HEALTH OVERVIEW & SCRUTINY PANEL

MINUTES OF THE MEETING of the Health Overview & Scrutiny Panel held on Thursday, 14 March 2024 at 1.30 pm at the Virtual Remote Meeting

Present

Councillor Mark Jeffery (Chair)
Councillor Leonie Oliver
Councillor Stuart Brown
Councillor Graham Heaney
Councillor Judith Smyth
Councillor Ann Briggs, Hampshire County Council
Councillor Martin Pepper, Gosport Borough Council
Councillor Julie Richardson, Havant Borough Council
Councillor Vivian Achwal, Winchester City Council

10. Welcome and Apologies for Absence (AI 1)

There were no apologies for absence.

11. Declarations of Members' Interests (AI 2)

Agenda Item 7 - Access to Primary Care
Councillor Brown declared a personal interest as he is a registered patient at the Island City Practice.

Councillor Jeffery declared a personal interest as he is a registered patient at Craneswater Group practice.

Councillor Smyth declared a personal interest as she is a registered patient at the Trafalgar Medical Group practice.

Councillor Oliver declared a personal interest as she is a registered patient at the East Shore Partnership.

12. Minutes of the Previous Meeting (AI 3)

Minute number 9 - it was noted that the dates should read 2024/25 municipal year (not 2023/24)

RESOLVED that the minutes of the meeting held on 25 January 2024 be agreed as a correct record, subject to the above amendment.

13. Adult Social Care Self Assessment - Preparing for inspection (AI 4)

Andy Biddle, Director of Adult Social Care and Debbie Young, Head of Quality and Performance, presented the report. Mr Biddle informed the Panel that the improvement plan would go to Cabinet in June 2024 and if the panel wished, this could be brought to HOSP as well.

In response to questions, Mr Biddle clarified the following:

It was not known when the CQC would carry out their inspection. All 153 local authorities will need to have an assessment process between December 2023 and December 2025. He explained that before the CQC arrive they will make contact to say that the authority is subject to an inspection and ask for a certain amount of information to be returned and there will then be a minimum of 6-8 weeks notice before they visit. The CQC will carry out some site work which will mainly be interviews with staff and people who access services within Portsmouth. They will also look at freely available published data around ASC in Portsmouth and will talk to people who colleagues work with on a professional level before they arrive on site. The CQC will be on site for 2 days in total, but they are anticipating that the pre work and 2 days will enable them to get enough evidence to triangulate a judgement. There will then be a report sent to the authority to check for factual accuracy, the report is drafted and ASC will communicate to everyone once it is published.

One of the Panel felt that she would like to see a sharpening up of the self-assessment to make sure the panel can see if life is improving for those clients in health and social care. Mr Biddle said that the document was very much a summary which is accessible and straightforward. The improvement plan will translate what has been put in these areas of improvement into outcomes. It was also noted that these outcomes would be tested as part of the CQC report.

Mr Biddle felt that PCC did many things well based on the feedback from residents. Residents mostly say that they can get hold of the ASC team relatively easily. The Independence and Wellbeing team work with individuals who may need services in the future and if they can help them develop their independence and wellbeing skills, they can prevent that happening. He felt there is a very personal relationship with their residents and the integrated system working was also very positive. There is however work to do and when CQC arrive it is important to say the honest opinion of where they are.

With reference to page 29 of the report pack and an area of development being to 'consistently compare regional and statistical neighbour performance on key measures' Mr Biddle said that in the past there has not been consistent use of the data. There is currently a transition in how data is collected with a move from submitting chunks of data to the Department of Health and Social Care, to client level data which looks at individual outcomes for people which gets aggregated up to a national level. Mr Biddle said he could share with HOSP the data that is nationally available and could include how PCC compares to its statistical neighbours.

With regard to the 220 responses, Mr Biddle said that this was the face to face responses and this was a reasonable figure. The ASC team work with roughly 2,000 in the city who have a funded service therefore a roughly 10% response rate is not bad and should be relatively representative. In addition to the online survey there was a postal survey and interviews carried out by door knocking by the engagement team.

The Panel thanked Mr Biddle and Ms Young for their report and noted the report.

14. Integrated Care Board: Recovery Support Programme and update on the Stroke Recovery Service (AI 5)

Dan Gibbs, Chief Delivery Officer presented the report and advised that Martin Sheldon, Deputy Chief Executive had been unable to join today.

In response to questions the following was clarified:

Typically the ICB would look for cost savings of approximately 4% across the board. The situation in the next financial year will be complicated due to some of the financial requirements they are needing to meet for NHS England as they will need to begin the process of paying back the deficit, as well as delivering cost improvements. The previous Minister for Health instructed the NHS to deliver cost savings for ICBs of 20% for the financial year 2024/25, followed by a 10% additional saving the following year which they are working hard to achieve. The ICB will therefore need to find a way to deliver the 4% cost improvement plus pay back the £105m deficit plus deal with any non recurrent savings identified in year plus cost savings of 20% this financial year, followed by 10% next year.

The ICB budget is £3.8 billion. A significant proportion of the ICB programme budget is the monies they are allocated nationally to commission services ringfenced for certain things. The 4% cost savings are on operational savings, for example making services more efficient and reducing the cost of delivery of the services to allow them to accommodate growth and inflationary costs over and above those allocated in the programme budget.

All organisations have savings targets that they need to achieve and the ICB have been very fortunate that Solent and Southern who are coming together as part of the Fusion programme, are in a reasonably good financial position this year.

The ICB are going through a process of planning submission with NHS England and there will be a period to reach an agreed deliverable final end of year position. This will not inhibit the ICB to be able to firm up numbers for the Better Care Fund for their partner organisations. The ICB have started the process of notifying partners of what those might be to allow more certainty in planning. It will be the new financial year before the ICB knows what the position will be at the end of that financial year.

The ICB is looking at areas where there are inherent inefficiencies and will look to rectify these areas as a priority. One of the biggest issues is the number of people in the acute hospitals, mental health and community hospitals who medically do not need to be there. Their aim is to improve as much as possible the services that they deliver whilst aiming to reduce the

cost to the taxpayer as well; not to remove services unless it can be delivered in a better way.

Mr Gibbs was not aware that the ICB had put a ban on working with the DWP to support people back into work due to the current budgetary position. He added that whilst the ICB is in recovery support, there are enhanced financial controls, but it does not mean that new projects will not be supported if they are warranted. There is a process to consider proposals from within the system where the ICB is the decision maker for those and there is an enhanced governance around the decision making which is a requirement of being in recovery support.

There are numerous examples where the ICB is taking advantage of the interconnectivity of the NHS. Mr Gibbs is talking to Mid and South Essex who have done some great work looking at reducing the number of people in hospital who do not need to be there and have improved the experience and outcome for patients and has produced financial efficiencies. Many of the 42 ICBs across England are finding themselves in a similar situation as Portsmouth; Portsmouth is gradually moving up the ranks. If members knew of any other ICBs who are doing things better, he would be pleased to hear about it so he could investigate.

The panel felt that the report did not do justice for the terrible situation that the ICB is in and wondered if there was anything the HOSP could do to put pressure on government. Mr Gibbs said there are many examples of duplication of work taking place in Hampshire and the IoW so it was important to hold the mirror up and look at if they are doing the best that they can do. All help to put pressure on government would be gratefully received. One of the biggest areas of concern if making sure the ICB can properly support social care for adults and children and young people, this would make a profound difference nationally to the delivery of healthcare.

With regard to agency staff, Mr Gibbs said he would share the details of the ICB workforce transformation plan, which is one of the five pillars of change that the ICB have adopted for Hampshire and IoW. Ron Shields from Southern Health is leading on this work which is looking at how to reduce agency costs. He added that Portsmouth Hospitals University NHS Trust have done exceptional work reducing their agency spend for trained nurses to zero. This is because they have done an amazing job with recruitment they have been able to cope with some of the additional challenges and pressures through winter. Those teams are working incredibly hard to address that problem. One of the constraints that they will face in coming years is the pipeline of professionals coming into the system therefore all partners need to work together to create opportunities for local people to be inspired to take up careers in health and social care to deliver services locally.

The panel were concerned that the ICB were going to undo the good work already taking place in particular localities. Mr Gibbs said that he was inspired by the work that has happened at the integrated units at HCP in particular and believed in the value of integration and doing things in partnership. He added though there is value in a localised approach and gave the panel the

opportunity for the Chief Medical Officer at the ICB to come to the panel to discuss the ICB local and primary care strategy which is focussed on the idea of integrated neighbourhood teams. It was important that when service models are created that it is done in partnership with partners in local authorities, primary care, practitioners, and the community itself.

In response to a question on whether Portsmouth should pull out of the ICB, Mr Gibbs said that the local authority's strategic direction is for the local authority to decide and agree. The ICBs position is they are in a challenging situation but the ICB is valuable and they want to continue the great work that is happening in HCP and to grow and develop this. The only way this will happen is in partnership with PCC and with the other partners involved. He did not think that PCC should withdraw from the ICB. He was not aware of any LAs that had withdrawn from an ICS but would research this. He added that Portsmouth ICB has the privilege of being the first to go through this process, which is a learning process for NHS England. Mr Gibbs said he was grateful for the level of challenge and support from PCC and felt that the ICB were in a position to more forward now and he looked forward to working collaboratively with partners in Portsmouth.

Mr Gibbs said the ICB had to move into a prospective rather than a reactive position and work with partners to look at how they can deliver the best possible service for residents. It was important to use the ICP to help drive the strategy around focus attention and to learn from experiences in the last six months in particular to help improve the way partners work together.

The Chair asked Mr Gibbs for an update on the Stroke Recovery Service and said that PCC had written to the ICB to ask if they will fund the service in the future. Mr Gibbs said that the ICB are working towards funding the service with the Wessex alliance and there is a piece of work looking at the pathway development for stroke rehabilitation and he expected that this would be commissioned. The deadline for completion is at the end of quarter 3 in this financial year and he felt that this needed to be sped up a little and he would do his best to expedite this. The panel asked that the ICB write to the Leader and Chief Execuitve of PCC to give an indication of progress and come back to a future HOSP meeting with an update.

The panel were pleased to hear this update.

In response to a follow up question, Bernie Allen, Deputy Place Director advised that the ICB are working with the Wessex Integrated Stroke Delivery Service to develop the detailed model. The Integrated Community Stroke Service Model (ICSSM) is part of the National Stroke Service Model and outlines key features of successful rehabilitation services. Bernie had prepared a supplementary paper which she would circulate straight after the meeting giving more detailed information.

Mr Gibbs said that the work being undertaken currently is looking at whether the service would be in house or a tendered service. Any updates would be shared with the panel.

The Panel thanked Mr Gibbs for attending today and it was noted that a report would come to the next HOSP in June with an update to also the ICB workforce transformation plan and the integrated neighbourhood strategy. The Panel noted the report with concerns.

15. Health and Care Portsmouth update (AI 6)

Bernie Allen, Deputy Place Director presented the report and explained that the urgent emergency care pathways are experiencing significant pressures nationally and attendances at emergency departments and the subsequent admissions to hospital have been as high as they have ever been. Mid-March there were some signs of recovery with improved performance against some key areas.

In response to a question, Ms Allen said that the extra pressures were a mixture of increasing levels of unwellness across all populations however this is not unique to Portsmouth.

The panel noted the report.

16. Access to Primary Care update (AI 7)

Bernie Allen, Deputy Place Director presented the report. In December there was a downturn in number of GP appointments which is linked with the number of bank holidays in the month and how they fell. In January 2024 the number of GP appointments that took place was 105,471. Rates per population also increased correspondingly. 44% of appointments were same day appointments and 86% were seen within 14 days. Portsmouth compares favourably with Hampshire and the IoW where 83% of appointments are seen within 14 days.

In response to questions, Ms Allen clarified the following:

With regard to the table on page 88 of the report pack not aligning with what is written in the paragraph above, Ms Allen said she would need to check the narrative and get back to the panel.

With regard to publicising the good work taking place with numbers of GP appointments increasing, Ms Allen said that these statistics are published on their social media which is well read. The panel noted that elderly people may not look at social media and those are the people who are often think that not enough is being done to increase access to GPs.

Ms Allen said she would find out why three of the practices listed in the table in paragraph 1.1.9 had not met the 95% threshold of delivering appointments within 14 days. She advised that they do regularly meet with all of the practices where access rates are discussed. She did not want to talk about specific practices before looking at the level of detail and she would report back to the panel.

The panel noted the report.

17. Solent NHS Trust update (AI 8)

Andrew Strevens, Chief Executive presented the report and explained that the creation of the single community, mental health and learning disability Trust for Hampshire and the IoW has been delayed for short time. NHS England wants Solent to spend more time with preparations to ensure a smooth transition. The plan is that the integration will take place in phases. The Hampshire Child and Adolescent Mental Health Service was transferred from Sussex Partnership on 1 February. The aim is for the IoW community mental health and learning disability service to be transferred to Southern Health on 1 May. The transfer of Solent NHS Trust services and the creation of the new Trust, Hampshire and Isle of Wight Healthcare NHS Foundation Trust was aimed for 1 July 2024.

In response to questions, Mr Strevens clarified the following:

With regard to parking at St Marys community health campus, there are a variety of green travel initiatives such as bike purchase schemes and hire cars for staff to use throughout the day to reduce parking pressures. The Chair said he felt the parking payment machines were more user friendly.

The organisations within Solent and Southern will essentially remain the same once the new trust is formed; any changes would be consulted upon. Some of the ways that services are delivered will have to change and any changes will be required to go through a quality impact assessment and where there are significant changes these will come through HOSP and Healthwatch for consultation.

There is no intention to reduce funding within the Portsmouth system for the new trust.

The Panel noted the report.

18. Southern Health update (AI 9)

Nicky Creighton-Young, Director of Operations presented the report.

The Panel noted the report.

19. Portsmouth Hospital's University NHS Trust update (AI 10)

Mark Roland, Deputy Medical Director presented the report and explained that Lee McPhail had been unable to join the meeting today.

In response to questions the following matters were clarified:

Maternity Services previous CQC inspection was 'Good'. The scrutiny is so close on maternity services at the present time so this was a big achievement. The panel passed on their congratulations to the maternity team.

The ambition of the firebreak was to get all health and care partners to work together to work out how to improve the situation and outcomes for patients and to improve working relationships between all partners.

PHU were recently joined by the National Clinical Director for Emergency Care visit recently who gave support and advice in terms of their progress with a view to towards building better emergency care.

The hospital has seen an increase in attendances over time along with increasing complexity and frailty of patients and high acuity. The firebreaks are having an impact; the current number of medically fit for discharge patients is at 150 which had reduced from 210 prior to the first firebreak. The answer is to try and support more people to have care in their homes or closer to their homes.

Gosport UTC had seen around a 200% increase in attendance over the last couple of years and are working hard to provide a good service.

In terms of comparison data, most would already be in the public domain and the ICB would be best placed to provide comparison data.

The Panel noted with pride the CQC report on maternity services and noted the update report.

The formal meeting endedat 3.46 pm.

.....

Councillor Mark Jeffery
Chair