HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at Council Chamber, County Hall, Lewes on 1 October 2015

PRESENT:

Councillors Michael Ensor (Chair), Councillors Ruth O'Keeffe, Frank Carstairs, Angharad Davies, Alan Shuttleworth, Michael Wincott and John Ungar (all East Sussex County Council); Councillors Sam Adeniji (Lewes District Council), Sue Beaney (Hastings Borough Council), Bridget George (Rother District Council) and Julie Eason (SpeakUp)

WITNESSES:

East Sussex Healthcare NHS Trust

Richard Sunley, Acting Chief Executive
Maggie Oldham, Director of Improvement

High Weald Lewes Havens Clinical Commissioning Group

Ashley Scarff, Head of Commissioning and Strategy

Eastbourne, Hailsham and Seaford Clinical Commissioning Group & Hastings and Rother Clinical Commissioning Group

Amanda Philpott, Chief Officer
Allison Cannon, Chief Nurse

Care Quality Commission

Tim Cooper, Head of Hospital Inspections
Terri Salt, Inspection Manager
Alan Thorne, Head of Hospital Inspection, South East

Sussex Community NHS Trust

Siobhan Melia, Commercial Director

NHS Trust Development Authority

Paul Bennett, Portfolio Director

OFFICERS:

Giles Rossington, Senior Democratic Services Adviser

13. APOLOGIES FOR ABSENCE

13.1 Apologies for absence were received from Cllr Pam Doodes (substitute Cllr Bob Standley) and Jennifer Twist. Cllr Peter Pragnell substituted for Cllr Bob Standley as an East Sussex County Council representative of HOSC.

14. DISCLOSURES OF INTERESTS

14.1 There were no disclosures of interest.

15. MINUTES OF THE MEETINGS HELD ON 22 MAY AND 16 JUNE 2015

15.1 The Committee agreed the minutes of the meetings of 22 May 2015 and 16 June 2015.

16. URGENT ITEMS

16.1 There were no urgent items.

17. EAST SUSSEX HEALTHCARE NHS TRUST (ESHT): CARE QUALITY COMMISSION (CQC) FOLLOW-UP INSPECTION REPORT

17.1. The Committee considered a report by the Assistant Chief Executive that recommended it consider and comment on the Care Quality Commission (CQC) Quality Report on services provided by East Sussex Healthcare NHS Trust (ESHT).

Care Quality Commission (CQC)

17.2. **Tim Cooper:** The following findings are taken from our inspection of 24-26 March 2015. We held a Quality Summit on 18 September 2015 to present our findings to stakeholders.

17.3. During this inspection we only looked at the four services that had caused us concern from our visit in September 2014: urgent and emergency services; surgery; maternity and gynaecology; and outpatients and diagnostic imaging (we now include diagnostic imaging in our outpatients inspection but did not during our first inspection).

17.4. The inspection process for this Trust has been protracted but was not meant to be. We have apologised to East Sussex Healthcare NHS Trust (ESHT) for our delays, and internally we have learned some lessons for how we can improve the process in the future.

17.5. We submitted our report from the three day follow-up inspection – undertaken from the 24-27 March 2015 – for comment to ESHT at the end of June with the intention to publish it in July. However, the Chief Executive of the Trust resigned before the intended publication date, and we felt it would be more helpful to hold a Quality Summit in September when the Trust Board was in a more stable state to be able to respond to the issues. Nevertheless, we continued to discharge our duty between July and the Quality Summit in September by working with the Trust on some of the issues in the report.

17.6. Our findings in the report relate to our March 2015 inspection. Judging by what we heard at the Quality Summit, some of the findings may no longer be relevant as ESHT appears to have taken a lot of action to address them.

17.7. Overall, our ratings are exactly the same as they were before. We found limited progress during our March inspection and again rated ESHT *inadequate* overall; *inadequate* for

the safe and well-led domains; *requires improvement* for the effective and responsive domains; and *good* for caring. The ratings for both Eastbourne District General Hospital (DGH) and Conquest Hospital remained the same as they had been in September 2014.

17.8. During our March 2015 inspection we made a number of key findings. We saw:

- There was an issue with staff engagement. When we spoke to members of the Trust Board – and in particular the Chief Executive – during the March 2015 inspection, they recognised that there was an issue; however, we found that it was much greater than the Trust Board understood. We heard a lot of positive discussion from people at senior management level and a lot more negative discussion from people on the ground. We found there was a widespread disconnect between the Board and staff; a culture where staff were afraid to speak out and share their concerns openly; were afraid for themselves and colleagues; and were concerned about their personal confidentiality – staff mentioned these concerns every time they spoke with us.

- ESHT performed poorly in the NHS staff survey. The NHS staff survey is an annual survey that asks staff for their views on 29 questions based around the six NHS pledges. The most recent survey results were published in January 2015 and relate to the survey carried out in late 2014. The Trust was below average for 23 of the 29 measures and in the bottom 20% for 18 of them. It was in the bottom 20% for “staff engagement” and “ability to contribute towards improvement at work”. When we spoke to the Chief Executive at the time he expressed disappointment at the results, but we did not see an overall programme that was going to address those concerns.

- The Trust had lost its credibility with the public and we did not see an engagement strategy to begin to rebuild some of that credibility. We saw ESHT fail to engage with significant elements of the community and key stakeholders.

- Issues in Outpatients Department had begun to be addressed. However, there was a long way to go to address in a sustainable way some of the major issues, such as referral times.

- Some improvements had taken place in surgical theatres, but a similar pace of sustainable improvement had not yet taken place in surgical wards.

- Patients were not being seen in the timescales set by their clinicians. The call centre – the interface between the Trust’s outpatient service and the patients coming through the door – was not effective. Patients were often unable to make contact with the call centre and there were insufficient staff to deal with the enquiries.

- Clinics were sometimes cancelled at short notice and patients were not informed. There were insufficient staff to ring patients to let them know that a clinic had been cancelled even if it was known beforehand; we saw examples where patients turned up on the day of clinics that had been cancelled 24 hours beforehand.

- Staff had lost faith in the incident reporting system, meaning that there was no continuous cycle of staff learning from the incidents. All hospitals should be learning environments where staff report when things go wrong – whether this is a near miss, or a patient coming to harm – so that they can at least take the learning from the incident and prevent it happening again.

- The governance structure for incident reporting was beginning to be designed but was still too early in its development to see any benefits from it, although in surgical theatres and maternity services we saw the early signs of some improvements.
- The risk register did not capture risks in a robust way.
- There were low staffing levels in many areas that were impacting on the quality and the effectiveness of care, for example, insufficient medical staff in A&E meant that the medical cover rota was insufficient to meet the needs of the service.
- In maternity we saw some improvements but the major change that was needed to make a sustainable difference had still not happened. We were assured during our March inspection that it was going to happen.
- The accuracy and robustness of data that people were relying on was making it challenging for the Trust to make decisions.
- The level of training in safeguarding and protecting vulnerable adults was well below acceptable levels for medical and surgical staff.
- There were challenges over medicines management, particularly with the register of controlled drugs. The register had shown that one drug was missing but nothing was being done to prevent other drugs going missing in a similar manner, such as more frequent and improved quality checks.
- The Trust was frequently breaching single sex accommodation guidelines, particularly in the clinical decisions unit. In this unit, men and women were being accommodated in the same areas of the building, sharing sleeping areas, and passing each other on the way to the toilets. Patients were meant to be there for 24 hours but we saw some there for up to 96 hours, which is a considerable amount of time for men and women to be sharing accommodation.
- In outpatients and radiology, particularly the latter, there were challenges to people's privacy and dignity in the waiting area, the changing rooms, and during clinical procedures – which we saw being carried out in corridors.
- There were challenges with people's health records. We first found this during our September 2014 inspection and we know in March 2015 that the Trust had agreed a new health record tracking system that would improve the situation, but it was not in place when we made our second inspection. I understand that it is now in place.
- The Trust was failing to meet the standards for the national schedule of cleanliness. Theatres, outpatient facilities and secretarial offices require different cleaning and auditing schedules and many of those schedules were not being followed.
- There was not appropriate training for staff to be able to fulfil their duty of candour. The duty of candour is the legal duty to be open with patients when things go wrong; it requires a particular process to be followed involving the clinician making a formal apology beginning with the words "I am sorry".

- The Trust received a higher number of complaints than we expected, and the complaints system still failed to give people appropriate redress and understanding of the issues that they had complained about.

17.9. Our key findings led us to produce our “must do actions”. These are a series of actions that we expect ESHT to do in response to our report that we were not assured were underway in March 2015. We expect the Trust to:

- Give serious consideration to how it will rebuild effective relationships with its staff, the public, and stakeholders.
- Create a culture grounded in openness that makes staff feel able to speak out and talk about their concerns.
- Undertake a Root and branch review across the organisation to address the perceptions of a bullying culture and create an organisation that is open, listens to staff, and treats them fairly.
- Review waiting times for outpatient appointments so that they meet government targets for referral to treatment waiting times. The measure of waiting times changed in June 2015, but to ensure that patients do not have to wait long for treatment, we expect the Trust to follow the spirit as well as the letter of the referral to treatment waiting times.
- Ensure that patients’ health records are available and data is managed confidentially.
- Review the way maternity staff are deployed to ensure that there is sufficient provision to meet the Royal College of Midwives guidelines.
- Reduce the proportion of outpatient clinics that are cancelled at short notice. Where this is unavoidable, we expect the Trust to notify patients in a timely way.
- Improve the governance of the incident reporting system so that the number of incidents reported reflects the numbers that have happened, and ensure that staff feel able to speak out to report those incidents.

17.10. There are a number of regulations under the Health and Social Care Act 2012 that we know have been breached by the Trust. Our judgement is that there was a breach of:

- Regulation 10: “Dignity and Respect”;
- Regulation 12: “Safe Care and Treatment”;
- Regulation 15: “Premises and Equipment”;
- Regulation 17: “Good Governance”; and
- Regulation 18: “Staffing”.

17.11. We have set timescales for when we expect to see significant action by the Trust on these breaches. Different breaches of the regulations have different timescales for resolution, for example, it takes longer to resolve staffing issues than it does to resolve breaches around dignity and respect. We have set our timescales of response

recognising the action that the Trust needs to take; we expect to see significant action and progress for some breaches by October 2015 and some by March 2016.

17.12. Due to the high number of regulation breaches, the CQC issued ESHT with a Section 29a warning notice in July 2015. The CQC issues a Section 29a warning notice – instead of individual warning notices – when: a number of regulations have been breached; there is a requirement of significant improvement across the Trust; and, importantly, the CQC considers that all the breaches are interrelated.

17.13. On the basis of the challenges, evidence and breaches of regulations that we saw, the Chief Inspector of Hospitals has recommended to the NHS Trust Development Authority (TDA) that ESHT be placed into special measures.

17.14. **Councillor Michael Ensor:** I think that I can speak for the rest of the Committee when I say that I am grateful to have been provided with this level of clarity, but at the same time I am saddened to see the deficiencies in the Trust that you are exposing – all of which require urgent attention, and some of which we had already assumed were common place. I would like to reflect that it is an unusual process for a trust to be put into special measures – only 4% of CQC inspections have shown a hospital to be inadequate overall.

17.15. **Councillor Michael Wincott:** On page 26 of the Summary Report it states that “in one instance we found that the Trust had directed staff to move evidence related to medical records that the staff themselves construed as a deliberate attempt to mislead the inspection team”. Are you confident that the people informing you of progress since the last inspection are not the same people who directed staff to deliberately mislead you?

17.16. **Tim Cooper:** We will not just take the word of the same people who could be the ones implicated in the report. During the next part of the process we will be working with the Trust on a very regular basis to identify the progress on issues we previously identified. We will measure progress from a number of sources; not just from the Trust but from staff and members of the public. If we are concerned that progress is not forthcoming, we will go into a hospital unannounced and test out what we have heard.

17.17. We are also of the opinion that work cultures are very difficult to describe, but you know them when you see them, and you can see when they change. We feel assured that the work culture at ESHT is beginning to change.

17.18. **Councillor John Ungar:** You said that there seems to be some improvement, but the report seems to indicate that only the radiology department has improved. You said that you have set timescales for responses to warning notices, but is there a date by which you expect that the Trust will be fit for purpose?

17.19. **Tim Cooper:** This depends on when the CQC returns for another comprehensive inspection of the Trust. Once we receive ESHT’s responses to the warning notices, we will carry out inspections in each area that triggered a warning notice to test whether those issues have been addressed. However, addressing the warning notices is not the same as addressing the overall improvement of the Trust in a follow up full inspection. The next follow up inspection will address the wider issue of whether the Trust is on an overall “improvement journey” based on the evidence that we find.

17.20. **Councillor Angharad Davies:** You stated that during the follow-up inspection there was improvement in surgery theatres but not surgery wards. What exactly did you mean by that? Also, when you are talking about surgery, are you talking about general surgery or all surgical services?

17.21. **Tim Cooper:** The CQC is referring to all surgical services across the site: theatres, anaesthetics, and surgical wards.

17.22. The CQC inspection reports of DGH and Conquest Hospital sets out specific examples of areas in surgery services that have improved and that have not improved. During the second inspection, surgical theatres in the Trust had begun to understand the issues identified in our first inspection: reporting, checking, and staffing all appeared to have improved. However, the same transformation had not taken place on the surgical wards. The reason for this may be to do with local leadership rather than wider leadership, as wards are managed by individual ward managers and theatre is managed by a separate theatre manager.

17.23. **Councillor Alan Shuttleworth:** I know that there has been two significant changes in the leadership of the organisation – and I welcome those, although they should have come sooner – but I am alarmed that in page 58 the lack of trust between the Board and frontline staff shows that the culture goes further down the management chain than the Chief Executive and Chairman. Can you comment on whether there needs to be some changes further down the organisation to address the underlying issues?

17.24. **Councillor Peter Pragnell:** You emphasised that the inspection was in March 2015 and that now, 7 months later, changes have been made; are you in a position to say what is improving and what is not?

17.25. **Councillor Bob Standley:** You have explained how the publication of the first two reports was delayed. How will the CQC ensure that the third report is released more promptly than the first two?

17.26. **Tim Cooper:** It would be wrong for me to comment on what the Trust is doing to improve its services because that is for the Trust to set out. Our role is to monitor, inspect and regulate whether that progress is meeting fundamental standards of quality and safety.

17.27. I want to reassure people that whilst we took the very difficult decision to delay this second report for what I think were the right reasons – to give the new leadership a chance to stabilise – one of the things that we set out to do was to ensure that members of the public are protected and services are provided safely, and to do that we need to take formal regulatory action.

17.28. Even though we delayed the Quality Summit and the publication of the report, we were taking action with the Trust as early as July, for example, we served our warning notices during July and had work going on with the Trust, CCGs and TDA so that we were cited on the progress being made. Consequently, we should not read too much into the fact that the report was delayed to September 2015 as things were happening in early July.

17.29. It is not right for me to comment on the leadership of the Trust – as it is not the CQC's role – but what we have done is insist on a root and branch review of a number of areas that you would term as part of the leadership and culture of the organisation. I would

make a comment: whilst the leadership comes from the top, there also needs to be a degree of stability in the Trust Board to carry forward the changes that need to be made.

East Sussex Healthcare NHS Trust (ESHT)

17.30. **Councillor Michael Ensor:** I am encouraged by the report that both critical and medical care throughout were classified as “good” and that care generally across the Trust was “good”. I would like to draw that to the Committee’s attention because I think it shows that the staff have an attitude of caring, even though the infrastructure, management and other aspects of the Trust are inadequate.

17.31. **Richard Sunley:** Today is not a day for celebrating success; it is a time for us to recognise where we are as an organisation, and to make a stand as a Trust Board for a new start. If there are only two points that you take away from our response today they are these: we are very disappointed about the shortfalls the CQC has identified, and we are sorry that we have let down our staff, colleagues and people who use our services. We acknowledge that we have not delivered the standards the people of East Sussex rightfully expect from us.

17.32. In our reflection as a Board, we accept the need to engage in a more meaningful way with our staff, stakeholders in the local healthcare economy, and the wider population. We have been through a difficult and challenging time and we know we need to urgently deliver improvements. I am here today to demonstrate that the Board and I are committed to that goal, are determined to make a new start, and are already working hard to meet our ambitions to improve at pace and deliver excellence to the people we serve.

17.33. As an organisation we need to rediscover our passion and ambition. We want the patient experience in all aspects of care to be exemplary, but we recognise, hand on heart, that we can’t say that about all aspects of the care we provide today. We want to be the healthcare provider of choice in East Sussex – of choice for patients and of choice for commissioners – but we also know that this is not currently always the case.

17.34. We know to achieve our aims we will need to deliver – and demonstrate that we have delivered – high quality care to patients. We need to be an employer of choice in East Sussex but – recognising that it is hard to recruit in East Sussex – we need to be more attractive to potential employees by emphasising the areas where we continue to deliver strong services, such as cardiology, haematology and urology.

17.35. We need to work with partners to be innovative in developing new roles. We need to work with the wider health and social care economy to optimise patient flow and deliver outstanding patient care, which we continue to do as part of the East Sussex Better Together programme (ESBT).

17.36. We need to listen to, and be responsive to, stakeholders – and re-forge relationships with bodies such as Healthwatch, campaign groups, and HOSC.

17.37. We know we need to work with our staff and local communities to help create a future with sustainable, high quality services for the people of East Sussex.

17.38. We need to support staff to speak out safely. It is shocking to me that a bullying culture exists; where this is the case it has to stop.

17.39. We need to be a learning organisation that learns from mistakes, complaints and incidents.

17.40. We need to deliver this change within our allocated funding agreed with Commissioners. This is our ambition. However, we know we have a long way to go.

17.41. I would restate our huge disappointment in the “inadequate” rating, but we recognise it is up us to demonstrate that we can improve significantly. I would once again like to emphasise our determination to do this and to realise our ambition for healthcare in East Sussex.

17.42. As I mentioned, this is not a time to celebrate success. However, specific areas of good practice were seen by the inspection team and are acknowledged in the CQC report. We are not underestimating the task ahead of us in improving our services, but we should recognise the things that we do well. As is already mention, care was rated as “good” across the whole Trust and that is a testament to our staff. The key to our success will be for us to sustain and exceed a “good” rating throughout the implementation of our Quality Improvement Plan (QIP) and beyond.

17.43. We have developed a QIP from the detailed reports of the September 2014 CQC inspection report and it now incorporates the March inspection findings. Our QIP is rightly owned by the whole Board and senior team, and is appropriated by teams throughout the organisation. The management of our plan is led by Alice Webster, Director of Nursing, supported by our Project Management Office, and benefits from the support and advice of our new Director of Improvement, Maggie Oldham. In addition, we set up a number of Task and Finish Groups and workstreams associated with the QIP. Delivery of the QIP action plan and targets are discussed at our Corporate Leadership Team on a weekly basis; the Clinical Management Executive on a monthly basis; Trust Board meetings and seminars; and team meetings and departmental meetings throughout our clinical unit structure.

17.44. We have made many changes to our services since the March 2015 inspection:

- Patient confidentiality and information governance in Outpatients Department has been improved. Space and equipment has been provided to support patient assessment and secure record storage, and there is building work planned to fix that patient confidentiality permanently. In Maternity Services we have already started building confidential handover space in the delivery suite.

- The number of breaches of regulations around mixed sex wards has fallen. It is a priority in our first Estates Strategy – developed by the new Director of Estates and Facilities – to achieve a sustained improvement in the privacy and dignity we provide patients by improving the layout of Radiology and A&E at both hospitals.

- A wireless tagging system was successfully implemented in August. It allows the tagging of all our medical records and allows proper organisation of our record libraries on the acute hospital sites. 22,000 records have been tagged off site from the Conquest Hospital and 52,000 tagged offsite from the DGH. We have the expectation that – as with other Trusts where this tagging system is in place – we will see reduced duplicate and temporary notes, and clinics will be supplied with notes in a more timely way.

- For the first time, standard operating procedures for our various booking processes have been developed – in consultation with our admin staff – that are designed to standardise and simplify the booking process. They are being implemented in October.

- We have sustained clinic cancellations at six weeks' notice for all but unforeseen, short notice changes. In April, we were routinely cancelling clinics with less than three weeks' notice due to a back log of requests. We do not underestimate our position on this crucial area of patient experience and we have a long way to go with our admin and booking processes. However, we have set up a task group that is meeting weekly to tackle this difficult issue by providing weekly reports to the senior team and carrying out staff engagement sessions.

- With the understanding of local Commissioners and the TDA, we have focussed on the last months on the waiting list backlog and as a result waiting times continue to improve. The last 52 week waiting time patient was reported in December 2014, the backlog for over 40 weeks has been eliminated, and we have turned our focus on to the next milestone: sustaining a position of nobody waiting over 35 weeks by November 2015.

- The incident reporting rate has increased from 600 per month at the time of the CQC visit to more than 800 per month during September. This has been achieved in part by awareness sessions by our Governance Team.

- I have worked with the Chief Pharmacist at the TDA to commission an independent review of the Medicines Management Service. As a consequence of this review – which took place a couple of months ago – we have made management changes at the highest level in the Service; we have identified partner organisations with exemplary practice; and we have jointly developed an action plan with the TDA.

- In acute surgery, a recent national audit of non-elective laparotomy shows that our Surgical Services are high performing. The audit demonstrated that the Trust has immediate, consultant delivered surgical and anaesthetic care with consequent fast decision making time to theatre; 100% of high risk surgery was shown to be delivered by both a consultant surgeon and a consultant anaesthetist.

- The Royal College of Surgeons will undertake an "invited review" of our surgical pathways next month. The terms of reference of the review will be shared with our partners.

- Health Education England and their branch for Kent, Surrey and Sussex carried out a visit two weeks ago of our Maternity Services and met with 20 trainees, students and all of the maternity and education team. In their verbal feedback they recognised the improvements made in identifying a generous and supportive culture, no safety issues, and a much improved staffing complement. We are keen to share the report with the CQC and HOSC when it is published in the next few weeks. The report will also talk about the culture of support, multi-professional working, and the use of daily multi-disciplinary risk meetings.

- We have reviewed our cleaning frequencies to reflect invasive procedures in outpatients – an issue highlighted by the CQC report – and have piloted a new role, Ward Orderly, to support nursing staff in equipment cleaning. We are in the process of recruiting to the Ward Orderly posts.

- We have invested resources into direct patient care areas and established a relationship with Allied Health professional nursing and midwives. We have seen successful recruitment drives – particularly in the healthcare assistant field – despite a difficult recruitment market.

- Mandatory training levels have significantly improved across the Trust, particularly in health and safety, mental capacity act, and deprivation of liberty.

- Our high standards for mortality and morbidity – and those given to us by our Commissioners in the form of SEQUIN targets – have been maintained, with excellent clinical engagement in reviews.

- Our handling of complaints has been recognised as improving, with the number of reopened staff complaints remaining low. We have launched a "speak-up, speak-out" initiative and have just recruited a full time "speak up guardian", which generated high interest from applicants. Volunteer champions in all areas of the Trust have also been signed up to support the delivery of this approach, for example, the whole of the joint staff committee volunteered themselves.

- There is a new Senior Management Team in place that is aligned to clinical units. A number of staff listening events have taken place since March, with a further 14 planned.

- Weekly staff drop-in forums are being delivered by myself and supported by other members of the Executive team. With a running "you said we did" log to demonstrate listening and action.

- Following positive discussion and the support of the Faculty of Medical Leadership, we are looking to sign up to a programme of medical leadership development, having firstly assessed our current engagement using the well-recognised Medical Engagement Score. We will next develop a more detailed programme for our clinical leads in November.

- We have engaged with Capsticks to undertake a review of our governance process in October.

- Through the support of the Deanery, we have started discussions about developing innovative training that plays on our position as a new integrated provider (of acute and community healthcare). We expect that this will lead to approaches of working across healthcare traditional boundaries.

- We have made significant progress on developing Locality Teams and new multi-disciplinary roles with the CCGs and East Sussex County Council through the ESBT programme. We are also strengthening our work with, and through, Healthwatch to engage with the local population and campaign groups.

17.45. In summary we are targeting our resources on improving operational delivery in key areas; and working with others to draw on expertise to deliver improvements in governance, medical management, staff engagement, and our understanding of how we might use their experience and learning to improve our own service delivery.

17.46. We need to deliver on our assurances to staff that we are a listening and learning organisation and to assure them that the perception that we are a bullying organisation

has been tackled. We must ensure our strategic direction delivers the aspirations of our commissioners and patients, and we must, as a Board, play our fully committed part in the local health and care systems. We need to work with commissioners, politicians, campaign groups, local councillors, carers, patients and their representative organisations in a new, more transparent, and collaborative way to deliver improved outcomes to our patients.

17.47. I am here today to make a stand on behalf of the Board of ESHT. This is not a time for celebrating success it is a time for recognition of where we are as an organisation and to make a new start as we recognise our mistakes and engage with the healthcare community to deliver change in a more meaningful.

17.48. **Maggie Oldham:** My appointment has been made by the TDA and I am salaried through them, not through ESHT. I am very glad to be bringing my experience from Mid Staffordshire NHS Foundation Trust (Mid Staffs) to support my colleagues here who are tasked with some of these challenges that lay ahead. I was at Mid Staffs from 2010-2012 as Chief Operating Officer and Chief Executive Officer from 2013- 2014, after which the Trust was dissolved and merged with its two neighbouring trusts.

17.49. I think that there are some commonalities between Mid Staffs and ESHT, but there are great differences between the two organisations. Some people think that because I have come from Mid Staffs that ESHT must be of the worst trusts in the country; obviously that is not for me to say, but I am not seeing the same levels of problems that I saw when I went to Mid Staffs in 2010.

17.50. I am looking forward to working with HOSC and providing you with assurances that the Trust is improving.

17.51. There are two major indicators that will demonstrate that the Trust is going in the right direction but unfortunately they are annual: the Staff Survey and the Patient Satisfaction Survey. We cannot wait a year to be able to show that the Trust has made progress, so we need a live, plain speaking, and transparent recovery plan that members of the public can access via our website – and which we will bring to HOSC.

17.52. There is an issue with just relying on Red, Amber, Green (RAG) ratings and being satisfied that we are moving from red to amber to green. We should be looking at the narrative of what it actually means to be improving and whether we are able to sustain that improvement. The ESHT Trust Board is clear that we need to provide a long term fix and we want to avoid a situation where we attend HOSC and show that we have regressed on our RAG ratings.

17.53. One of our central workstreams is around leadership and changing the management culture. Major changes in this workstream include:

- The Chair, Chief Executive, Director of Strategy, Director of Finance and one of the Non-Executive Directors have left the Trust over the last few weeks. We are now in the process of formally recruiting to these posts.

- Changes have been made in the Senior Nursing Team and within the Pharmacy Department.

- A Director of Estates and Facilities and a new Senior Manager for Performance have been recruited.
- Changes have been planned to how our Business Information Unit, Performance Team and our Programme Management Office work to ensure there is a robust monitoring of the assurances that we are giving to people.

17.54. In my experience that is a huge amount of change in a short period of time. One of the most difficult hurdles to overcome in Mid Staffs was the lack of organisational memory. Without senior managers to provide some of the history behind the problems that have occurred – and the solutions that have been attempted – patients can be put at risk and the pace of change can be too slow. It is easy to get carried away with the emotion, but the reality is that the loss of further senior posts within the Trust will set us back on our road to recovery.

17.55. The special measures include a capacity and capability review of the governance arrangements of the Trust Board and Senior Management Team that will expose senior managers' skills and deficits. This will provide us with the opportunity to develop training packages for individual senior managers that will help equip them with the necessary skills to carry out the required improvements to the Trust.

17.56. At Mid Staffs we successfully employed this method of identifying deficiencies in people and providing appropriate training to give those people the skills to be able to work at the right level. The vast majority of employees who are in Mid Staffs now who celebrated some of the successes between 2010-2014 were the employees who were there during the times that services were very poor.

17.57. My experience at ESHT so far has shown me that there is an overwhelming willingness from front line staff to grasp the issues that were raised in the CQC report and work with the management team to make the necessary improvements.

17.58. I think that it is good that the QIP has been generated in those service areas that were rated "inadequate" by the CQC; a QIP will not be effective if it is developed as a top down recovery plan that is forced upon service areas with their own specialities and issues.

17.59. The development of the QIP involves teams in the affected service areas telling the management team why things are not working as they should, and how the management team can assist them with putting in the necessary resources to make them work. The QIP should be available to share with HOSC by November 2015.

17.60. I cannot speak for what has gone on in this health economy previously, but what I can say is that we can only sustain this improvement if we all work together.

NHS Trust Development Authority (TDA)

17.61. **Paul Bennett:** The package of special measures we are putting in place at ESHT include:

- Employing a Director of Improvement (Maggie Oldham) at ESHT to provide experience, drive change, and make an impact on the ground. This is a critical part of the special measures package.

- Carrying out a capability and capacity review (as mentioned by Maggie Oldham) to help us understand how the Trust is performing – we may consider whether the scope of the review reaches further into the organisation than just the Trust Board and Senior Management Team. Due to the number of vacancies and the inevitable time it will take to get people into posts, we think that it is important that the review is completed in time for the new Chief Executive and other senior managers to have something to help them develop an understanding of the Trust, and how they might want to take the leadership of the Trust forward.

- Providing ESHT with a “buddy organisation”, which is a successful trust with clear strengths in areas where we know ESHT has deficits. Critically, the buddy organisation will need to have the capacity to provide the support as many trusts are under extreme pressure. It is a complex process that we began after the CQC recommended that ESHT go into special measures.

- An ongoing monitoring programme of the improvements at ESHT alongside the CCGs and NHS England, as well as HOSC and other agencies. This is a tried and tested approach that we are working with all of these agencies to get into place.

- Increased oversight and scrutiny of the Trust Board’s day-to-day business by the TDA.

- Bespoke elements of assistance that come from the diagnostic process that we perform on the Trust.

17.62. **Councillor Michael Ensor:** It is my understanding that – unlike Ofsted – the TDA does not have the power to remove a trust board of a trust in special measures. Could you explain the legislative powers of the TDA?

17.63. **Paul Bennett:** The NHS does have the power to remove a trust board but it is only when the trust goes into administration – which is what happened in Mid Staffs – and it needs to be agreed by the Secretary of State.

17.64. The TDA monitors, supervises and holds trusts to account at different levels depending on how they are performing – these various levels of scrutiny are set out in an accountability framework. The highest level in the framework that the TDA can subject a trust to without reference to the Secretary of State is to put it into special measures on the basis of a recommendation from the CQC, as it has done with ESHT.

17.65. NHS England has also now introduced a special measures category for CCGs that is different to the special measures category that applies to providers.

17.66. **Councillor Michael Ensor:** What is the progress on the appointment of the chief executive and chairman?

17.67. **Paul Bennett:** The appointment of a chief executive is the most important decision that a chairman makes. The Chairman of ESHT (Stuart Welling) originally committed to stay in post until he had appointed a new chief executive and a new chairman was appointed to replace him. However, he has recently announced that he is stepping down.

17.68. The TDAs first task is to find a suitable interim chair. We have also started the process of recruiting for a substantive chair and we would anticipate that an advert will be put out in

the next couple of weeks. We will also run a parallel process for appointing a chief executive that will be sequenced so that they are in appointment in the right order.

17.69. **Councillor Ruth O'Keeffe:** I am concerned at the Trust Board's use of phrases such as "very disappointed" and "making a stand as a Board" as it suggests that the Board expected another outcome and is not reaching out to staff.

17.70. A lot of what ESHT said is very aspirational, but HOSC has heard a lot of aspiration before – what we will be looking for is actual evidence of positive outcomes, and I hope that in the future we will receive trustworthy information. I would also not want to underestimate the power of seeing RAG ratings go to green.

17.71. **Julie Eason:** HOSC has been waiting a long time for senior managers at ESHT to acknowledge that they have problems and we welcome this acknowledgement. However, I am disappointed to hear the term "perception of bullying". This Committee has said for a long time that it is not a perception of bullying – there has been bullying and the CQC report proves this. I would like to see no more mention of a perception of bullying and would like to see what is being done to address bullying.

17.72. I appreciate the importance of organisational management, but fundamentally you have a leadership team – in the form of your Trust Board and Senior Management Team – that is largely unchanged from the one that got a pretty horrific and, not surprising, damning indictment from the CQC. How do you take that team of people who oversaw a Trust where only the Crowborough Birthing Centre was well led and turn them in to the leaders the staff of the organisation can believe in?

17.73. **Councillor Michael Wincott:** I agree about the perception of bullying comment – the bullying is real. In both CQC reports there were lots of incidents recorded with specific examples of where there had been really bad management, a bullying culture, people feeling they were not listened to, and reports not being followed up – how many of those people responsible for these specific examples have been asked to leave, how many have moved on, and how many have been retrained?

17.74. **Richard Sunley:** We also like to see RAG ratings go green. RAG ratings will be used to help demonstrate in a digestible way to staff, the public, and stakeholders how our QIP will address the issues that we face. To make sustainable improvements on a number of those issues – such as those found in A&E and radiology – will require quite substantial time and investment. RAG ratings will help us to demonstrate to HOSC and other groups that we have made improvements in these areas.

17.75. I think that you are right about the use of the word "perception". We understood that staff working in the organisation perceived that they could be bullied and that we needed to address this as an issue. However, I think that it is clear from the issues being raised at the hour-long open forum sessions – which I have been running every week at DGH and Conquest Hospital – that staff have experienced definite bullying.

17.76. We are combating bullying by creating a structure outside of the management structure where staff complaints and thoughts about bullying will be channelled. This structure includes a guardian – who has been recently appointed – and enthusiastic champions who have been volunteering throughout the organisation.

17.77. **Tim Cooper:** You are absolutely right that the report sets out clear examples of bullying in a number of areas, but the phrase "perception of bullying" comes from our report and we are very clear what we mean by the term. The term is not used to derogate actual examples of bullying but to describe the wider perception by staff who may not have been bullied that – due to actual examples of bullying – they may be bullied themselves.

17.78. **Richard Sunley:** The Trust Board and Senior Management Team are limited by what they can oversee directly, so a lot of the improvements that the Trust needs to make must be carried out by managers at a grass roots level, for example, they need to understand that drug fridges are routinely locked, or that patient's notes in the Outpatients Department are routinely locked away and treated with respect. The dilemma we have is that we do not want to be seen to be identifying individuals recognised in the CQC report as having failed to perform these activities as this would build on the culture of bullying. Instead, we have to work with staff in an organised way – using our QIP as a guide – so that they understand what is acceptable and what is not.

17.79. I went back and looked at the issue of staff deliberately misleading the CQC around medical records in the Outpatients Department. I understand that when the Department was carrying out a check – with full knowledge that the CQC was coming – they came across a cupboard in the outpatients site at DGH that was broken but was still being used by staff. The decision was made that the notes should be moved from the cupboard to a secure place, which was clearly a decision that the CQC would pick up on. The cupboard has now been replaced with a lockable cupboard, but it is disappointing that staff had not replaced it as a routine task and instead chose to act only in the face of a CQC visit. I would dispute that this decision was deliberately misleading and I think that it shows there needs to be a proportionate approach to how we respond to the individual incidents in the CQC report.

17.80. **Councillor Michael Wincott:** The example of patient records is not the only example. The CQC state "we heard about several other examples which pointed towards potential misrepresentation of data"; this says to me that there was a more deliberate attempt by managers to mislead the CQC.

17.81. You say that you do not want to perpetuate the bullying culture by naming individuals that might have been implicated in the CQC report. Are you saying that there is basically an amnesty on managers no matter how badly they behaved?

17.82. **Richard Sunley:** I apologise if I am giving the impression that it all needs to be forgotten. Clearly the agenda we have been set by the CQC is challenging and it involves dealing with managers to ensure that they deliver the things that we expect them to deliver. The question is how do we do that?

17.83. There are a number of legitimate things that are happening to improve the capability of our management teams, including:

- Looking at the skills that our clinical unit leads possess and helping them to build them up so that they are able to develop their own clinical units.
- Opening roots of communication between the Senior Management Team and our staff, as it is a way of understanding how staff feel and allows us as managers to talk to them

about what is and is not acceptable behaviour. We previously did not have this capability, which was a failing on our part.

- As previously mentioned, there will be a capacity and capability review of the Trust Board as part of the special measures.

17.84. **Julie Eason:** how do you provide a new leadership model with fundamentally the same leadership?

17.85. **Maggie Oldham:** I want to be clear that I like nothing more than a RAG rating chart, but the excitement we get from it is not shared by the public; this was my experience at Mid Staffs. I also do not want to sit in front of HOSC with a RAG rating chart that we do not have substance behind.

17.86. I have a lot of energy and aspiration for this Trust. I have met so many people over the last few weeks and I think that the recovery is very much within our grasp. I do not expect that it will take two years as it has in some parts of the country – there is a real commitment from the staff to demonstrate to the public that the services are what they should expect. However, at the moment I do not have hard evidence to put in front of you and the public and I do not simply want to say that it has anecdotally improved.

17.87. I am of the opinion that during the working day you (as a senior manager) are a role model and everything you see and do during the working day is seen by thousands of other people across your organisation.

17.88. We are doing a piece of work looking at the last three annual NHS Staff Surveys to try and pick up patterns in management issues, for example, it is possible to pick out poorly performing managers who are shuffled from area to area by assessing the staff surveys in the different areas they have managed and finding a common decline in the workplace environment shortly after they arrive. Where this is the case, it is possible to sit down with the manager and set objectives for them to comply with within three months or warn them that the Trust’s conduct and capability process will kick in. We have not previously tracked poorly performing managers in this way.

17.89. All of the Trust Board Directors will be given clear objectives by the Interim Chief Executive over the next six weeks that will cover the areas in their portfolio; those who we know have evidence of bullying in their portfolio will have performance monitoring objectives that require them to show that it is improving over a short period. Our Director of Human Resources is looking at how we can do more timely interactions with staff instead of waiting for the NHS Staff Survey. This will allow us to look at detailed feedback from staff every few months in those areas where there are high instances of bullying to see whether it is improving.

17.90. Speaking for the Trust Board, any evidence of bullying or harassment made by a member of staff in a formal way in our Trust will be dealt with very seriously in accordance with standard NHS processes for dealing with such complaints.

17.91. I have worked with Tim Cooper in other organisations and it is frustrating to us when staff are too frightened to come forward to say that they have witnessed poor behaviour from managers, colleagues and other members of staff. I think that those who do give the name of their managers are very brave, as CQC inspectors and people like myself go home and they are often left with the consequences of their decision. However, it is

frustrating not to be given the name of a manager, or have a member of staff not prepared to give a statement, as we cannot deal with the issue formally.

17.92. Staff at ESHT do not feel able to give the names of managers who they consider have been engaged in bullying or harassment. We need to continue to build staff confidence so that they can come forward with the names of managers and know that we are serious about dealing with their complaint. Our QIP sets out how we will tackle this issue, for example, we will appoint a single point of contact for staff that will have champions across the Trust; we will set up staff helplines; and the Senior Management Team and Trust Board is currently running drop-in sessions.

17.93. During the six weeks I have been at ESHT I have seen a change in how staff use the drop-in sessions. Initially staff sat and listened to senior managers, but more recently staff have been feeding back what they have seen to senior managers; thanking the executive team where changes have been made; or telling the senior managers team that in certain areas they want more action.

17.94. We are going to spend some time setting the objectives of the Senior Management Team and Trust Board based on the results of the TDA capability and capacity review, which will list their strengths and weaknesses. We are also considering extending the review to the next level of management, but in the mean time they will monitored on an individual basis through the existing appraisal process.

17.95. **Amanda Philpott:** Reiterating what Dr Martin Writer said at the Quality Summit, the CCGs are really clear that it is the responsibility of all healthcare professionals to change a trust's culture and help us all get where we need to be as a health and social care system. National NHS support organisations can bring in expertise, but the solutions to the issues raised by the CQC have to be locally owned and system wide.

17.96. System wide solutions require commissioners and providers to be able to work together. This is helped by the fact that in our CCG team all of the senior colleagues have had Chief Executive or director level experience at provider organisations.

17.97. We need to work with ESHT's inspectors to help create a healthcare culture in East Sussex that is more open and transparent. I can say that even over a short period of time we have seen ESHT become a different, more transparent, and open trust that is looking to help solve these wider healthcare pressures together.

17.98. There is historic pressure across the whole of the East Sussex healthcare system, not just in acute care. We need to ensure that our health and social care professionals can work better across primary and secondary care pathways. The new ESHT leadership's endorsement and engagement in ESBT is a critical step to achieving this goal.

17.99. **Councillor Alan Shuttleworth:** I welcome and am reassured by Maggie Oldham's comments today, especially around bullying, but the Trust is in special measures and the CQC report shows that there is a lot of work still to do.

17.100. I welcome the capacity and capability review; I welcome the proposal to extend it to lower tiers of management; and I accept the notion of keeping people in place to ensure continuity. However, I remain deeply concerned that the majority of the Trust Board members have been through the process and failed to tackle the problems, even though they told us that they were aware of them.

17.101. I was disappointed when the TDA chose to keep on the Chair of the Board – although I understand the reason that they gave – as it means that we are behind schedule in appointing a replacement chief executive. I think that an interim chair should have been appointed from the outset to get the process moving faster.

17.102. I was worried to hear that the QIP was going to be owned by the Trust Board and senior managers; it should be owned by all staff from every level of the organisation, and they should be involved fully in the preparation of the plan. Until you get ownership and buy-in from the whole organisation, I do not think you will see real improvements.

17.103. **Councillor John Ungar:** I am glad to hear that the CCGs are working in partnership with ESHT, but I am concerned that in the past the CCGs did not appear to raise the concerns that we are now hearing about. If the CCGs had been working with ESHT closely before, then surely they would have also seen these issues arising – after all, the CCGs are paying ESHT to deliver services. I think that as reasonable and responsible organisations, the CCGs should have done some quality checks to know the quality of the service was meeting their specified requirements.

17.104. Are the CCGs prepared to give specific funding to help deliver those improvements that the CQC recommended ESHT make to its services?

17.105. **Councillor Peter Pragnell:** The important thing with RAG ratings is to achieve a “green” rating. However, improvements that are made to reach a “green” rating must be continuous, maintained, and strengthened.

17.106. The job of the non-executive directors is to question, take an overview of, advise, and challenge the executive directors. Did the non-executive directors know what was happening, and if so why did they not say anything? Does the TDA have the power to ask non-executive directors to step-down?

17.107. **Councillor Bob Standley:** I share this view on the performance of the non-executive directors, but I have taken a lot of positives from today. We need to look forward; we can learn from the past, but we should not dwell on it. Delivery of the QIP will indicate if there has been success, but my overall feeling is positive.

17.108. **Councillor Angharad Davies:** What comes across to me in all of the CQC reports is an impression that the senior doctors and nurses aren’t really playing a part – they are the leaders who innovate, bring in new ways of working, and who are on the ground doing everything on a day-to-day basis. In the NHS at the moment there is this attitude of managers coming up with a new strategy – usually as a reaction to there not being enough money – and telling people “this is how you are going to do it”. I get the impression that this is what is happening at ESHT. I do not get the impression that there has been collaboration or discussion with consultants about how they can make ideas work – unless that happens, the Trust will not turn around. I would like you to reassure me that this is the way you will go about it.

17.109. **Councillor Michael Ensor:** These were mainly comments from Members of HOSC. I think that you gathered the depth of our passion to see changes in ESHT and to support you in doing so. Some of the questions today have been about how you are going to change the management process, and I think that this will unfold over time. Members of HOSC are asking for reassurances and I am sure you can provide them.

17.110. We may be looking for the TDA to resource the changes Cllr Ungar asked about. I asked recently about the £30m capital full business case ESHT submitted to the TDA a few years ago (for its Clinical Strategy) – the TDA said that this money is no longer on the table.

17.111. **Paul Bennett:** I have been here 6 weeks and so am not aware of all the details around the full business case. As I understand it, the money is related to capital development and I would guess that with the appointment of a new Director of Estates it is being reviewed. I will report back to you, but my sense is that the findings in the CQC report are likely to lead to a different proposition from the Trust that may be more or less than the £30m, but my understanding is that is where we are in the process.

17.112. Cllr Ungar's question was about revenue and payment for services and not capital funding – that is a commissioning responsibility of the CCGs and NHS England. Is there money? No. The NHS has a significant deficit and is challenged nationally and there are very significant improvements we need to make to have sustainable health services in the way we want them – that is the context we are in. The TDA is not a funder of services; it finances the support for special measures.

17.113. **Amanda Philpott:** HOSC is wholly aware that when East Sussex was put into Challenged Health Economy arrangements 2 years ago, it was made clear that if no changes were made to how we provided services, there would be £240m shortfall in funding within the next 5 years. I just remind HOSC that (along with social care pressures) this is what led us to undertake ESBT. The way that we integrate services as part of ESBT involves working really carefully with all providers to make sure we make sensible transitions.

17.114. The CCGs have a whole year contract with ESHT for 2014/15 that includes not only paying for services at the national tariff rate, but also a risk share contract that means the Trust undertakes additional activities around responsibility for managing care pathways. The consequence of the risk share contract is that ESHT received £9 million above national tariffs for 2014/15.

17.115. We recognise that there are financial pressures across the whole of the health and social care system, but we have one pot of money. If we give more money over and above the level we are already giving ESHT, we will have to take it from somewhere else, for example, mental health services or primary care. GPs have already had their allocation reduced across the country from 10-7.5% and more money is needed for primary care to help reduce pressure on hospitals. Instead, we must work closely with ESHT to make sure its financial plans enable it to become sustainable in a managed way, and we must change the way services are provided through ESBT.

17.116. **Councillor Michael Ensor:** I will draw a line under the discussion here as I am sure there are a number of matters we will continue to look at. HOSC has already agreed to set up a review board to look at ESHT's proposed actions in response to the CQC reports and Members of the Committee have indicated which of the 5 service areas they will look at as part of a sub-group. This will ensure that we are able to work closely with ESHT to understand the progress they are making. We will provide an update on our progress at the next Committee meeting.

17.117. I have had communication from Caroline Ansell MP who has asked if HOSC will reconsider the reconfiguration of maternity and paediatric services. I have answered that we will not in the immediate term. Obviously, HOSC agreed to the reconfiguration subject to a number of recommendations, and if ESHT is unable to fulfil them then no doubt we will start asking questions.

17.118. **Councillor Alan Shuttleworth:** I am one of the Members of HOSC who was opposed to the reconfiguration – and there are others. A lot of the information we were given at that time I think now is challengeable, so I don't share your view. I think that a lot of what we were told before will need to be re-examined in the future, and I do think that we need to revisit the decision we made and consider if it was the right decision.

17.119. **Councillor Michael Ensor:** Your comment is noted.

17.120. **The Committee RESOLVED that it had commented on the ESHT CQC report.**

18. SUSSEX PARTNERSHIP FOUNDATION NHS TRUST (SPFT): CARE QUALITY COMMISSION (CQC) INSPECTION REPORT

18.1 The Committee considered a report by the Assistant Chief Executive summarising the recent CQC Report on Sussex Partnership NHS Foundation Trust (SPFT) services and SPFTs Action Plan developed in response to the report.

18.2 In addition to the report by Colm Donaghy, Chief Executive of SPFT, the following points were made in response to Members' questions:

- SPFT was in the process of developing its Strategic Plan at the time of the CQC inspection in January 2015. The CQC recognised that the Plan was in development, but indicated that they would comment on the current situation and so reported that SPFT "lacked strategic direction" at the time of the inspection.

- Wards for People with Learning Disabilities were rated as inadequate for effectiveness because of the performance of the 11-bed Seldon Centre in Worthing. The CQC noted in their inspection that the way that staff were treating patients at the Centre was causing risk. SPFT has now carried out the necessary training to address staff practices and the Centre has improved as a result. The Centre does not require capital investment in order to improve.

- Long Stay/Rehabilitation Mental Health Wards for Working Age Adults were rated inadequate on safety grounds because of one facility: Hanover Crescent in Brighton, which is now closed. Hanover Crescent was a community rehabilitation facility where patients were stepped down in preparation for community living. SPFT procured the facility several years ago and safety regulations have been tightened in the intervening period. Consequently, the facility was deemed to have had too many ligature points to be deemed safe, although there had not been any serious incidents at the facility. SPFT could not put this right without major capital investment, so the decision was made to close the facility.

- Wards for Older People with Mental Health Problems were rated inadequate on safety grounds primarily due to dementia inpatient beds in East Sussex. SPFT has proposals

in place to ensure that the two inpatient facilities are centralised, which is due to take place soon. This reconfiguration will require capital investment.

- SPFT is currently hiring three Non-Executive Directors. This is not because of CQC recommendations to replace the Non-Executive Board, but because three current Non-Executive Directors have left simultaneously for different reasons:
  - one Non-Executive's term of service is up, so their role is being advertised;
  - one has been appointed to a senior post elsewhere and cannot commit to the workload;
  - the third has resigned due to ill health.
- SPFT is carrying out a Governance Review to ensure governance arrangements in the organisation work as effectively and as efficiently as possible. Monitor requires foundation trusts to review their governance each year, but this review has additional motivation:
  - the CQC report identified the SPFT did not deal with risk as well as it should;
  - the new Chief Executive considered the governance process to be slightly unwieldy.
- In cooperation with the Grassroots, SPFT has produced a suicide prevention app called StayAlive that provides information to users about a whole range of organisations and services that can provide help to them if they are having suicidal thoughts. The number of users of the app has increased considerably and it is now used across Sussex. The app has won a couple of national wards.
- SPFTs Suicide Prevention Strategy – which is currently under development – is characterised by a targeted approach to certain high risk groups and a greater involvement in suicide prevention. The Strategy sets out how SPFT will target certain groups of people who are at a higher risk of suicide, for example, people who have been discharged from SPFT services less than 3 days previously; people who have been admitted to SPFT services for less than 3 days; and those people with mental health illnesses that evidence suggests are more at risk of suicide. The Strategy also sets out how SPFT is working with each Public Health Department in Sussex to ensure that the Trust is playing its part in the wider suicide prevention agenda. This is in recognition that 70% of people who take their own lives are not known to the system and that, as a consequence, there needs to be a much wider public health response from across the health and social care system.
- SPFT's Children and Adolescents Mental Health Services (CAMHS) also covers Hampshire and Kent. The main concern of the CQC for this service were the waiting times in those localities – which are longer than SPFT would want them to be because demand outstrips SPFT's capacity. This fact is recognised by our CCGs in those two areas.
- The three CAMHS in Sussex, Kent and Hampshire look to learn good practice from each other, for example, the Hampshire CAMHS service developed an app for young people that provides them with different ways to access services other than to be seen in person by a clinician (which can be stigmatising for them). SPFT is planning to make the app available across all three counties.

18.3 The Committee RESOLVED to:

1) note the report and its appendices;

2) request to see the Suicide Prevention Strategy once it has been agreed.

19. HIGH WEALD LEWES HAVENS (HWLH CCG): PROCUREMENT OF COMMUNITY SERVICES

19.1 The Committee considered a report by the Assistant Chief Executive setting out the plans of High Weald Lewes Havens CCG (HWLH CCG) and the new provider, Sussex Community NHS Trust(SCT), for community services in the High Weald, Lewes and Havens locality.

19.2 In addition to a presentation on the new community services, Siobhan Melia, SCT, confirmed that SCT was in the process of appointing a new senior leadership team of operational and clinical leaders in the High Weald Lewes Havens locality to manage the new community services. The current ESHT management staff provided more than two thirds of their duties outside of High Weald Lewes Havens – as they operated community services across East Sussex – so TUPE rule state that they cannot be transferred across. As current managers cannot be TUPE'd there is a shortfall of staff. Whether or not there would be redundancies in the community services senior leadership team at ESHT – as a result of the loss of High Weald Lewes Havens – would be for that Trust to confirm.

19.3 The Committee RESOLVED to:

1) to note the report and its appendices;

2) thank Sussex Community NHS Trust for their presentation;

3) request that HWLH CCG confirm via email whether pace maker and audiology clinics will continue to be commissioned at community hospitals as part of elective services, as this issue had not yet been clarified.

20. HOSC FUTURE WORK PROGRAMME

20.1 It was agreed that the following items should be added to the Committee's work programme for 3 December 2015, in addition to the reports already requested:

- A report by the CCGs on the plans in place by the NHS to cope with winter pressures;
- A report by the CCGs on the NHS Strategic Investment Plan – which sets out the budget across the health and social care economy – and the Year End Projections for the 2015/16 financial year;
- A report by the CCGs on the devolved commissioning of GP services to the three CCGs, which begins on 1 April 2016 – to also include the issue of GP vacancies.

The Chairman declared the meeting closed at 1.00 pm