BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00pm 24 NOVEMBER 2021

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Moonan (Chair)

Also in attendance: Councillor Deane (Group Spokesperson), McNair (Group Spokesperson), Brennan, Grimshaw, John, Lewry and West

Other Members present: Frances McCabe (Healthwatch)

PART ONE

8 PROCEDURAL BUSINESS

8.1 Apologies were received from Cllrs Wilkinson and Meadows.

8.2 There were no declarations of interest.

8.3 There were no substitutes.

8.4 **RESOLVED –** that the press & public be not excluded from the meeting.

9 MINUTES

9.1 The draft minutes of the 14 July 2021 committee meeting were agreed.

10 CHAIR'S COMMUNICATIONS

10.1 This meeting of HOSC should have taken place on 13th October. Unfortunately we had to postpone the original meeting because the Council Chamber was unavailable due to another meeting taking much longer than anticipated.

The agenda for today's meeting is largely the same as for the October meeting. However, one item has dropped off: this is the report on plans to re-commission Sussex Sexual Abuse Referral Centres (SARC). I've taken this report off because NHSE commissioners have informed me that they have temporarily halted their plans to re-design services, and will seek to extend contracts with the current SARC providers for another 18 months. When revised long term plans for SARC services do become available, they will be brought to the HOSC for consideration.

An item that is featured today, but that wasn't on the original agenda is Cllr Grimshaw's question about Child & Adolescent Services for children with autism. This is an important issue, and one we will explore in more depth with commissioners and providers of children's mental health services at our January 2022 HOSC meeting.

Re-scheduling a meeting at relatively short notice inevitably causes inconvenience for members and officers from the council and NHS partners. I'd like to thank everyone who had to make adjustments so they could attend today's meeting. Unfortunately, some NHS colleagues have urgent meetings that overlap with the HOSC and won't be able to join this meeting until 5pm. Depending on how swiftly we move through the agenda, I may need to call a brief pause in the meeting to accommodate this.

Finally, Covid infection rates remain worryingly high, both locally and nationally. Covid boosters are now available for over 50s, health & social care workers and those with underlying health conditions. If you're eligible and it's been 6 months since your 2nd jab you can book your booster online on the national booking system or by calling 119. Walk-in boosters are also currently available every day for those that are eligible from the vaccination centre at Churchill Square. Please check www.sussexhealthandcare.uk/get-my-jab

It's also not too late to get your first or second dose. Vaccinations can be booked or walk-in locations are available every day across the city.

11 PUBLIC INVOLVEMENT

11.1 Mr Ken Kirk asked the following question:

"Worries about NHS under an ICS are ….

1. Rationing of care - owing to specified financial limit, care will be limited, possibly denied, quality downgraded;
2. More privatisation without transparency, see HSSF's list of mainly private companies https://www.england.nhs.uk/hssf/supplier-lists/#shared-or-integrated-care-records
3. Private executives in decision-making positions, despite Bill amendments, can be on place-based committees, IC Partnerships;
4. Patients at risk – removes need for discharge assessment;
5. Deregulation of professions – down-skilling of medical care and 'race to the bottom' on pay/T&Cs.

Some councils have issued demands (a) – spending determined in partnership with LAs, guaranteed full access to services etc.

What action should you take to defend our health services?"

a. See Appendix of https://councillors.knowsley.gov.uk/documents/s71697/HWBB%20SP.pdf?StyleType=standard&StyleSize=none

11.2 The Chair responded:

There are several parts to this question, which raises a number of serious concerns about the current NHS reforms. I am not an expert on the Bill but I have spoken to many system leader locally and done a lot of reading and I can see both advantages and disadvantages in the government proposals.

Regarding financial limits, this has always been the case. CCGs have had spending caps from their inception and sadly rationing of NHS care, in different guises, has been here for many decades. We spend far less a proportion of GDP on health care than most advanced economies and get great value for money. But the real solution is to properly fund the NHS, and I might add social care.

The lack of transparency in procurement is defiantly of concern and I agree it could lead to more and more major contract going to private providers with little openness. It might also lead to more contracts going to NHS providers and the voluntary sector, but this remains to be seen and will require close scrutiny.

Private providers on NHS boards is, I agree, also a cause for concern. But I would say that this is not the only potential conflict of interest in the new Board structure as major NHS providers are also represented on Boards, as is primary care. The potential benefit here is the removal of the internal market which costs so much time and money, and in its place having greater partnership working and commissioning across the whole patient journey, which will lead to better patient outcomes and more cost effective services. The risk is that vested interests have influence on millions of pounds of public money with no improvement in care and privatisation by stealth.
On your concern around discharge assessment, I would say that this has been local practice for a while as you can provide a much better assessment of care needs when someone is back in their own home or care home, than in a hospital bed. Once someone is medically fit to leave hospital it is definitely the best thing to get them out as soon as possible. But discharge to assess only works if there are the right patient pathways in place, adequate step-down services, social workers to carry out the assessment, and providers to cover the new care packages. It is vital the whole system works together with the patient at the centre, which has not always been the case around hospital discharge. When someone vulnerable leaves hospital they need a soft landing as it is only the beginning of recovery.

Finally, you raise a concern about deskilling the workforce and this is another area of the Bill that has caused widespread concern. Closer partnership working with the VCS shouldn't equate to the same service for less money!

You conclude Mr Kirk by asking what HOSC can do about this and the short answer is very little in terms of the primary legislation. There is only passing mention of HOSC in the guidance, but we will continue to work with organisations such as Heath Watch and scrutinise wherever we can.

11.3 Mr Kirk asked a supplementary question, requesting the Chair's views on the establishment of a Sussex Integrated Care Board (ICB) which would potentially have private sector representatives, but only one local authority representative; on the risks of post-discharge assessment leaving vulnerable people without the care they needed; and on new NHS budgeting arrangements which would leave NHS provider Trusts rationing services because they would be unable to run deficits as they can currently.

11.4 The Chair asked NHS and social care colleagues if they wished to respond to these questions. Rob Persey, BHCC Executive Director, Health & Adult Social Care, noted that the Directors of Adult Social Care from all three Sussex upper-tier local authorities would in fact have seats on the ICB. In terms of discharge prior to social care assessment, Discharge to Assess schemes have been in place for several years now and offer better and more holistic assessment of people's care needs than assessment in hospital. The Chair told Mr Kirk that she would be happy to meet him outside the meeting to discuss in more depth the points he raised and to explore ways in which the HOSC might scrutinise these issues.

12 MEMBER INVOLVEMENT

12.1 There was a member question from Cllr Grimshaw: "Mascot has brought the issue of its complaint to Sussex Partnership NHS Foundation Trust (SPFT) to me and asked me to raise at the HOSC."

12.2 In response, the Chair noted that a joint response from SPFT, NHS commissioners and BHCC Families, Children & Schools was included in the committee papers. There is a scheduled item at the January 2022 HOSC meeting on young people mental health, and officers will ensure that this includes information on services for young people with autism.

13 PRESENTATION, HASC COMMISSIONING STRATEGY

13.1 This item was introduced by Rob Persey, BHCC Executive Director, Health & Adult Social Care (HASC). Mr Persey told the committee that a draft Commissioning Strategy had been presented to the Health & Wellbeing Board in 2020. Completion of the Strategy had not progressed as planned, as officers had been required to focus on responding to the Covid emergency. However, the principles of the draft Strategy are being used to inform commissioning – e.g.:

- Partnership & collaboration
- Prevention & empowerment
- Person-centred and outcome focused
- Co-production with service users
- Value for money
- Valuing the workforce.

13.2 Since 2020 the context within which social care commissioning has operated has changed significantly, due to the pandemic, to increased workforce pressures, and to the establishment of an Integrated Care System (ICS), due to go live in April 2022.

13.3 Major commissioning activity in 2022/23 will include:

- Domiciliary Care contract
- Residential/Nursing Care contracts
- Supported Living/Community Support/Day Services contracts
- Community Equipment Service contract

- Knoll House.

13.4 Currently, local authorities across the South East are working to develop a co-ordinated Market Position Statement. The Brighton & Hove HASC Commissioning Strategy will need to reflect, and must therefore follow, the publication of this Statement.

13.5 Fran McCabe asked whether thought had been given to designing seamless services around service users, rather than commissioning discrete services that people had to navigate between. Mr Persey acknowledged the value of this holistic approach and noted that aspects of this type of care were already being commissioned. For example, where people have a temporary placement in a care home setting and then return to their own homes, some care homes have been commissioned for their staff to provide initial homecare support in order to ensure continuity of care. Moving to more holistic commissioning models is complicated by the need to deliver all statutory services and to maintain a sustainable local care market, but commissioners are committed to working with service users and experts by experience to deliver person-centred services.

13.6 Ms McCabe noted that more imaginative models of working might have workforce benefits also. Mr Persey agreed, and told members that a health & care system workforce strategy was being developed at ICS level. This includes identifying new roles that the system requires, looking across health and care services; and also seeking to optimise the capacity of the whole system workforce. BHCC Human Resources are involved in this work as is the Voluntary & Community sector.

13.7 Cllr McNair asked a question about whether the roles of community nurses might change. Lola Banjoko, Brighton & Hove CCG Managing Director, responded that this is being actively considered as part of the development of place-based planning, particularly in terms of providing wrap-around support for patients with complex needs (e.g. multiple Long Term Conditions). The system recognises that there are currently significant staffing challenges in community healthcare.

13.8 In response to a question from the Chair on financial pressures on Adult Social Care, Mr Persey told members that there is less money available in real terms than 10 years' ago, despite an increase in demand and in acuity of need. In recent months there has been increased funding via Government grants and a significant degree of additional support from the local NHS. This has enabled more funding to be passed on to care providers; and there has been really effective working between ASC and the NHS: for example, the joint procurement of care beds. This additional support and funding has been welcome, but short-term and short notice funding does not allow for the proper planning of services; what is required is a long-term ASC funding settlement.

13.9 In reply to a question from the Chair about capacity within the HASC Commissioning team, Mr Persey told the committee that HASC is working closely with BHCC Families, Children & Schools and with NHS commissioners to align commissioning activity. It is currently too early to say what if any additional capacity may be required in HASC commissioning.

13.10 In answer to a question from the Chair about co-production, Mr Persey told members that officers are seeking to identify best practice in current commissioning in order to embed this in the new strategy.

13.11 The Chair asked what care workforce problems are specific to Brighton & Hove, rather than just shared issues nationally. Mr Persey responded that Brighton & Hove has a large hospitality and retail sector which can attract care workers as pay and conditions in hospitality and retail may be better than in care. Also, the city care market is made up of a large number of small providers. This means that providers are not always able to provide the staff training that larger providers could, with the council having to offer additional support. In addition, organisational staff career pathways may be limited for small providers; the system needs to think about how to offer career progression in order to retain staff in the sector.

14 SUSSEX-WIDE WINTER PLAN 2021/22

14.1 This item was introduced by Rob Persey, BHCC Executive Director, Health & Social Care; Lola Banjoko, Managing Director, Brighton & Hove CCG; Dr Sarah Richards, CCG Medical Director; Becky Woodiwiss, Public Health Principal; and Ben Stevens, University Hospitals Sussex (UHS) Chief Operating Officer.

14.2 Lola Banjoko explained that winter planning is an annual process as there is a consistent surge in health and care demand in the winter months. The biggest risk this winter is likely to be capacity in the local care market, particularly in terms of the interrelations between the care market and hospital admission avoidance and timely discharge. There are also significant challenges across the health and care workforce, particularly as staff have been working ceaselessly on the pandemic and then on service recovery, so have had no opportunity to take a breath before the winter surge. The system has been working hard to provide enhanced nursing support to care homes; on public messaging (working closely with Healthwatch Brighton & Hove); and on enhanced primary care services, with a particular focus on identifying and supporting vulnerable people in the community.

14.3 Ben Stevens added that the main challenges for UHS are around workforce and demand. There is a particular focus on managing hospital bed capacity, especially in terms of the timely discharge of patients who are Medically Fit for Discharge. The Trust is trying to recruit more medical and clinical staff, but is also investing in community services such as admission avoidance. UHS is also working to enhance critical care capacity and general bed capacity, but workforce is a factor here.

14.4 Becky Woodiwiss told the committee that having an annual Cold Weather Plan (CWP) is a statutory requirement. Cold weather typically impacts on people with respiratory conditions, and particularly on those who struggle to afford to heat their homes. This impact can be felt even when the weather is not especially cold: e.g. where temperatures are below 8 degrees outdoors/18 degrees indoors. Really severe weather can create additional problems: e.g. snow and ice can impede people's access to services. This year there will be additional risks and pressures from Covid and it is vital that as many people as possible get vaccines and booster jabs. The CWP is a relatively high-level plan, with detailed service plans sitting beneath it.

14.5 Cllr West asked a question about staff getting to work in harsh weather. Mr Stevens responded by noting that UHS, and other providers, have severe weather plans, which include the use of volunteer 4x4 drivers.

14.6 Cllr West asked whether there is capacity within severe weather plans to deal with prolonged extreme weather. Mr Persey replied that there is capacity for severe weather within the plans, but there will inevitably be challenges in a really harsh winter.

14.7 Cllr John asked whether both a system winter plan and a local CWP are really required. Ms Woodiwiss responded that the plans do have different focuses, with the CWP looking at broader determinants of health and the winter plan at services. However, both are national requirements, so the local system is obliged to plan in this way.

14.8 In response to a question from Cllr John about fuel poverty in the context of rising energy prices, Ms Woodiwiss told members that fuel poverty is challenging to measure, and that there is an unavoidable lag in data reporting. However, an Excess Death Working Group does meet regularly to evaluate the latest data, so the system is as up to date as it can be.

14.9 In answer to a question from Cllr John on support for homeless people, Dr Richards told the committee that locally homeless people have been classified as clinically extremely vulnerable and have been prioritised for vaccination and boosters. Services have worked closely with Arch Healthcare to provide outreach to homeless people and to other vulnerable communities.

14.10 Cllr Grimshaw noted that the funding for fuel poverty work seems limited, and that advice on managing heating costs may not be relevant to everyone at risk, particularly for people who have pre-pay meters. Ms Woodiwiss agreed that fuel poverty is a big worry this winter. The council is working closely with the Local Energy Advice Partnership to ensure that good advice is communicated as widely as possible.

14.11 Cllr Brennan noted that advice to keep warm (e.g. by leaving heating on overnight) was of limited use to people who simply can't afford to keep their heating on for long periods. Could the council look at other measures, such as loaning out small electric heaters? Cllr Brennan also noted that the Severe Weather Emergency Protocol (SWEP), designed to offer beds to rough sleepers in cold weather, will only accept people after a key worker assessment. However, some people feel unable to take part in assessments. What can be done for these people, and how many SWEP beds will be available this winter? Ms Woodiwiss agreed to provide a written response to these questions and also to pass on member comments about pre-pay meters and an electric heater scheme to the Excess Deaths Working Group.

14.12 Cllr McNair asked a question about the availability of face-to-face GP appointments. Dr Richards responded that GP services have been open throughout the pandemic and that GPs have been meeting patients face-to-face when clinically indicated. However, demand is very high, and GPs are also leading on the Covid vaccination programme. In addition, with rates of Covid remaining high, there is a clinical risk for patients in attending GP surgeries. For these reasons it is not possible to give a percentage target for face-to-face appointments.

14.13 RESOLVED – that the report be noted.

15 CANCER SERVICES (DIAGNOSIS AND TREATMENT)

15.1 This item was presented by Ben Stevens, University Hospitals Sussex (UHS) Chief Operating Officer; Lola Banjoko, Managing Director, Brighton & Hove CCG; Becky Woodiwiss, Public Health Principal, BHCC; and by Dr Sarah Richards, Brighton & Hove CCG Medical Director.

15.2 Mr Stevens told the committee that the pandemic has impacted cancer services, with a significant reduction of referrals as fewer people have been accessing healthcare. This is reflected in performance against the national cancer targets:

- 62 day referral to treatment target: the national target is for 85% of people to begin receiving treatment within 62 days of referral. UHS is currently performing at 65-75%. This is a national problem, and many systems are struggling with this target.

- 28 Day referral to diagnosis target: the national target is for 75% of people to begin diagnosis within 28 days of referral. UHS is currently meeting this target.

15.3 Services are planning to increase treatment and diagnostic capacity to meet these challenges. This includes the deployment of a new community diagnostics hub at the Amex in addition to diagnostic services at the Royal Sussex County Hospital. Services are also looking at re-designing treatment pathways: e.g. by enhanced use of virtual appointments and by using new diagnostic techniques. There is a major focus on NHS restoration & recovery around cancer, particularly targeting long waits.

15.4 Ms Woodiwiss told members that there are three main national cancer screening programmes:

- Breast screening – the national target is to screen 70% of those eligible. Current local performance is 66%.

- Cervical screening – the national target is 80%. Current local performance is 68%.

- Bowel screening – the national target is 60%. This is currently being met locally.

15.5 The pandemic has had a major impact on screening, but rates are beginning to pick up locally. Services strive to communicate about screening, working closely with Albion in the Community.

15.6 Lola Banjoko told members that services are very conscious of the importance of inequalities in screening rates, with some geographical communities and some groups of people having much lower rates of screening.

15.7 Dr Richards told the committee that there is an enhanced early diagnosis service now in primary care. Primary care is also starting to follow-up on patients who do not attend screening appointments. Brighton & Hove is also a pilot area for targeted health checks: e.g. offering x rays/CT scans for any smokers. Ms Banjoko added that there is additional annual funding from NHS England for enhanced cancer services.

15.8 Cllr Grimshaw noted that current difficulties in getting non-urgent GP appointments may discourage people from seeking advice on possible cancer symptoms. Ms Banjoko

acknowledged the problem, and that some communities are much more reluctant to come forward than others. Dr Richards agreed that current access to primary care is sub-optimal, particularly for the most deprived communities. There is investment in digital and in longer opening hours to improve access. However, GPs are exceptionally busy, and there is no easy fix to this.

15.9 Cllr Deane noted that historically breast screening rates were lowest in areas of the city with no easy access to the Preston Park screening centre. Ms Woodiwiss responded that access is a recognised problem. However, schemes such as travel vouchers have not proved successful. There is more to unpick here in terms of what the real access barriers are.

15.10 Cllr Brennan noted that the Princess Royal Hospital has arrangements in place that allow people to travel free on buses as long as they show proof of an appointment. Ms Banjoko responded that this such a scheme would be the responsibility of the council.

15.11 Cllr Brennan also noted that the diagnostics centre at the Amex is poorly signed from bus stops. Ms Banjoko agreed to feedback to the service on its signage.

15.12 The Chair noted that Brighton & Hove had poor performance against cancer screening and treatment targets long before the pandemic, and that this was an issue that the HOSC should maintain an overview of. Members agreed to receive an update report in 18 months' time.

15.13 RESOLVED – that the report be noted.

The meeting concluded at Time Not Specified

Signed Chair

Dated this day of