BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00pm 25 JULY 2016

PORTSLADE TOWN HALL

MINUTES

Present: Councillor Simson (Chair)

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

Other Members present: Councillors

PART ONE

1 APOLOGIES AND DECLARATIONS OF INTEREST

1.1 There were no declarations of interest.

1.2 Lorraine Prince attended as substitute for Caroline Ridley (Community Sector co-optee); David Liley attended as substitute for Fran McCabe (Healthwatch co-optee).

1.3 Members resolved that the press and public should not be excluded from the meeting.

2 MINUTES

2.1 The minutes of the March 2016 OSC meeting were noted.

3 CHAIRS COMMUNICATIONS

3.1 The Chair informed members that a sound recording of the meeting was being taken.

3.2 The Chair welcomed everyone to the first meeting of the new Health Overview & Scrutiny Committee (HOSC).

3.3 The Chair told members that there had been a number of health-related issues making the headlines recently. In addition to the issues being covered at this meeting, it was her intention that GP sustainability and the Sustainability & Transformation Plan (STP) would come to the July HOSC meeting. The Care Quality Commission (CQC) inspection report on Brighton & Sussex University Hospitals Trust (BSUH) would also be reported to a future meeting.

4 PUBLIC INVOLVEMENT

4.1 There were no public questions, deputations or petitions.

5 MEMBER INVOLVEMENT

5.1 There were no member questions.

6 HOSC TERMS OF REFERENCE

6.1 This item was introduced by Abraham Ghebre-Ghiorghis, BHCC Head of Law and Monitoring Officer.

6.2 Cllrs Simson, Allen and Knight were nominated to sit on the HOSC urgency sub-committee.

6.3 Members RESOLVED to:

a) Note the HOSC Terms of Reference;
b) Establish an Urgency Sub-Committee
c) Agree the appointment of non-voting co-optees from the Youth Council, the Older People's Council, Healthwatch and the Community & Voluntary Sector.

7 SUICIDE PREVENTION

7.1 This item was introduced by Clare Mitchison (Public Health), Miranda Frost (Grassroots Suicide Prevention), and Kate Hunt (Sussex Partnership NHS Foundation Trust: SPFT).

7.2 Clare Mitchison told the committee that Brighton & Hove has a historically high suicide rate, although recent years have seen a reduction in the number of suicides. However, given the relatively small numbers of suicides annually, caution must be taken in interpreting trends in local suicide statistics.

7.3 Analysis of local suicide data over time shows a clear link between suicide and deprivation. Suicides that take place in public spaces tend to cluster around the seafront, but overall there is no particular geographical pattern to city suicides.

7.4 As is the case nationally, men in Brighton & Hove are far more likely than women to die by suicide (although they are not necessarily more likely to attempt suicide). Suicide rates are highest amongst middle-aged men, both nationally and locally. Redundancy and/or relationship break-up are key factors in making this group more vulnerable to suicidal thoughts.

7.5 Suicide prevention is a complex task. It includes preventative work, and support for people in crisis, as well as working to ensure that there are physical measures in place to deter suicide attempts. The city has a partnership Suicide Prevention Strategy Group which publishes an annual Action Plan.

7.6 Miranda Frost told members that suicide is a community health problem. Grassroots is working towards making Brighton & Hove a 'Suicide Safer City' by implementing a number of community wide suicide prevention activities following the 9 pillars that define

a suicide safer community as laid out by Living Works, an international suicide prevention organisation Grassroots also delivers suicide prevention training to professionals, organisations and the general public in Brighton & Hove, Sussex and other areas of England. The majority of this is funded via contracts from Public Health / Local Authority and some is commissioned outside of contracts or supported by community fundraising.

7.7 Kate Hunt told the committee that suicide is one of SPFT's four Quality priorities for 2016/17. The trust is rolling-out training on suicide risk assessment to staff, and is also focusing on carer engagement and support.

7.8 In response to a question from Cllr Deane on the impact of recessionary pressures and of benefit reductions, members were told that these could increase suicide rates. It was important that, where public sector funding for suicide prevention work might be reducing, an equivalent level of community support was identified to compensate.

7.9 In answer to a query from Cllr Deane on work with people in prison and with former prisoners, the committee was told that there was some help available both in prison and subsequent to release, although this group of people could be difficult to reach.

7.10 In response to a question from Cllr Taylor on where ultimate responsibility for suicide prevention lay, the committee was informed that the Health & Wellbeing Board (HWB) is ultimately in charge of co-ordinating this work across the city. As an NHS trust, SPFT is accountable to its regulators (i.e. the CQC).

7.11 Cllr Allen told members that he was very concerned with young people's ability to access Child & Adolescent Mental Health Services (CAMHS), with the complexity of CAMHS services, with the speed that CAMHS responded to requests for help, and with the provision of services for younger children. He also queried why no representative from Community CAMHS had attended the Suicide Prevention Partnership meetings. Clare Mitchison confirmed that Community CAMHS were invited to attend meetings and did engage with suicide prevention work via the Schools Programme. Kate Hunt noted that it was extremely rare for younger children (i.e. under eight) to attempt suicide, so resources were targeted at children older than this. Miranda Frost told members that there are good materials available to support parents and offered to provide some examples.

7.12 Cllr O'Quinn stated that she was particularly concerned with the 16-18 year olds, especially regarding exam stress and the impact of social media. Kate Hunt agreed that this is a key group, and noted that incidents of self-harm amongst teenagers are known to be under-reported.

7.13 In response to questions from Cllr Peltzer-Dunn on why the suicide rate has seemingly fallen more rapidly in recent years, Clare Mitchison told the committee that it was not really possible to link the local suicide rate to the success or failure of particular interventions, though it is believed that the local Suicide Prevention Action Plan contributes to a reduction in the rate. Locally, female suicide rates have fallen more sharply than male rates. It is uncertain why this is so, and it runs counter to national trends. Cllr Peltzer-Dunn noted that he was concerned with the persistently high levels of male suicide locally.

7.14 A member of the Youth Council told members that he thought having Counsellors in schools was key to helping young people who may be self-harming or experiencing suicidal thoughts. Miranda Frost agreed, noting that local schools have a good record in terms of providing counselling services. Kate Hunt added that self-harm was a growing issue in schools and is more common among young people. Self-harm may be an expression of distress rather than an indication of suicidal intention, although there is a strong relationship between completed suicide and previous self-harming behaviour.

7.15 Cllr Cattell queried whether a reliance on social-media based suicide prevention tools could be problematic given the higher prevalence of suicide amongst the most deprived. Miranda Frost agreed and stressed that Grassroots also provides lots of information in hard copy form.

7.16 The Chair thanked all the presenters for their contributions.

8 SOUTH EAST COAST AMBULANCE TRUST UPDATE ON RED 3 TRIAGE SCHEME

8.1 This item was introduced by Geraint Davies, SECAmb Acting Chief Executive; Terry Parkin, Non-Executive Director; Ben Banfield, Customer Account Manager (Sussex); and Tim Fellows, Operating Unit Manager for Brighton & Hove.

8.2 The committee was told that the Red 3 triage scheme was well-intentioned, but was poorly executed, particularly in terms of governance processes. Lessons have been learnt from this: there have been significant changes at the top of the organisation; and key improvement actions are captured in the Joint Recovery Plan. These include developing a truly unitary Board, making the organisation more transparent, and ensuring that staff concerns are properly addressed. The impact review on the triage scheme is due to be published in June 2016, although to date no patient harm has been identified.

8.3 The Chair alerted members to an error in the cover report for this item (prepared by HOSC support officers): at 3:1 the triage scheme is described as adding an additional 10 minutes to call target times. This is inaccurate and should read “up to an additional 10 minutes.” In fact, the average additional wait occasioned by the triage scheme was only 40 seconds.

8.4 In response to questions from Cllr Marsh about how stakeholders could be confident that similar mistakes would not be made again, Mr Parkin told members that fundamental changes had been made to SECAmb’s governance system making it impossible for a major initiative to be undertaken without appropriate governance and risk oversight.

8.5 RESOLVED – that the information provided by SECAmb be noted and a further update provided once the clinical impact review is published (i.e. at the July 2016 HOSC meeting).

9 AMBULANCE TO HOSPITAL HANDOVER UPDATE

9.1 This item was introduced by Geraint Davies, Terry Parkin, Tim Fellows and Ben Banfield of SECAmb. Dr Magnus Nelson, XXXXX, represented Brighton & Sussex University Hospitals Trust (BSUH).

9.2 Mr Davies told the committee that handover represented an area of very high clinical risk for the trust. This risk is increasing, as handover times continue to lengthen – for example handover delays at the Royal Sussex County Hospital (RSCH) are up 35% on this time last year.

9.3 Mr Fellows told members that SECAmb does all that it can to manage RSCH delays. This includes holding a daily conference call with colleagues from BSUH, being in regular contact with social care, and regularly diverting patients to other hospitals. Although relations between SECAmb and BSUH staff are inevitably strained at times, the two organisations are working really hard together to provide the best service possible in the circumstances.

9.4 Mr Parkin added that SECAmb was currently undertaking around 3.5 ambulance calls (rather than the target 5-6) in a 12 hour shift because of excessive handover delays. Patients waiting in ambulances are safe, but ambulance crews cannot respond to additional calls whilst queueing at A&E, and this means that call targets cannot be met. This situation must be swiftly resolved, with handover waits of 30 minutes at most.

9.5 Dr Nelson told the committee that there was a very strong working relationship between BSUH and SECAmb, but that the system was experiencing extreme pressures for which there was no ready solution. The core problem is the increasing acuity and complexity of patients presenting for treatment, which has not been properly recognised in resourcing terms. This is a system-wide problem, but A&E is an obvious pinch-point.

9.6 Mr Davies told members that there needed to be a system-wide conversation about how to better manage handover. This needs to include HOSCs. HOSCs have no reason to feel confident that the system is managing handover effectively, and ought urgently to seek assurance on this issue. Agreement needs to be reached with NHS commissioners as to how to move swiftly to achieving a maximum 30 minute 'turnaround' time from arrival at hospital to being clear to respond to new incidents. Mr Parkin added that SECAmb could not continue managing this level of risk alone, particularly as this is a system-wide problem. The trust has internally debated this issue for a number of months and the Board has decided that there is no option other than to speak publicly and candidly with stakeholders.

9.7 Mr Davies noted that there are local examples of good practice with regard to handovers. Very poor handover times at Medway Hospital Trust have been addressed by the use of dedicated handover nurses.

9.8 In response to a question from Cllr Marsh on the potential to divert patients from A&E, Mr Fellows told members that SECAmb does all that it can in this respect, with more than 50% of ambulance attendances not resulting in conveyance to A&E. Brighton & Hove currently has no Acute Medical Assessment Unit to offer an alternative to A&E, and the development of such a unit might help ease pressures.

9.9 In response to a question from Cllr Peltzer-Dunn on the trend of performance, Mr Davies told the committee that things were getting worse rather than better. For this reason it is important that the HOSC holds the local System Resilience Group (SRG) to account for handover performance.

9.10 In answer to a query from Cllr Taylor on when delays peak, Mr Banfield explained that peaks tended to be out of primary care hours and on Mondays (when services are put under increased pressure by numbers of people who have become ill over the weekend but have waited to present for treatment).

9.11 Mr Parkin told the committee that the four hour A&E target is a problem, distorting attempts to triage patients. However Dr Nelson disagreed, arguing that the target had driven improvements in A&E performance. There was agreement that different agencies will inevitably prioritise the targets that mean most to them, and as these targets are not always compatible, that the SRG has a key role in ensuring that agencies work smoothly together.

9.12 In response to a statement from Colin Vincent, suggesting that delayed transfers of care are at the core of hospital flow problems, Mr Davies agreed that discharge is an important factor and again urged the HOSC to take to the SRG about this as this is another matter that the SRG is responsible for co-ordinating.

9.13 RESOLVED – that the information provided be noted and that this issue be revisited at the July 2016 HOSC meeting, with the Brighton & Hove System Resilience Group asked to attend and contribute.

10 NHS PATIENT TRANSPORT

10.1 This item was introduced by John Child, Chief Operating Officer, Brighton & Hove CCG; Sally Smith, XXXXX, High Weald Lewes Havens CCG; Alan Beasley, Director of Finance, High Weald Lewes Havens CCG; and Michael Clayton, Managing Director, Coperforma. Terry Parkin, SECAmb Non-Executive Director; and Geraint Davies, SECAmb Acting Chief Executive, also contributed to this discussion.

10.2 John Child told members that, in 2014, SECAmb had announced its intention to cease providing patient transport services (PTS) in Sussex when its contract ended in 2015. A one year contract extension until March 2016 had subsequently been agreed to allow time to procure an alternative provider. A tender process had been undertaken. This was led by High Weald Lewes Havens CCG (HWLH), on behalf of Sussex CCGs. All decisions with regard to the tender were unanimously agreed by all Sussex CCGs.

10.3 Coperforma was eventually appointed as the new PTS provider. However, there have been significant issues with the performance of the new service. The CCGs have commissioned an independent review of the tender and of the contract handover, and an improvement plan is in place to try to address performance.

10.4 Terry Parkin told the committee that he wished to correct some misunderstandings about SECAmb's role in this matter. SECAMb's view was that the PTS model proposed by the CCGs would have been neither safe nor appropriate for the trust to run (although

this did not necessarily mean that it would be so for a different organisation). They therefore withdrew from the tender process as did all but one of the other bidders.

10.5 Alan Beasley noted that some bidders had withdrawn because of timing issues, and that SECAmb had told the CCG that they were withdrawing for financial rather than forsafety reasons. Geraint Davies responded that safety and finance are inexorably connected: SECAmb felt that it would be unable to deliver the specified service safely within the available financial envelope, and had withdrawn, as it did for similar reasons from the Kent PTS contract. The trust had, however, bid for the Surrey contract because the financial envelope there would allow SECAmb to deliver a safe service.

10.6 Geraint Davies told members that SECAmb had engage positively with all issues relating to the contract handover, including TUPE. 84% of staff eligible to transfer in fact did so. SECAmb had been criticised for not releasing patient data, but this data was in fact not held by SECAmb but by the (CCG controlled) Patient Transport Bureau.

10.7 In response to a question from Cllr Marsh as to why the procurement went ahead even when it became apparent that there was only one bidder, Mr Beasley told members that the PTS market is a specialist one and not very many bidders were anticipated. There is no requirement to halt a tender process if there is only one bidder. In this instance, the evaluation criteria were not changed: Coperforma still had to meet these criteria even though there was no alternative bid. At every stage, the decision to proceed with the procurement was agreed by all seven Sussex CCGs.

10.8 In answer to a question from Cllr Cattell as to why Coperforma had missed its performance targets by such a distance, Mr Clayton told members that the KPIs were based on the data available, but the actual activity had been much higher (by up to 30%) than this data predicted. Coperforma has now put extra transport capacity resources in to deal with this – something that it is only possible because of the 'Managed Service' model. Call volumes have been much higher than anticipated: many patients are very anxious and need reassurance, which takes up a good deal of call handler capacity. However, the actual level of transport required is not far in excess of that predicted. Mr Beasley added that the contract KPIs will ensure a high quality service once they are met.

10.9 Mr Clayton also claimed that performance in some significant aspects of the contract was good and represented an improvement from performance under the old contract. Mr Davies did not recognise the performance figures quoted by Mr Clayton, and Sally Smith told committee members that comparing performance was complicated because many of the KPIs have changed, meaning that there is no simple way to compare performance across the old and new contracts. The CCG will seek to produce comparative performance information and will share this with the HOSC.

10.10 Mr Beasley told members that there was no real terms financial saving on the new contract, although the new provider is expected to absorb future demand growth.

10.11 In response to a question from Cllr Taylor on whether there was a 'plan B' should Coperforma prove unable to deliver, members were told that the CCG could not break the contract by appointing a different provider and was committed to supporting Coperforma to improve.

10.12 David Liley told the committee that Healthwatch organisations across Sussex are working together on this issue, and have offered to assist in terms of providing information on PTS, speaking directly to consumers and supporting those who may wish to make complaints. Healthwatch want to see the independent enquiry report published, want to see details of any clinical impact review published, and would like to see a Learning Event. Ms Smith welcomed Healthwatch support and agreed to publish the enquiry report and to hold a Learning Event.

10.3 In response to a question on TUPE from Cllr Peltzer-Dunn, Mr Clayton told the committee that only 15 of the 51 staff expected to TUPE in fact did so. However, Mr Davies told members that 154 out of 184 staff TUPED over (the latter figure includes SECAmb drivers who transferred to organisations other than Coperforma). Mr Child noted that this was a complex issue, not least because it was important to differentiate between headcount and Full Time Equivalent posts.

10.4 In response to questions from the Chair about volunteer drivers and the use of the app, Mr Clayton told the committee that it had been assumed that the number of volunteers would reduce due to more rigorous vehicle and driver vetting. Coperforma is investigating whether it may be possible to relax some of these rules whilst maintaining quality: for example waiving the demand that all cars be less than six years' old in certain situations. Mr Clayton claimed that the app has generally been welcomed by volunteer drivers, as it reduces the time they are sat around waiting. Mr Davies told members that he wanted it made clear that SECAmb had previously operated a robust vetting regime, and would never have used drivers with convictions.

10.5 RESOLVED – that the HOSC requires an update report at its July 2016 meeting. This should include current performance data and the independent investigation report.

11 SETTING A HOSC WORK PROGRAMME FOR 2016/17

11.1 Members discussed the report and agreed to hold a workshop to set an annual committee work plan.

11.2 Members considered the proposed agenda for the July meeting. They resolved that the main items at this meeting should be patient transport and ambulance to hospital handover. To make room for these items, members agreed to postpone the 3Ts update until a future meeting and to take the Sustainability & Transformation Plan update as a written and informally circulated briefing rather than as a formal committee item.

The meeting concluded at Time Not Specified

Signed Chair

Dated this day of