Brighton & Hove City Council

HEALTH OVERVIEW & SCRUTINY COMMITTEE ADDENDUM

4.00PM, WEDNESDAY, 19 OCTOBER 2016

COUNCIL CHAMBER, HOVE TOWN HALL, NORTON ROAD, HOVE, BN3 4AH

ADDENDUM

ITEM		Page
28	**MINUTES**	**1 – 14**

To consider the minutes of the last scheduled meeting held on 20 July 2016, and of the special meeting held on 05 October 2016 (copy attached)

30	**PUBLIC INVOLVEMENT**	**15 – 20**

To consider the following matters raised by members of the public:

A deputation on Sustainability & Transformation Plans (STP) has been received from Mr Ken Kirk and Ms Madeleine Dickens. This is a revised version of a deputation originally submitted to Full Council in July 2016 and referred on to the HOSC. Since it is several months since the deputation was originally submitted, Mr Kirk and Ms Dickens were invited to revise their submission in light of more recent developments. A response to the revised deputation will be given at the 19 October HOSC meeting. (Copies of both the revised and the original deputations are included for information.)

BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00pm 20 JULY 2016

THE RONUK HALL, PORTSLADE TOWN HALL

MINUTES

Present: Councillor Simson (Chair)

Also in attendance: Councillor Allen, Bennett, Cattell, Deane, Knight, Marsh, Peltzer Dunn, Taylor and Moonan

Other Members present: Caroline Ridley (Community & Voluntary Sector), Fran McCabe (Healthwatch), Colin Vincent (Older People's Council)

PART ONE

12 APOLOGIES AND DECLARATIONS OF INTEREST

(a) Declarations of Substitutes

12.1 Councillor Moonan was present in substitution for Councillor O'Quinn.

(b) Declarations of Interest

12.2 There were no declarations of interest.

(c) Exclusion of Press and Public

12.3 In accordance with Section 100A of the Local Government Act 1972 ("the Act"), the Committee considered whether the public should be excluded from the meeting during consideration of any item of business on the grounds that it is likely in view of the business to be transacted or the nature of the proceedings, that if members of the public were present during it, there would be disclosure to them of confidential information as defined in Section 100A (3) of the Act.

12.4 **RESOLVED** - That the public are not excluded from any item of business on the agenda.

13 MINUTES

13.1 **RESOLVED –** That the Chair be authorised to sign the minutes of the meeting held on 25 May 2016 as a correct record.

14 CHAIRS COMMUNICATIONS

14.1 The Chair gave the following communications –

"Welcome everyone to the health overview and scrutiny meeting.

We will be looking at a range of important issues this afternoon, including the sustainability of primary care in the city, Patient Transport, and what the local System Resilience Group is doing to design an effective urgent care system for Brighton & Hove.

Some of you may have seen that Brighton & Sussex University Hospitals Trust (BSUH) was recently issued with a Section 29a warning notice by the Care Quality Commission (CQC).

A S29a warning notice is issued when an NHS provider needs urgently to improve specific services. We are not going to discuss the notice in detail today, as its contents are not in the public domain, and as we expect the full CQC inspection report to be published in August. We plan to hold a special meeting in September to discuss the CQC report findings and quality improvement planning in response to the report. A meeting date for this will be sent round in the next couple of weeks."

15 PUBLIC INVOLVEMENT

15.1 The Chair noted that there were no items for consideration from the public for the current meeting.

16 MEMBER INVOLVEMENT

16.1 The Chair noted that there were no items for consideration from Members for the current meeting.

17 GP SUSTAINABILITY AND QUALITY

17.1 Steven Ingram, NHS England; and John Chard, Chief Operating Officer B&H CCG, introduced the report and gave a presentation. They highlighted the importance of ensuring the GP service in Brighton & Hove was sustainable for the future with all residents registered to a practice. GP services are under pressure across the country.

17.2 In response to Councillor Marsh it was explained that the workload for GPs has increased significantly in recent years. The main driver for this is demographic, with an ageing population meaning that there are more elderly, frail people in need of regular GP input. There are also significant workforce issues, with young doctors not choosing to enter into general practice, some existing GPs opting to emigrate, and older GPs increasingly looking to take early retirement.

17.3 The committee was informed that city GP practices have been brought together in six clusters, giving GPs the opportunity to work more closely together with similarly situated colleagues.

17.4 In response to Caroline Ridley's concerns for residents in the Bevendean area having access to transport to access GP services, following the closure of the Bevendean GP practice, Mr Chard explained that the CCG was working on securing a transport provider.

17.5 It was explained to Councillor Deane that there was a national problem with the partnership GP practice model as this was not necessarily an attractive model for younger doctors unwilling to take the financial risk or make the long term commitment that buying into a partnership entailed.

17.6 The Chair noted that she felt assured by the progress described by the presenters, although there were clearly major long term challenges facing primary care in the city. The Committee agreed to take a further report in six months or so time.

17.7 **RESOLVED** – That the Committee agreed to note the report.

18 GP SERVICES IN BRIGHTON & HOVE: HEALTHWATCH PERSPECTIVE

18.1 Roland Marsden introduced the report, telling members that a large scale survey had been undertaken across the city and around 500 responses had been received. Approximately 80% of respondents thought the quality of care by GPs and practice staff was good.

18.2 A number of concerns were raised by respondents. These included: accessibility; booking appointments (including waiting times); and waiting times for referrals (which approximately 50% of patients raised as a concern). Other findings were that there is a low awareness of preventative services; and sometimes poor communication from surgeries to their patients regarding available services.

18.3 In response to Councillor Deane it was explained that the expectation would be that if more residents had their full health checks, this would reduce demand on services in the long term. However, there was an additional resource requirement in the short term. Mr Marsden agreed that providing more options for booking and cancelling appointments would be positive for patients and would potentially reduce the pressure on GP phone lines.

18.4 Mr Marsden agreed to include information on where referrals were being delayed in a subsequent Healthwatch report. He added that patients felt that there was particularly poor communication regarding referrals. This is acknowledged by services and there are plans to address this problem.

18.5 In response to a question from Councillor Marsh on how the GP practices are inspected, it was explained that Healthwatch had worked closely with the Clinical Commissioning Group (CCG) and the Care Quality Commission (CQC) to identify which GP practices should be prioritised by the CQC.

18.6 In response to a question from Councillor Allen on continuity of care in primary care, it was explained that the majority of patients are happy to see any GP when they need to see a doctor. However, some respondents very much want to be able to see their own GP.

18.8 In response to Councillor Moonan on Patient Participation Groups (PPG), it was explained that GP practices have an obligation to attempt to establish PPGs.

18.9 Councillor Cattell noted that she was shocked with the low figures of preventative care in the city, and suggested that letters should be sent to residents with booked appointments that could be cancelled, similar to women's breast cancer screening. NHS representatives acknowledged that adopting an "opt out" approach could be positive and would feed this back. Councillor Allen added that it was likely that the figures for preventative care would be even lower if the survey had been taken by all residents of Brighton and Hove.

18.10 It was agreed that a copy of the survey would be circulated to Committee Members.

18.11 The Committee agreed that a further report should be presented at a future Health Overview & Scrutiny Committee.

18.12 **RESOLVED** – That the Committee agreed to note the report.

19 URGENT CARE

19.1 Lola Banjoko and John Child, B&H CCG; Andrew Stanton, Brighton & Sussex University Hospitals Trust (BSUH); and James Pavey and Ben Banfield, South East Coast NHS Foundation Ambulance Trust (SECAmb), introduced the report.

19.2 In response to Colin Vincent, it was noted that the report presented was on behalf of the System Resilience Group (SRG) and included the areas the group had reviewed and improved. The SRG minutes are not routinely published as the SRG is an operational officer meeting. However, these could potentially be shared with HOSC members on request.

19.3 It was explained that it was recognised that moving patients into the hospital more quickly from ambulances would free up ambulance staff; however, there were internal problems within the hospital that needed to be solved before this could happen.

19.4 In response to Councillor Moonan, it was explained that an assessment would be completed by Adult Social Care if a homeless patient was to be discharged from a hospital bed. The hospital would work closely with the Housing department and street services to prevent patients being discharged without having any accommodation or support.

19.5 In response to a question from Councillor Cattell on delays in social care assessments, it was stated that the CCG worked closely with social workers and community health departments to ensure a seamless transfer of care for elderly patients.

19.6 **RESOLVED** – That the Committee agreed to note the report.

20 NHS PATIENT TRANSPORT: UPDATE

20.1 John Child, Brighton & Hove CCG; Sally Smith and Alan Beasley, High Wealds & Lewes Haven CCG; and Michael Clayton, Coperforma, introduced the report. It was highlighted that it was an update report and the data showed that the service was improving. A summary of actions since the last Committee were outlined, including: additional call handling capacity in the demand centres to improve resilience; and additional transport capacity and new providers introduced into the Sussex service to improve inbound and outbound performance. It was agreed that the presentation would be circulated to Members.

20.2 In response to the Healthwatch representative it was noted that it could be difficult to get through to the contact centre at certain times of the day. However, performance was improving and additional staff had been rotated for the busier times. It was added that since the last Committee an individual line for staff to contact the centre had been trialled and this had made a positive impact.

20.3 It was explained to Councillor Moonan that approximately 42 complaints per day were being received in the initial weeks of the contract, but that this had subsequently been reduced to approximately two per day.

20.4 In response to Councillor Taylor, members were told that there was a learning group reviewing the customer feedback and it was explained that online tools were being used more to improve the storage of feedback that was received.

20.5 In response to Councillor Allen, Mr Beasley explained that it was important to set a key performance indicator to improve the inbound time to narrow the window of patients arriving and departing. It was highlighted that the report stated that patients should not arrive earlier than 40 minutes before their appointment. It was added that there 100% of patients were collected within 45 minutes of their appointment and 95% were collected within 30 minutes.

20.6 In response to Councillor Peltzer Dunn, it was explained that abandoned calls were monitored and that performance had improved. It was agreed that these figures would be included in a future report.

20.7 The Committee agreed that an update report would be presented at the Health Overview & Scrutiny Committee in October 2016.

20.8 **RESOLVED** – That the Committee agreed to note the report.

21 A WORK PROGRAMME FOR THE HEALTH OVERVIEW & SCRUTINY COMMITTEE

21.1 Barbara Deacon, Public Health Business Manager, introduced and explained that the work programme was provisional and welcomed suggestions from the Members.

21.2 Councillor Peltzer Dunn noted that he wished for a report on the effectiveness of communication for residents.

21.3 Councillor Allen stated that an Adult Social Care report should be presented at the Health Overview & Scrutiny Committee.

21.4 Councillor Knight requested that a report should be presented with more information regarding Patient Participation Groups.

21.5 Councillor Deane noted that she wished to have a report on the referral delays that should detail the specific areas where there were concerns. Colin Vincent added that information on the appointment system should be included in this report.

21.6 **RESOLVED** – That the Committee noted the work programme.

The meeting concluded at 6:30pm

Signed Chair

Dated this day of

BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00pm 5 OCTOBER 2016

COUNCIL CHAMBER, HOVE TOWN HALL, NORTON ROAD, HOVE, BN3 4AH

MINUTES

Present: Councillor Simson (Chair)

Also in attendance: Councillors Cattell, Deane, Marsh, O'Quinn, Mac Cafferty, Miller, Russell-Moyle and Wealls

Other Members present: Colin Vincent (Older People's Council Co-optee)

PART ONE

22 APOLOGIES AND DECLARATIONS OF INTEREST

(a) Declarations of Substitutes

22.1
- Cllr Mac Cafferty attended as substitute for Cllr Knight
- Cllr Wealls attended as substitute for Cllr Taylor
- Cllr Miller attended as substitute for Cllr Peltzer Dunn
- Cllr Russell-Moyle attended as substitute for Cllr Allen

(b) Declarations of Interest

22.2 There were no declarations of interest.

(c) Exclusion of Press and Public

22.3 In accordance with Section 100A of the Local Government Act 1972 ("the Act"), the Committee considered whether the public should be excluded from the meeting during consideration of any item of business on the grounds that it is likely in view of the business to be transacted or the nature of the proceedings, that if members of the public were present during it, there would be disclosure to them of confidential information as defined in Section 100A (3) of the Act.

22.4 **RESOLVED** - That the public are not excluded from any item of business on the agenda.

23 CHAIRS COMMUNICATIONS

23.1 The Chair gave the following communications –

"I'd like to remind everyone that this is a special meeting to look at the Care Quality Commission (CQC) inspection report on Brighton & Sussex University Hospitals Trust (BSUH). There is also a HOSC meeting on October the 19th where we'll be looking at Patient Transport, the South East Coast Ambulance Trust (SECAmb) CQC report and the Sussex Review of Stroke Services. We're meeting today because the BSUH Board have to attend a national event on the 19th.

Please note that, as this is a special meeting, we won't be signing-off the minutes of previous meetings or taking public questions.

As BSUH provides services for people in East and West Sussex as well as for Brighton & Hove residents, I invited the Chairs of neighbouring HOSCs to attend today. Cllr Bryan Turner, Chair of West Sussex HASC, was able to make it and I'd like to welcome him to the meeting. I think it's a really good idea that HOSCs in the region work closely together, particularly where we're looking to ask very similar questions of NHS bodies."

23.2 Members also took the opportunity to express their regret on hearing of the recent death of Julian Lee, the former Chair of BSUH.

24 PUBLIC INVOLVEMENT

24.1 The Chair noted that there were no items for consideration from the public for the current meeting.

25 MEMBER INVOLVEMENT

25.1 The Chair noted that there were no items for consideration from Members for the current meeting.

26 CQC INSPECTION OF BRIGHTON & SUSSEX UNIVERSITY HOSPITALS TRUST (BSUH)

26.1 The Chair introduced the main agenda item:

"Moving on to the main item of business, you'll all be aware that the CQC inspected the hospital trust back in April. The CQC issued a Section 29a notice in June this year, listing changes that BSUH had to make urgently. The full inspection report followed in August, and there was a Quality Summit where the CQC and BSUH presented the report's findings to key local stakeholders. The CQC report rated the trust as inadequate and it was placed in special measures by the trust regulator, NHS Improvement.

I wanted to give BSUH the opportunity to respond to the CQC report; to explain what actions it has already taken in response to the Section 29a notice and to the findings of the CQC inspection report; and to describe its plans to further improve quality, safety and performance.

I'd therefore like to welcome Tony Kildare, Interim Chair of BSUH; Dr Gillian Fairfield, the Trust Chief Executive; Dr Steve Holmberg, the Medical Director; and Lois Howell, Director of Clinical Governance.

Before we start I'd like to stress that scrutinising the improvements required by the CQC report on BSUH is going to be a long and complex task – this meeting is just the start of the process. However, it's important to be clear that it isn't the HOSC's job to come up with ways to improve performance or quality at the trust – there are plenty of people already working on this. Our role is to monitor the implementation of improvement planning to ensure that the promised changes are being made – and crucially to check that changes actually lead to better services for local people.

We all recognise that the CQC report is pretty disturbing – lots needs to change at BSUH and it needs to change quickly. It is the job of HOSCs to make sure that the required changes do take place and to escalate our concerns if they don't. However, it is also important to recognise that the trust does lots of amazing work and has really dedicated and caring staff. We're here to be a critical friend to BSUH and to assist its vital improvement work.

Finally, although CQC reports focus on individual organisations, it's important to recognise that many of the issues facing BSUH are system problems and will require system solutions. The hospital alone can't resolve problems like Delayed Transfers of Care. When we focus on the implementation of quality improvement measures, we're going to need to look, not just at BSUH, but at the whole of the local health and care system."

26.2 Lois Howell (LH) gave a PowerPoint presentation on the CQC inspection and on the trust's quality and safety improvement work. (A copy of the presentation slides is included for information in the document packs for the 05 October 2016 and the 19 October 2016 HOSC meetings.) Trust representatives then answered member questions.

26.3 In response to a question from Cllr Marsh on the role of the NHS Improvement (NHSi) appointed Improvement Director, Dr Fairfield (GF) told members that the Director would offer the trust advice and support for its improvement work. Typically an Improvement Director will take responsibility for developing a trust's quality improvement action plan in response to the CQC's findings. However, BSUH had already developed its own Quality & Safety Improvement Programme before the appointment of the Improvement Director because the trust had advance notice of some of the CQC's findings via the Section 29a warning it was issued in June this year.

26.4 In response to a question from Cllr Marsh on when substantive appointments for trust Chair and Chief Executive would be made, Mr Kildare (AK) told the committee that there was no date set for these appointments. It is likely that the Chair will be appointed first, with the Chair and the Board then appointing a Chief Executive in the normal manner. AK stressed that there had been considerable recent change in the composition of the Board, with several new Non-Executive Directors joining.

26.5 In answer to a question from Cllr Marsh about recruitment, GF told members that the trust was seeking to recruit following CQC criticism of the medical staffing mix in the

Emergency Department (ED) at the Princess Royal Hospital (PRH). However, BSUH is also trying to clarify the CQC's position on this point, as the trust believes that its current level of consultant-grade staffing is an appropriate one given the nature of the PRH ED. It may be that BSUH is able to recruit additional medics at Senior House Officer (SHO) grade rather than consultants.

26.6 Cllr Miller noted that, unlike NHS Foundation Trusts (FT) which have a Council of Governors to scrutinise the trust's Board, BSUH appears unduly reliant on the Board's ability to hold itself to account on a day to day basis. GF responded that Non-Executive Directors have a key role to play here in holding the trust's executive to account. The point about the lack in non-FT NHS trusts of the equivalent of a Council of Governors is a valid one. It is important that key stakeholders such as HOSCs, Healthwatch and the User & Carer Forum act to hold the trust to account. Cllr Russell-Moyle suggested that it would be useful for HOSC members to meet BSUH Board members. GF agreed and offered to host a future HOSC meeting which could be combined with a tour of the hospital and the opportunity to meet Board members. HOSC members welcomed this offer.

26.7 In response to a question from Cllr Miller as to whether the trust needed more bed capacity, GF agreed that this would be helpful, noting that options are being explored via the Sustainability & Transformation Plan (STP) programme. BSUH is also looking at the use of additional modular buildings at PRH. Dr Holmberg (SH) added that it was particularly important to find more space for ambulatory care as this can offer an alternative to admission.

26.8 In answer to a question on staff absence rates and general staff morale, GF told the committee that the staff absence rate was currently 4.2% against a target of 3%. The trust is committed to working more closely with staff and plans to survey all staff this year to garner their views. Other innovative measures to engage with staff are also planned.

26.9 In response to a question from Cllr Russell-Moyle as to whether the trust has the right staff in place to make the move from inadequate to excellent, GF told members that it was important to bring in fresh staff with experience of working in excellent organisations and staff with experience of improving failing organisations. GF noted that she had previously successfully led two trusts through the FT pipeline as well as being the Chief Executive of trusts which have achieved outstanding CQC reports. The trust has also recently recruited Lois Howell as Director of Clinical Governance and is seeking to recruit a new Executive HR Director. However, it is also crucial that the trust retains its organisational memory.

26.10 Cllr Russell-Moyle also queried what the impact of the recent reduction in neurological trauma bed capacity had been. SH told members that the CQC had identified problems with neurological intensive care staffing. This was a consequence of the recent re-siting of these services at RSCH (from PRH): some staff had opted not to make the move and the trust was still in the process of recruiting/training to fill this gap. In the interim BSUH has decided to temporarily close one neurological bed. This has had some impact on elective waiting times, but not on emergency performance, as this takes priority over planned procedures. BSUH works closely with the neurological trauma departments in Southampton; St Georges, Tooting; and King's hospitals, and patients would be diverted

to one of these centres should there be no capacity at RSCH. There is increasing demand for this service following the re-siting and the trust plans to expand provision.

26.11 In response to a question from Cllr Russell-Moyle on recruitment, SH told members that there were national problems in recruiting to certain specialities, particularly emergency medicine, pathology and care of the elderly. LH added that there are particular local challenges posed by the cost of living in Brighton & Hove. Many BSUH staff (particularly non-medical staff) do not live in the city, instead travelling into work from across East and West Sussex. This can make staff retention difficult as people are tempted by work that is nearer their homes. It can also make persuading staff to work additional hours problematic, as some staff who are willing to take on additional work find it easier and more remunerative to travel to London to do so. AK noted that it was important that the trust does all that it can to persuade its own medical students to make careers in the city.

26.12 Cllr Wealls noted that the CQC report was particularly damning about BSUH organisational culture and wondered how this might be improved. GF agreed that this was a very significant challenge. In the past the Board has been too remote from staff and there needs to be much better engagement. There is a workforce programme in place to change the culture, although this is not a short term process and may take five years or more to turn around. The trust also recognises the CQC's criticisms of its handling of Black & Minority Ethnic (BME) staff and aims to do more in terms of supporting BME workers and indeed all workers with protected characteristics. AK added that the Board was committed to doing much more to engage with staff, including a staff forum, Board members and senior managers engaging in 'ward rounds', and the emailed 'Monday Message' to all staff.

26.13 In response to a question from Cllr Wealls as to whether the trust has sufficient funding given the size of its 15/16 deficit (C£40M), GF told the committee that it was too early to say what the 16/17 position would be. However, the trust is doing a good deal of work to increase its efficiency – mostly incrementally via making small improvements in day to day processes across a very wide range of services.

26.14 In response to a question from Cllr Wealls about the feasibility of making the required quality improvements whilst also delivering the 3T programme, GF acknowledged the scale of the task. The two projects must be treated as functionally discrete, as hospital services have to continue as normal despite 3T. However, there are obvious ties between 3T and aspects of BSUH's improvement work – e.g. workforce modernisation has to be responsive to the opportunities and demands presented by 3T. There is a good deal of Treasury oversight of the 3Ts work as it is a very significant NHS capital project.

26.15 In response to a question from Cllr Mac Cafferty on staff disengagement and on whistle-blowing arrangements, LH told the committee that this was being addressed via changes to BSUH's clinical governance structures, by increasing senior manager ward presence, and by innovations such as the Clinical Council. In terms of whistle-blowing, the trust is in the process of appointing an independent 'Speak-Up Guardian' to support staff. GF added that she has started to get staff coming directly to her with whistle-blowing concerns, which is a positive development.

26.16 In answer to a question from Cllr Mac Cafferty on co-working with other NHS organisations, AK told the committee that the trust was committed to work positively with its partners. GF added that BSUH is actively engaged with the STP process. There have been recent problems with co-working, for example around Patient Transport services, but the trust has worked positively with Brighton & Hove CCG to address these concerns.

26.17 Cllr Mac Cafferty noted that the BSUH quality improvement programme was an important issue and it would be helpful to find some way of making more elected members aware of it and of the steps being taken to improve quality and safety at the trust.

26.18 Colin Vincent (Older People's Council representative) expressed concerns about incidents identified by the CQC where patients' privacy and dignity had been severely compromised. GF said that these incidents were totally unacceptable and that much has subsequently been done to ensure that patients are accorded privacy and dignity – e.g. the introduction of comfort rounds for people waiting in the ED.

26.19 Mr Vincent expressed concern about levels of Delayed Transfers of care (DToC) from BSUH beds back into the community. SH noted that this was a very complex matter. The ambition is for patients to experience a seamless transition from hospital back to the community, but this is complicated because this is a multi-agency issue. However, it ought to be possible to develop a single-assessment tool accepted by all the agencies involved. There is a good deal of work being undertaken to address DToC – for example the Hospital at Home programme. This was initiated at a fairly small scale, but will be scaled-up.

26.20 In response to a question from Mr Vincent about the size of RSCH A&E, GF told members that an additional four cubicles have recently been added to A&E and there are plans to restructure the department to free yet more space.

26.21 Cllr Turner (Chair of West Sussex Health & Adult Social Care Scrutiny Committee) told members that the HASC had already considered this issue, but that the additional information supplied by BSUH for this meeting was useful. Cllr Turner also noted that it was challenging to scrutinise BSUH from Chichester – the distance involved made considerable demands on the time of BSUH staff. He therefore welcomed proposals for Sussex HOSC to jointly monitor BSUH's improvement work.

26.22 In response to a question from Cllr Turner as to how BSUH's improvement planning was linked to outcomes, LH assured members that outcomes measures would play a significant role in the indicators identified to measure the success of the improvement programmes. SH added that mortality indicators also have an important role to play in assessing the success of trust services.

26.23 Cllr Deane stated that it was quite proper that the HOSC should act as a critical friend to BSUH. However, it was important that the trust should be candid with the HOSC. In the past the trust has been over-optimistic about its ability to improve services.

26.24 Cllr Cattell enquired about the possibility of some estates held by BSUH being used for key worker housing, thereby helping to improve the recruitment situation. AK responded that unfortunately the trust has no spare estates – the very small amount of free land it did have is being used to facilitate the 3Ts build.

26.25 In response to a question from Cllr Cattell on electronic prescribing, SH told the committee that electronic prescribing has been introduced for discharge medications, but in-hospital and outpatient prescribing are still paper-based.

26.26 In response to a question on the use of long term prescriptions, SH told members that there was a difficult balance to be struck here. BSUH medics are comfortable with long term (i.e. 6 month) prescriptions, but national guidance is increasingly for much shorter term periods.

26.27 RESOLVED - That members note the general information on the CQC inspection process and specific information relating to the BSUH inspection included in this report and its appendix; and that

Members agree to appoint three members to an informal joint HOSC working group to monitor the implementation of quality improvement planning in response to the CQC's recommendations.

The meeting concluded at Time Not Specified

Signed Chair

Dated this day of

Revised Deputation

Submission for deputation to HOSC on the Sustainability and Transformation Plan

Summary of financial arrangements imposed by NHS England

- Although the government fulfilled its NHS funding commitment – with funding increasing by an average of 0.8 per cent per year in real terms – the increases delivered were less than the estimated growth of 3 to 4 per cent per year required to meet higher costs of new medical technologies and increases in demand for health care. Over the same period local government has seen a real reduction in spending on adult social care of 12%.
- All but one of the 44 STPs is in deficit overall, according to research carried out by the HSJ, and about a third have deficits of more than 4% of their turnover. The STP must show how local services will become sustainable over the next five years. It must set out initiatives to manage demand, increase provider efficiency, reconfigure services and, the most important of all, balance the budget in the local area. The Kings Fund has said "It is inconceivable that the NHS will be able to achieve both financial sustainability and large-scale transformation within these financial constraints."

Local democracy and Equalities impact

STP was introduced in December with no parliamentary mandate, no democratic accountability and no legal basis. 21st October is the deadline for submission. Details of Plans elsewhere have been released but our regional Plan has been kept secret from the public.

There is already a rapidly growing equality gap in the local health and social care economy – successive cuts and privatisation taking their toll. Since 2012 the Public health department budget has reduced by 18%, a reduction projected to reach at least 25% by 2020. GP practices and NHS services have (or are being) closed. Such developments have the biggest impact on the most vulnerable and most in need in the most deprived neighbourhoods. With the level of savings necessary to balance the STP budget this equality "gap" can only widen further.

To break even STP Boards will have to implement massive change – across the board workforce reductions, sale of NHS estate, greater influx of private companies, with serious implications for the local economy. In April the LGA highlighted the democratic deficit underlying STP - "The pace of implementation of STP undermining local ownership and squeezing out LA and community involvement." Not only will STP have devastating implications but it is becoming clear that the existing governance structure of the NHS is being torn up and started again. As our democratic representatives should you not question this headlong contraction, some would say destruction, of a once comprehensive but still cherished local health service?

HOSC councillors requested action:

- The full council recommended that the HWB call public consultation meetings on STP

at the earliest opportunity. It has since become clear that councillors and officers will participate in the proposed new STP governance structures. The lack of any public

consultation or engagement in decisions of this magnitude flies in the face of democratic and legal (see Gunning) principle. Urgent action should be taken to redress this.

- The most effective means of soliciting the opinion of city residents on the tendering

out of local NHS services should be identified along the lines of the University of Brighton Citizens' Health services survey examining attitudes to privatisation.

- In view of emerging information about wholly new NHS governance structures councillors communicate their disquiet about the proposed STP arrangements to the STP Board and request the attendance of the Board Chair at a specially convened HOSC meeting.
- A recommendation be made back to full council to propose a delay in acceptance of

the STPlan pending much fuller objective consideration of its consequences.

Deputation concerning proposed Sustainability and Transformation Plan
Spokesperson – Madeleine Dickens

Summary of financial arrangements imposed by NHS England

- Comparisons of percentages of GDP spent on health and social care.
- Although the government fulfilled its NHS funding commitment – with funding increasing by an average of 0.8 per cent per year in real terms – the increases delivered were less than the estimated growth of 3 to 4 per cent per year required to meet higher costs of new medical technologies and increases in demand for health care. Over the same period local government has seen a real reduction in spending on adult social care of 12%.
- Sustainability and transformation fund – the fallacy
- All but one of the 44 STPs is in deficit overall, according to research carried out by the HSJ, and about a third have deficits of more than 4% of their turnover. The STP must show how local services will become sustainable over the next five years. It must set out initiatives to manage demand, increase provider efficiency, reconfigure services and, the most important of all, balance the budget in the local area.
- The Kings Fund has said "It is inconceivable that the NHS will be able to achieve both financial sustainability and large-scale transformation within these financial constraints."

Equalities impact, democracy and STP

STP was imposed and draft plans submitted on the 30th June with no parliamentary oversight or mandate, no consultation, and by their own admission - no legal status.
There is already a rapidly growing equality gap in the health and social care economy – successive cuts and privatisation taking their toll on local services. The Public health department budget has reduced by 18%, projected to rise to 25% by 2020, since its re-creation under the Health and Social Care Act. Major services have gone out to non LA contractors, Children's and young people's services currently out to tender. At the same time, 9 GP practices across the city have closed (with more closures looming)….list of further services affected. These developments inevitably have the biggest impact on the most vulnerable and those most in need living in the most deprived neighbourhoods. With the level of savings necessary to balance the STP budget this equality "gap" can only widen further.

Local Democracy

To break even STP Boards are going to have to implement massive change – the selling-off of NHS estate and land, workforce reductions, the even greater influx of private companies, with serious implications for local communities and the local economy. Yet in April the LGA no less highlighted the democratic deficit underlying STP, criticising -
"Pace of implementation undermining local ownership and squeezing out LA and community involvement.
Lack of democratic accountability, eroding the role of HWBs
Footprints over-ride devolution or local govt transformation boundaries.
Angry concern is being expressed by some HWBs and other bodies about STP.

Requested action

- This submission be referred to the OSC to request a copy of the draft STPlan, gather evidence on its implications and to make recommendations to full council.
- The full council recommends that the HWB call public consultation meetings on STP at the earliest opportunity.
- The council look at the best means of soliciting the opinion of city residents on the tendering out of local NHS services along the lines of the University of Brighton Citizens' Health services survey examining attitudes to privatisation.

Background paper - NHS Funding and NHS England's Sustainability and Transformation Plans

1. The UK currently spends 8.8% of its GDP on health services. This compares with an OECD average of 8.9%, Greece spends 9.1%, France 10.9%, Germany 11%, and the big spender US 16.4%. It is true that of that proportion of UK's GDP most is public funding, but this is also the case with all other countries. So don't let's get carried away with the idea that we are big spenders on health – **we're not.** In fact under government's plans the GDP proportion spent on the UK's health is set to fall to 6.7% by 2021. **This will make us one of the lowest health spenders in the world.**

2. In 2015 the politically neutral Kings Fund said of the Coalition government
   Although the government fulfilled its NHS funding commitment – with funding increasing by an average of 0.8 per cent per year in real terms – the increases it delivered were less than the estimated growth of 3 to 4 per cent per year required to meet higher costs of new medical technologies and increases in demand for health care. Over the same period local government has seen a **real reduction in spending on adult social care of 12 per cent**. (1)
   So, to meet increasing demand the NHS requires a 3-4% budget increase, and it got 0.8% while at the same time adult social care had 12% reductions in its budget. This resulted in most hospital trusts falling into colossal deficits (2) of £2.8 billion, to pay for bills, staff wages, energy bills and drugs; unprecedented in the history of the health service.

3. The STP (3) must show how local services will become sustainable over the next five years. It must set out initiatives to manage demand, increase provider efficiency, reconfigure services and, the most important of all, balance the budget in the local area.

4. So NHS England is demanding that trusts must absorb the deficit, accumulated because of underfunding through the Coalition years, in their plans for the next five years and prove that they balance the books. So trusts ability to meet the demands for services in the next 5 years will be hampered by having to absorb the previous 5 years' deficit.

5. There is funding available for the STPs, known as the **Sustainability and Transformation Fund (STF)**. This fund is held by NHS England, but it is ring-fenced and can only be released with agreement from both the Department of

Health and HM Treasury. The fund is released quarterly, in arrears, to the organisations in the STP footprint.

6. Other funding available for transformation is held by NHS England and this has been added to the pot (amounting to £339 million in 2016/17), creating a total Sustainability and Transformation Fund of £2.1 billion for 2016/17. The fund grows to reach £3.4 billion by 2020/21.
7. The catch is that none of this funding is available unless the STP footprint can show that it is able to balance its books. For 2016/17 the providers (NHS trusts) must show they are cutting their deficits and demonstrate that the plan leads to staying within their budget for 2016/17. The STP must then work to keep the footprint within its budget for the next four years in order to qualify for further funding from the STF.

8. The STPs bring together NHS trusts that are in a very difficult position financially, with almost all of them in deficit, with other organisations, including CCGs, most of which are not in deficit, although not flush with money either. The result is that the overall financial situation of the STP footprints is very poor; all but one of the 44 STPs is in deficit overall, according to research carried out by the HSJ, and about a third have deficits of more than 4% of their turnover.

9. *Anita Charlesworth, chief economist at the Health Foundation, has noted that, " turning that sort of financial performance around when there are so many other underlying issues is an enormous if not impossible task."*
   The normally cautious Kings Fund has said "It is inconceivable that the NHS will be able to achieve both financial sustainability and large-scale transformation within these financial constraints." (4)

10. The first tranche of money from the £2.1 billion STF for 2016/17 has already been allocated to NHS trusts, however due to the dire finances of the trusts, all £1.8 billion will be spent on bailing out the providers' deficits.

11. The government through NHS England is therefore set to limit the range of services provided, downgrade the quality of remaining services, more often than not provided by private profit-seeking companies, with reductions in staffing levels involving even lower morale with industrial disputes on an unprecedented level. What we are witnessing is the contraction of a health service from one driven by patient need and heralded by the Commonwealth Fund as the best in the world (5), to one controlled primarily by impossible financial targets.

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