

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

THURSDAY, 24 MARCH 2016

10.00 AM COUNCIL CHAMBER, COUNTY HALL, LEWES

- MEMBERSHIP -** East Sussex County Council Members
Councillors Michael Ensor (Chair), Ruth O'Keeffe (Vice Chair),
Frank Carstairs, Angharad Davies, Alan Shuttleworth, Bob Standley and
Tania Charman
- District and Borough Council Members
Councillors John Ungar (Eastbourne Borough Council), Sue Beaney
(Hastings Borough Council), Sam Adeniji (Lewes District Council), Bridget
George (Rother District Council), and Johanna Howell (Wealden District
Council)
- Voluntary Sector Representatives
Julie Eason (SpeakUp), Jennifer Twist (SpeakUp)

AGENDA

1. **Minutes of the meeting held on 3 December 2015** (*Pages 7 - 18*)
2. **Apologies for absence**
3. **Disclosures of interests**
Disclosures by all members present of personal interests in matters on the agenda, the nature of any interest and whether the member regards the interest as prejudicial under the terms of the Code of Conduct.
4. **Urgent items**
Notification of items which the Chair considers to be urgent and proposes to take at the appropriate part of the agenda. Any members who wish to raise urgent items are asked, wherever possible, to notify the Chair before the start of the meeting. In so doing, they must state the special circumstances which they consider justify the matter being considered urgent.
5. **High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG):
Withdrawal from the East Sussex Better Together (ESBT) Programme** (*Pages 19 - 20*)
6. **East Sussex Clinical Commissioning Group (CCG) 2016/17 Operating Plans: High Weald Lewes Havens CCG** (*Pages 21 - 22*)
7. **East Sussex Clinical Commissioning Group (CCG) 2016/17 Operating Plans: Eastbourne, Hailsham & Seaford CCG and Hastings & Rother CCG** (*Pages 23 - 32*)
8. **Kent, Surrey & Sussex Stroke Review** (*Pages 33 - 38*)

9. **Co-commissioning of GP Services** (*Pages 39 - 52*)
10. **Scrutiny Review Board: ESHT Quality Improvement Plan** (*Pages 53 - 90*)
11. **HOSC future work programme** (*Pages 91 - 94*)
12. **Any other items previously notified under agenda item 4**

PHILIP BAKER
Assistant Chief Executive
County Hall, St Anne's Crescent
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16 March 2016

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Future HOSC meetings: 10am, Thursday, 30 June 2016, County Hall, Lewes

Please note that the meeting will be available to view live or retrospectively on the internet via the HOSC website: www.eastsussexhealth.org

You can subscribe to updates on Twitter: @ESCCScrutiny

Map, directions and information on parking, trains, buses etc

Map of County Hall, St Anne's Crescent, Lewes BN7 1UE



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166 – Haywards Heath

VR – Plumpton, Ditchling, Wivelsfield, Hassocks, Burgess Hill.

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Commonly Used Acronyms Glossary

A&E	Accident and Emergency department
ASC	Adult Social Care
BSUH	Brighton and Sussex University Hospitals NHS Trust
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
DGH	District General Hospital
DH	Department of Health
EHS	Eastbourne, Hailsham and Seaford
ESCC	East Sussex County Council
ESHT	East Sussex Healthcare NHS Trust
FT	Foundation Trust
GP	General Practitioner
H&R	Hastings and Rother
HCAI	Healthcare Associated Infection
HOSC	Health Overview and Scrutiny Committee
HW	Healthwatch
HWB	Health and Wellbeing Board
HWLH	High Weald, Lewes, Havens
LTC	Long Term Condition
MIU	Minor Injury Unit
MLU	Midwife-led Unit
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NSF	National Service Framework
OPMH	Older People's Mental Health
PALS	Patient Advice and Liaison Services
QIPP	Quality, Innovation, Productivity and Prevention
QOF	Quality and Outcomes Framework
SECamb	South East Coast Ambulance Service NHS Foundation Trust
SPT/SPFT	Sussex Partnership NHS Foundation Trust
TDA	(NHS) Trust Development Authority
WIC	Walk in Centre

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HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at Council Chamber, County Hall, Lewes on 3 December 2015

PRESENT:

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

WITNESSES:

East Sussex Healthcare NHS Trust

Richard Sunley, Acting Chief Executive
Maggie Oldham, Director of Improvement
Susan Bernhauser, Acting Chair
Alice Webster, Director of Nursing

South East Coast Ambulance Service NHS Trust

Paul Sutton, Chief Executive
Geraint Davies, Director of Commercial Services

High Weald Lewes Havens CCG

Wendy Carberry, Chief Officer
Ashley Scarff, Head of Commissioning and Strategy
Kim Grosvenor, Dementia Programme Lead

Hastings and Rother CCG

Amanda Philpott, Chief Officer
Susan Rae, Clinical lead for urgent care and health inequalities
Nicky Young, Whole Systems Programme Manager, Joint Commissioning East Sussex

Martin Packwood, Head of Joint Commissioning (Mental Health)
Richard Hallett, Chair, East Sussex Maternity Service Liaison Committee
Dr Mokhtar Isaac, Clinical Director East Sussex, Sussex Partnership NHS Foundation Trust

LEAD OFFICER:

Giles Rossington

21. MINUTES OF THE MEETING HELD ON 1 OCTOBER 2015

21.1 The Committee agreed the minutes of the meeting held on 1 October 2015.

22. APOLOGIES FOR ABSENCE

22.1 Apologies for absence were received from Cllr Pam Doodes (substitute Cllr Johanna Howell) and Cllr Michael Wincott.

23. URGENT ITEMS

23.1 Cllr Michael Ensor updated the Committee on two recent health issues:

- Matthew Kershaw, the Chief Executive of Brighton & Sussex University Hospital NHS Trust (BSUH), will be departing from the Trust at the end of 2015. Amanda Fadero, the current Deputy Chief Executive, will step into the role of Acting Chief Executive until a permanent Chief Executive is appointed.
- BSUH had informed Cllr Ensor that the Trust still intends to progress with the construction of the cancer radiotherapy unit at Eastbourne District General Hospital (EDGH). The pause in its implementation was due to a funding issue that the Trust assured Cllr Ensor would be resolved.

24. EAST SUSSEX HEALTHCARE NHS TRUST QUALITY IMPROVEMENT PLAN SCRUTINY REVIEW BOARD: PROGRESS REPORT

24.1 The Committee considered a report by the Assistant Chief Executive providing an update on the progress of the Scrutiny Review Board established to examine East Sussex Healthcare NHS Trust's (ESHT) quality improvement planning in response to recent Care Quality Commission (CQC) inspection reports. The report also included an update from ESHT on the progress of their Quality Improvement Plan (QIP).

24.2 Richard Sunley, Chief Executive of ESHT, and Alice Webster, Director of Nursing, provided the Committee with a PowerPoint presentation on the progress of ESHT's QIP to November 2015.

24.3 Richard Sunley, Alice Webster, and Susan Bernhauser, Interim Chair, provided the following additional information in response to questions from HOSC:

Recruitment

- ESHT is recruiting 40 nurses from the Philippines. This is the maximum number that can be recruited at this time, but the Trust will look to recruit a similar number in 2016.
- The nurses recruited from the Philippines must first obtain visas and so are unlikely to join the Trust until March or April 2016. They will not become nurses registered with the Nursing & Midwifery Council until summer 2016 as they must first complete a period of consolidation and competency and sit a competency exam at the University of Northampton.
- These nurses will not be affected by the Government's recent changes to visa requirements as nurses are on the special occupational list.
- ESHT has increased the number of student nurse placements it provides and is in discussions with Health Education England to increase the number of student nurses it receives to fill these placements. However, these additional students will take three years to fully train so the benefits of the increase in student nurses will not be felt until 2018. The Trust recruited all 23 student nurse graduates in October 2015.
- There is a national problem recruiting middle grade doctors – particular in A&E – that is putting considerable and increasing pressure on the hospital services. ESHT has had great difficulty in recruiting sufficient numbers of middle grade doctors and the Kent,

Surrey and Sussex Deanery (KSS) has found it difficult to provide staff to fill middle grade training posts; between 70-80% of locum staff at ESHT are middle grade doctors.

- The shortage of middle grade doctors is predominantly due to the fact that middle grade doctors are joining employment agencies. These agencies pay considerably higher wages than NHS trusts are permitted to pay permanent members of staff under the NHS pay scales scheme, which makes it financially attractive for middle grade doctors to join an agency.
- ESHT is working with the KSS to focus the limited resource of middle grade doctors, for example, by developing a physician's assistant role. A physician's assistant would carry out some of the middle grade doctors' non-clinical roles which would allow them to focus on clinical care.

Culture

- ESHT's Trust Board recognises that addressing the cultural issues that the CQC identified will be a slow and difficult process, but it is putting in place a number of initiatives:
 - Holding Quality Summits at the EDGH and the Conquest Hospital; and holding a weekly Open Staff Forum led by Richard Sunley – or another Board Executive – that is attended by anything from three to 33 staff.
 - Beginning a "You Said, We Did" programme in response to feedback from the Quality Summits that involves Trust management providing evidence to staff about what they have done to deal with a query or complaint that has been raised. This information is publicised in various formats – such as posters and newsletters – throughout the Trust.
 - Looking to hire additional staff to increase the capability of the communications and engagement team to promote the changes that are being made to improve the culture at ESHT. The current team has 2.3 full-time staff out of 7,000 total staff across the Trust.
 - Developing a quarterly survey for staff that will contain the key questions of the annual NHS Staff Survey. This will allow the Trust Board to view incremental changes to staff morale throughout the year.
 - Hiring a new Speak Up Speak Out Guardian. This role provides a route for staff to raise issues outside of their management structure if they are concerned that they will not be dealt with in a satisfactory way by their line manager.
 - Setting up a clinical leaders' training programme for the clinical unit clinical leaders in partnership with the Faculty of Clinical Leadership and Management that is due to begin in December 2015. In 2016, a similar training programme will be provided for general management and heads of nursing.
 - Providing a number of national NHS Leadership Programmes at the request of frontline staff on Bands 6 & 7.
- The deadline for the annual NHS Staff Survey closed this month so it is unlikely that any of the changes that have been made will make much difference to the results this year, but the Trust Board is starting to hear more positive feedback from staff and hopes to see some difference in next year's survey.

- The Trust Board recognises that ESHT had admirable objectives that were similar to those of many successful NHS trusts, but the Trust was let down by its governance structure that was supposed to track and deliver those objectives, for example, the Quality and Standards Committee failed to perform to the standards set in its own terms of reference.
- The Trust Board has commissioned Capsticks to review ESHT's governance arrangements and the Board expects that some revisions to all of the committees will need to be made during 2016.
- The NHS Trust Development Authority (TDA) will carry out a capacity and capability review of the Trust Board as part of the package of assistance it provides to trusts in special measures. The TDA has appointed Ruth Carnell, Director at Carnall Farrar, to carry out this review of the Board early in 2016. The review will enable the Trust Board to demonstrate to stakeholders how it conducts itself and how it communicates with the rest of the Trust.
- All changes to the Trust need to be made with a lot of care and consideration, and the Trust Board is keen to avoid 'new initiative overload' because there remains some uncertainty about what systems still work well and which ones need fine tuning.

Medical records

- ESHT provides acute services from two main sites and patients are sometimes required to move between these sites to receive care. The Trust needs to be able to move medical records between the sites too, and the less this involves the movement of physical records, the better.
- From September 2016, the Trust's strategy is to move some services on to electronic records, which will involve scanning paper records into a central electronic database. The move towards electronic-only records is a long-term goal across the NHS.
- The Trust has invested in an electronic tagging system that makes records much easier to find. Physical medical records are tagged as they are retrieved from the archives for use by clinicians– the programme has been a success so far and the Trust is accelerating its implementation.
- In addition to the proposed scanning of physical records, and the ongoing tagging of them, the Trust Board is also working with staff on the arrangements for the centralising of medical records. The main reasons for centralising services are:
 - There is insufficient space on both hospital sites to safely store all medical records, which is a health and safety issue.
 - There are at least four different numbering systems being used on the two sites for the medical records.
 - Investment in medical records over last 12 years been very low.
 - The two medical record store rooms are on prime clinical real estate on the two hospital sites – the Trusts' Clinical Investment Plan includes making space within the two hospital sites to expand the accident& emergency and radiology departments.

- The centralising of medical records is the best course of action from a logistics perspective. The Trust will be able to have a proper, well organised, and clean medical records store room for the first time at a separate site from the two acute hospitals.
- The Trust Board needs to do something to improve the current medical record storage system – due to the health and safety issues – but the centralising of records to a single site is a cause of concern for the Trust’s medical record staff. The Trust Board understands the issues that staff have – they are not the highest paid staff within the organisation and the potential implications of the centralising of records for them is that they will have to travel further to their place of work.
- The Board is in discussions with the medical records staff to develop a medical record system that all parties agree on and that meets the Trust’s strategy. The Board will meet with Eastbourne staff and Hastings staff in early December to discuss issues such as whether transport arrangements can be put in place for staff.

Midwifery

- The Trust has recruited a lot of extra trainees to the midwifery department. ESHT has reduced considerably the number of midwife vacancies over the past 12 months to 2.2 across the Trust.
- ESHT signed up to the Productive Ward programme. This means that when the Trust refurbishes a ward it is committed to try and ensure that generic equipment storage locations – such as linen and drug cupboards – are in similar places from ward to ward. The purpose is to reduce the amount of training required for new staff to learn the layout of the ward. However, it is difficult to ensure continuity for more ward specific equipment that has to be stored in particular ways.

Next CQC inspection

- The Trust Board has set up monthly meetings with the CQC – with the next one due to take place in January – and is talking to them regularly. However, the next CQC inspection date is unknown as it will be unannounced. Fewer people are raising issues about ESHT to the CQC which makes it less likely they will return sooner.

Radiotherapy

- Capital money has been difficult to obtain across the NHS since the Government began its spending review. Now that the spending review has concluded, capital should become available for schemes that have already begun, such as the Radiotherapy Ward in EDGH. Brighton & Sussex University Hospital NHS Trust (BSUH) is managing the construction of the ward, but ESHT meets monthly with the BSUH radiotherapy team to talk through the logistics of managing the site.

Junior Doctors strike

- The announcement of the cancellation of the junior doctor strike was not timely enough for ESHT to reinstate appointments that were cancelled in anticipation of the strike. The Trust had cancelled 30 operations, mostly for inpatients, and 300 outpatient clinics.

Winter planning

- ESHT is part of the local resilience group and is working with the CCGs to secure funding for extra capacity. There is extra capacity available at the EDGH, but little available at the Conquest Hospital.
- The CCGs are also supporting ESHT to develop the resilience of its community services, for example, by making beds available within nursing and residential homes. These extra beds free up hospital beds by providing clinicians with a location where they can move patients categorised as “discharge to decide”, i.e., who are medically fit but require a care or nursing home placement before they can be formally discharged.

24.4 The Committee RESOLVED that it had considered and commented on the report, its appendices, and the presentation.

25. SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST (SECAMB) WINTER PRESSURES AND OTHER ISSUES

25.1 The Committee considered a report by the Assistant Chief Executive providing information on South East Coast Ambulance NHS Foundation Trust’s (SECAMB) planning for 2015/16 winter pressures and other issues.

25.2 Paul Sutton, Chief Executive, and Geraint Davies, Director of Commissioning, provided HOSC with a PowerPoint presentation and, in response to questions from the Committee, provided the following additional information:

Winter period

- SECAMB considers that the key focus period during winter takes place between 1 December and 12 January – even though the worst winter weather may come after that period – because it is during that time when the availability of NHS staff is at its lowest. After 12 January, the system begins to get back to its normal availability.

Handover times

- There is a national standard for handover time of 15 minutes after arrival at hospital. However, because three-hour delays are a routine occurrence in some hospitals in the South East, this target is nowhere near to being met.
- SECAMB considers it to be inappropriate from both a clinical and patient experience perspective that patients often have to wait for hours at a time on an ambulance trolley. As a result, the Trust continues to point out to Monitor, NHS England, and the NHS Trust Development Authority (TDA), that the 15 minute handover time is being ignored.
- It is the policy of SECAMB to tolerate a certain amount of delay in the handover time between ambulance crew and the hospital staff and the Trust tries to support the situation by both keeping its ambulance crews on site for as long as it can, and employing a Hospital Ambulance Liaison Officer (HALO) to try to help coordinate and speed up the process of handover.
- SECAMB now has in place an Immediate Handover Policy that is used when there is a very serious incident that necessitates the immediate withdrawal of ambulance crews

who are waiting to handover patients at a hospital, for example, when there is a cardiac arrest in the community that requires an immediate response and there are no free ambulance crews to attend to it. The ambulance crew inform the HALO and hand over their patient to the care of hospital medical staff.

- If the national standard for handover times was enforced, it is arguable that acute trusts would recognise that responsibility for the cohort of patients in the hospital rested firmly with them and would do more to achieve the handover time, for example, by employing handover nurses who fulfil the role currently performed by ambulance staff. ESHT and BSUH have carried out initiatives that have improved handover times at the Royal Sussex County Hospital in Brighton, EDGH, and Conquest Hospital. The Sussex-wide Urgent Care Network is meeting on 16 December to discuss handover times.

111 patient triage

- During the winter period 2014/15, 111 activity was at its peak and there was low confidence within the organisation of the accuracy of the categorisation of those 111 calls. In response, the Trust Board developed a pilot programme that involved paramedic practitioners reviewing the calls transferred across from 111 to 999 in order to determine whether they should join the 999 'call stack'; where in the stack they should join, for example, mis-diagnosed cardiac arrest patients would join at the top; and whether they could be dealt with in another way that did not require an ambulance despatch – one third of assessed calls did not require an ambulance despatch. The purpose of the pilot was to ensure the accuracy of the call categorisation by 111 call handlers in order to prioritise which patients got an urgent ambulance despatch.

Recruitment and retention

- SECamb plans for and understands seasonal variations in demand based on the accurate demand analysis it carries out. However, matching capacity to demand is more difficult; SECamb is 20% more busy in December than in April but sufficient additional staff are not available to meet this demand – although some of the capacity is made up for by bank staff, the private sector, and third sector.
- There are recruitment, capacity, and retention challenges with paramedics across all ambulance trusts due to the high demand for their skill set from ambulance trusts and GP surgeries. Furthermore, proposed regulations that will allow them to prescribe medicine are likely to make them considerably more desirable, making them harder still to retain. Often, paramedics will join GP surgeries as paramedic practitioners to carry out home visits but will re-join SECamb as bank staff to retain their 999 response skills and their registration as a paramedic.
- Paramedic degrees are highly sought after – and more subscribed than medical degrees at the University of Brighton – so SECamb is keen to retain its paramedics and believes it has an attractive clinical model that results in it being a net importer of paramedics.
- The retention of paramedics was one of the main reasons for SECamb's decision to develop the role of 'community paramedic'. The purpose of community paramedics will be to provide home visits to patients who are triaged as lower grade 999 calls, who have called 111, or who have called GP out of hours. The only difference between these three

categories of calls is the patient's access point. This will benefit SECamb as it can retain paramedics, and it will benefit GP surgeries as they will not have to go through the process of recruiting paramedic practitioners to deal with out of hour calls. The CCGs have also expressed support for the community paramedic programme.

25.3 The Committee RESOLVED:

- 1) that it had considered and commented on the report, its appendices, and the presentation; and
- 2) that it wished to commend SECamb for its work in attending to the airshow disaster at Shoreham.

26. WINTER PRESSURES

26.1 The Committee considered a report by the Assistant Chief Executive providing an update on the planning across the local health economy to deal with seasonal demand surges, extreme weather, and other issues associated with the winter months.

26.2 Wendy Carberry, Chief Officer, HWLH CCG; and Dr Susan Rae, Clinical lead for urgent care and health inequalities, Hastings and Rother Clinical Commissioning Group (HR CCG); provided the Committee with a presentation on System Resilience Planning - which is used to prepare for and manage periods of increased demand such as winter, and other periods, throughout the year.

26.3 In response to questions from HOSC, Wendy Carberry, Dr Susan Rae, and Nicky Young, Whole Systems Programme Manager, provided the following additional information:

- The CCGs have invested £4.1m to address additional patient flow to ESHT during winter – this is additional money provided by the Government specifically for investing in services that mitigate against winter pressures. Some of that funding is to support additional wards opened up in either acute or community hospital sites called “escalation areas”. The funds have also been spent on additional social workers and therapists to support the flow out of these beds both in the community and in A&E departments. The CCGs are also investing in out of hours services, for example, to ensure that there is a prescribing pharmacist to deal with repeat prescriptions over the weekend to free up GP capacity.
- As part of the System Resilience Planning, CCG project managers work across the healthcare system to assess the number of beds that will be needed, and where best they should be located, for example, an extra 12 step-down beds were identified as being needed in the Eastbourne area. The CCGs then discuss with the private sector home care and care home providers about their available bed capacity to meet this demand, for example, Milton Grange is providing these step down beds. This system resilience work also provides the CCGs with the opportunity to test and evaluate commissioning strategies that, if successful and popular, could be rolled out across East Sussex.

26.4 The Committee RESOLVED that it had considered and commented on the report, its appendices, and the presentation.

27. THE RECONFIGURATION OF NHS DEMENTIA ASSESSMENT BEDS

27.1 The Committee considered a report by the Assistant Chief Executive to provide an update on a) plans to reconfigure East Sussex dementia assessment beds; and b) on recent performance and new developments in diagnosis.

27.2 Martin Packwood, Head of Joint Commissioning (Mental Health), East Sussex County Council; and Dr Mokhtar Isaac, Clinical Director East Sussex, Sussex Partnership NHS Foundation Trust (SPFT); provided the following responses to the Committee's questions about the dementia assessment bed reconfiguration plans:

- The reason for the delay in the implementation of the reconfiguration of dementia assessment beds is that the project has had to pause twice in order to build a stronger consensus between stakeholders. In the long term, the project has to command the confidence clinically of SPFT and the CCGs.
- The first pause was made in order to carry out clinical engagement with SPFT to ensure that the Trust was absolutely content with the proposed numbers of beds, and the proposed levels of reinvestment in community services that would be made using the savings generated through the closure of existing bed capacity.
- The second delay was due to decision to engage with partners – such as Healthwatch and Care for the Carers – to ensure that the proposed site – St Gabriel's Ward at Conquest Hospital – was the most inclusive and appropriate site for the long term inpatient dementia care.
- The reason that it will take two years to implement the reconfiguration is that the St. Gabriel ward will be refurbished into a purpose built dementia intensive care unit. This will be, effectively, a new build that will require significant capital planning and expenditure.
- Significant interim refurbishment of the Beechwood Unit in Uckfield has been undertaken to ensure that it is safe and effective enough to deliver services whilst the St. Gabriel Ward is redeveloped.

27.3 Martin Packwood, and Kim Grosvenor, Dementia Programme Lead, HWLH CCG; provided a presentation on the Memory Assessment Services in East Sussex. They provided the following information in response to questions:

Golden Ticket

- Golden Ticket is a new model of care being piloted in the HWLH CCG area. The Golden Ticket pilot included 40 patients living in their own homes with their carers. However, the principals of the Golden Ticket – to support dementia patients throughout the dementia journey – will also apply to patients in nursing and residential homes. In addition, some of the interventions for the 40 pilot patients have been delivered to nursing homes in the Buxted area; and the CCG is working with the Care Home In-reach Team and the GPs who do home visits to care and nursing homes to raise awareness of the Golden Ticket programme.
- At the start of the Golden Ticket pilot, each of the 40 patients and their carer was visited in their own home by a GP to explain the purpose of the project and the organisations involved in delivering it. All patients had to sign a document to say that they were happy to be visited and that their information would be shared with the list of providers involved in the Golden Ticket pilot.

- The reason why health and social care professionals visited patients in their capacity as part of the 'Golden Ticket team' – and not in the capacity as an employee of the organisation they were employed by – was in response to patient and carer feedback that said the complexity of being visited by a multitude of different people and having to tell their story more than once was an inconvenience that they wanted to see eradicated in the future. The health visitor would still introduce themselves and their role and reason for being there; and the system is being robustly monitored.
- There will be an intensive evaluation of the Golden Ticket pilot from December 2015 to March 2016, and the full business case will go to the HWLH CCG Governing Body in April or May 2016. The full business case will include a plan for the roll-out of the Golden Ticket programme in two phases. The first phase will probably involve the roll out of the Golden Ticket to specialist GPs within the 'communities of practice' areas of the High Weald Lewes Havens area who can help advise other GPs. The model will be refined over next few months, but the first phase is expected to be rolled out by September 2016 and the second phase – to the wider GP community – by March 2017.
- HWLH CCG is committed to continue providing the same level of support to the 40 patients and their carers beyond the end of the pilot – including some of the community aspects of care that they are receiving.
- The voluntary sector organisations working with the CCGs as part of the Golden Ticket are equal partners with shared responsibility and have been set up with NHS email accounts so that information can be shared securely. The voluntary sector staff are located in the practice where the programme is being piloted acting as an 'eyes and ears' of the community.

Integrated Community Care Ltd

- Integrated Community Care Ltd (ICC) is a GP-led service for diagnosing dementia in the rest of East Sussex. Guidance for diagnosing dementia had previously recommended only secondary care older people healthcare specialists, geriatricians, and neurologists should diagnose dementia. However, whilst the ICC was in the pilot phase, the HR CCG and Eastbourne, Hailsham and Seaford Clinical Commissioning Group (EHS CCG) commissioned the development of a national diploma in dementia diagnosis that the five GPs who now run the ICC all completed. There are now 14 GPs who have achieved the diploma, as well as nurses and pharmacists, and there are more applicants on the way.
- The HR CCG and EHS CCG have commissioned for the past three years a Care Home In-reach Service from SPFT comprising specialised psychiatric nurses for dementia and a psychiatric staff grade doctor. The service goes in to care homes to disseminate good practice, increase awareness, train staff, and help to develop individual care packages for particularly challenging clients.

27.4 The Committee RESOLVED to that it had considered and commented on the report, its appendices, and the presentation.

28. HIGH WEALD MATERNITY PATHWAYS

28.1 The Committee considered a report by the Assistant Chief Executive providing an update from High Weald Lewes Havens (HWLH) CCG on maternity pathways in the High Weald.

28.2 Ashley Scarff and Richard Hallett also provided presentations to the Committee.

28.3 Ashley Scarff added that the patient records used in Crowborough Birth Centre will not be the same format as Pembury Hospital, Tunbridge Wells, but there will be fewer differences between the formats in future. Maidstone and Tunbridge Wells NHS Trust (MTW) and ESHT use the same ICT system but they use different versions of it; in the coming months they will go onto the same version which will also reduce the differences between patient records.

28.4 The Committee RESOLVED that it had considered and commented on the report and its appendices.

29. HOSC FUTURE WORK PROGRAMME

29.1 The Committee considered a report by the Assistant Chief Executive containing information on the Committee's progress against current work programme items and suggestions for additional issues to consider at future meetings.

29.2 The Committee RESOLVED to agree the proposed work programme.

The meeting ended at 1.20 pm.

Councillor Michael Ensor
Chair

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Report to: **East Sussex Health Overview and Scrutiny Committee (HOSC)**

Date: **24 March 2016**

By: **Assistant Chief Executive**

Title: **High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG): Withdrawal from the East Sussex Better Together (ESBT) Programme**

Purpose: **To update the HOSC on the reasons for HWLHCCG's withdrawal from ESBT and its plans to further integrate health and social care and to reduce hospital admissions**

RECOMMENDATIONS

HOSC is recommended to consider and comment on the presentation from High Weald Lewes Havens CCG

1. Background

- 1.1 HOSC members are requested to consider a presentation that will be made by High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG) regarding the CCG's withdrawal from the *East Sussex Better Together* (ESBT) programme.
- 1.2 The CCG has been requested to outline the reasons for withdrawing from ESBT; what this means for the CCG's future planning, and in particular what it means for further integrating health and social care and for reducing unnecessary hospital admissions.
- 1.3 The HWLH CCG presentation will be led by Wendy Carberry, Chief Officer, and will cover the following:
 - The reasons the CCG has left ESBT including:
 - The need to address the health needs of all HWLH residents, not just to focus on the 10% of resident treated by East Sussex Healthcare NHS Trust (ESHT)
 - The opportunity to plan services with our new community service provider, adult social care, our mental health provider and neighbouring CCGs to meet the needs of all residents
 - The CCG's programme of work that will deliver the aims of the 5 Year Forward View in the High Weald, Lewes and the Havens.

2. Conclusion and recommendation

- 2.1 HOSC members are asked to consider and comment on the HWLH CCG presentation regarding the CCGs withdrawal from the East Sussex Better Together programme.

PHILIP BAKER
Assistant Chief Executive

Contact Officer: Giles Rossington, Senior Democratic Services Adviser
Tel No: 01273 335517, Email: giles.rossington@eastsussex.gov.uk

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Report to: **East Sussex Health Overview and Scrutiny Committee (HOSC)**

Date: **24 March 2016**

By: **Assistant Chief Executive**

Title: **East Sussex Clinical Commissioning Group (CCG) 2016/17 Operating Plans: High Weald Lewes Havens CCG**

Purpose: **To update the HOSC on CCG priorities for the 2016/17 financial year**

RECOMMENDATIONS

HOSC is recommended:

- 1) To consider and comment on the High Weald Lewes Havens CCG 2016/17 operating plan;**
 - 2) To note the CCG's end of year financial projections.**
-

1. Background

- 1.1 Clinical Commissioning Groups (CCGs) are required to produce annual plans detailing their commissioning intentions and spending plans for the coming financial year.
- 1.2 CCG operating plans are lengthy and often highly technical documents. East Sussex CCGs have therefore been asked to outline their 2016/17 priorities to the HOSC.
- 1.3 High Weald Lewes Havens CCG will be presenting their plan to HOSC on the day of the meeting, these having been presented to the CCG's own Governing Body for approval on the 23rd March 2016.
- 1.4 The presentation by High Weald Lewes Havens CCG will be led by Dr Elizabeth Gill, Chair of the CCG and will include a contribution from Sussex Community NHS Trust as the community services provider for the CCG. The presentation will cover:
 - 2016/17 planning context
 - HWLH CCG local transformation programme 'Connecting 4 You'
 - Strategic workplan
 - Developing 'Communities of Practice' with Sussex Community NHS Trust and the wider Sussex Alliance
 - Financial plans
- 1.5 The full operating plan in draft form, subject to Governing Body review and approval will be available on the [High Weald Lewes Havens CCG website](#) (from 16 March onwards).
- 1.6 HWLH CCG's end of year financial projections will also be included in the presentation.

2. Conclusion and recommendation

- 2.1 HOSC members are asked to consider and comment on the HWLH CCG operating plan and end of year financial projections.

PHILIP BAKER
Assistant Chief Executive

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Report to: **East Sussex Health Overview and Scrutiny Committee (HOSC)**

Date: **24 March 2016**

By: **Assistant Chief Executive**

Title: **East Sussex Clinical Commissioning Group (CCG) 2016/17 Operating Plans: Eastbourne, Hailsham & Seaford CCG and Hastings & Rother CCG**

Purpose: **To update the HOSC on CCG priorities for the 2016/17 financial year**

RECOMMENDATIONS

HOSC is recommended:

- 1) To consider and comment on the Eastbourne, Hailsham & Seaford CCG and Hastings & Rother CCG 2016/17 operating plan;
 - 2) To note the end of year financial projections for each CCG.
-

1. Background

- 1.1 Clinical Commissioning Groups (CCGs) are required to produce annual plans detailing their commissioning intentions and spending plans for the coming financial year.
- 1.2 CCG operating plans are lengthy and often highly technical documents. East Sussex CCGs have therefore been asked to outline their 2016/17 priorities to the HOSC.
- 1.3 Papers from Eastbourne, Hailsham & Seaford CCG and Hastings & Rother CCG are included as **Appendix 1** to this report. Each CCG's end of year financial projections are also included in the appendix. The full operating plans will be available on the CCGs' websites:

[Eastbourne, Hailsham and Seaford CCG](#) (from 18 March onwards):

[Hastings and Rother CCG](#) (from 18 March onwards):

2. Conclusion and recommendation

- 2.1 HOSC members are asked to consider and comment on the CCG operating plans and end of year financial projections.

PHILIP BAKER
Assistant Chief Executive

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EHS and HR CCG Operating Plan 2016/17 – Our Priorities

Background:

1. As part of the planning guidance '[Delivering the Forward View: NHS Planning Guidance for 2016/17 – 2020/21](#)' the CCGs are required to produce a one year, organisation based Operating Plan (business plan) for 2016/17.
2. The plan consists of a high level narrative covering the CCGs' key priorities for 2016/17, supported by a range of specific technical template returns which are submitted to NHS England (at a combination of local and national level). These returns cover areas such as finance, activity and growth assumptions, operational resilience, the plan for the Better Care Fund and Quality, Innovation, Productivity and Prevention (QIPP) plans covering the 2016/17 period.
3. Our draft plans have been developed to reflect the progress and ambitions of the East Sussex Better Together (ESBT) Programme as we work to develop a fully integrated health and social care system which delivers proactive, joined up care to the people of East Sussex, aligned with the aims of NHS Five Year Forward View. The plans also reflect the focus on delivery against the nine 'must dos' for every local system in 2016/17, as set out in the planning guidance.
4. Running throughout the plan is our continued focus on ensuring that the decisions we make about the future of local services are driven by improving the health of local people and fully informed and shaped by local GPs, as well as the public, patients and other stakeholders. There is also focus on our cross cutting enabling workstreams for us to deliver plans, such as IM&T and workforce.
5. The 2016/17 plan has also been designed to reflect the nationally required emerging Sustainability and Transformation Plan (STP) which is currently being developed across Sussex and East Surrey (due for agreement in June 2016) and the five year strategic investment overview, which will inform longer term strategic planning, developed through the ESBT framework.
6. Our plan outlines that, as we further progress with our year of delivery in ESBT, our focus is on developing an effective model of accountable care for our patients and the public, in order to improve outcomes for local people and achieve provider and system sustainability in the long term.

2016/17 priorities:

7. **Drive up quality and performance against NHS standards:** Our plan emphasises that, as clinically led commissioners, enhancing the quality and experience of patient care in our local system is at the heart of what we are striving for. For 2016/17 our priorities include a focus on the local system 'must dos' of:
 - Getting back on track with A&E access standards and working to deliver ambulance response times.
 - Improving and maintaining performance against the 18 week Referral to Treatment time target.
 - Working to deliver Cancer targets.
 - Delivering and maintaining new mental health waiting time access standards and continue to meet dementia diagnosis rates.
 - Addressing the sustainability and quality of general practice including workforce and workload issues, with a clear vision for primary care.
 - Planning for the improvement in quality including publishing avoidable mortality rates.

- Delivering transformed care for local people with learning difficulties, including improved choices for people and their families and more say in their care, and the development of more innovative services to give a greater range of options.

8. **Delivering better outcomes for our population:** Through the ESBT Transformation Programme our focus is on achieving against the identified Public Health outcome measures of success during 2016/17:

- Reduction in preventable mortality for East Sussex.
- Reduce the gap in preventable mortality between the most and least deprived areas across East Sussex (including through targeted investment within the Healthy Hastings and Rother Programme).
- Reduction in mortality amenable to healthcare for East Sussex.
- Reduce the gap in mortality amenable to healthcare between the most and least deprived areas across East Sussex.
- Improve health related quality of life for older people in East Sussex
- Reduce the gap in health related quality of life for older people between areas in East Sussex.
- Reduction in excess weight (overweight or obese) in children aged 4-5 years in East Sussex.
- Reduce the gap in excess weight of 4-5 year olds between the most and least deprived areas across East Sussex.
- Reduction in excess weight (overweight or obese) in children aged 10-11 years in East Sussex.
- Reduce the gap in excess weight of 10-11 year olds between the most and least deprived areas across East Sussex.

9. **Reducing excess weight in children:** Four of the ten agreed ESBT overall Programme measures of success relate to reducing excess weight in children. In January 2016 we reviewed the measures at the ESBT Programme Board, and can see that whilst we are meeting the trajectory for improvement in reducing excess weight for the two age groups we measure, the gap between the most and least deprived areas of East Sussex is not improving in the 4-5 year old age group, and is in fact worsening in the 10-11 year old age group.

Substantial funding from the Public Health Grant has been identified and is being used to support all schools and colleges across East Sussex to create a school health improvement plan and undertake health improvement activity with a particular focus on childhood obesity. In 2016/17 EHS and HR CCGs will additionally fund a programme of grants and support to early years settings (nurseries) within the CCG areas to develop, implement and embed health improvement plans and activity to create a step change in addressing childhood obesity as a core element of their provision.

10. **Strategic planning to address acute clinical networks on a bigger footprint:** We will work with our partners across the Sussex and East Surrey Sustainability and Transformation Footprint in 2016 to develop an agreed STP plan. This will include how we will address acute clinical networks on a much bigger footprint, whilst reflecting our place based ESBT plans as the primary vehicle to drive forward local integration of health and social care to meet the needs of our population, and to deliver the whole system transformation required.

By June 2016 our CCGs and partner organisations within our STP footprint will have come together to outline as a collective system how we will:

- improve health outcomes for our local populations, closing the health and wellbeing gap.
- drive transformation to improve quality and patient experience, closing the care and quality gap.
- seek to reduce the per capita care of cost, closing the finance and efficiency gap.

We will additionally work with the STP footprints which cover Kent and the wider Surrey area, given the complex local factors across the area geography and our natural patient flows to the East and West across our CCGs.

- 11. Returning the system to aggregate financial balance:** We are developing a Strategic Investment Plan (SIP) which sets out in activity and finance terms how the ESBT Programme will deliver the CCGs' commissioning investment in health and social care to increase the proportion of funding in community based care within the overall resource available to the two CCGs, and the relevant parts of East Sussex County Council. The SIP will express this in terms of the annual available funding and the funding actually spent per head of population (year of care).

Our SIP will be underpinned by an investment approach, whereby health and social care commissioners seek to achieve the maximum health/social functioning gain from the available resources across ESBT, taking an integrated, whole systems approach to health and social care. The plan will be increasingly shaped by the Commissioning Reform work of ESBT. The key next steps for us are:

- modelling the longer term impact of the ESBT workstreams and to develop plans for further investment and disinvestment, across the whole system.
- To **use the new Right Care**¹ analysis to identify new areas for commissioning work, improving value and reducing avoidable spend.
- To review our business processes to ensure the on-going delivery and evaluation of redesigned services across the health and social care economy.

- 12. Our budget allocation – EHS CCG:** The CCG's financial plan builds from the NHS England published allocations for 2016-2021. The CCG plans to have a surplus of £2.7m (1%) in 2016/17, which is maintained in each of the years through to 2020/21. EHS CCG will receive £7.7m Growth in 2016/17. Demand growth and cost pressures for 2016/17 plus the requirement of the CCG to contribute £12.9m to the Better Care Fund means that a savings target of £10.5m is required to deliver the £2.7m surplus. In future years the savings programme will be broadly stable at £12m in 2017/18, reducing to £7m in 2018/19 and 2019/20 and to £3m in 2020/21.

The Better Care Fund commenced in 2015/16. In 2016/17 the CCG contribution to the Better Care Fund is £12.955m. Future years' contributions will be confirmed as the transformation of services emerges. Savings are predominantly identified from transforming existing acute spend which, together with the expected deflation in prices results in a reduction of spend in acute care and an increase in the amount spent in primary and community care.

- 13. Our budget allocation – HR CCG:** The CCG's financial plan builds from the NHS England published allocations for 2016-2021. The CCG plans to have a surplus of £5.9m (2.1%) in 2016/17, which gradually reduces in 2017/18 to £4.2m (1.5%) and

¹ Right Care focuses on commissioning for - and maximising - value, including the value a patient derives from their own care and treatment and the value the whole population derives from the investment in their healthcare. The Programme uses data on what CCGs spend on patient care and the health outcomes patients get for that spend in order to highlight 'unexplained' variations compared to other CCGs. CCGs can then drill down into their local health system to understand why there is a variation and then what improvements can be made.

1% from 2018/19 in each of the years through to 2020/21. HR CCG will receive £5.8m Growth in 2016-17. Demand growth and cost pressures for 2016-17 plus the requirement of the CCG to contribute £13.3m to the Better Care Fund means that a savings target of £6.4m is required to deliver the £5.9m surplus. In future years the savings programme will be broadly stable at £6.5m in 2017/18, increasing to £8.4m in 2018/19 and £9.2m in 2019/20 before reducing again to £8m in 2020/21.

In 2016/17 the CCG contribution to the Better Care Fund is £13.263m. Future years' contributions will be confirmed as the transformation of services emerges. Savings are predominantly identified from transforming existing acute spend which, together with the expected deflation in prices results in a reduction of spend in acute care and an increase in the amount spent in primary and community care, as with EHS above.

14. Implementing our joint Medicines Optimisation Strategy 2015-2018: The ESBT Programme affords us the opportunity to work more collaboratively across health and social care boundaries to ensure that patient centred care is offered right across the medicines pathway. In 2016/17 we will be implement our medicines strategy across the both CCGs to support the best use of medicines. The key strategic objectives are supporting patients with their medicines, improving the quality and safety of medicine usage, reducing inappropriate variations in Primary Care Prescribing, Medicines optimisation integrated across health and social care, managing clinical and financial risks associated with medicines and developing the workforce to deliver the strategy. The Medicines Management work plan for 2016/17 is planned to deliver £2.8 million savings across both CCGs.

15. Developing a model of accountable care, as we look to secure a sustainable provider landscape for the future: Research and evidence tells us that an accountable care model is the best way to achieve this locally, and positively incentivise the system to deliver improvement. Accountable care focuses on delivering NHS and social care services based on the outcomes for patients and service users, meaning the health and care system is geared towards preventing ill health - keeping people well - and promoting independence and wellbeing, while ensuring we have high quality hospital, care and specialist services when people need them. This approach is already being used successfully in other countries around the world, but we believe we will need to create a bespoke solution or solutions for the ESBT area that meets the particular needs of our communities, and that encompasses local District General Hospitals as well as Community and primary health and social care. In 2016/17 we will be working with partners to:

- Review and evaluate the different models of Accountable Care and accountable care characteristics best suited to deliver transformation locally (April 2016)
- Further develop the full business case, design outcomes and finalise contracting options for the preferred model that will best meet the needs of East Sussex and be supported by all organisations involved. (May - November 2016).
- Consider the full business case for moving to a bespoke model of accountable care (November 2016).

Next steps for the 2016/17 operating plan:

23 March 2016	Final draft operating plan narrative to be reviewed at the Governing Bodies' meeting in March 2016. Comments fed back for inclusion in the final narrative plan by 30 March 2016.
24 March 2016	HOSC meeting
4 April 2016	Final draft 2016/17 Operational Plan narrative and finance and activity returns to be submitted to NHSE South (South East) for comment prior to National Submission deadline for finance and plans (11 April 2016).

16. The full draft high level narrative for the 2016/17 operating plans for EHS and HR CCG will be available on the CCG websites at the following locations from 18 March 2016: <http://www.hastingsandrotherccg.nhs.uk/about-us/publications/?categoryesct19945566=19095> and <http://www.eastbournehailshamandseafordccg.nhs.uk/about-us/publications/?categoryesct10153982=19084>

Kat Banaghan, Corporate Services and Business Planning Manager
EHS and HR CCGs
11 March 2016

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EHS CCG and HR CCG 2015/16 Forecast Outturn

At the end of M11 the year to date financial position for both EHS and HR CCGs is on plan and forecasts are to achieve the planned surplus at year end.

The planned surplus for HR CCG is £7.847m surplus and in EHS CCG £2.990m surplus.

EHS CCG	Annual Budget £'000	Year end Forecast £'000	Forecast Variance £'000
Acute	146,244	146,382	-138
Community	16,834	17,430	-596
Mental Health	21,339	21,339	0
Other	30,616	32,430	-1,814
Commissioning	215,032	217,581	-2,549
Prescribing	35,449	34,899	550
Primary Care Commis	23,673	23,673	0
Running costs	4,280	3,674	606
Reserves & Other	2,588	850	1,738
Total Expenditure	281,023	280,677	346
Resource Limit	283,667	283,667	0
Plan Surplus	2,644	2,990	-346
HR CCG	Annual Budget £'000	Year end Forecast £'000	Forecast Variance £'000
Acute	143,400	144,431	-1,031
Community	24,733	25,279	-546
Mental Health	23,303	23,240	63
Other	30,926	31,787	-861
Commissioning	222,361	224,737	-2,376
Prescribing	37,462	36,762	700
Running costs	4,443	3,785	658
Reserves & Other	5,632	4,335	1,297
Total Expenditure	269,898	269,619	279
Resource Limit	277,466	277,466	0
Plan Surplus	7,568	7,847	-279

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Report to: **East Sussex Health Overview and Scrutiny Committee (HOSC)**

Date: **24 March 2016**

By: **Assistant Chief Executive**

Title: **Kent, Surrey & Sussex Stroke Review**

Purpose: **To update the HOSC on the ongoing regional review of stroke services**

RECOMMENDATIONS

HOSC is recommended to consider and comment on the progress of the Kent, Surrey & Sussex Stroke Review.

1. Background

- 1.1 This report provides an update on progress of the regional NHS review of stroke services.
- 1.2 **Appendix 1** to this report contains detailed information on the review provided by the NHS Sussex Collaborative.

2. Conclusion and recommendation

- 2.1 HOSC members are asked to consider and comment on the progress of the Kent, Surrey & Sussex Stroke Review.

PHILIP BAKER
Assistant Chief Executive

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Subject:	Update on progress of the Sussex Collaborative Review of Stroke Services
To:	East Sussex Health Overview and Scrutiny Committee
From:	Eastbourne, Hailsham and Seaford CCG Hastings and Rother CCG High Weald Lewes Havens CCG
Purpose of briefing:	For Information: To provide the East Sussex HOSC with an update on progress of the Sussex Stroke Review. It includes an update on: <ol style="list-style-type: none"> 1. Context of the Review; 2. Outputs of the Review to date; 3. Next stages in the Review
Author:	Lisa Forward, Senior Programme Manager, Sussex Collaborative
Date:	March 2016

1. Introduction

- 1.1 The NHS across Sussex as a whole has an ambition for high quality, patient-focused stroke services; services which reduce mortality and improve the functional outcome for patients following stroke.
- 1.2 Improvements have been made over recent years to some of the current stroke services, particularly following reconfiguration of services in East Sussex, but Sussex commissioners and providers are in agreement that more could be done to make services even better for patients, and their carers. Collectively, the local NHS wants to further improve clinical outcomes and to reduce further the number of people dying as a result of a stroke, to improve the quality of life for people following a stroke, for example reducing disability, and make sure there is equity in access, outcome and experience across local stroke services.
- 1.3 Providers and commissioners are working together to make sure patients and carers across Sussex receive the best possible treatment at the time of their stroke, and then high quality supportive care, designed around their needs.
- 1.4 The Sussex Stroke review has been undertaken in response to concerns that were raised over performance of some current services and a lack of progress in some areas against the standards outlined in the National Stroke Strategy published in 2007. In East Sussex, where the consolidation of stroke services onto a single site at the Eastbourne District General hospital has had a positive impact on the quality of services provided, there is some room for improvement, particularly in relation to access to therapy services.

2. Context

- 2.1 In January 2014 a Sussex wide strategy meeting took place with a focus on stroke. It was acknowledged by health and care systems represented at that meeting that the approach to stroke care was inconsistent across Sussex and that there were clear opportunities for improvement.
- 2.2 Acute stroke services are defined as being delivered via a Hyperacute stroke Unit (HASU) for the first 3 days and Acute Stroke Unit (ASU) for the remainder of hospital stay unless specialist inpatient rehabilitation is required. Patients are discharged to a community neurological rehabilitation team for on-going care.
- 2.3 East Sussex HOSC will be aware there is strong evidence to support the centralisation of specialist services, such as stroke as it ensures a higher quality services through care given by a skilled workforce. The centralisation can focus on just HASUs or for them to be co-located with ASUs.
- 2.4 At the Sussex wide strategy meeting East Sussex Healthcare NHS Trust (ESHT) presented their experience of single siting services from Conquest Hospital to Eastbourne District General Hospital EDGH) as part of the Trust's long term clinical strategy. They demonstrated an improvement in the operational delivery which resulted in an improvement in the national Accelerated Stroke Improvement (ASI) measures (now superseded by the Sentinel Stroke National Audit Programme (SSNAP) length of stay and in-patient mortality.
- 2.5 It was agreed at the strategy meeting to complete a Sussex wide review of current stroke services and identify how these could be improved by learning from the ESHT experience and other stroke re-configurations nationally.

2.6 Local performance in East Sussex

- The CCGs are monitoring on-going performance against the SSNAP indicators and have additionally introduced some local stretch performance targets to continue to drive continuous quality. This is because ESHT perform well with national comparators in areas such as in the proportion of patients scanned within 1hr (national average is 47.4%, ESHT 84.9%: quarter 2 figures 2015/16); the proportion of patients scanned within 12 hours (national average is 91%, ESHT 99.1%: quarter 2 figures 2015/16); the proportion of patients who spent at least 90% of their stay on a stroke unit (national average is 86.1%, ESHT 96.5%: quarter 2 figures 2015/16).
- Some challenges remain around the delivery of thrombolysis and therapy services continue to be a challenge and this is mainly due to the shortage of workforce which is a national issue.
- Brighton & Sussex University Hospitals Trust (BSUH) and Maidstone & Tunbridge Wells NHS Trust (MTW) also achieve well in some areas, but they struggle to maintain consistent scores within their current configuration. They are also experiencing similar challenges with therapy services.

3. **Sussex Wide Stroke review**

- 3.1 A review of best practice evidence was completed and a gap analysis against current stroke service provision in Sussex has been concluded resulting in a draft case for change document. The clinical review has evaluated the pathway from prevention to community rehabilitation with the most significant recommendation being to reconfigure some stroke services that are outside of East Sussex but which do provide for some East Sussex residents. The main four acute providers in Sussex all have co-located HASUs and ASUs. Potential reconfiguration does not apply to ESHT where this has already successfully been implemented.
- 3.2 Options are currently being developed by BSUH and by Western Sussex Hospitals NHS Foundation Trust, in conjunction with their lead commissioners, to develop thinking regarding the best clinical configuration.

4. **Outputs from the Review to date**

- 4.1 The stroke review across Sussex has been undertaken in stages, the outputs of which have informed a case for change for some areas and are now supporting the development of options to address the issues raised in the case for change. It has also highlighted some areas where improvement could be made across all services.
- 4.2 Outputs have been:
- **Review of best practice evidence** - collated and agreed via a Clinical Reference Group.
 - **Gap analysis** – current service provision measured against best practice. Key gaps:
 - No stroke unit in Sussex fully meets the all of the national stroke standards or has fully implemented the Kent, Surrey and Sussex Stroke Service specification. Meeting all the standards would assure that a high quality service is being provided which will provide the best clinical outcomes;
 - Not all units provide a 24/7 hyper-acute Stroke Service, although BSUH and ESHT do;
 - Not all HASUs admit the minimum 600 confirmed stroke admissions required to maintain skills and competencies with the exception of ESHT which achieves this now that services are co-located at EDGH;
 - Transient Ischaemic Attack (TIA) and Early Supported Discharge (ESD) services are not all provided 7 days a week. This is achieved in ESHT and at Royal Sussex County Hospital.
 - Workforce does not meet the required WTE standards and there are recruitment issues both locally and nationally. To ensure rapid assessment, treatment and effective rehabilitation to give the patients the best clinical outcomes, an expert workforce is required;
 - Follow up is currently variable, including in East Sussex. Follow up post discharge in the community is vitally important for continued rehabilitation and psychological welfare;
 - There is an ageing population with a significant increase expected in the 70+ age group over the next 10 years, therefore an increase in demand must be planned for;
 - Stroke prevention has been included in the review. Atrial Fibrillation (AF) in particular is a high risk factor for stroke and Atrial Fibrillation strokes are associated with significant

disability. The identification and management of AF remains challenging as people are not necessarily aware they have an arrhythmia and when it is identified, anti-coagulation therapy can be difficult to establish.

- **Development of proposals**

- This review and the subsequent case for change is informing proposals currently being developed by Brighton and Sussex University Hospitals NHS Trust (BSUH) and Western Sussex Hospitals NHS Foundation Trust (WSHFT); it is possible these may involve reconfiguration proposals and a full programme of engagement will inform this. These are anticipated at the end of April 2016. A Central Sussex Stroke Programme Board has been established to support BSUH and the community providers with developing their services and to oversee the development of options in response to the review. High Weald Lewes Havens CCG are members of this board.
- Robust programme governance arrangements are in place including independent clinical oversight.
- It should be noted that services delivered at EDGH are not subject to further review given the previous reconfiguration. Services delivered at East Surrey Hospital (ESH) are not subject to change due to the co-dependencies with Surrey.

4.3 Impact on East Sussex

- A **new service specification** had been developed by the South East Cardiovascular Strategic Clinical Network based on the NHS Midlands and East specification that has since been incorporated into an NHS England toolkit on how to review stroke services. This will help all organisations as there are now specific recommendations around workforce. ESHT will be ensuring action is developed to address this.
- **SSNAP data** has been analysed at each quarter. SSNAP data is a useful data source to assess areas of the stroke pathway where there are improvement opportunities. The ambition is for all stroke services to achieve a score of A across all the domains and all providers continues to work towards this. SSNAP scores range from A to E. Currently EDGH and RSCH are achieving an overall score of C (it should be noted that EDGH scores consistently highly in some of the domains such as Scanning and access to stroke unit) whilst Princess Royal Hospital and Tunbridge Wells Hospital are a D. Performance is regularly reported to the relevant CCG Governing Bodies. The CCGs currently oversee action to improve ESHT performance across all SSNAP domains as relevant. Improvements and learning from this will be fed back into the Sussex review. Surrey & Sussex Healthcare NHS Trust (SASH) which is responsible for East Surrey Hospital (ESH) is also developing a plan to improve performance against SSNAP).
- High Weald Lewes Havens CCG will continue to develop their community neuro rehabilitation pathway with their new provider, Sussex Community NHS Trust. The gap analysis highlighted that this service was not fully available with their previous community provider. The rest of East Sussex has access to a community neuro rehabilitation team.

5. Kent Stroke review

5.1 Kent currently has seven providers delivering acute stroke services. They are undertaking a detailed appraisal on a 3, 4 and 5 site model. Each model has scenarios that could deliver improved stroke services. Tunbridge Wells Hospital is an option in each of the models. The 5 site model looks increasingly more challenging and in a 3 and 4 site model, we have considered the impact on the Sussex patients when putting together the configurations based on travel time for patients.

5.2 NHS High Weald Lewes Havens are involved in this review.

6. Next steps

- BSUH and WSHFT have agreed to develop proposals in conjunction with their lead commissioners by mid-April;
- SASH and ESHT have agreed to present action plans addressing any issues noted in the review by mid-April. For ESHT this will be their continued action plans to improve against SNAAP targets which Eastbourne, Hailsham & Seaford (EHS) and Hastings & Rother (HR) CCGs currently monitor monthly.
- Recommended options would be submitted to the relevant CCG Governing Bodies in May 2016

for agreement to progress to consultation if required. For East Sussex this will involve High Weald Lewes Havens CCG only because of their patient pathways that include services provide by BSUH.

- HOSC will be kept informed of recommended options and any decision to be made regarding public consultation in May/June 2016.

Report to: **East Sussex Health Overview and Scrutiny Committee (HOSC)**

Date: **24 March 2016**

By: **Assistant Chief Executive**

Title: **Co-commissioning of GP Services**

Purpose: **To update the HOSC on East Sussex Clinical Commissioning Group (CCG) arrangements for co-commissioning GP services**

RECOMMENDATIONS

HOSC is recommended to consider and comment on the East Sussex CCG arrangements for co-commissioning GP services.

1. Background

- 1.1 The Health & Social Care Act (2012) changed commissioning arrangements for GP practices. Formerly the responsibility of local Primary Care Trusts (PCTs), primary care commissioning was transferred to NHS England (NHSE) Area Teams from April 2013.
- 1.2 In November 2014, the Department of Health introduced a co-commissioning initiative. This offered CCGs the opportunity to work with NHSE Area Teams to 'co-commission' GP services.
- 1.3 In East Sussex, Eastbourne, Hailsham & Seaford CCG and High Weald Lewes Havens CCG both opted to be early adopters of co-commissioning. Hastings & Rother CCG chose not to engage in the initiative at an early stage, but will begin co-commissioning from April 2016.
- 1.4 Information on co-commissioning at Eastbourne, Hailsham & Seaford CCG and at Hastings & Rother CCG is included as **Appendix 1** to this report. Information on co-commissioning at High Weald Lewes Havens CCG is included as **Appendix 2**.

2. Conclusion and recommendation

- 2.1 HOSC members are asked to consider and comment on the update on co-commissioning of GP services.

PHILIP BAKER
Assistant Chief Executive

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Report: Delegated Commissioning of GP Services in Eastbourne, Hailsham and Seaford and Hastings and Rother CCGs

To: East Sussex Health Overview and Scrutiny Committee

From: Fiona Kellett, Head of Finance

Date: 24 March 2016

Recommendations: The committee is asked to note the progress made in delivering co-commissioning of primary care in Eastbourne, Hailsham and Seaford (EHS) CCG and future plans for co-commissioning in EHS and Hastings and Rother (H&R) CCGs from April 2016

1. Introduction to Primary Medical Services

- 1.1. Primary Care covers healthcare provided in the community by General Practitioners, Community Pharmacists, Dental Practitioners and Optometrists. In total these services account for around 90% of all patient interaction with health services.
- 1.2. This paper focuses on services provided by General Practitioners (GPs). Eastbourne, Hailsham and Seaford CCG assumed delegated responsibility from NHS England (NHSE) for commissioning these GP (primary medical) services as of 01.04.2015. Hastings and Rother CCG will assume the same responsibility from 01.04.2016. The responsibility for commissioning Pharmacists, Dental Services and Optometry remains with NHS England (NHSE).
- 1.3. There are several different contractual arrangements for general practitioners to provide medical services as follows:
 - General medical Services contract (GMS) where the contract must be held by a GP or GPs (the traditional model)
 - Personal Medical Services contract (PMS) which must also be held by a GP or GPs
 - Alternative Provider of Medical Services contract (APMS) which can be provided by a GP or GPs or a company.
- 1.4. Each of these arrangements must include essential services but can include additional services and enhanced services as follows:

- Essential services must be provided by all contractors and covers the clinical management of patients who are ill or believe themselves to be ill with acute, chronic or terminal conditions.
 - Additional services are normally provided by all contractors but some may choose to opt out of providing some or all of these. This covers services such as cervical screening, contraceptive services, childhood vaccinations and immunisations, child health surveillance and maternity services. All practices in EHS and H&R CCGs offer all of these services.
 - Enhanced services are services that the contractor can choose whether or not to provide. These can either be services commissioned nationally or locally. Locally commissioned services are those that sit outside the core contract and are commissioned to improve the health of the local population.
- 1.5. Examples of nationally and locally commissioned services are attached on Appendix 2
- 2. Current Primary Care Profile in Eastbourne, Hailsham and Seaford and Hastings and Rother CCGs**
- 2.1. Within Eastbourne, Hailsham and Seaford CCG there are currently 21 practices serving a total CCG population of 192,597. Practices range from a small practice with a list size of 1,500 to large multi-partner practice with a list size of 17,800.
- 2.2. Within Hastings and Rother CCG there are currently 29 practices serving a total CCG population of 186,415. Practices range from a single handed practice with a list size of 2,700 to a larger multi-partner practice with a list size of 16,500.
- 2.3. The CCGs encourage practices to move away from single hander providers to ensure resilience in the service offered to patients and to enable practices to share back office functions and support.
- 3. Delegated Commissioning of primary medical services**
- 3.1. Primary Care Co-Commissioning was initially set out in the NHS Five Year Forward View published in October 2014. It aims to support the development of integrated out of hospital services based around the needs of local people through an increased local focus. In order to deliver this, NHS England invited CCGs to take on an increased role in the commissioning of GP services through a choice of three co-commissioning models ranging from greater involvement and collaboration to full responsibility for the commissioning of general medical services under full delegation.
- 3.2. Eastbourne, Hailsham and Seaford CCG member practices voted in February 2015 to take on full delegated commissioning from NHS England with effect from 1 April 2015, being one of 63 CCGs to do so in the first wave.

- 3.3. Hastings and Rother CCG voted in September 2015 to take on full delegated commissioning from April 2016 in the second wave, being reassured by the experiences in Eastbourne, Hailsham and Seaford CCG where the limited risks and identified benefits of delegated commissioning are becoming apparent.

4. The benefits of delegated commissioning

- 4.1. Under delegated-commissioning, decisions affecting primary care services are made by CCG teams based in the area who have the knowledge, expertise and awareness of local circumstances and communities and are best placed to improve the offer for local people and affect positive change.
- 4.2. Primary care services are a key component of our East Sussex Better Together (ESBT) transformation programme and delegated commissioning offers greater flexibility to support our ambitions. In particular, to increase our investment in primary care and develop integrated out of hospital services based around the needs of local people. We are also able to positively impact on the day to day workings of local GPs and strengthen all services for local patients by reducing restrictions that currently exist as a result of the numerous organisations commissioning services for the same population.
- 4.3. Our knowledge of the local communities we serve and the relationships we have in place with local GP members, communities and stakeholders means we can introduce strategic developments in local health services that span across primary, community and secondary care. In particular we will have an opportunity to change the inherent lack of alignment of incentives across the whole health system.
- 4.4. Moving forward, we intend to do this by designing health systems so that all parts, including primary care, are working together in line with an accountable care model of health and social care, focussing on delivering services based on outcomes for patients and service users. Whilst primary care is a relatively small percentage of our total spend, it is a key component for the delivery of our planned system change.
- 4.5. Both CCGs have committed to making significant additional investment in primary care, over the national funding, to support the ESBT programme. Our initial plans would see investment increase from £61m in 2015/16 to £92m by 2020/21 across both CCGs. This would take primary care's share of funding (excluding specialist services) from 8% in 2015/16 to 11% in 2020/21.

5. Progress and achievements within EHS in the first year

- 5.1. During the first year of delegated commissioning the CCG has been working to use this flexibility to improve services locally and further develop our strong relationships with practices to enable effective participation within the ESBT transformation programme.
- 5.2. Benefits have been delivered both to patients and to practices as follows:

- Consolidation of the arrangements for dementia services delivered in primary care, previously dispersed across a variety of different schemes. This will improve the service delivery to patients and ease the administrative burden for practice staff.
- Improved communication with practices with the generic enquiry service with improved response times.
- A reduction in the administration burden for practices in claiming for locally commissioned services.
- Development of a practice support programme to help practices maintain and improve quality, maximise the use of new technology and to share best practice across the local community.

6. Future Plans

6.1. The next tranche of developments will include work in the following areas:

- A review and refresh of the Avoiding Unplanned Admissions direct enhanced service (DES) to build on the basic structure of risk stratification and care planning. This will ensure that a wider group of patients is included and that care plans are multi-agency and shared amongst key providers allowing for better co-ordinated care.
- A review of the existing pattern of extended hours provision to ensure best fit with the emerging models of Primary Care Led Urgent Care under ESBT.
- Working with practices on primary care premises developments to ensure new developments will support the sustainability of primary care which is a key element in the delivery of the ESBT transformation plan.

7. Governance Arrangements for delegated commissioning

- 7.1. As the CCG is a membership based organisation, an additional level of assurance has been put in place to manage the responsibilities of co-commissioning and to avoid any potential conflicts of interest. The Primary Care Commissioning Committee (PCCC) meets in public and is chaired by one of the CCG lay members. Operational aspects of primary care co-commissioning are managed by a Primary Care Operational Group (PCOG) chaired by the Chief Finance Officer with representation from a board GP, the local medical committee and CCG staff. The operational group makes recommendations to the PCCC and provides assurance that the delegated responsibilities are being managed effectively.
- 7.2. The Committee makes decisions on the review, planning and procurement of primary care services in Eastbourne, Hailsham and Seaford (and from April there will be a committee for Hastings and Rother, that will meet together with

that of EHS) under delegated authority from NHS England. This includes the following activities:

- General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS) contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing breach/remedial notices, and removing a contract);
- Newly designed enhanced services (“Local Commissioned Services” and “Directed Enhanced Services”);
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area and approve practice mergers

7.3. In addition, the committee has the following responsibilities:

- To ensure that the work of the committee aligns with the strategic intentions of the East Sussex Better Together programme;
- To plan and review primary medical care services in Eastbourne, Hailsham and Seaford (and from April for Hastings and Rother)
- To co-ordinate a common approach to the commissioning of primary care services generally and to provide oversight of the financial planning for the commissioning of primary care services.

8. Developing a sustainable workforce

- 8.1. A strong and sustainable primary care workforce is critical to the delivery of the ESBT programme and to achieve the vision set out for primary care in the five year forward view.
- 8.2. NHS England, Health Education England, the British Medical Association (BMA) and the Royal College of General Practitioners have worked together on a range of initiatives designed to expand and strengthen the GP workforce and these have been incorporated into our Primary Care Workforce Strategy which highlights the short and medium term tasks we need to address sustainability in primary care.
- 8.3. Several of our practices are experiencing difficulties in recruiting to existing vacancies and assuming a retirement age of 60 we expect to need an additional 28 whole time equivalent (wte) GPs in H&R and 17 wte GPs in EHS within the next five years. We will also need 18 wte practice nurses in H&R and 15 wte in EHS over the same period to cover expected retirements.
- 8.4. We have developed a focused primary care workforce plan that will inform an ESBT workforce strategy going forward. Key to this are the following aims:

- To make our practices attractive places to work
- To reduce workload on practices
- To develop the skills of our practice staff
- To build the workforce of the future
- To lengthen medical and nursing careers
- To find new ways to recruit medical and nursing staff into our CCGs

8.5. This plan supports our wider workforce aims as part of ESBT to enable us to deliver the health and social care transformation needed to ensure sustainable, quality services into the future. Currently there are approximately 36,000 GPs in England but the net increase in GPs is around 260 per year. The government has made a commitment to increase the number of doctors in primary care by 5,000 and other primary care staff by 5,000 by 2020.

8.6. Our workforce plan will ensure that EHS and H&R are in the best position to recruit and retain many of these new doctors. The CCGs are regularly attending careers fairs, have offered a number of education bursaries to newly qualified GPs to support them to stay in the local area and are working closely with the Primary Care Workforce Tutor who supports training and education for all staff in general practice.

8.7. The ESBT programme board has recently approved the setting up of a Community Education Provider Network (CEPN) for the ESBT footprint. The network will be a delivery board consisting of primary and community care organisations that will be working collaboratively on an integrated and multi-disciplinary approach to workforce planning.

9. Finance

9.1. The delegated co-commissioning budget for EHS CCG for 2015-16 is £24m which is 8% of the CCG's total allocation (£284m). The largest part of the primary care budget, £16m, relates to general medical services with the remaining £8m covering directly enhanced services, QOF, prescribing and dispensing fees, premises costs and other GP services. NHSE have issued allocations for 2016-17 and assumptions through to 2020-21 as follows:

EHS CCG	2016/17	2017/18	2018/19	2019/20	2020/21
Primary Medical Allocation £m	25	26	26	27	28
Growth %	4	2	2	3	4
Distance from target %	-3	-4	-5	-5	-5
Population	193,764	195,169	196,580	198,040	199,547
Per capita allocation £	129	130	133	137	142

HR CCG	2016/17	2017/18	2018/19	2019/20	2020/21
Primary Medical Allocation £m	26	26	27	28	29
Growth %	4	2	2	3	4
Distance from target %	0	-1	-2	-2	-2
Population	187,253	188,425	189,677	190,982	192,342
Per capita allocation £	139	141	142	146	151

- 9.2. NHS England has also published target allocations which describe what the CCGs should be spending on primary care based on current spending assumptions, taking into account population characteristics and need. NHS England's aim is to bring every CCG to within 5% of their target allocation by 2020/21.

Appendix 2

1.1 Direct Enhanced Services (not all practices provide all services)

- Extended Hours Access
- Learning Disabilities
- Avoiding Unplanned Admissions
- Special Patient Scheme (previously Violent Patient scheme)
- Out of Area Patient Registration
- Dementia (from April 2016 this will be part of the GMS contract and no longer a direct enhanced scheme)

1.2 Locally Commissioned Services (whilst not provided by all practices, all patients have access to these within the CCG area)

- Anti-coagulation
- Cardiology Diagnostics
- Chronic obstructive pulmonary disease
- Cardiovascular disease
- Dermatology
- Diabetes
- Deep vein thrombosis
- Ear Nose and Throat
- Minor Injuries
- Minor Surgery
- Near Patient Testing
- Neonatal Checks
- Over 75s
- Palliative Care
- Phlebotomy
- Wound Care

HOSC Report – NHS High Weald Lewes Havens CCG update report on delegated primary care commissioning

NHS High Weald Lewes Havens Clinical Commissioning Group (NHS HWLH CCG) was one of the first wave of CCGs to take on delegated co-commissioning, and one of only two CCGs in Surrey, Sussex and Kent to assume this role in 2015.

As required in the Delegation Agreement, HWLH CCG established a Primary Care Commissioning Committee (PCCC), constituted in accordance with the guidance issued by NHS England to oversee and govern the commissioning duties. The CCG appointed a new additional Governing Body lay member with responsibility for Primary Care, who was established as Chair of the PCCC committee.

The CCG also successfully appointed a Primary Care Contract Manager and Primary Care Support Officer. These two roles were considered fundamental for the CCG to provide an enhanced delegated commissioning service for GP practices, supporting and ensuring the contractual requirements and responsibilities of practices to provide Primary Care services for the patients in the CCG.

The first three months of the handover was a period of 'shadowing', with NHS England providing support to the CCG for the contracting and commissioning functions. This shadowing continued into the second quarter, but with reduced input from NHS England. The handover of co-commissioning responsibility included the transfer of all relevant contractual documentation, policies and procedures, required from NHS England to the CCG. These documents included the GMS and PMS contracts for all contractors (GPs and GP partnerships), together with the Standard Operating Procedures, enabling the smooth transition of delegated functions and thus no disruption to services provided to patients or GP practices

One of the first actions undertaken by the newly appointed Primary Care Contract team was to conduct a round of practice visits, assessing and confirming full compliance to the NHS contract and ensuring awareness and preparedness for implementation of contract changes to be made in 2015/16. In addition the team started to collect key practice level data relating to practice size, location, condition and CQC compliance, as well as mapping workforce information to identify a baseline regarding lead GP partner's, salaried GPs, practice manager and nurse establishment gaps in order to develop a better understanding of the risks around primary care workforce, quality and estates.

The objectives and benefits of delegated commissioning originally set out by the CCG were Improved Strategic fit with overall plans; better alignment between community services and primary care planning and delivery; and as a result more effective investment in primary care.

The CCG has made good progress these objectives, having identified primary care as a key priority workstream for the 2016/17 operational plan; developed plans for Communities of Practice locality based planning involving primary care and the new community services provider; and investing in additional prescribing and roving GP support for General Practices.

Specific pilots and initiatives introduced by HWLH CCG to improve the services provided by General Practices for patients include the following:-

- The Pharmacy Workforce Pilot. This pilot project blends both clinical focus and optimisation of drug choice for patient and financial benefit. The 12 month pilot will have the option to be continued if benefits for patients, GP capacity and finances are demonstrated.
- The Practice Connect Worker Pilot aims to introduce and test a social prescribing model to targeted GP practices in the Newhaven and Peacehaven area. The role primarily aims to improve support for people with long term conditions, those at high risk of developing long term conditions or who are socially isolated through improved signposting to appropriate services.
- PCCC reviewed a new Practice Performance Dashboard to monitor information to assist with primary care commissioning by providing quality and performance information in a single integrated place. The dashboard pulls together a range of data and information and aims to help identify positive trends, best practice and areas for improvement. The dashboard includes NHS England measures, Quality Outcome Framework information, CQC domains and National measures.

A further role for the CCG under delegated co-commissioning involves the commissioning and procurement of Primary Care medical services. In September 2015 a single-handed contractor in Peacehaven submitted his resignation of a GMS contract. Options for the future care of the patients from this practice were considered, and an appraisal of the local situation conducted. As part of the options appraisal, discussions were held with local practices to investigate the possibility and feasibility of a partnership or merger with the resigning GP, together with the options of procurement of new GP contract or dispersal of patients.

Patients and stakeholders were informed of the resignation, and invited to submit comments on the future of the practice, which were considered as part of the options appraisal. Discussions with local practices indicated the potential for patients to be dispersed and thus ensure the continued availability of primary care services for patients in Peacehaven.

The CCG provided on-going patient and stakeholder correspondence to ensure regular updates for all, and deliver a package of support and assistance to practices to facilitate the registration of patients through a number of registration sessions held to provide patients with advice and guidance.

The CCG Medicines Management team also initiated additional support to the practices to help manage the influx of patients by facilitating new patient checks and medicines reviews.

The knowledge the CCG had regarding the demographics of the Peacehaven area and GP membership, provided good insight into the challenges and issues

surrounding the closure and proved invaluable in the management and dispersal of patients to local practices.

Another key area of focus in the forthcoming year is to review and update the CCG Estates Strategy so that it continues to reflect the needs of the population demographics and demand, and to support practices to ensure their estate is fit for purpose. To facilitate this, the CCG commissioned a review of all primary care estate to assess its current compliance with relevant legislation; and ability to respond to anticipated increased in patient numbers in the medium and long term. The results of this audit has enabled the CCG to prioritise those practices which would most benefit from accessing the Primary Care Transformation fund and/or other sources of capital funding using a transparent and equitable process. In addition, this strategy and funding will enable the CCG to incorporate the Communities of Practice initiative into future plans, assisting in bringing the Five Year Forward View into reality.

Finally, to further support the development and redesign of primary care to increase resilience and future sustainability, the CCG has reorganised its senior management team and identified lead members to work with GPs and individual Communities of Practice to progress planning and development of local pathways, new ways of working, and workforce solutions.

HWLH CCG continues to perform the delegated functions in a manner to ensure compliance with NHS England's statutory duties in respect of the Delegated Functions and to enable NHS England to fulfill its Reserved Functions.

NHS High Weald Lewes Havens CCG
March 2016

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Report to: **East Sussex Health Overview and Scrutiny Committee (HOSC)**

Date: **24 March 2016**

By: **Assistant Chief Executive**

Title: **ESHT Quality Improvement: Report of the Scrutiny Review Board**

Purpose: **To endorse the Review Board report on East Sussex Healthcare Trust (ESHT) Quality Improvement**

RECOMMENDATIONS

HOSC is recommended to:

- 1) endorse the Review Board report on ESHT Quality Improvement; and**
 - 2) agree to refer it to the relevant NHS bodies for consideration.**
-

1. Background

- 1.1 In June 2015 the HOSC agreed to establish a Review Board to examine East Sussex Healthcare NHS Trust's (ESHT) quality improvement planning in response to the 2015 Care Quality Commission (CQC) inspections of the trust.
- 1.2 The Review Board, and its five themed sub-committees, have subsequently been taking evidence from a wide range of ESHT staff. Review Board members have agreed a report, which is included as Appendix 1 to this report.
- 1.3 A copy of this draft report has been shared with ESHT in advance of the 24 March HOSC meeting.

2. Conclusion and recommendation

- 2.1 HOSC members are asked to endorse the Review Board report and agree to refer it to the relevant NHS bodies for consideration.

PHILIP BAKER
Assistant Chief Executive

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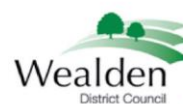
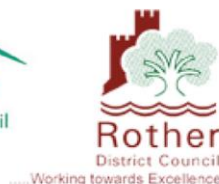
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East Sussex Health Overview and Scrutiny Committee (HOSC)

East Sussex Healthcare NHS Trust (ESHT) – Quality Improvement in Response to the 2015 Care Quality Commission (CQC) Inspections

Final HOSC report

24 March 2016



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Chair's Foreword

This Health Overview & Scrutiny Committee (HOSC) Review Board was established in response to the critical Care Quality Commission (CQC) report on East Sussex Healthcare NHS Trust (ESHT) services to the residents of East Sussex, and has been delivered in an environment where several other agencies have also been conducting oversight of ESHT.

During the period of this Review Board we have seen a significant re-profiling of the management of ESHT. Not only did the Chairman and the Chief Executive resign from their posts, with a new Chairman and a new Chief Executive appointed to take forward a new culture in ESHT; but also a number of Non-Executive and Executive Directors have been changed.

I would like to give thanks to all committee members of HOSC for their careful and diligent scrutiny of the various aspects of this review, and for applying their experience and particular interests in examining the performance and behaviour of the different aspects of ESHT provision.

I would also like to give thanks to the management and staff of ESHT who have studiously explained and demonstrated the changes and improvements being implemented to tackle the criticisms from the CQC report, and the implementation of the ESHT Quality Improvement Plan.

This Review Board report is provided not only to give feedback to ESHT on our findings, observations, and recommendations, but also to provide the CQC and the NHS Trust Development Authority (now NHS Improvement) with the HOSC's views on the provision of healthcare to the residents of East Sussex, and also our view of the direction of travel of ESHT.

This Review Board report will also provide the HOSC with a baseline against which we will take forward our own work programme of scrutiny over the coming year.

It is hoped that our deliberations will give a degree of assurance to the residents of East Sussex that the HOSC is representing the views and is acting on their behalf in seeking to hold the NHS to account.

A handwritten signature in black ink, reading 'Michael Ensor'. The signature is written in a cursive style with a long horizontal line extending from the bottom of the name.

Cllr Michael Ensor
Chair
East Sussex Health Overview and Scrutiny Committee

Recommendations

Recommendation about the general potential for sustained quality improvement at East Sussex Healthcare Trust (ESHT)

- 1) In the HOSC's view, ESHT's interim management team has shown that it understands the need for, is committed to, and is capable of delivering, sustained organisational improvement.

Recommendation about monitoring ESHT quality improvement

- 2) The HOSC will continue to monitor ESHT quality improvement, particularly in terms of: sickness absence rates, bullying and harassment, complaints, incident reporting, and staffing and recruitment.

Recommendation about ESHT capital projects

- 3) ESHT should report to the HOSC confirming whether funding for the promised Better Beginnings capital works and for any works that form part of the Quality Improvement Plan (QIP) has been secured. Should the predicted NHS or corporate funding no longer be available, ESHT should set out its alternative plans for securing key projects.

Recommendation about surgical bed capacity

- 4) ESHT needs to develop a strategy to deal with general medical capacity demands without impacting on the performance of the trust's surgical units.

Recommendation about leadership

- 5) ESHT is asked to report to the HOSC on its plans for board development in response to the CQC's criticisms of trust senior leadership.

Recommendation about strategic risk management

- 6) ESHT is asked to report to the HOSC on what it is doing to ensure that the trust's system of strategic risk management is fit for purpose.

Recommendation about hospital discharge

- 7) ESHT is asked to report to the HOSC on what it is doing to ensure that hospital discharges are not unduly delayed by waits for take-home medicines or other factors within the control of the trust.

Recommendation about incident reporting and complaints

- 8) ESHT is asked to report to HOSC on the measures it is taking to cross-reference the trust's incident reporting and complaints data.

Recommendation about seven day working

- 9) ESHT is asked to report its plans to move to a seven day working model to the HOSC.

Introduction

Background

1. The Care Quality Commission (CQC) is the independent regulator of health and social care in England. It inspects and rates NHS provider trusts in terms of five quality domains: **safe, well-led, caring, effective** and **responsive**. Key service areas at each trust hospital and clinical unit are scored as either **outstanding, good, requires improvement** or **inadequate** against each of these domains. In its reports on individual trusts, the CQC also publishes a headline rating for each domain as well as overall ratings for each trust hospital and for the entire trust.

2. The CQC inspected East Sussex Healthcare NHS Trust (ESHT) in September 2014, and published its inspection reports on the 27th March 2015. The reports rated ESHT inadequate in terms of the safe and well-led domains; requires improvement in terms of effective and responsive; and good in terms of caring. Overall, ESHT was deemed inadequate.

3. The CQC undertook a follow-up inspection in March 2015, and these inspection reports were published in September 2015. The trust was again deemed to be inadequate and was subsequently placed in special measures by the Trust Development Authority (TDA). The TDA is the NHS body responsible for overseeing all NHS trusts which are not foundation trusts. The CQC inspection reports can be found here:

www.cqc.org.uk/provider/RXC

4. In May 2015, the East Sussex Health Overview & Scrutiny Committee (HOSC) held a special meeting to question ESHT, the CQC and the TDA about the initial inspection findings. HOSC members were concerned by the failings identified in the inspection reports; and also worried by the attitude of ESHT's most senior leaders, who appeared reluctant to acknowledge the scale of the challenge identified by the CQC. In consequence, HOSC members agreed a motion calling for the resignation of the Chair and Chief Executive of ESHT. Minutes and webcasts of all East Sussex HOSC meetings are available here:

www.eastsussexhealth.org/

5. In June 2015, HOSC members decided that they needed to establish a Review Board to monitor ESHT's plans for quality improvement in response to the CQC's findings. It was agreed that substantive work on this would not commence until the CQC had published its follow-up report.

6. The follow-up CQC report was published on the 22nd September 2015. The CQC found that ESHT services had got better in some respects, but that in a number of the most significant areas of concern there had been little or no improvement or even a worsening performance. By this point, both the Chair and the Chief Executive of ESHT had resigned and an interim senior management team led by acting Chief Executive Richard Sunley was in place. The TDA had also appointed a Director of Improvement, Maggie Oldham, to work with the trust. ESHT, the CQC and the TDA discussed the second inspection report with HOSC members at the 1st October 2015 HOSC meeting.

The Review Board

7. Given the scale and importance of this issue, it was decided that the whole committee should have the opportunity to take part in reviewing ESHT's quality improvement planning. It was therefore agreed that the ESHT Quality Improvement Scrutiny Review Board should include all HOSC members. Sitting under this Review Board would be five 'sub-committees', each exploring one of the key service areas identified by the CQC: surgery, maternity, patient records, outpatients and pharmacy.
8. In addition to focusing on these service areas, the CQC inspection reports also found serious flaws in ESHT's leadership and organisational culture. Since these cultural issues typically cut across service areas, HOSC members agreed that they should be explored by the Review Board as a whole rather than by the sub-committees. The Review Board met in plenary session on 30th July 2015 to determine how to tackle the project. Members agreed that they would focus on the trust's Quality Improvement Plan.

Quality Improvement Plan (QIP)

9. Following an inspection, NHS trusts are required to develop a Quality Improvement Plan (QIP) in response to the CQC's recommendations for improvement. QIPs typically take the form of a RAG (red, amber, green) performance report, listing progress against a series of actions. QIPs are public documents and should be regularly updated and reported to the trust's Board.
10. ESHT had produced a QIP in response to the initial (March 2015) QCQ inspection report. However, HOSC members had concerns as to whether this plan was ambitious enough to deliver the scale of improvement required, and whether it demonstrated that trust leaders fully accepted how poor performance in some areas actually was.
11. The QIP was substantially revised following the publication of the follow-up CQC inspection report and the establishment of a new senior management team at the trust. This new QIP was appreciably more comprehensive and challenging, recognising that ESHT had to make very significant quality improvements. Whereas the initial QIP seems to have been largely the construct of senior managers, the revised QIP actions were developed with the active input of relevant departmental staff and it consequently captures much more front-line intelligence around how to achieve service improvements. HOSC members are more confident that the current QIP reflects the findings of the CQC inspections and represents a robust blueprint for improvement.
12. It should be noted that the QIP represents only one aspect of ESHT's quality improvement work, albeit a very significant one. There are other quality improvement work-streams which are distinct from, but aligned with, the QIP.

Sub-Committees

13. HOSC members volunteered to sit on the five themed sub-committees of the Review Board. Membership was:
- **Surgery Sub-Committee:** Cllr Angharad Davies, Cllr John Ungar (Eastbourne Borough Council representative)
 - **Maternity Sub-Committee:** Cllr Angharad Davies, Cllr Ruth O'Keeffe MBE, Julie Eason (Community Sector representative)

- **Pharmacy Sub-Committee:** Cllr Bob Standley, Cllr Bridget George (Rother District Council representative)
- **Patient Records Sub Committee:** Cllr John Ungar (Eastbourne Borough Council representative), Cllr Alan Shuttleworth, Cllr Bob Standley
- **Outpatients Sub-Committee:** Cllr Sam Adeniji (Lewes District Council representative), Cllr Ruth O’Keeffe MBE, Cllr Bridget George (Rother District Council representative), Cllr Alan Shuttleworth, Cllr Frank Carstairs.

14. Every sub-committee held a planning meeting, agreeing priorities and identifying potential witnesses. Each of the sub-committees subsequently met with key ESHT staff. All the sub-committee members were keen to talk to a range of operational staff including medical staff and technicians rather than just with senior managers. It was also decided that, whenever possible, evidence-gathering meetings should take place at The Conquest or Eastbourne District General hospitals, both so there was minimal inconvenience to trust staff and so sub-committee members had the opportunity to talk to people in situ and to see hospital facilities for themselves.

15. In all, the Review Board sub-committees spoke to more than 40 ESHT staff representing a wide range of services. Review Board members were struck by the evident pride that many ESHT employees take in their teams’ achievements, and by the shared enthusiasm to further improve services. The Review Board would like to thank all those who took the time to contribute.

The Purpose of the Review

16. The ultimate aim of ESHT’s quality improvement work is to transform the trust from **inadequate** to **outstanding**. This is a considerable task. Several of the biggest improvement plans require significant structural investments, such as the creation of a new patient records depot in Hailsham. Many of the cultural changes required will not happen overnight either: staff who are afraid to raise safety issues will take time to learn to trust leaders, even if it is genuinely the case that the culture of the trust has changed for the better.

17. It was therefore never intended that the Review Board should come to a view on whether ESHT has succeeded in dealing with all the quality issues identified by the CQC. Rather, the Review Board wanted to be assured of three things:

- Firstly that ESHT’s leaders recognise the scale of the challenge facing them;
- Secondly that there is a serious, long-term commitment to improve quality;
- And thirdly, that the actions ESHT is taking are commensurate with the magnitude of the changes that are needed.

None of these can be taken as a given – and it is not at all clear that an objective observer would have felt that ESHT was in a position to deliver any of them following the publication of the first CQC report in March 2015.

18. This report is intended to assist the CQC and the TDA in carrying out their regulatory roles by detailing whether HOSC members have confidence in the leadership of ESHT and in the trust’s direction of travel. However, some of the ESHT quality improvement projects may well inform the HOSC’s future work programme also.

Organisational Culture

19. Both the March and September 2015 CQC inspection reports rated ESHT as **inadequate** in the **well-led** domain. Problems identified by the CQC included a disconnect between the trust board and front-line workers; poor communication with key stakeholders; a climate in which staff were afraid to speak out about safety concerns; and a refusal by senior managers to deal with or even acknowledge serious and systemic performance issues.

20. It was evident that the CQC had limited faith in ESHT's most senior leaders, a view that was shared by a number of key stakeholders. The appointment of Sue Bernhauser OBE as acting Chair and Richard Sunley as acting Chief Executive was a welcome move therefore; as was the appointment by the TDA of Maggie Oldham, albeit only for four months, as Improvement Director. HOSC members noted an immediate change for the better in relations with ESHT following these appointments, and ESHT's interim senior leadership team should be commended for the way in which they have managed the trust under very difficult circumstances.

21. The ESHT Quality Improvement Review Board met with Richard Sunley, the ESHT acting Chief Executive; Monica Green, Director of HR; and Alice Webster, Director of Nursing, on the 17th November 2015 to talk about organisational culture. The Review Board focused particularly on: complaints (e.g. how complaints information is used to improve services); incident reporting (how staff are encouraged to report incidents and how learning from incidents informs service improvement); the Friends & Family test (i.e. what percentage of users would recommend the trust to their friends or family); staff satisfaction (particularly as expressed in the annual NHS staff survey); sickness absence (i.e. as an indicator of stressed or disengaged staff); bullying & harassment; and recruitment/staffing.

Staff Satisfaction

"We saw a culture where staff remained afraid to speak out or to share their concerns openly. We heard from several sources about detriment staff had suffered when they raised concerns about patient safety." (CQC Sep 15 Summary Report p3)

"The trust board continues to state they recognise that staff engagement is an area of concern but the evidence we found suggests there is a void between the Board perception and the reality of working at the trust. At senior management and executive level the trust managers spoke entirely positively and said the majority of staff were 'on board', blaming just a few dissenters for the negative comments that we received." (CQC Sep 15 Inspection Summary)

22. The March 2015 CQC inspection reports show ESHT as an organisation with a worrying disconnect between senior leaders and front-line workers; with poor staff engagement; and with a culture in which bullying and harassment are tolerated and where there is a perception that people voicing legitimate concerns about safety or efficiency are likely to be punished rather than supported.

23. Despite this being a headline finding in the March reports, the September 2015 reports found that the problems still persisted and that senior leaders seemed to be in denial about the level of disconnection between board and ward. The CQC stated that: *"there remains a clear disconnect between the views of the staff and those of the executive leadership. We saw examples where the staff view was a clear contradiction (more negative) from the senior leadership's position. We remain convinced that the executive leadership is not acknowledging this as a significant challenge for the future of the trust."* (CQC Sep 15 Summary Report p20)

24. This breakdown in relationships has been reflected in recent staff surveys. As the CQC notes: *“the most recent NHS staff satisfaction survey showed the trust performing badly in most areas. It was below average for 23 of the 29 measures, and in the bottom 20% (worst) for 18 measures.”* (CQC Sep 15 Summary Report p3) ESHT staff survey results can be found here: www.nhsstaffsurveys.com/Page/1006/Latest-Results/2014-Results/

25. Richard Sunley acknowledged that there are important issues to be addressed here and detailed some of the trust's actions to date:

- To improve the management skills of middle managers such as Clinical Leads, ESHT is providing several **Leadership Programmes**. These include a 3 day Senior Medical Team Leadership Programme run by the Faculty of Medical Leadership; a Master class for Engaging with Staff by Sally Cray Associates; and an Out of Hospital Services Leadership and Change Development Programme. These programmes will help to ensure that clinical leads have the skills to engage with individuals and teams – in some cases clinical leads have been recruited for their medical prowess and not their leadership skills.
- The trust has set up **listening events** for staff. These include events where staff say what they want and managers endeavour to provide it for them: for example, staff have stated that often they do not understand or follow procedures regarding the reporting of risk and the trust is now working on providing them with the relevant training. There are also separate listening events for staff to raise concerns about undermining behaviours in their workplace.
- ESHT's Board and senior managers meet regularly for **leadership conversations** where they look at, amongst other things, examples of best practice in the trust that can be spread to other areas. For example, new governance and staff engagement activities in the Surgery Department have been disseminated to other areas.
- Richard Sunley and other board members attend and listen at **staff forums and open sessions** every week throughout the trust.
- The trust has launched a **'You Said We Did' Campaign** that tells staff what the trust has done about their suggestions and complaints. The campaign is publicised in the form of posters, newsletters, departmental meetings, and direct conversations with staff.
- There has been an increased emphasis on recognising the stresses that staff are subject to. Resilience training has been successfully piloted and will be rolled-out across the workforce. 'Schwartz Centre Rounds' have also been introduced. These are structured monthly forums, supported by a psychologist, that enable staff to come together to share and reflect on their experiences and offer mutual support.

26. ESHT expects these measures to have a positive impact across the trust. However, these improvements are not likely to show in the 2015 Staff Survey, since positive changes will take some time to spread through the organisation and be felt as improvements by staff.

27. This issue was also explored with trust staff at a number of the sub-committee meetings, and the consensus was that there has been a significant recent shift away from 'top-down' management to a more genuinely inclusive approach. For example, the pharmacy leadership group has been enlarged, bringing in a wider range of staff, with additional workers regularly invited in to contribute to specific discussions. The sub-committee was also told that the pharmacy actions in the QIP developed in response to the initial CQC report had been very top-down, with little direct involvement of pharmacy staff. In contrast, the revised pharmacy QIP following the second CQC report was developed by the pharmacy service itself, utilising the experience and expertise of front-line workers.

28. Similarly, the maternity sub-committee was told that all staff in maternity units have been invited to contribute to the current quality improvement process, and front-line staff input has already been instrumental in the planning and design of the new birthing room at the Conquest.

29. ESHT has also recently appointed a 'Speak Up Guardian', who will raise staff concerns with the trust's leadership. Workers will be signposted to the Guardian by 'Speak Up Supporters', who will include all the ESHT Trade Union representatives. This is a concept that was successfully piloted at Mid-Staffs Hospital Trust. It enables workers to communicate concerns to leaders without having to do so via their line-managers.

Sickness Absence

"Low staffing levels were compounded by high and increasing sickness levels. The papers presented to the Board dated 25 March 2015 showed a trend of increased sickness from August 2014 to January 2015. The annual sickness rate in January 2015 was 4.8% against a target of 3.3%." (CQC Sep 15 Summary Report p23)

30. The Review Board was concerned with the issue of sickness absence both because of the number of absences and because sickness rates are widely seen as a useful proxy measure of how well an organisation supports its workers. For reference, according to the Carter report on Operational Productivity and Performance in English NHS Acute Hospitals, the range of sickness and absence rates across English hospital trusts is 2.7 – 5.8%, with a median of 4.1% (Carter, 2016 p17).

31. The Review Board heard that the trust has recently introduced a Health & Wellbeing training programme for staff. The programme includes support for weight loss. This has initially been targeted at the departments with the highest sickness rates, and its success will be measured in terms of sickness rate reduction. This is a welcome development given the CQC's criticisms of ESHT Occupational Health support. Trust sickness reporting arrangements have also recently been revised after consultation with staff, and in-year data shows sickness rates reducing across the trust. It is too early to say whether these improvements are sustainable.

Bullying and Harassment

"We had a larger than expected number of staff contact us during and subsequent to this inspection visit who were not prepared to reveal their identity until we could assure their confidentiality but who shared detailed information about the way they had been treated as a result of raising concerns. We found a real culture of blame and holding people to account for things they had very little control over. This remained unchanged since the previous inspection." (CQC Sep 15 Summary Report p25)

ESHT must: **"Undertake a root and branch review across the organisation to address the perceptions of a bullying culture, as required in our previous inspection report."** (CQC Sep 15 Summary Report p30)

32. ESHT staff reports of being bullied are higher this year than in previous years. However, the Review Board was told this is more likely to be because staff now feel more confident at reporting incidents than because bullying has increased. When the Review Board met with them, the trust wasn't in a position to report back on the results of its review of bullying and harassment. This is an important issue, and a very challenging one: when staff in an organisation believe that bullying is tolerated it can take a long time to convince them it is not, even if leaders have genuinely adopted a no tolerance policy.

33. In discussions with the trust, and even with the new leadership team, it has not always been clear to HOSC members that ESHT's leaders unequivocally accept that there has been a serious and widespread culture of bullying in the trust rather than just a "perception of bullying." The CQC inspections found clear evidence of both. This remains an issue of concern: ESHT is unlikely to make positive changes to its culture without first recognising that bullying has been wide-spread.

34. That bullying and harassment should be the consequence of staff speaking out on safety issues is of particular concern. NHS workers have both a right and a duty to raise concerns about patient safety or excessive workloads; and they must be actively encouraged and supported to do so, even if what they report is uncomfortable or embarrassing for their employer. There is a very considerable cultural shift required here, but an essential one if ESHT leaders are serious about quality improvement. ESHT has recently launched a 'values' programme, which involves all staff embracing the values of: **working together; engagement & involvement; respect & compassion; and improvement & development**. A key part of this must surely involve requiring managers to support workers to share their safety or workload concerns.

Internal Communication

"Overall the trust was amongst the bottom 20% of all trusts in England for staff engagement. Only 18% of staff reported good communications between managers and staff against a national average of 30%." (CQC Sep 15 Summary Report p3)

35. Engaging with the whole of ESHT's workforce presents considerable challenges, particularly as not all staff have ready access to email or to the trust's intranet pages. This is made more difficult by the fact that the trust only has a very small Communications team – the size of the team seems indicative of the importance that ESHT has historically given to effective communication. ESHT has applied for TDA funding to expand this service as part of the trust's plans to emerge from special measures.

External Communication

"There remained a poor relationship between the board and some key community stakeholders. We found the board lacked a credible strategy for effective engagement to improve relationships." (CQC Sep 15 Summary Report p3)

36. ESHT's communication with key stakeholders, including the HOSC, has long been problematic. The CQC identified a breakdown of relations with stakeholders following the often controversial reconfigurations of surgery and maternity services. For the CQC, whilst ESHT recognised that there had been a deterioration of trust with community stakeholders, *"senior executive officers remained convinced that the root cause of the trust problems was malicious objection to the reconfiguration, rather than any failings by the trust board and executive team. This was not what staff and local people told us during and subsequent to the inspection."* (CQC Sep 15 Summary Report p21)

37. The CQC further found that: *"when we spoke with senior staff about the communication strategy post reconfiguration they acknowledged that it wasn't working but said they were going to continue with it regardless of the lack of effectiveness."* (CQC Sep 15 Summary Report p21)

38. The HOSC has also struggled to get the previous management regime at ESHT to talk candidly about the scale of the problems at the trust. For example, there was a HOSC meeting on the 26th March 2015 (the day before the publication of the first CQC inspection report) at which members considered ESHT maternity services following their

reconfiguration. Although ESHT contributed to this item, there was no mention of the significant problems with the service that had been identified by the CQC inspectors. (The second CQC inspection in March 2015 found a number of these problems had persisted, so it was not the case that the CQC report referred to a situation at the time of inspection in September 2014 that had been resolved by March 2015.) Whilst detailed discussion of the contents of the CQC report was quite properly embargoed until its publication, the general failure to acknowledge that all was not well with maternity services fell far below the level of candour to be expected of NHS trusts reporting to a HOSC.

39. The acting ESHT Chief Executive, Richard Sunley, and his leadership team have engaged much more positively with the HOSC than their predecessors, and this relationship at least has considerably improved. ESHT managers and clinicians have also been supportive of the work of the ESHT Quality Improvement Scrutiny Board.

Complaints

“The trust does receive a higher than average number of complaints for its size although numbers of complaints have fallen over the last two years. We found a complaints system that gave both poor support for people who wished to raise a concern, and concerns on how the trust handled complaints.” (CQC Sep 15 Summary Report p4)

40. The Review Board was concerned with the way in which the trust responded to complaints. ESHT leaders acknowledge that the trust had not been responsive enough, and in recent months there has been investment in the complaints function, including the appointment of a new Complaints Manager, additional staff and funding for broader workforce training in dealing with complaints. There is also an increased focus on analysing complaints data to drive service improvement – for example by identifying and offering training to staff who have had multiple complaints made against them.

41. Systems are also now in place to ensure that all complainants are contacted by phone to ensure that their complaint has been dealt with and to enquire whether they have additional concerns.

42. It is not yet clear whether these measures have significantly improved the situation. Complaints have actually risen in recent months, although the number of complaints that have been re-opened because they have not been adequately resolved has reduced significantly which may indicate better performance.

Friends & Family Test (FFT)

43. The FFT is a survey which aims to ask all patients whether they would recommend an NHS service to their own friends or family. ESHT is not an outlier in terms of its FFT scores: 95% of those using in-patient services who responded to the survey in April 2015 said that they would recommend the trust to their friends & family. Some FFT feedback to the trust has led directly to practical improvements – for example complaints about the (unavoidable) noise in wards at night from electronic monitoring equipment led to the provision of ear-plugs for those patients who required them.

Incident Reporting

“Staff remained unconvinced of the benefit of incident reporting, and were therefore not reporting incidents or near misses to the trust. The trust was not able to benefit from any learning from these. This position had not improved.” (CQC Sep 15 Summary Report p3)

“Within the trust, we did not see a cycle of improvement and learning based on the outcome of either risk or incidents.” (CQC Sep 15 Summary Report p3)

44. Hospital staff are required to report a wide range of clinical incidents. This includes a nationally prescribed set of ‘serious incidents’. There is also a consensus that high quality incident reporting should go well beyond serious incidents, with workers being encouraged to report even relatively low level ‘no harm’ incidents so that the organisation can learn from them.

45. As the September 2015 CQC report acknowledges, National Reporting and Learning Service (NRLS) data suggests ESHT is a good (i.e. high) reporter of safety incidents (CQC summary report p10). Nonetheless, the CQC identified significant concerns with incident reporting, particularly in terms of how data on incidents was being used to drive improvement. The CQC stated: *“incident reporting, the feedback from incidents and the learning by both the organisation and individual staff was not as good as it should have been. We did not see evidence of learning; nor did we see a systematic approach to sharing information or a culture to support this.”* (CQC Sep 15 Summary Report p10)

46. Since March 2015 there have been a number of initiatives to improve performance in this area:

- The trust has introduced a phone line that enables lower grade staff to report incidents without having to do so via their line-manager.
- There is a weekly patient safety summit involving all clinical leads and head nurses at which Level 3, 4 and 5 incidents (moderate, significant and catastrophic) as well as near misses are discussed in detail. This meeting is led by the Director of Nursing and a Clinical Director. In addition, less serious Level 1 and 2 incident reports are randomly reviewed by senior clinicians to check whether they have been appropriately graded.
- The average time taken to report incidents at the trust has fallen from 6 to 2-3 days (there is still work to be done here as the national target is for all incidents to be logged within 48 hours). The trend for incident reporting across the trust is also upwards, with 250 additional incidents reported this year compared to last.
- The CQC was particularly critical of incident reporting in the surgical departments, and the trust has commissioned an external review of this.
- Poor incident reporting can also be a consequence of having too few administrative staff to enter the required data. ESHT is currently recruiting an additional Band 4 administrator for each clinical unit, in part to improve incident reporting rates.

Staffing/Recruitment

“We saw low staffing levels that impacted on the trust’s ability to deliver efficient and effective care.” (CQC Sep 15 Summary Report p4)

47. Staffing was identified by the CQC as a concern in a number of services across the trust. ESHT has long term issues with recruiting workers, as do many NHS trusts across England – it is clear that there are serious national staff shortages, especially in terms of nurses and of medical staff in certain specialities. However, some trusts have been much more successful than others in recruiting and retaining staff and there is a good deal that NHS organisations can do to increase their staffing levels by adopting best practice.

48. NHS trusts are increasingly seeking to recruit staff from abroad and ESHT has recently been successful in recruiting 14 nurses from the Philippines. The trust plans to recruit from Spain in the near future. Although visa restrictions have recently eased, mass foreign recruitment remains a complex process, and recruiting suitably qualified people with fluent English is a challenge. When foreign nurses are recruited they are typically initially employed as Healthcare Assistants until they can demonstrate their professional competency and English skills in a real work environment.

49. ESHT is actively examining whether it might make sense to re-design some job roles to ease recruitment pressure. For example, if some roles currently undertaken by doctors could be re-assigned to physician’s assistants or to ward support workers then this might mean that fewer hard-to-recruit doctors need to be employed. This initiative is part of a national programme supported by Health Education England.

50. There has been a surge in demand for nursing staff across England following the 2013 Francis report on Mid-Staffordshire NHS Foundation Trust, which made challenging recommendations for safe staffing levels. In the short term most trusts have sought to employ agency workers to cover the emerging staffing gap. The use of agency workers to cover staff shortages significantly increases NHS trust staffing costs. It can also impact upon quality if the agency staff used are not fully familiar with trust policies, procedures and working practices. The September 2015 CQC summary report notes that: *“there was a high reliance on agency staffing in surgical services. There was no documentary evidence to show temporary staff had received induction or were made familiar with the area”*. (p13)

51. ESHT has developed a ‘bank’ of trust staff willing to work additional shifts. Bank staff are typically paid at lower rates than agency staff (and no agency fees are involved), and they are already familiar with ESHT working practices, so they generally represent a better option to deal with short-term staff shortages. However, many workers choose to sign-up for agencies rather than the bank because the pay is better, so there is no immediate prospect of eliminating reliance on agency workers (and in fact the ESHT agency spend has increased very significantly over the past year, in line with many other acute trusts). Ongoing Government attempts to cap agency costs may have a positive impact here.

52. The relatively small size of the Conquest and Eastbourne District General Hospitals also means that it has been historically difficult to attract or to retain training-grade medical staff: doctors typically prefer to train at larger hospitals where there is a more varied case load and a greater opportunity for hands-on learning. The recent reconfigurations of key services may help address these issues to a degree, and the Review Board was told that the number of trainees has increased as a consequence of ESHT being able to offer more direct supervision. Nonetheless, attracting training-grade staff is likely to remain a challenge going forward.

53. Trusts that struggle to recruit staff need to make a particular effort to ensure that their staff retention is good, and that staff who leave the trust are actively encouraged to return. The maternity sub-committee was told that the trust has a high rate of returners, which managers believe is indicative of a positive working culture. Recently the trust has also

persuaded some midwives to return to practice, filling vacancies in a particularly challenging area. This is all positive, although the turn-over of staff is relevant here also: retaining staff in the first place is a better option than persuading previous employees to return.

54. The current staffing position at ESHT seems relatively positive. However, it seems unlikely that NHS recruitment problems will ease significantly in the near future, especially in the service areas where there are national shortages of suitably qualified staff. There are particular problems associated with recruiting in the South East of England, where living costs are higher than the national average, but salaries are not (other than in London). It is also typically more difficult to recruit to smaller hospitals, which offer fewer opportunities for career development than do larger units such as the teaching hospitals in London or Brighton. Staffing is likely to remain a problem for ESHT therefore, and it is important that the trust continues to learn from national and regional best practice and to develop its own initiatives to entice workers to Eastbourne and Hastings.

Review Board Sub-Committees

Pharmacy Sub-Committee

Cllr Bob Standley; Cllr Bridget George (Rother District Council representative)

55. The Review Board pharmacy sub-committee visited Eastbourne District General Hospital (EDGH) on the 15th January 2016 to meet with pharmacy staff, tour the pharmacy department and visit a hospital ward to see how drugs are stored and supplied. The **Pharmacy Team** told the sub-committee that:

56. Pharmacy services were due to be restructured in 2014, but this was put on hold because community healthcare in the High Weald Lewes Havens Clinical Commissioning Group area was being re-tendered (the contract, formerly held by ESHT, was eventually awarded to another NHS provider). The sub-committee was told that this unsettled workers and meant that plans to address staffing shortages were delayed.

57. Pharmacy staffing issues were added to the trust risk register in 2012, but were removed by the then Chief Pharmacist in 2014, although there were still significant unresolved establishment issues. Pharmacy staffing was not communicated to the CQC as a risk prior to its initial September 2014 inspection. However, the CQC immediately recognised that staffing was an issue, and also identified a number of issues with medicines management. The Chief Pharmacist did not consider these issues to be significant. The former Chief Pharmacist has now left and the current pharmacy leadership team thinks that the CQC comments about medicines management were fair.

58. CQC concerns about staffing levels were also reasonable, although the timing of the visit was unfortunate in that the trust had recently recruited an additional six pharmacists, but they had not assumed their posts at the time of the first inspection.

59. Relatively little had changed by the time of the second CQC inspection. The initial pharmacy QIP was very top-down, and didn't utilise the expertise of front-line staff. There was some reluctance at a corporate level to acknowledge that the department needed to make significant changes.

60. Subsequently, there has been a step-change in the pace of improvement. The revised QIP following the second CQC inspection was developed with the input of all pharmacy staff. Progress is monitored weekly, and currently all QIP actions have been completed or are on target.

61. The Pharmacy Team said that recruitment was also progressing well. Rather than conforming to the traditional service structure, pharmacy recruitment policy now attempts to attract staff with the particular skills to meet service priorities and to fill the gaps identified in the CQC inspections – e.g. a lead clinical unit pharmacist for Women's and Children's services who can help with the provision of medicines management leadership within that clinical area.
62. The lack of corporate grip on medicines management issues is being addressed through the development of a new set of key performance indicators (KPIs) which will translate highly technical data from audits of controlled drug management, the safe and secure handling of medicines, and a drug chart audit. This will be presented as a KPI and set of quality measures that Board members will readily comprehend and that relates to the overall picture of medicines management and patient care within the Trust.
63. Internal pharmacy audit arrangements have been recently strengthened, with medicines management now being audited quarterly (rather than on an ad hoc basis), and controlled drug management audited quarterly rather than six monthly. Increased staffing resources have made this improvement possible.
64. ESHT has agreed a medicine safety thermometer CQUIN (Commissioning for Quality and Innovation payment) for 2015/16. This is nurse-led with all acute wards participating. It is intended to encourage greater matron awareness and ward autonomy in medicines management, making the point that it is part of everyone's job not just a pharmacy issue. The data is being used to analyse and support improvements within patient safety.
65. Corporate engagement with pharmacy has increased, both in terms of funding (e.g. for additional staffing and for the roll-out of Omnicell medicines storage cabinets across key wards), and via the inclusion of medicines management as part of the trust's internal CREWS (Caring, Responsive, Effective, Well-led and Safe) review process. ESHT is also increasingly recognising the key strategic role that pharmacy services have to play - e.g. in facilitating timely discharge or in minimising the nurse time spent on ordering and administering medicines, thereby helping the Trust manage staff shortages elsewhere.
66. There is an increased focus on medicines reconciliation (the process of ensuring that patients are taking appropriate medication – e.g. that their prescribed drugs are necessary and that they are actually taking the drugs as intended).
67. The CQC criticisms of supply to third parties have now been resolved, and ESHT no longer supplies to third parties.
68. Pharmacy currently operates a five day service, with on-call arrangements for out of hours and weekend working. Once quality improvements in the current service have been sustained, the aim is to develop a seven day service.
69. The Pharmacy Team has found engagement from the CQC and TDA to have been a positive experience. Both organisations have been very supportive, particularly in terms of the expert peer input from Lewisham & Greenwich NHS Trust. Making service problems public has meant that long-standing issues are finally being addressed. Managers expect the next CQC inspection findings to be much more positive and welcome further input from the CQC.

Maternity Sub-Committee

Cllr Angharad Davies, Cllr Ruth O’Keeffe MBE, Julie Eason (Community Sector representative)

70. The maternity sub-committee visited the Conquest Hospital, Hastings on the 8th January 2016 to meet with managers and clinicians and to tour the maternity and neonatal facilities. Key points made by witnesses from the Maternity Department included:
71. All departmental staff were invited to contribute to the development of the current QIP. Outstanding QIP actions are reviewed weekly at a meeting chaired by the Director of Nursing.
72. Ward security issues highlighted by the CQC have now been addressed – doors that were opened for ventilation have now been re-designed so that they can be partly opened to provide a breeze but not access to the wards.
73. CQC criticism of incident reporting had some foundation. Whilst serious incident reporting was robust, the investigation and learning process for minor incidents was less so. In the maternity unit there is now a daily consultant-led incident review, in contrast to the previous monthly round-up. Staff are encouraged to record all levels of incident on Datix, and there is a daily focus on a ‘theme of the week’ captured via incident reporting at each shift handover across all three maternity sites (the themes are updated weekly).
74. There is also a monthly newsletter on incidents. In addition, labour ward consultants cascade learning from incidents to junior doctors, and similar information is disseminated to matrons and midwives. There is also a quarterly seminar titled “Lessons Learnt” which is multidisciplinary and led by the Midwifery and Consultant Risk leads.
75. The CQC identified that ESHT was not following guidelines for pre-eclampsia. However, managers told the sub-committee that this concerned correctly documenting the activity that routinely took place rather than staff not undertaking the recommended activity. Witnesses explained to HOSC that there were no actual negative outcomes from the trust’s actions here and that the problems identified by the CQC were being addressed.
76. Post-partum haemorrhage procedures were criticised by the CQC, although the sub-committee was told that a recent clinical audit suggests that no patient actually experienced inappropriate care. Sub-committee members were informed that ESHT has recently improved protocols around responding to this condition, and ‘PROMPT’ training (Practical Obstetric Multiprofessional Training) is being rolled out to staff.
77. In response to CQC criticism of maternity department management, the sub-committee was told that the trust has increased managerial capacity, freeing up manager and consultant time for a greater focus on strategic planning and on staff development. An externally-led development course for matrons has also been introduced, and has proved very popular.
78. Staffing is not currently far from establishment, but this may be a blip rather than a long term trend. The problems remain of recruiting to a small unit that is a relatively long way from London. There is a significant national gap in the supply of middle-grade doctors and has been since the introduction of the European Working Times Directive. This gap used to be filled by non-EU doctors, but this is no longer wholly the case.
79. The relatively small size of the maternity department makes it difficult to attract trainees, who will tend to opt for larger units, such as the London teaching hospitals (which give them more hands-on experience of a wide range of procedures, enhancing their employability). The trust has 60% of middle grade posts filled by non-consultant career grade doctors. There is a risk that junior doctors who are not seeking or unable to progress

to becoming consultants may stagnate, so ESHT offers a strong professional development programme, including the capacity to develop in sub-specialty areas.

80. The trust also uses simulations to provide training in scenarios that may rarely occur in a relatively small unit. The simulation programme has recently been revised and strengthened.

81. Midwife numbers are almost at establishment levels following recent successful recruitment rounds. Some midwives have been recruited from Spain and from Italy, and some have been persuaded to return to practice. The trust has also recruited midwives with specialities in bereavement, infant feeding, and perinatal mental health. The trust is seeking funding for specialists in teenage pregnancy and in substance misuse.

82. The HOSC sub-committee was informed that there are no significant capacity issues in the labour ward. Post-natal capacity has recently been increased, and a dedicated post-natal ward has been created. Capacity issues do arise in terms of post-natal beds, and these are managed by expediting the discharge process of mothers who are fit to be discharged. There are discharge bottle-necks – e.g. women who are ready to leave but who frequently have to wait for medical checks. A group of midwives has been trained to perform these checks to alleviate the bottle-necks and funding is being sought to train more midwives in these skills.

83. The trust permits women who are fit for discharge but who have babies in the special care unit to remain in post-natal beds where there is bed space.

84. Witnesses told the sub-committee that there is adequate ante-natal capacity. In line with national moves, the trust has recently introduced outpatient induction, although there has been relatively little demand for this service to date.

85. The sub-committee was told that the trust has responded to CQC criticisms of the cleanliness of wards by doing a good deal in terms of tidying and redecoration. Managers said that, while the wards were indeed tired and cluttered looking, it was debatable whether they were ever actually dirty. The sub-committee found the ward environment to be clean and less cluttered than on previous visits.

86. Managers are confident that the next CQC inspection will find that there have been significant improvements to maternity services, particularly in terms of recruitment and retention of staff, staff training, the physical ward environment, better incident reporting procedures and a more healthy corporate culture.

87. The sub-committee was informed that medical students have recently nominated paediatric consultants for Teaching awards, an indication of how improved the working environment now is.

Patient Records Sub-Committee

Cllr Alan Shuttleworth; Cllr John Ungar (Eastbourne Borough Council representative), Cllr Bob Standley

88. Patient Records sub-committee members met with patient records staff at EDGH on the 1st February 2016. Key points explained by **ESHT witnesses** were:

Background to the current situation

89. For some time prior to August 2014, the East Sussex Healthcare NHS Trust (ESHT) trust Board was aware of clear and significant risks within the Health Records service and

had added them to its risk register. The risks were not ignored but were not addressed in as timely a manner as they could have been: the Care Quality Commission (CQC) acknowledged in its September 2014 inspection that the Health Records service had developed a strategy but had not yet implemented it.

90. The trust board had been aware of some of the risks associated with the Health Records service in 2005 as the risk register from that time mentions those risks. These risks were not prioritised in the intervening years, perhaps because the NHS National Programme for IT was expected to address many of them (through the creation of a national electronic medical record database). Since the abandonment of the NHS National Programme for IT in 2011, ESHT has remained dependent on paper records – which must be moved physically between acute and community sites – to help with the assessment and treatment of patients.

91. The discussions around the impact of ESHT's clinical strategy did not include the clinical support units and, as a result, the health records service has had to "catch up" with the logistical challenges caused by the single-siting of stroke, general surgery and obstetrics in 2012.

92. The ESHT witnesses were confident that the combination of iFIT (electronic document tracking); the completion of the Operational Services Model for the records storage facility at Apex Way, Hailsham; and the implementation of the Electronic Document Management (EDM) will help to future-proof health records for the next 10 years.

Physical condition of the health records

93. Many health records are in a poor physical condition because:

- The materials that they are constructed from (paper and cardboard) degrade over time.
- The storage areas are inadequate across both acute sites.
- The single-siting of stroke, general surgery and obstetrics as part of the trust's clinical strategy means that records have to be moved between sites more frequently, increasing wear and tear.
- There is lack of appreciation from staff outside of the Health Records and Clinical Prep Teams that they are also responsible for ownership of the records.

94. Health records are repaired by a repair team at both acute sites on an ongoing basis. However, the distribution of records to clinics is a priority and the team is often diverted from repairs to aid with distribution.

95. Alternatives to cardboard are very expensive, so the government funded EDM scheme, which will start to go live in October/November 2016, is the long term solution to paper records. Worthing Hospital and Queen Victoria Hospital (East Grinstead) will also be implementing EDM.

Temporary records

96. ESHT records the number of temporary records it creates on a weekly basis as a percentage of the total number of outpatient appointments. There is no national target for what percentage of temporary records are being used, but ESHT has set itself the target of 0.5% per week – amounting to approximately 80 patients. Another local trust has reported reducing its temporary files from 18% to 4% over the last 3 years as a major improvement. The weekly performance against the target of 0.5% is published in the trust Clinical Administration Dashboard.

97. There has not been a breakdown of the reasons for temporary medical records being used: for example, because the patient is on holiday in East Sussex. The data is collected manually and relies on honesty from those reporting the use of temporary medical records. The number of reported temporary records increased after the trust responded to the CQC's criticism of its low level of incident reporting. The number of reported incidents has reduced slightly since then, suggesting that the figures are now fairly reliable.

Health record storage

98. The number of health records held by ESHT grows at a rate of around 2,000 per month. There are approximately 700,000 records in storage, of which 400,000 are 'live'. There are strict legal rules for retaining, storing and destroying health records, which, combined with an aging population, means the total number of records continues to grow.

99. The current storage areas for live health records are not fit for purpose. Health records are currently dispersed across:

- The records library at the EDGH (built in 1976 and too small for current demand)
- Two satellite rooms in EDGH
- A leased warehouse in Apex Way, Hailsham
- A leased warehouse in Brampton Road, Eastbourne
- A records library at the Conquest Hospital
- Five satellite rooms in the Conquest Hospital.

100. Under the current arrangement, it is not unusual for a member of the Clinical Prep Team to find nine of 10 required health records in 30 minutes and spend 45 minutes finding the final record due to movement between the various storage locations or ESHT offices.

Health record transportation

101. Patients in East Sussex may receive appointments, follow-up appointments or inpatient care from one of 10 community or acute sites. The trust's courier service has been relied upon to deliver a patient's health records to the appropriate sites. However, the courier service is unable to prioritise health records or deliver them separately to other deliveries made between sites – which is an issue if the health record needs to be at the another site on the same day.

102. The Clinical Administration service has launched a pilot dedicated courier service for health records. The courier service comprises a single courier who transfers records between the two acute sites (via Bexhill Hospital) during the day – health records transferred in the evening still use the existing trust courier service. Since the pilot was implemented, there have been no instances of late deliveries or early pickups of health records. It is anticipated that this service will be maintained, and possibly expanded, in the next financial year.

Operational Services Model for Apex Way

103. In order to address the issues around storage and transportation of health records, and the health and safety concerns of staff, a new Operational Services Model is being developed. The proposed Operational Services Model involves the creation of one main records library at Apex Way, Hailsham, where all live records will be kept, with satellite offices at both acute sites. Brampton Road warehouse will be retained as back up for old

files. Apex Way is already leased and used for storing community records for the CCGs, for which ESHT receives reimbursement. In addition, proposals are being developed to expand the courier service so that it can deliver and return the files from Apex Way each day.

104. Other options were considered by management but were deemed unsuitable, for example:

- **The expansion of the existing records libraries in EDGH and Conquest** – the CQC report was critical of the lack of sufficient dignity provided to patients in the A&E and radiology departments. The estates strategy for ESHT recognises that these two departments need to expand in order to address this CQC concern. The space currently occupied by the records libraries in EDGH and Conquest Hospital is pivotal to creating additional clinical space and retaining essential on-site services.
- **The construction of new buildings on site at the acute hospitals** – this is beyond the available funding for the project.
- **Alternative sites** - Bexhill would be the ideal location for a single storage site, but managers told the sub-committee that there are no suitable locations in that town.

105. Given that Brampton Road is already used as a site for storing 'live' health records, the practice of moving files from an offsite location is already established. Furthermore, a travel survey indicated that 40% of ESHT's patients use both acute sites for their care, so, practically speaking, health records are often stored "offsite" currently.

106. Staff from the Conquest Hospital records library are concerned about the proposals: their job role is graded at band 2 and many of the staff are in the role partly because it provides a local job. They are also concerned about the safety of the site due to alleged higher incidents of crime.

107. The trust has undertaken several activities to try and ensure that the needs of staff are met and that it is a positive process, including:

- Staff side representatives and key union representatives sat on the project board for the planning stage of the project over the summer. The project board consensus was for the Apex Way site.
- Modelling work was carried out with staff to try and develop buy-in to the project by developing the specifications together.
- Assurance provided to staff that they would receive excess mileage reimbursement for four years for travel costs as this is written into their current contracts.
- Discussion about providing a mini bus service for staff – although they were not used often when provided for maternity staff following the reconfiguration of that service in 2014.
- A trust security adviser has undertaken a review and is satisfied with the level of security.
- An independent review of the proposals will also model how many staff will be affected by the changes – this will be reported to the trust board at a future date.

iFIT tracking

108. iFIT was introduced in August 2015 to replace the previous tracking facility which was part of the PAS Oasis system (the previous tracking system which was increasingly underused) and to address the three separate filing systems that existed as a result of the mergers of the two acute hospitals and East Sussex community healthcare services.

109. iFIT is based on location filing – not digital or alphabetical filing – meaning that shelves are divided into areas with their own unique RFID barcodes. A health records team member attaches an RFID barcode to the medical record and scans it and scans the RFID barcode on the shelf. When someone looks for the health record on the iFIT software, it will tell them the location. Records are not associated with one particular shelf, so can be put anywhere and as long as the two RFID barcodes are scanned, it can be easily recovered. At least eight or nine other NHS trusts now use iFIT.

110. Witnesses said that the other benefits of iFIT included:

- Sensors dotted around the trust and handheld scanning machines that emit a signal when near the desired medical record make it easy to find records that have gone missing.
- Temporary records can be tagged and then later merged with permanent records.
- Permanent records can also be split into volumes so that older information can be archived.
- Duplicate files can be merged if a duplicate is produced (rather than a temporary record) – which often happens in A&E when records cannot be found.

111. Medical records are also handled by ward clerks, medical secretaries, clinical clerks, and cancer pathway assistants (amongst others) who are all given 'wasp' scanners to scan the medical record when they receive it. The trust's philosophy is that using the tracking system is so easy that it must be used. The iFIT system can monitor who is not using it (as the scanners will show where the records have been) and recalcitrant staff can then be constructively challenged. It can also be used to track medical equipment and alert staff to upcoming clinics a week or more in advance.

112. 100,000 medical records have now been tagged with RFIDs in a rolling programme. Capital funding is being sought to systematically tag the other 400,000 medical records using a private organisation that specialises in health record tagging. This is currently being costed and is expected to take 8-12 weeks if funding is made available.

Other changes to Health Records team

113. The Health Records team was reorganised in the summer and this was further refined in early 2016 in order to give the team the ability to prepare health records two or three days in advance of clinics. Since the reorganisation, no deadlines for submitting health records to clinics have been missed.

114. An escalation procedure has been added for when medical records cannot be found. The local supervisor is alerted in the first instance; followed by the managers of the Clinical Preparation Team and the health records library; and then – if the records still cannot be found – the Head of Service and Assistant Director 48 hours before the clinic. In the past, there had been an acceptance that records had been lost and other teams were not informing health records that they were missing, for example, seven operations were cancelled in September 2015 due to missing notes – even though the majority must have been available two weeks before during the pre-operative assessment.

115. Management has carried out several initiatives to ensure that it is more open to suggestions and complaints, for example:

- A monthly newsletter is now sent to staff containing plaudits, a “did you know?” section, and general information about iFIT.
- Weekly management meetings are held to agree information to cascade to team meetings.
- Monthly team meetings are held, which senior managers also attend.
- In addition to the trust-wide Staff Forums, Clinical Administration also holds a monthly staff forum that senior managers attend, although staff attendance has been patchy in recent months.

Surgery Sub-Committee

Cllr Angharad Davies, Cllr John Ungar (Eastbourne Borough Council representative)

116. The surgery sub-committee met with ESHT staff and toured the surgical wards at the Conquest Hospital on the 25th February 2016. Key points from the **ESHT witnesses** included:

117. Sub-committee members were told that the reconfiguration of surgery caused a good deal of disruption and ill-feeling, some of which was captured in the CQC inspection reports. However, the rationalisation of services was essential to managing the consultant rota efficiently, to improving performance across a number of specialities, and to attracting and retaining high quality medical staff.

118. In the wake of reconfiguration, there are still cultural issues across the surgical department that need addressing. TDA interventions, following ESHT being placed under special measures, have focused on supporting the trust board rather than on supporting the surgical teams.

119. The sub-committee was informed that the reconfiguration of surgery and delivery of the trust clinical strategy included a programme of capital improvements, supported by a full business case. Around 80% of these improvements have now been delivered, which represents excellent progress given the general financial situation of the NHS and given the need for ESHT to use capital funding to address other issues identified by the CQC.

120. Current capital improvements are being undertaken whilst keeping the relevant wards open. This is challenging, but has been successfully achieved to date.

121. All on-call consultants now live within a 30 minute drive of the Conquest Hospital, or are happy to be based nearby (e.g. at a hotel) when on-call.

122. ESHT continues to provide surgical support at EDGH – a surgical registrar is always on site. However, demand for this support remains very low. In terms of the surgery still undertaken at EDGH, there are robust protocols in place for urology. There is a case for conducting more robust risk assessments of gynaecological procedures, with some higher risk operations potentially transferring to the Conquest hospital.

123. There is capacity on the surgical wards to cope well with surgery patients. However, the demand on general hospital beds means that surgical beds are routinely used for medical overflow. This inevitably makes it harder to run effective surgical services. It also means that relatively long-stay patients are occupying beds that are intended for very short

surgical stays (e.g. with no TV facilities) and being treated by nursing staff who are trained to support surgical rather than general medical patients. Some elective surgical procedures are being cancelled due to a lack of beds, and this is due to medical overflow, not to any lack of surgical capacity.

124. The sub-committee was told that here had been some issues with incident reporting in the department, but these have now been addressed. There is wide staff involvement in risk meetings: staff who report incidents now invariably receive feedback on the actions taken in response to their alerts; all staff can easily report incidents (agency workers are encouraged to approach permanent staff who will log incidents for them); and the number of low level incidents reported has significantly increased.

125. Analysis of mortality was identified as a weakness by the CQC. The HOSC sub-committee was told that here had always been robust analysis within the department, although the disruption caused by single-siting and the turnaround programme meant that this became somewhat ad hoc and activity that took place was not always fully recorded. This has now been addressed: there are regular mortality meetings and data on deaths is shared and analysed via specialist software.

126. Core surgical services already operate 7 days a week. However, key support services such as physio and ultrasound do not.

127. Managers maintain that discharge arrangements always functioned relatively well, but have been further improved in recent months, and that most discharge from hospital is fairly rapid. There are still problems with patients with co-morbidities (particularly in terms of dementia), and with patients who require minor adaptations to their homes before they can return to them. There is an effective fast-track process for patients with a terminal diagnosis.

128. All emergency trolleys have been renewed. Contrary to the CQC's assertions, the sub-committee was told that the trolleys had always been checked in preparation for the coming day. However, these checks used to be undertaken by night staff just before ward lights were dimmed at 11pm, which meant that there was no check recorded for the following calendar day. Checks now take place after midnight, meaning that should a trolley be inspected it will always show a check on the current day.

129. The CQC identified some medicine management issues within the department. These have now been addressed. The sub-committee was told that there was no actual patient harm arising from any of these problems.

130. Staffing is currently near establishment levels, although this remains a risk factor. It is important that recruitment is pro-active, whenever possible identifying future issues before they arise. In the longer term, co-working with local councils will be essential – e.g. in terms of the provision of more affordable housing for key workers.

Outpatients Sub-Committee

Cllr Alan Shuttleworth, Cllr Frank Carstairs, Cllrs Bridget George (Rother District Council representative), Cllr Sam Adeniji (Lewes District Council representative)

131. The Outpatients Sub-Committee met with ESHT staff and toured the Conquest Hospital outpatient facilities on the 29th February 2016. Key points raised by ESHT witnesses from the Outpatients Department included:

132. ESHT clinical administration was centralised in August 2014 as part of the trust's financial turnaround programme. However, the sub-committee was told that this was not as

well planned as it could have been and significant problems quickly emerged. It has taken a number of months to address these problems, and there are still some outstanding issues, but the trust now understands how the administration system works and where the stresses are. Previously it was not always clear why particular problems had arisen.

133. The majority of outpatient (OP) work is coordinated by the centralised administration service, although there are still services that manage their own appointments (e.g. radiology, physio). These areas have specific systems or processes that do not sit within the standard operating procedures for main outpatient clinics; however in the longer term the intention is for the centralised administration service to coordinate all general outpatient activity.

134. The trust works to achieve nationally set performance measures when appointing to OP clinics, such as the 18 week 'referral to treatment' target (RTT). The department also records achievement against a number of locally set milestones to help meet the national targets.

135. ESHT delivers OP appointments at several sites across East Sussex. Following clinical triage patients will always be offered the first available appointment whether or not this is at the location nearest to them. Patients may always opt to wait longer for an appointment at a location of their choice (other than for some specialist services which may only be available at one location). This can impact on RTT times, although there is a tolerance built into the target to accommodate this type of eventuality.

136. ESHT sends a reminder seven days before each appointment, and again 24 hours before. These are automated calls or text messages, except for patients who are over 70 who receive personal calls. Patient phone number information is not always available, and the team is active in soliciting and recording this information at all opportunities when speaking to patients.

137. In recent months there has been lots of work to analyse OP activity. For example, demand has been measured across a 12 month period and this information has been used to identify hot-spots and to allocate staff resources accordingly.

138. There has been a concerted effort to address the clinic DNA (Did Not Attend) rate, which was at around 10% (an outlier). This has proved successful and DNA is now 6.8%, which places ESHT towards the top quartile of acute trust performers.

139. Short notice (i.e. less than six weeks) cancellation of clinics was another problem for the trust. Analysis of the reasons has identified annual leave as a major factor (clinical staff are expected to give at least six weeks' notice of leave requirements, but have not always done so or the internal processes do not facilitate timely transfer of information). This type of analysis is an essential first step in addressing the problem of clinic cancellations, and recent months have seen steady progress on this front.

140. The trust has invested in an enhanced switchboard and new telephone system for the main appointment centre at the Conquest Hospital. The new system provides real-time data as well as capturing much more information about calls, and will help the trust better match staff resources to times of high customer demand. Since the new system was brought in, customer complaints about having to wait for calls to be answered have fallen significantly.

141. The outcome of clinic appointments (ensuring that follow-up appointments are booked and the appropriate patient pathway is recorded) remains a problem for the trust, although performance is improving. ESHT is aware of the causes and does hope to hit its targets here in the near future through a number of mechanisms. In the longer term, concerted improvement depends on the greater use of digital rather than paper-based systems.

142. The OP department had historically been considered low risk in terms of national cleaning standards and was consequently seldom audited. However, this risk assessment did not really take account of the range of work undertaken by OP, including minor surgery and other invasive procedures. OP is now considered high risk, which means that it is audited more frequently, helping support staff to deliver consistent high quality services. This also means that OP is better able to access ESHT's limited pot of capital funding in order to make improvements to estates.

143. The OP Department argued that CQC criticisms of aspects of OP cleanliness were not unreasonable, but didn't necessarily reflect the whole picture – e.g. equipment was regularly checked and cleaned, but this maintenance wasn't always properly documented. This has now been addressed: a 'fit to fly' checklist is completed at the start of each working day to ensure that all the required checks have been undertaken and documented.

144. OP now has much more robust processes in place than it did at the time of the CQC inspections and managers are confident that a future CQC inspection will have much more positive things to say.

Conclusion and Recommendations

How is ESHT Doing?

145. The Review Board started out asking three basic questions about the ESHT Quality Improvement process:

- Do the trust's leaders accept the scale of the improvement challenge?
- Is it evident that there is a serious and sustained commitment to change?
- And are the planned improvements commensurate with the magnitude of the task in hand?

146. It is clear that the interim leadership team has recognised the scale of the challenge that ESHT faces. However, at the time of this report a permanent trust Chair had only recently been appointed, and a Chief Executive has been announced but is not yet in post, so it is simply not possible to say what the attitude of the new leadership team will be. The Review Board hopes and trusts that the new ESHT leaders will build on the good work of Richard Sunley, the acting Chief Executive, and his team.

147. The Review Board has found a serious commitment to improvement. ESHT's interim leadership team has been open about the need to make fundamental changes to the way that the trust operates. The Review Board's sub-committees also saw that this commitment mirrored by senior clinicians and managers across a number of hospital departments. However, time will tell whether this commitment is sustained. It is obviously much more difficult to maintain tight focus across several years than over a few months, and it will take years to address some of ESHT's most entrenched cultural flaws.

148. The Review Board believes that the current Quality Improvement Plan (QIP) is much more robust and challenging than the plan developed under ESHT's previous leadership regime. Clearly the QIP actions alone will not move ESHT from *inadequate* to *outstanding*, but the QIP does appear to provide a solid foundation for future improvement programmes to build on.

149. In summary, the Review Board is satisfied that ESHT's leaders understand that considerable improvement is required and that the trust is committed to and in a position to deliver significant and sustained quality improvement. There are important caveats to this support, because the trust is in the process of appointing a new leadership team; and also because we are still in the early stages of some of the most important improvement initiatives, particularly those which seek to transform elements of ESHT's organisational culture.

Recommendation 1: In the HOSC's view, ESHT's interim management team has shown that it understands the need for, is committed to, and is capable of delivering, sustained organisational improvement.

Monitoring Quality Improvement

150. The East Sussex Health Overview & Scrutiny Committee (HOSC) has a key role to play in monitoring ESHT's quality improvement actions over time. HOSC will consequently add the following issues to its work programme:

- Sickness Absence Rates (an annual report from ESHT on its work to reduce sickness absences, with data on sickness trends across the year)

- Bullying and Harassment (an annual report from ESHT on its ongoing work in this area. To include input from the Speak Up Guardian, data from the annual Staff Satisfaction Survey and feedback from ESHT's internal bullying & harassment review)
- Complaints (an annual report on complaints, to include information about the number of complaints and actions being taken to use complaints as a learning opportunity)
- Incident Reporting (a report to HOSC on the initiatives to improve incident reporting, to include: input from the Speak Up Guardian; information on the success of the staff incident phone line; data on performance against the national target of 48 hours for logging incidents; and information on the external review of incident reporting in the ESHT surgical department)
- Staffing and Recruitment (an annual report on ESHT staffing levels plus information on initiatives to improve recruitment and retention)
- 'Cashing-Up' rates (the rate at which outpatient follow-up appointments are booked following an initial appointment) a report-back to HOSC.

Recommendation 2: the HOSC will continue to monitor ESHT quality improvement, particularly in terms of: sickness, absence rates, bullying and harassment, complaints, incident reporting, and staffing and recruitment.

151. The Review Board has also chosen to make some more specific recommendations, based on the evidence gathered by Board members.

Capital Investment

152. A number of the improvements planned by ESHT, either as part of the QIP or as other quality improvement measures, are reliant upon capital funding. The most significant of these measures is perhaps the plan to renovate Eastbourne Midwife-Led Maternity Unit. This was a key element of the improvements promised as part of the reconfiguration of East Sussex acute maternity services (Better Beginnings). Other improvements that depend on capital funding potentially include the roll-out of Omnicell medicine cabinets across the trust and the digital tagging of patient records. However, pressure on national NHS capital funding and on individual NHS trust budgets means that the future of many capital projects is uncertain. We need to ensure that there is no ambiguity about local capital projects and that, where capital funding may no longer be accessible, other options are actively being pursued.

Recommendation 3: ESHT should report to the HOSC confirming whether funding for the promised Better Beginnings capital works and for any works that form part of the QIP has been secured. Should the predicted NHS or corporate funding no longer be available, ESHT should set out its alternative plans for securing key projects.

Pressure on Surgical Beds

153. The surgery sub-committee heard that a shortage of beds for general medical patients often leads to overflows into the surgical wards. This means that beds that ought to be used for very short-stay surgical patients are being filled with potentially much longer-stay medical patients. Not only is this a less than optimal use of a specialist resource, but it can mean that elective surgical procedures have to be postponed because no surgical beds are available. This inconveniences elective patients, even if there is no actual detriment to their health, and it also impacts on the trust's performance against the key 18 week 'referral to

treatment' target. This is an unacceptable situation, other than as a response to a truly unanticipated demand surge, and suggests that ESHT has too few general beds available, particularly during periods of higher demand. It is important that the trust develops a strategy to deal with this demand issue rather than just shifting the burden on to elective waiting times.

Recommendation 4: ESHT needs to develop a strategy to deal with general medical capacity demands without impacting on the performance of the trust's surgical units.

Leadership

154. The Review Board has heard a good deal about plans to improve leadership skills for fairly junior managers, but relatively little about the leadership skills of ESHT's leaders. However, the CQC identified serious failings at board level, particularly in terms of a disconnect between 'board and ward'. Although many former board members are no longer in place, there remains an evident need to address leadership at the highest level of the trust to ensure that these problems do not persist into the future. It would be helpful for the HOSC to get a picture of what kinds of senior leadership development is being undertaken.

Recommendation 5: ESHT is asked to report to the HOSC on its plans for board development in response to the CQC's criticisms of trust senior leadership.

Strategic Risk Management

155. Most large organisations, including NHS provider trusts, maintain some kind of risk register in order to identify, quantify and mitigate emerging strategic risks. It ought therefore to have been the case that ESHT knew in advance about the major issues identified in the CQC inspection reports and had plans to deal with these issues. However, it is evident from the CQC's findings and from the Review Board's investigations that the trust's risk procedures were not robust enough to capture and address some major strategic risks at a relatively early stage.

156. This was certainly the case with patient records, where the deterioration of the system was identified as a risk, but never adequately addressed. The risk of under-staffing across a number of departments also seems to have received inadequate attention, with a reactive rather than pro-active approach to recruitment. Whilst it is obviously easy to be wise about risk in hindsight, the failure to appropriately manage so many risks does suggest that ESHT's risk management system is in need of an overhaul.

Recommendation 6: ESHT is asked to report to the HOSC on what it is doing to ensure that the trust's system of strategic risk management is fit for purpose.

Hospital Discharge

157. Ensuring that patients who are medically fit to be discharged are in fact able to leave hospital in a timely manner is one of the most important challenges facing local health economies. Timely discharge maximises the beds available for new patients, as well as minimising inconvenience to patients and their families. Given how difficult it is to provide additional beds at many hospital sites, more efficient use of the current beds may be the best available method we have to manage increasing demand. Discharge can be an involved process, particularly for frail patients who require a complex package of care in order to return to their homes. This is typically a multi-agency problem, and delays in discharge may be due to issues within adult social care or community NHS services rather than being the fault of hospital trusts.

158. However, while not all the levers of timely discharge are held by acute providers, some certainly are. For instance, a common national problem is caused by patients who are declared ready for discharge early in the day but who then have to wait many hours for their discharge medications. Although no single patient's discharge may be delayed for more than a few hours due to waiting for medicines, the aggregate impact may be very significant across a hospital if such waits are commonplace. This is particularly important when hospital capacity is stretched – as it is in ESHT, with medical patients regularly overflowing into surgical beds.

Recommendation 7: ESHT is asked to report to the HOSC on what it is doing to ensure that hospital discharges are not unduly delayed by waits for take-home medicines or other factors within the control of the trust.

Incident Reporting and Complaints

159. The CQC criticised the way in which ESHT dealt with and learnt from staff incident reporting and also the way that the trust processed and learnt from customer complaints. These issues are now being addressed via the trust QIP and it appears that much more robust systems have been instituted, although it may be some time before we see a clear improvement in performance. Review Board members welcome these moves, but are particularly interested in the intersection of incident reporting and complaints.

160. It is evidently not the case that every incident that staff record will lead to a complaint: many incidents that cause no harm will never even be noticed by patients or their families. Equally, not every complaint links to an incident: some complaints may be ungrounded; others will be about issues such as staff behaviour or cancelled appointments rather than about a clinical 'incident' as such.

161. However, there will obviously be some potential cross-over between incidents and complaints: some incidents will have resulted in a complaint; some incidents will not, but would present reasonable grounds for complaint; some complaints may allege that an incident took place when staff have not reported anything. There is therefore a good deal to be gained from a comparative analysis of incidents and complaints. At the very least, cross-checking complaints against incidents should provide some assurance that the incident-reporting system is functioning properly. One would presumably expect that the great majority of complaints arising from 'incidents' will have been logged as incidents by staff at the time they occurred; and if this has not taken place it may suggest that incident reporting within a particular service is not as good as it might be.

Recommendation 8: ESHT is asked to report to HOSC on the measures it is taking to cross-reference the trust's incident reporting and complaints data.

Seven Day Working

162. The NHS is currently committed to moving from five to seven day working. Whilst it is not always clear what such a move would entail, and whilst a number of services already operate on something like a seven day model, there are nonetheless some obvious hospital services that will need to be redesigned to fit a seven day model. For example, the Review Board was told that further significant efficiencies in the pharmacy department will require the adoption of a seven day working model. Similarly, whilst surgical services already operate across seven days, some key supporting tools such as ultrasound scans and a full range of physio services do not. The HOSC would welcome early sight of ESHT's plans to move to a seven day working model.

Recommendation: ESHT is asked to report its plans to move to a seven day working model to the HOSC.

Appendix 1: HOSC/Review Board membership and project support

Committee membership

East Sussex County Council Members (Voting)

Councillor Michael Ensor (Chair)
Councillor Frank Carstairs
Councillor Angharad Davies
Councillor Ruth O’Keeffe (Vice-Chair)
Councillor Alan Shuttleworth
Councillor Bob Standley
Councillor Michael Wincott

District and Borough Council Members (Voting)

Eastbourne Borough Council

Councillor John Ungar

Hastings Borough Council

Councillor Sue Beaney

Lewes District Council

Councillor Sam Adeniji

Rother District Council

Councillor Bridget George

Wealden District Council

Councillor Johanna Howell

Voluntary Sector Representatives (Non-voting)

Ms Julie Eason (SpeakUp)
Ms Jennifer Twist (SpeakUp)

Project support – East Sussex County Council

Project Manager: Giles Rossington
Project Support: Harvey Winder

HOSC email: healthscrutiny@eastsussex.gov.uk

HOSC website: www.eastsussexhealth.org

Committee meeting dates

22 May 2015, 16 June 2015, 01 October 2015, 03 December 2015, 24 March 2016

Review Board meeting dates

16 June 2015, 30 July 2015, 03 March 2016

Witnesses providing evidence to HOSC and sub-committee meeting dates

17 November 2015: Organisational Culture

East Sussex Healthcare NHS Trust

- Richard Sunley, Acting Chief Executive
- Alice Webster, Director of Nursing
- Monica Green, Director of Human Resources

08 January 2016: Maternity

East Sussex Healthcare NHS Trust

- Michele Small, General Manager, Women, Children's & Sexual Health Clinical Unit
- Jenny Crowe, Head of Midwifery and Gynaecology
- Cathy O'Callaghan, Service Manager, Maternity
- Darren Langridge Kemp, Complaints and PALS Manager
- Dr Graham Whincup, Consultant Paediatrician
- Mini Nair, Consultant Obstetrician & Gynaecologist and Specialty Lead
- Fran Edmunds, Head of Nursing, Children's Services

15 January 2016: Pharmacy

East Sussex Healthcare NHS Trust

- Jonathon Palmer, Acting Chief Pharmacist
- Melanie Adams, Pharmacy Governance Manager
- Michelle Elphick, Theatres & Clinical Support General Manager
- Karen Strachan, Senior Aseptics Technician
- Rosie Furner, Acting Clinical Pharmacy Manager/Deputy Chief Pharmacist
- Emma Jones-Davies, Medicines Management Nurse/VTE
- Maria Andrade, Pharmacist Site Lead EDGH and Lead Clinical Unit Pharmacist for Theatres and Surgery
- Ben Clark, Pharmacist Site Lead: Conquest Hospital and Lead Clinical Unit Pharmacist for Specialist Medicine
- Kirsty Sully, Senior for Pharmacy Distribution
- Alan Hopkins, Dispensary Manager, EDGH
- Stephanie Collins, MI Manager
- Neville Sharma, Lead Antimicrobial Pharmacist
- Orla McCaffrey, Clinical Pharmacist and Beth Attwood, Medicines Management Service Lead Technician

01 February 2016: Patient Records

East Sussex Healthcare NHS Trust

- Liz Fellows, Assistant Director Operational Planning
- Jo Byers, Head of Clinical Administration
- Janice Horton-Wood, Health Records Manager - Projects
- Ciara Pooley, Clinic Preparation Supervisor
- Lesley Saunders, Health Records Manager – Operational

24 February 2016: Surgery

East Sussex Healthcare NHS Trust

- Miss Imelda Donnellan, Clinical Unit Lead, Surgery Clinical Unit
- Jayne Cannon, Head of Nursing Surgery Clinical Unit
- Matt Hardwick, General Manager Surgery Clinical Unit

29 February 2016: Outpatients

East Sussex Healthcare NHS Trust

- Liz Fellows, Assistant Director
- Jo Byers, Head of Clinical Administration
- James Blake, Performance Analyst
- Mike McKernan, Business & Governance Manager, Clinical Administration
- Sue Winser, Outpatient Matron - Conquest Hospital

HOSC Member visits

Conquest Hospital Maternity, 08 January 2016

Eastbourne District General Hospital Pharmacy, 15 January 2016

Eastbourne District General Hospital Patient Records, 01 February 2016

Conquest Hospital Surgery, 24 February 2016

Conquest Hospital Outpatients, 29 February 2016

Contact officer for this review: Giles Rossington, Senior Democratic Services Adviser

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Appendix 2: Glossary of terms used in this report

CQC	Care Quality Commission (statutory regulator of health & social care)
The Conquest	The Conquest Hospital, Hastings
CQUIN	Commissioning for Quality & Innovation payment framework (local quality targets agreed by an NHS trust and CCG commissioners)
Datix	Specialist patient safety software system used for recording reports of clinical incidents, patient morbidity and mortality etc.
DNA	Did Not Attend (a patient failed to attend or to cancel an appointment)
EDGH	Eastbourne District General Hospital
EDM	Electronic Document Management – a system for digitally managing patient records
ESHT	East Sussex Healthcare NHS Trust
FFT	Friends & Family Test (after receiving NHS care all patients have the opportunity to say whether they would recommend the service to their friends or family)
HOSC	(East Sussex) Health Overview and Scrutiny Committee
iFIT	A system for electronically tracking patient medical records via barcode technology
Omnicell	A system for intelligently storing and dispensing medicines on hospital wards
OP	Outpatients Department
QIP	Quality Improvement Plan (the action plan produced by NHS trusts in response to CQC inspection report recommendations)
RDIF	Radio Frequency Identification – a system for electronically tagging and tracking objects such as patient records
RTT	Referral To Treatment – the standard national 18 week target for elective procedures
Speak Up Guardian	An ESHT internal appointment whose job it is to communicate staff concerns to senior managers
TDA	NHS Trust Development Authority (oversees non-Foundation NHS trusts)

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Work Programme for Health Overview and Scrutiny Committee



Future work at a glance

Updated: **March 2016**

Please note that this programme is correct at the time of updating but may be subject to change. The order in which items are listed does not necessarily reflect the order they will appear on the final agenda for the meeting.

<i>Issue</i>	<i>Objectives and summary</i>	<i>Organisation providing evidence</i>
30 June 2016		
ESHT Quality Improvement Plan	<p>HOSC carried out a review of East Sussex Healthcare NHS Trust's (ESHT) Quality Improvement Plan (QIP) – which was developed in response to the Care Quality Commission's (CQC) Inspection Report of the Trust.</p> <p>The Committee will now receive periodical monitoring reports on the implementation of the QIP.</p> <p>Healthwatch may also report back on aspects of ESHT's performance in relation to Quality Improvement.</p>	East Sussex Healthcare NHS Trust (ESHT)

If you have any comments to share about topics HOSC will be considering, as shown above, please contact:
HOSC Support Officer: Giles Rossington, 01273 335517 or giles.rossington@eastsussex.gov.uk

Acronyms

A&E – Accident and Emergency department
ASC – Adult Social Care
AT – Area Team (of NHS England)
BSUH – Brighton and Sussex University Hospitals NHS Trust
EDGH – Eastbourne District General Hospital
CCG – Clinical Commissioning Group
CQC – Care Quality Commission
EHS – Eastbourne, Hailsham and Seaford
ESCC – East Sussex County Council
ESHT – East Sussex Healthcare NHS Trust
H&R – Hastings and Rother
HOSC – Health Overview and Scrutiny Committee
HWLH – High Weald, Lewes, Havens
MTW – Maidstone and Tunbridge Wells NHS Trust
NHS – National Health Service
SECAMB – South East Coast Ambulance Service NHS Foundation Trust
SPFT or SPT – Sussex Partnership NHS Foundation Trust
TBC – to be confirmed
TDA – Trust Development Authority

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