HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at Council Chamber, County Hall, Lewes on 30 July 2024

PRESENT:

Councillors Colin Belsey (Chair), Sam Adeniji, Abul Azad, Sorrell Marlow-Eastwood, Sarah Osborne, Christine Robinson and Alan Shuttleworth (all East Sussex County Council); Councillors Dr Kathy Ballard (Eastbourne Borough Council) and Mike Turner (Hastings Borough Council), Janet Baah (Lewes District Council, substituting for Councillor Christine Brett).

WITNESSES:

East Sussex Healthcare NHS Trust (ESHT)

Joe Chadwick-Bell, Chief Executive

Dr Matthew Clark, Consultant Paediatrician, Chief of Women and Children Division

Richard Milner, Chief of Staff

NHS Sussex

Ashley Scarff, Director of Joint Commissioning and Integrated Care Team Development (East Sussex)

Wendy Young, Director of Acute Services Commissioning and Transformation

South East Coast Ambulance NHS Trust (SECAmb)

Ray Savage, Strategic Partnerships Manager (Sussex)

Matt Webb, Associate Director of Strategy and Partnerships

Richard Harker, Operating Unit Manager East Sussex

LEAD OFFICER:

Martin Jenks and Patrick Major

1. MINUTES OF THE MEETING HELD ON 7 MARCH 2024

1.1 The minutes of the meeting held on 7 March 2024 were agreed as a correct record.

2. APOLOGIES FOR ABSENCE

2.1 Apologies for absence were received from Councillor Christine Brett (Councillor Janet Baah substituting), Councillor Graham Shaw, and Jennifer Twist.

3. DISCLOSURES OF INTERESTS

3.1 Cllr Colin Belsey declared a personal non-prejudicial interest under agenda item 6 as he has a hearing problem and had previously visited East Sussex Hearing Resource Centre

3.2 Cllr Alan Shuttleworth declared a persona non-prejudicial interest under agenda item 6 as he has a hearing problem.

3.3 Cllr Mike Turner declared a personal non-prejudicial interest under agenda item 6 as he has a hearing problem.

3.4 Cllr Janet Baah declared a personal non-prejudicial interest as she is a Governor for Sussex Community NHS Foundation Trust.

4. URGENT ITEMS

4.1 There were no urgent items.

5. CHANGES TO PAEDIATRIC SERVICE MODEL AT EASTBOURNE DISTRICT GENERAL HOSPITAL (EDGH) - UPDATE REPORT

5.1 The Committee considered a report updating on the outcomes of the changes to the paediatric service model at EDGH, and East Sussex Healthcare NHS Foundation Trust's (ESHT) response to the recommendations of the Committee's review report. Dr Matthew Clark, Chief of Women and Children Division ESHT, introduced the report and highlighted that there had been a slight decrease in the number of children being transferred to Conquest Hospital in

Hastings, and that no patient safety incidents had been raised since the implementation of the new model.

5.2 The Committee asked for an update how the Scott Unit would be used in the future.

5.3 Dr Clark confirmed that the Scott Unit, which had previously housed the short-stay paediatric unit, was reserved for paediatric services. The area was currently being used as a paediatric outpatient area as the usual area on Friston Ward had needed to be temporarily closed for fire safety work. There was ongoing work on how the space could be used in the future to create a child-friendly environment for both acute and community paediatric services.

5.4 The Committee asked why the Committee's recommendation of having the paediatric consultant responsible for GP telephone triage on-site at Eastbourne was not being progressed.

5.5 Dr Clark noted that presently there was a split between where the paediatric consultant doing telephone triage was located depending on where they were based. Roughly a third to half of the time the consultant was based at EDGH, and half to two thirds of the time they were based in Conquest. Having run the new model for six months there had been no noticeable advantage of having the consultant permanently based on-site at Eastbourne. Extensive discussions had taken place with the consultant body where there was an almost unanimous view that they did not need to be based at Eastbourne and the independent review had agreed. Dr Clark also confirmed that staffing of all services were under constant review, and where staff were based could and would be moved to match need and demand.

5.6 The Committee asked if ESHT had data on whether any families were travelling independently to Conquest Hospital in Hastings as a result of the changes.

5.7 Dr Clark noted that there was not a robust way for capturing this information, recognising that the ability of patients to choose where to be treated was a feature of how people accessed NHS healthcare. Dr Clarke added that if a child is unwell enough to be taken to hospital by ambulance, the ambulance would take them to the Conquest hospital and this has not changed.

5.8 The Committee asked for confirmation of whether there were any trainee paediatric consultants working at EDGH.

5.9 Dr Clark confirmed that there were currently no resident doctors (previously known as junior doctors) training to be paediatric consultants.

5.10 The Committee asked if there had been any changes in the number of complaints from staff, patients or families.

5.11 Dr Clark noted that the number of complaints had remained stable, and there had not been a noticeable increase or decrease in the number. There had also been no formal staff grievances made and despite some initial disruption people had successfully moved into their new roles. The additional Advanced Paediatric Nurse Practitioners in the Emergency Department were working well with the team. Richard Milner, ESHT Chief of Staff, added that if a formal complaint came into the Trust, it would be reviewed by either himself of Joe Chadwick-Bell (Chief Executive), and he confirmed that there had not been a single formal complaint from a member of the public about the new model.

5.12 The Committee asked if ESHT were confident it had sufficient capacity to deal with the level of demand in Hastings.

5.13 Dr Clark confirmed that the new model had not resulted in increased demand for paediatric care in Hastings. It was unusual for Hastings to not have enough capacity on the ward to meet demand, although it did occasionally happen. There was consultant ward rounds seven days a week and a consultant always on call. In addition, there were now two consultants on site during winter to support the level of demand and had made recent changes to resident doctors rotas to make them more available. He added that ESHT was also pleased to be supporting local GPs to deliver paediatric services closer to communities, especially in areas with greater deprivation.

5.14 The Committee whether high ambulance wait times impacted on children when they needed to be transferred from Eastbourne to Hastings.

5.15 Dr Clark answered that if a child was sufficiently unwell that they needed to be transferred between hospital sites they would be prioritised by the ambulance service. The Trust had an existing transport policy to support vulnerable families to travel between sites that are unable to do so via their own means.

5.16 The Committee asked for an update on the implementation of recommendations 5 and 6 of HOSC's review, relating to finalisation of care pathways and communications to families.

5.17 Dr Clark confirmed that all care pathways had been finalised and were to be signed off at an internal meeting soon, although children were already being cared for along those pathways. ESHT agreed to share the details once they had been formally ratified. Dr Clark also confirmed that there had been communication with families of those with very complex needs who are regular attendees at the hospital to develop their individual care pathways. There was still work to develop some chemotherapy pathways, which was highly specialised and needed careful consideration to ensure it was done correctly.

5.18 The Committee asked if there had been any significant safety issues or service incidents since the Committee last received an update in March.

5.19 Dr Clark confirmed that there had been no serious patient safety incidents reported since the new model had been implemented.

5.20 The Committee asked if Healthwatch's feedback related to the new model and paediatric space could be shared with the Committee.

5.21 Dr Clark answered that the Trust was happy to share the feedback Healthwatch had provided.

5.22 The Committee asked how patients and families would be consulted on the future use of the Scott Unit.

5.23 Dr Clark explained that there was an ongoing programme of work on how the Trust could best utilise its estate for paediatric services, which would involve consultation with staff and service users. ESHT would hopefully be in a position to provide a more detailed update at the December HOSC meeting.

5.24 The Committee RESOLVED to note ESHT's response to HOSC's review recommendations, ESHT's update report, and the independent report on the new service model in Appendix 2.

6. NHS SUSSEX AUDIOLOGY SERVICES OVERVIEW

6.1 The Committee considered a report from NHS Sussex providing an overview of audiology services in East Sussex, including an outline of pathways, barriers to accessing audiology services and how services were commissioned including whether there were any commissioning gaps. The report also outlined future commissioning plans, noting the fragility of the provider market, and that NHS Sussex was seeking to implement a new model from July 2025.

6.2 The Committee noted that current audiology pathways were confusing to patients asked how this was being addressed.

Wendy Young, NHS Sussex Director of Acute Services Commissioning and Transformation, accepted that the pathways could be confusing for patients, as the Any Qualified Provider (AQP) contract model resulted in there being number providers. As part of the future commissioning of the service NHS Sussex aimed to make access to information and services much simpler, which would likely move away from the AQP model and to a single-Sussex model that would provide patients with a single point of entry for accessing the service.

6.3 The Committee raised concerns that there were insufficient levels of provision in some areas of the county, especially rural ones, and asked for comment.

6.4 Wendy Young noted that the current AQP model made it difficult to ensure there was sufficient coverage in areas with lower population density, because providers were paid based on activity, which made it more cost effective for them to be based in more densely populated areas. Wendy also noted that there was good coverage across East Sussex, but this could be improved under the new commissioning approach.

6.5 The Committee noted that in some cases people were being directed to private services where their GP practice did not provide earwax removal services and asked for explanation.

6.6 Wendy Young responded that the expectation of locally commissioned services was that if a particular practice did not offer earwax removal, then there should be an inter-practice referral to another practice that does offer it. There were ten practices in East Sussex that did not offer the service which should be offering inter-practice referral, and Wendy agreed to check that this was happening.

6.7 The Committee asked what services were available for people in domiciliary and care home settings.

6.8 Wendy Young explained there was a domiciliary service for patients unable to travel to appointments and this would continue under new commissioning arrangements. Wendy agreed to share the detail of the provision and criteria for access outside the meeting.

6.9 The Committee asked for detail on what the expected new commissioning model would look like.

6.10 Wendy Young responded that consideration was being given to a number of different commissioning models, noting that the AQP model incentivises providers to base themselves where they get the highest footfall and therefore highest income. It would most likely move towards a single-Sussex primary provider model, which would enable NHS Sussex to have more influence on the location of provider sites and ensure better access for patients.

6.11 The Committee noted that better access was hugely important, and an understanding of where the current gaps in provision were should inform future commissioning. It therefore asked that information be provided on which specific audiology services were provided at each GP practice in the county. Wendy Young agreed to share the information requested outside of the meeting.

6.12 The Committee asked about access for those on lower incomes, noting that some people were being signposted to private providers, but could not afford those services.

6.13 Wendy Young answered that practices should not be signposting for earwax removal services to private providers. NHS funded ear irrigation and microsuction services were available and agreed to confirm that practices which did not provide those services were signposting to NHS-funded services.

6.14 The Committee asked for confirmation on whether microsuction was the safest means for earwax removal and why it was not more widely offered.

6.15 Wendy Young answered that the NHS Sussex three-tiered pathway of self-care first, followed by ear irrigation, followed by microsuction, followed National Institute for Health and Care Excellence (NICE) guidance.

6.16 The Committee noted that Hastings had fewer primary care providers than other parts of the county, and asked what plans were in place to support access and improvement to audiology services in Hastings.

6.17 Wendy Young responded that audiology services were provided in Hastings, and agreed to share information on current volumes of activity and locations of services in the borough. If there were issues with access to services via the locally commissioned service then Wendy agreed to investigate these further.

6.18 The Committee asked that NHS Sussex further consider how to improve communications to residents about availability and access to audiology services, especially in more deprived areas.

6.19 Wendy Young agreed further consideration would be given to this, in particular to ensure people understood that NHS funded services were available and that people did not need to seek private provision if they did not wish to.

6.20 The Committee noted that in areas with high GP wait times patients were more likely to feel compelled to access private services, and asked how this was being addressed.

6.21 Wendy Young answered that consideration could be given to pathways that would allow patients to self-refer for audiology services, as access to a GP could be a limiting factor for

some patients. Wendy agreed to consider whether self-referral could be built into the pathways as part of the future service specification.

6.22 The Committee asked why a significant proportion of people surveyed [by Healthwatch] went to private providers for earwax removal if there was sufficient NHS provision.

6.23 Wendy Young responded that communication of what services were available was important, and that there was an issue in primary care about patients being signposted to NHS funded services if their practice could not offer earwax removal. Private sector provision was often easier for people to access, and there was a need for improvement to messaging and signposting.

6.24 The Committee asked what monitoring and regulation of private sector providers there was.

6.25 Wendy Young responded that if NHS Sussex did not commission a service, then it did not have oversight of them. All healthcare providers should still be registered and have Care Quality Commission (CQC) regulation. Wendy agreed to provide further clarification outside of the meeting.

6.26 The Committee asked where the new provider, The Outside Clinic, was based.

6.27 Wendy Young agreed to provide information of where the provider came from outside of the meeting. Even if it was not a local organisation it could still provide a local service within the county to NHS standards.

6.28 The Committee commented that its view was that the audiology services in East Sussex did not appear to be provided consistently or as intended, and was insufficient in some areas. It agreed to establish a Review Board of the Committee to explore the issue further and make recommendations about future service provision. Wendy Young and Ashley Scarff, Director of Joint Commissioning and Integrated Care Team Development (East Sussex) accepted that there were issues with the service and welcomed the opportunity to work closely with HOSC to improve these.

6.29 The Committee RESOLVED to:

1) note the report from NHS Sussex; and

2) carry out a review of the provision of audiology services in East Sussex.

7. SOUTH EAST COAST AMBULANCE FOUNDATION NHS TRUST (SECAMB) CARE QUALITY COMMISSION (CQC) INSPECTION - UPDATE REPORT

7.1 The Committee considered a report providing an overview of SECAmb's progress in its Improvement Journey following the findings of its 2022 CQC report, and updating on the latest performance figures of the Trust.

7.2 The Committee asked how SECAmb was working with other NHS bodies to prevent a loss of staff to other services, including GP practices.

7.3 Richard Harker, SECAmb Operating Unit Manager East Sussex, answered that staffing levels in East Sussex and across SECAmb were improving, following a fall in staff a few years ago. In the East Sussex area there was a fully established paramedic workforce. This was attributed to the improving culture within the service, and rising staff satisfaction. Matt Webb, SECAmb Associate Director of Strategy and Partnerships, added that the professional development offer at SECAmb, from working in a variety of healthcare settings, was one of its strengths and something that would improve staff retention levels.

7.4 The Committee asked how patients who had difficulty articulating their issues were triaged to ensure that the right support was sent to them.

7.5 Richard Harker noted that there was always a slight risk of mis-categorisation of priority, but call handlers were supported by the NHS Pathways system to ensure they were asking the right questions and people were correctly triaged. If there was any level of uncertainty that a patient could be in a higher category or a risk that they could deteriorate then an ambulance would always be dispatched. Matt Webb added that NHS Pathways was a tried and tested triaging system that was used nationally with a number of safety nets and a high risk threshold built. SECAmb's service model of triaging quickly and accurately was to ensure patients were supported by the most appropriate clinician, as this was shown to be key to improved patient outcomes. An immediate physical response would not guarantee the right clinician was sent to a patient and therefore would not necessarily lead to the best patient outcome.

7.6 The Committee asked if there was always a paramedic present on every ambulance.

7.7 Richard Harker explained that there would not always be a registered paramedic onboard a dispatched ambulance. There were a number of grades below registered paramedic, such as associate ambulance practitioners and ambulance technicians who were qualified clinicians who could work on ambulances.

7.8 The Committee asked how ambulance crews had enough information to provide the correct support to patients.

7.9 Richard Harker explained that an ambulance crew would look for a number of different forms when it arrived at a scene, including ReSPECT (Recommended Summary Plan for Emergency Care and Treatment), do not resuscitate, and treatment escalation plans. The condition of the patient would determine the urgency of asking for or finding these forms. SECAmb also had a service where these forms could be uploaded to its computer systems, giving ambulance crews advance sight of them prior to arrival on scene.

7.10 The Committee asked why the information referenced in the previous answer was not available at every incident.

7.11 Richard Harker explained access to information would depend on the condition of the patient and how quickly the crew arrives on scene, as it depended on correctly identifying the patient and required information such as their NHS number and date of birth. It was also dependent on the information having been uploaded to SECAmb's systems, which was not something all care providers did. Ray Savage, SECAmb Strategic Partnerships Manager (Sussex), added that SECAmb was currently working with NHS Sussex to access the countywide Plexus Care Record platform which brought together primary and community care plans on one system. This would give clinicians in Emergency Operations Centres access to further information on patient incidents, to improve clinical decision making. This would

hopefully be in place within the next few months. Ray agreed to confirm how care providers linked into the Plexus system.

7.12 The Committee asked when SECAmb expected handover delays at Eastbourne and Conquest hospitals to reach the target of 65% under 15 minutes.

7.13 Richard Harker explained that the handover delays at Eastbourne and Conquest hospitals were relatively good compared to other areas. SECAmb worked closely with East Sussex Healthcare NHS Trust to reduce handover delays, holding regular meetings to discuss the issue. Ray Savage, added that SECAmb compared well to other ambulance trusts on the level of ambulance delays.

7.14 The Committee asked how SECAmb measured improvements in organisational culture and what the key metrics were.

7.15 Matt Webb explained that getting things right for its staff was a key element of SECAmb's Improvement Journey. This included a review and overhaul of freedom to speak up (FTSU) processes to ensure people felt comfortable to raise concerns. There had been an increase in the number of FTSU grievances raised following that review, which showed people felt safer to report issues within the workplace. There was also a focus on meeting sexual safety charter commitments, which had involved senior leadership and managers completing sexual safety training to foster a safe working environment across the organisation. SECAmb had also enhanced its Equality, Diversity and Inclusion plan, improving workforce equality data monitoring and presenting equality reporting to the Trust's Board to ensure compliance. A key metric for measuring improvement was the number of individual and collective grievances being opened and the subsequent closure of those grievances once they had been resolved in an appropriate timeframe, with an aim to reduce average case length. There was now a downward trend in the number of bullying and harassment, disciplinary and sexual safety grievances being opened. Richard Harker also noted that NHS staff survey results showed an increase in satisfaction, which suggested they culture was improving.

7.16 The Committee asked how ambulance response times in Seaford compared to average response times.

7.17 Richard Harker agreed to provide comparative figures outside of the meeting.

7.18 The Committee asked if ambulances were placed outside of ambulance stations during core hours to improve response times along the coast.

7.19 Richard Harker explained that ambulance crews were sent to ambulance community response posts at the start of shift if there were no outstanding emergencies. There was a prioritised list of where crews would be sent if there was capacity, and there was one in Seaford.

7.20 The Committee asked what the outcomes had been of the Flow Improvement Workshop with the Royal Sussex County Hospital (RSCH).

7.21 Ray Savage explained that the multi-partner workshop took place in May 2024 and there were a number of actions and outputs that different organisations had taken away to improve patient flow. The Brighton and Hove health and care system was particularly challenged, and consideration was being given to whether an unscheduled care navigation hub could be placed in Brighton to reduce the number of patients needing to present to the RSCH. Further information could be provided in a future report to the Committee.

7.22 The Committee asked what response category children's mental health issues and epileptic seizures were placed in.

7.23 Ray Savage explained that the category would be determined through with the support of NHS Pathways to ask the right questions understand how a patient is presenting and what support they need. Category 1 was a life-threatening condition that would receive an immediate ambulance dispatch. Category 2 covered heart attacks and strokes, and could also cover epileptic fits, and in most cases, this was an automatic ambulance dispatch also. Category 3/4 were classed as urgent, which a majority of mental health issues would likely fall into. SECAmb was working with the mental health trust to improve how mental health incidents were responded to. Category 3/4 response times were improving, and through the new SECAmb strategy there would be improvements in the call-back rate to those patients to understand their conditions and unsure the right clinician is available to them when they need one. Richard Harker added that patients were advised to call 999 again if they notice a condition worsening, and these would always be re-triaged and in some cases would result in the response Category changing.

7.24 The Committee asked when the Trust would be in a position to exit the Recovery Support Programme (RSP).

7.25 Matt Webb responded that there were some benefits to the Trust remaining in the RSP, including the support of an Improvement Director from NHS England, as well as other support from NHSE. SECAmb had demonstrated significant progress which had been recognised by commissioners and NHSE, particularly in the areas of clinical and corporate governance, risk management and organisational culture. It was important the Trust was also set up to successfully deliver its new strategy and that it was financially sustainable before it exited the RSP. SECAmb was aiming to exit the RSP between Q3 and Q4 of the current financial year, but no proposed date had been set.

7.26 The Committee asked why ambulances did not carry CPAP for people with breathing difficulties.

7.27 Richard Harker explained that ambulances have never routinely carried CPAP, and ventilators were not required to be carried by ambulances either. There were critical care paramedics at each dispatch desk who do carry CPAP, and they had the right equipment for responding to Category 1 emergencies which could be transported to a scene if needed.

7.28 The Chair noted that the Committee had previously requested a visit to SECAmb's Medway Emergency Operation Centre, and Ray Savage agreed to work with HOSC officers to arrange that.

7.29 The Committee RESOLVED to:

1) note the report; and

2) receive an update report from SECAmb in March 2025.

8. HOSC FUTURE WORK PROGRAMME

8.1 The Committee discussed the items on the future work programme.

8.2 The Committee noted that it had received a report outside of the meeting from NHS Sussex on access to diabetes technology and agreed that it was not necessary to have anything further on this issue on the work programme.

8.3 The Committee RESOLVED to amend the work programme in line with paragraphs 6.29 and 7.29.

9. ANY OTHER ITEMS PREVIOUSLY NOTIFIED UNDER AGENDA ITEM 4

9.1 None.

The meeting ended at 12.07 pm.

Councillor Colin Belsey

Chair