contract also includes an element of funding for chronic disease management).

13.32. **The Committee asked what the cost of the capital works would be.**

13.33. Hugo Luck confirmed that the proposed capital is around £520k. half has been awarded by NHS England and the CCG has approached the Friends of Lewes Victoria Hospital for the remainder.

13.34. **The Committee asked what different service people in Lewes would receive from the UTC.**

13.35. Hugo Luck explained that patients would receive an improved service as the current Minor Injuries Unit (MIU) only deals with minor injuries and not ailments. Patients with minor ailments currently need to contact their GP, the out of hours GP service, or attend the nearest A&E. The UTC, on the other hand, will cater for minor ailments 12 hours a day, seven days a week and will also provide diagnostics.

13.36. **The Committee asked how patients in the north of the county receive urgent care from Kent**

13.37. Hugo Luck explained that integrated urgent care is being planned and delivered at a Sussex-wide level and patient flows for patients in the north of the county are expected to use the MIU at Crowborough. By contrast, patients in the north east are nearer to Pembury and will use the UTC there. He said he understood there may be delays in developing the UTC at Pembury and discussions are underway with SCFT about enhancing the MIU at Crowborough or Uckfield to include improved primary care access until the UTC at Pembury is up and running. He confirmed that there were no plans to downgrade either the Crowborough or Uckfield MIUs.

13.38. **The Committee asked why the Hastings and Eastbourne UTCs only opened 12 hours a day and what would happen to patients arriving at the hospital sites when the UTCs are closed.**

13.39. Hugo Luck said that the national specification for UTCs called for them to be open 12 hours per day and opening hours will best reflect patient flow. In addition, some contact with the out of hours GPs on Saturdays is for patients requesting repeat prescriptions and people will be able to receive repeat prescriptions via 111-CAS in the future.

13.40. **The Committee asked whether the CCGs would have come up with a better scheme if UTCs and their specifications were not mandatory**

13.41. Jessica Britton suggested that it was difficult to say whether the service would have looked the same were it not for the national requirements, but it is likely that the local health system would have been working on simplifying urgent care and using resources to best effect regardless. Ultimately it does not matter what the services are called or how they arranged, so long as the service is seamless for patients, for example, being able to book appointments and receive repeat prescriptions via 111; or arrive at A&E and be triaged to be seen by a GP if clinically safe to do so.

13.42. **The Committee asked whether the shortage of GPs in Hastings would lead to higher usage of the UTC.**

13.43. Jessica Britton confirmed that GP numbers have been taken into account when planning new urgent care services and agreed that the number of patients per GP in Hastings was below the national average, however, she said there had been improvements in the recruitment of GPs in recent months.

13.44. Jessica Britton explained that CCGs are planning urgent and primary care services based on the principle that it is important to see a GP when you need to see one, but also that there are a number of other services and clinical staff available for patients who do not need to see a GP. Dr Susan Rae added that GPs are better left to deal with complex problems and chronic conditions whilst an increasingly wide range of other healthcare professionals could see patients for other ailments and injuries, for example, it was better for some patients to see an emergency nurse practitioner who was used to seeing minor injuries, fractures and trauma than a GP who sees such things infrequently. Dr Rae said there are also advanced nurse practitioners who can prescribe and deal with minor ailments, as well as paramedics, physiotherapists for MSK issues and social prescribers working in primary care.

Walk-In Centres (WICs)

13.45. **The Committee asked what the difference was between the WIC and the new Primary Care Led Hub (PCLH)**

13.46. Jessica Britton explained that the key differences people would notice from the beginning of the new service would be the earlier closing time of 6.30pm rather than 8:00pm, and the shift from a GP-led to testing an advance nurse practitioner-led service. The earlier closing times were due to very low demand between 6:30pm and 8:00pm and the availability of GP extended access appointments on site during those times. The advanced nurse practitioner-led service would mean that patients would see an advanced nurse practitioner in the first instance who would be able to manage a wide range of need, however, they would be able to see a GP if they have a medical need to do so.

13.47. Jessica Britton added that the other main difference would be the availability of non-medical services on site over time. The existing WIC has limited integrated services and is not really networked well into other non-medical services available in the town, such as mental health services, or housing and benefits advice. The complexity of issues of those presenting at the service, however, suggests that it would be beneficial to provide access to a wide range of social prescribing, mental health and other specialist services for patients' non-medical needs at the PCLH. For patients this would mean over time the ability to access these services in one place at the Station Plaza rather than being signposted to other services around Hastings, although patients would not see this in place at the start of the service in December.

13.48. Jessica Britton confirmed that the PCLH model will be tested out over the coming months and a specification for the new service will be developed by July 2020, ahead of a permanent service being commissioned for April 2021.

13.49. **The Committee asked whether patients without a registered GP would find it difficult to access one at the PCLH.**

13.50. Jessica Britton said that research showed the majority of patients using the WIC are registered with a GP. This means that they have access to a GP if required but choose to use the WIC for various reasons. There are, however, a small number of unregistered patients who use the WIC and clinical governance arrangements will be in place to ensure that they can access a GP at the PCLH if required. The volume of required GP appointments at the PCLH will be measured during the test period to help inform the development of the final specification for the service.

13.51. **The Committee asked whether the proposals for Hastings WIC would also be developed at Eastbourne WIC given the support locally for saving the Eastbourne WIC**

13.52. Jessica Britton explained that it was difficult to comment on the Eastbourne proposals in advance of the plans being finalised in November. She confirmed that the issues raised during the engagement work in Eastbourne will be given due consideration ahead of any proposals for the WIC being published. These include, for example, the demography of service users; other services available locally; how people access these services and the level of activity at them; and any issues raised locally as part of ongoing engagement,

13.53. The Committee RESOLVED to:

1) note the report;

2) agree that the proposals for Hastings Station Plaza walk-in centre no longer constitute a substantial variation in services;

3) request a report on the progress of the primary care led hub and future plans for Hastings Station Plaza in June;

4) request a report on the progress of NHS 111 after April 2020;

5) arrange a visit to the 111-contact centre in Crawley; and

6) request the engagement plan for the new urgent care service, including the 111 service, is circulated to via email.

14. CANCER PERFORMANCE IN EAST SUSSEX

14.1. The Committee considered a report providing an update on developments in improving cancer care in East Sussex. The Committee then asked the witnesses present a number of questions.

14.2. **The Committee asked whether the national bowel cancer screening programme had been introduced in East Sussex.**

14.3. Lisa Elliott confirmed that bowel scope screening has not started in East Sussex yet due predominantly to endoscopy capacity. NHS England commissions bowel scope screening and the CCGs are working with them to increase the available capacity. The personal test has recently changed from the FOBT (Faecal Occult Blood Test) to the Faecal Immunochemical Test (FIT). The implementation of the FIT test for screening began in June 2019 for people over 60-74. For symptomatic patients presenting to their GP, FIT test is also available.

14.4. Lisa Elliott said that she would feedback the Committee's concerns that GPs may not be offering the FIT for people under 60, even those with a family history of the disease.

14.5. **The Committee asked why there is a lack of endoscopy if there are newly opened units at both hospital sites.**

14.6. Lisa Elliott explained that East Sussex Healthcare NHS Trust (ESHT) has increased its capacity, and endoscopy demand is continuing to increase. The Trust is reviewing how it can increase its capacity further.

14.7. Ashley Scarff added that Brighton & Sussex University Hospital NHS Trust (BSUH) has similar capacity issues around availability of staffing and equipment, so increasing capacity at the trust's hospital sites is a key area for improvement.

14.8. **The Committee asked to what extent missing the 62-day referral to treatment was due to a shortage of oncologists and other specialists and whether they could be attracted to work in East Sussex**

14.9. Ashley Scarff confirmed that some of the capacity constraints at BSUH were due to lack of workforce capacity and equipment, as well as the need to improve pathways, and plans are in place to address all of these issues. ESHT is also experiencing workforce constraints and is continuing work to improve cancer pathways in order to meet the 62-day referral target. The focus of these improvements to cancer pathways will be on deploying existing staff more effectively.

14.10. Ashley Scarff added that the increasing demand for diagnosis and treatment from an aging population and higher referral rates, albeit being offset by increasing preventative services, meant that there would be a longer term need to review the size of the workforce required to deliver the target in the future.

14.11. Jessica Britton said that there is an improving picture of recruitment at ESHT. Ashley Scarff added that the performance of the providers was a virtuous circle and that for both BSUH and ESHT coming out of special measures would help attract staff.

The Committee asked when the Sussex Cancer Board was established

14.12. Lisa Elliott said the Sussex Cancer Board was established in August 2019. During the previous three years, strategic guidance had come from the Sussex and Surrey Cancer Alliance. However, the Alliance identified that the Sussex and Surrey areas had different priorities and needs, and the Board was established in response. It had now met twice and is chaired by Lola Banjoko, Managing Director for Brighton and Hove CCG and senior responsible officer for cancer across Sussex. Ashley Scarff said the Board would help deliver the Long Term Plan's cancer priorities locally, as well as NHS England's assessment framework metrics for cancer.

14.13. Ashley Scarff added that there is a long history of working at scale across cancer care, and prior to the Cancer Alliance there was a Cancer Network for Sussex. This is due to the fact that some cancer types are only treated by BSUH, as the local tertiary centre, or at specialist centres in London, resulting in complex pathways for patients who may be initially diagnosed at their local hospital and the need to coordinate these across specialist centres covering large geographical areas.

14.14. **The Committee asked about East Sussex patients accessing cancer services in Kent**

14.15. Ashley Scarff explained that there had been significant improvement with access times for cancer care at Maidstone and Tunbridge Wells NHS Trust (MTW) and this would apply for both East Sussex and West Kent patients.

14.16. **The Committee asked what role clerical staff play in delays to treatment**

14.17. Ashley Scarff explained that patient's views of the treatment they receive from clinicians is invariably very good. Issues with patient experience tend to arise in the logistical, pathway elements of their care that are critically dependent on administrative support, processes and systems working correctly, for example, ensuring appointments are sent to patients in a timely manner. The patient experience metric CCGs are assessed on by NHS England helps to show whether the logistical element is or isn't working well. Where it is not working well, further

training for administrative support staff may be necessary together with reviews of capacity and ways of working which can help to improve the 62-day target and other access standards.

14.18. **The Committee asked whether additional funding would be received for cancer** services**.**

14.19. Jessica Britton said that the NHS Long Term Plan has highlighted some national investment in certain specialties including cancer. How this is allocated to CCGs has not been confirmed yet but some will likely be provided specifically for cancer care improvement via primary care networks (PCNs). The Local response to the NHS Long Term Plan would likely provide further details.

14.20. **The Committee asked whether the facilitator role in GP practices was being rolled out**

14.21. Lisa Elliott explained that the role had been funded through the Healthier Hastings and Rother programme and had now finished. Cancer Research UK, however, is now providing a similar dedicated facilitator who will work three days a week across both CCGs raising awareness of cancer in GP practices.

14.22. The Committee RESOLVED to:

1) note the report

2) confirm via email the number of vacancies in oncology and radiology teams;

3) request an update at a future meeting.

15. HOSC FUTURE WORK PROGRAMME

15.1 The Committee RESOLVED to note the work programme subject to the addition of:

1) the reports requested in earlier items;

2) a report at the 28 November meeting on the proposals for a new Patient Transport Service (PTS), including an update on the PTS performance from Healthwatch;

3) a report at the 28 November meeting on the local health and social care system's winter plan.

The meeting ended at 12.15 pm.

Councillor Colin Belsey
Chair