HEALTH OVERVIEW AND SCRUTINY COMMITTEE

THURSDAY, 1 DECEMBER 2016

10.00 AM COUNCIL CHAMBER, COUNTY HALL, LEWES

MEMBERSHIP -

East Sussex County Council Members
Councillors Colin Belsey (Chair), Ruth O'Keeffe (Vice Chair), Frank Carstairs, Angharad Davies, Alan Shuttleworth, Bob Standley and Tania Charman

District and Borough Council Members
Councillors Janet Coles (Eastbourne Borough Council), Mike Turner (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 29 September 2016** *(Pages 7 - 20)*

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. **Sussex and East Surrey Sustainability and Transformation Plan** *(Pages 21 - 40)*

6. **Urgent Care redesign** *(Pages 41 - 74)*

7. **Patient Transport Service** *(Pages 75 - 80)*

8. **HOSC future work programme** *(Pages 81 - 84)*

9. **Any other items previously notified under agenda item 4**

PHILIP BAKER

Assistant Chief Executive
County Hall, St Anne's Crescent
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23 November 2016

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Future HOSC meetings: 10am, Thursday, 23 March 2017, 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

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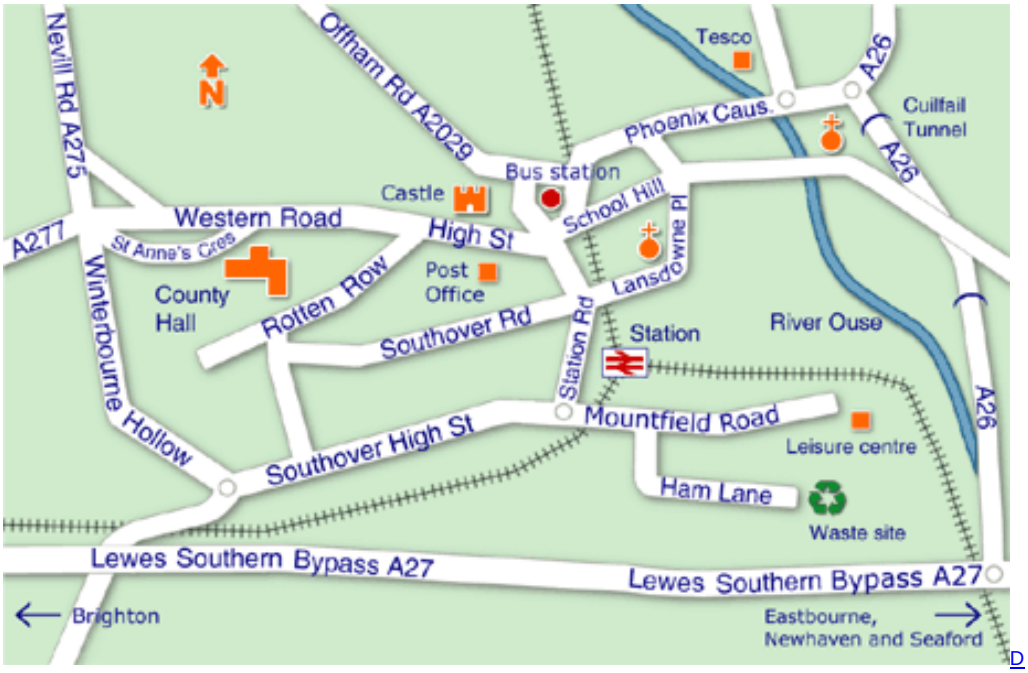

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Commonly Used Acronyms Glossary

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

DRAFT MINUTES of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Lewes on 29 September 2016

PRESENT:

Councillors Colin Belsey (Chair), Councillors Ruth O'Keeffe, Frank Carstairs, Angharad Davies, Mike Pursglove, Peter Pragnell and Alan Shuttleworth (all East Sussex County Council); Councillor Janet Coles (Eastbourne Borough Council), Councillor Mike Turner (Hastings Borough Council), Councillor Johanna Howell (Wealden District Council), Julie Eason (SpeakUp) and Jennifer Twist (SpeakUp)

WITNESSES:

Brighton & Sussex University Hospital NHS Trust

Lois Howell, Director of Clinical Governance

East Sussex Healthcare NHS Trust

Dr Adrian Bull, Chief Executive
Catherine O'Callaghan, Service Manager for Maternity

Coperforma

Michael Clayton, Chief Executive

High Weald Lewes Havens Clinical Commissioning Group

Wendy Carberry, Chief Officer
Alan Beasley, Chief Financial Officer
Ashley Scarff, Head of Commissioning and Strategy
Dr Peter Birtles, Urgent Care Clinical Lead
Sally Smith, Director of Delivery

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

Amanda Philpott, Chief Officer
Allison Cannon, Chief Nurse

LEAD OFFICER:

Claire Lee, Senior Democratic Services Adviser

12. MINUTES OF THE MEETING HELD ON 30 JUNE 2016

12.1 The Committee agreed the minutes of the meeting held on 30 June 2016 as a correct record.

13. APOLOGIES FOR ABSENCE

13.1 Cllr Sam Adeniji, Cllr Frank Carstairs (substitute: Cllr Mike Pursglove), Cllr Bob Standley (substitute: Cllr Peter Pragnell), Cllr Tania Charman and Cllr Bridget George gave their apologies.

14. DISCLOSURES OF INTERESTS

14.1 Cllr Ruth O'Keeffe declared a personal interest as an active member of Healthwatch East Sussex.

15. URGENT ITEMS

15.1 The Chair informed the Committee that the Care Quality Commission (CQC) had just published its inspection report on South East Coast Ambulance Service NHS Foundation Trust (SECAmb) which rated the Trust 'inadequate' and recommended that it be placed in special measures. He acknowledged that the Trust had been rated 'good' under the caring domain and said that was a reflection of the dedication of the staff at the Trust. The Chair added that he had attended the Quality Summit held by CQC and NHS Improvement on 28 September.

15.2 In recognition of the logistical difficulties of SECAmb reporting on progress to each of the six health scrutiny committees in the Trust area, the Committee RESOLVED to:

1) permit the Chair and Vice Chair to scrutinise SECAmb's response to the inspection report and overall recovery plan at a separate joint meeting with representatives of the other five HOSCs;

2) be presented with all of the information to be considered by the joint group before each meeting to afford Members the opportunity to propose questions for the Chair/Vice-Chair to ask SECAmb;

3) request that the joint group report its findings to HOSC; and

4) agree that the joint meeting be conducted publically as far as is practicable.

16. BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST (BSUH) CARE QUALITY COMMISSION (CQC) INSPECTION

16.1. The Committee considered a report on the findings of a recent Care Quality Commission (CQC) inspection of Brighton & Sussex University Hospitals NHS Trust (BSUH) and the Trust's response.

16.2. Lois Howell, Director of Clinical Governance, BSUH, provided an update and answered a number of questions from HOSC in relation to the CQC report and BSUH's quality improvement programme.

A&E Department waiting times

16.3. HOSC asked whether the improvements to the A&E Department made since the CQC's warning notice was issued in April had made any difference.

16.4. Lois Howell said that improvement in the A&E Department had been significant. BSUH has reduced the number of 12 hour waiting time breaches from 12 during April 2016 to five in total between May and the end of September 2016. The longest a patient had to wait since April had been more than 26 hours, but this had been for patient safety reasons and was now the subject of a serious incident review. BSUH had also improved 4 hour waiting times to 86% compliance, although the 95% target is unlikely to be met until after this financial year when building works at the Royal Sussex County Hospital (RSCH) – designed to improve patient flow and capacity in other wards – are completed.

16.5. Lois Howell said that the improvements to the A&E Department included:

- changing staffing rotas at both hospital sites, in particular altering staffing levels at the Princes Royal Hospital (PRH) to match the increased attendance levels during the evenings;

- requiring staff to use a checklist to monitor patients' welfare and a checklist to monitor signs of patient's deterioration, based on the National Early Warning Scores. There is currently a 100% compliance with both checklists;

- carrying out audits of patients' notes to ensure that they are being treated properly and that staff are using checklists.

Patients in corridor area at A&E Department

16.6. HOSC asked whether it was acceptable to allow patients to wait in corridors, and what BSUH was doing to reduce or eliminate the need for this practice.

16.7. Lois Howell explained that a corridor area is used when there are no available cubicles for patients who have entered the A&E Department on ambulance trollies, or who are too sick to go into the waiting room; it is safer to have them in the corridor area where a nurse is allocated to them than to put them in the waiting area. She said that putting a patient in the corridor is a difficult judgement call based on what is the safest place for the patient within the circumstances. It is not a situation that the Trust is happy with and is one that the Chief Executive has apologised for.

16.8. Lois Howell said that if more than five patients are in the corridor a trust wide escalation policy is initiated. Less than 10% of patients now have to spend any time in the corridor, these patients have to wait in the corridor for about an hour on average, and it is rare for five patients to be there at any one time.

16.9. In response to the CQC's findings on the use of corridors, Lois Howell said that BSUH has:

- Replaced some offices with four new assessment cubicles to reduce the use of the corridor area;

- improved the privacy and dignity of patients by ensuring that all treatment and assessment is conducted in a cubicle area and not in a corridor;

- bought more substantial screens for patients to allow more privacy in the corridor area;

- begun building works in the A&E Department and work to improve patient flows elsewhere in the hospital and increase available beds; and

- improved ambulatory care areas so that some patients can avoid A&E and go directly to the newly opened surgical assessment unit, for example, those referred by their GP.

16.10. Lois Howell said that BSUH is working towards a target of patients spending no more than 15 minutes in the corridor. However, improvements to patient flows throughout the rest of both hospital sites would need to be completed before a target of no one waiting in corridors could be achieved. This is because a lack of available beds in the rest of the hospital is often the cause of A&E cubicles becoming fully occupied.

Leadership and clinical governance

16.11. HOSC asked whether the Trust's senior leadership has the capacity to address the findings of the CQC.

16.12. Lois Howell clarified that there had been significant changes to the Board since the inspection. There is a new Chair and Chief Executive in place, along with a number of new non-executive and executive directors.

16.13. She also said that clinical governance at BSUH is in the process of being overhauled. The Trust is aiming to achieve this by:

- developing a leadership programme for clinical directors and other clinical leads;
- holding monthly senior management team meetings of all clinical and executive directors to ensure that there is a better link between the two;
- Holding improvement meetings for senior nurses and ward managers.

16.14. Lois Howell acknowledged that there is a serious cultural issue at the Trust and previous attempts to address it have failed. The Trust is investing significant money in recruiting external assistance to help it work more effectively with staff with particular protected characteristics. Some of the projects underway include:

- a regular staff forum;
- a commitment by the senior management team to 1,000 hours of participation with staff in frontline services;
- the establishment of an equalities group to ensure that the needs of all staff with protected characteristics are looked after across the Trust;
- an Equalities Committee to seek assurance and generally provide governance around the question of service provision – to ensure that when it is delivering services, the Trust is doing so in fair and equitable ways for all patients with protected characteristics.

Sharing good practice from the Children's Services Department

16.15. HOSC asked why the Children's Services Department was outstanding when the rest of the Trust was not, and what lessons could be learned from it and applied across the Trust.

16.16. Lois Howell said that the performance of the Children's Services Department was in part due to factors that could not be applied across the Trust, for example, the modern Royal Alexandra Children's Hospital building was designed with modern patient flows in mind, whereas many other parts of the RSCH site were built during the Victorian era. In addition, there are different commissioning requirements for children's healthcare, for example, lower demand for children's A&E services, which could not be applied elsewhere. However, the Children's Services Department's governance, teaching, learning and supervision methods will be shared as part of the overhaul of clinical governance.

Staffing in clinical areas

16.17. HOSC asked what was being done to recruit staff to clinical areas, in particular critical care areas, and reduce the use of agency staff.

16.18. Lois Howell said that BSUH's neuro-intensive care unit was of most cause for concern to the CQC. In response, the Trust has reduced capacity at the ward by one bed, and developed an in-house training programme for neuro-intensive care staff. The additional capacity will be reinstated once the ward has developed the right staffing skills to meet patient needs and the demonstrable ability to provide that additional capacity safely.

16.19. Lois Howell said that BSUH is attempting to recruit additional staff but recruitment is a national problem, particularly for roles such as A&E doctors. By way of illustration, PRH already had 4 consultant vacancies in its A&E Department that have not been filled and, in response to the CQC inspection, BSUH has now committed to providing further senior medical cover creating an additional 5 vacancies in A&E. The Trust is therefore looking at alternatives, for example, using senior doctors who are not consultants but have significant medical expertise and have received additional training.

16.20. BSUH has increased nursing staff and healthcare assistants in key areas and is recruiting and training its own bank staff in key areas rather than relying on agency locum staff wherever possible. The Trust is also developing clinical fellowship roles in a number of posts that allow staff to work part time clinically and part time in a research role. Agency staff are used when there is not sufficient permanent staff available.

16.21. The Committee RESOLVED to:

1) note the reports and its appendices;

2) agree to establish a joint working group with West Sussex County Council and Brighton & Hove City Council HOSCs to scrutinise the BSUH Quality Improvement Plan;

3) nominate Cllrs Belsey, Howell and O'Keeffe to the joint working group;

4) circulate papers to the rest of the committee in advance of the joint working group meetings; and

5) report back the findings to HOSC at a future date.

17. PATIENT TRANSPORT SERVICE

17.1. The Committee considered a report which provided a further update on the performance of the Patient Transport Service (PTS) in Sussex.

17.2. Wendy Carberry, Chief Officer; Alan Beasley, Chief Finance Officer; and Sally Smith, Director of Delivery, attended on behalf of High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG). Michael Clayton, Chief Executive, attended on behalf of Coperforma.

Accuracy of PTS data

17.3. HOSC asked what the PTS data anomalies were; why there was a mismatch between the large improvements in the data and the continued negative anecdotes HOSC members have been receiving; how occasions when no ambulance arrived for a booked journey were recorded; and to what extent HWLH CCG trusted the data it received.

17.4. Michael Clayton said that all journeys which do not meet the standards agreed in the service level agreement are recorded by Coperforma as 'service exceptions'. They are then categorised on their severity and investigated accordingly – the categories are critical, high, medium or low. Medium or low exceptions are dealt with together whereas each high or critical level exception – for example, a vehicle not arriving at all – is investigated individually. The continuous improvement team works together with the operations team to record and resolve the service exceptions.

17.5. Alan Beasley confirmed that Coperforma is providing the data as requested by the CCG. The data is of a good quality but it requires further analysis, which is being undertaken by the specialist Patient Transport Advisor who has now been recruited by the CCG. The Patient Transport Advisor had identified data anomalies and is working with Coperforma to understand whether the anomalies represent issues with the service or faulty recording methods. These findings will be fed into the CCG's contractual discussions with Coperforma.

17.6. Wendy Carberry added that the PTS contract specifies exactly what information the providers must provide to CCGs, rather than this being determined by the provider. One of the performance notices issued to Coperforma was around the data being provided. The CCG also triangulates Coperforma data with other sources, such as feedback from Trusts, in order to gain assurance about its accuracy.

17.7. Alan Beasley said that HWLH CCG had not seen any evidence from the data that if one patient's pick-up slot is missed they are then de-prioritised in favour of a different patient on the grounds that the target had already been missed.

Complaints about PTS

17.8. HOSC asked how the CCGs are recording and addressing complaints about the PTS.

17.9. Sally Smith said that reports from patients about delays to their patient transport appointments are classed in the CCG's complaints process as 'incidents'. CCGs analyse the complaints through their Patient Safety Groups –whose remit is to investigate incidents and complaints. All acute trusts and other healthcare providers have an incident reporting process and any complaints about the PTS made to them are shared with Coperforma. HWLH CCG also holds a monthly forum with the patient transport leads of all acute trusts that use the PTS service to consider the number and nature of the complaints; whether there are trends; and how the acute trusts feel about the impact on the patients in their units and hospitals. Sally Smith said that the number of incidents has gone down and patients are generally reporting that the service improvement is being maintained.

Future procurement processes

17.10. HOSC asked HWLH CCG what lessons had been learnt from the PTS procurement which could be applied to similar future commissioning processes.

17.11. Alan Beasley said that the two key lessons for any future procurement process were:

- ensure that the commissioner has access to specialist advice from a provider perspective as well as on the commissioning side.

- when there is a change in both service provider and service delivery model, the service change should be implemented in phases to reduce the risk to the service.

Recognising impact on patients

17.12. HOSC asked whether the CCG recognised the stress the failures in service had caused patients.

17.13. Sally Smith said that although the ongoing investigation led by a GP had not identified any physical harm, HWLH CCG fully recognised the stress the quality of the service had caused patients.

Training requirements for subcontractors

17.14. HOSC asked what training is required of subcontractor staff, and how standards are monitored.

17.15. Sally Smith said that HWLH CCG has written into the PTS contract that Coperforma, as managed service provider, must fulfil certain training obligations. Michael Clayton confirmed that all subcontractors go through a training programme and they are assessed before the contract goes live, and assessed via random spot reviews after the service has commenced. The outcomes of service exception reports are also fed back to the relevant subcontractors, and performance data is reviewed with all subcontractors on a monthly basis. Michael Clayton confirmed that two subcontractors had contracts terminated since April (out of 22).

17.16. Sally Smith said that the CCG's monitoring arrangements require Coperforma to provide evidence that its subcontractors are registered with CQC and Monitor; quality and safety checks have been performed on the vehicles; and training records of staff are available. HWLH CGG's Patient Transport Advisor will also visit Coperforma and its subcontractors to corroborate this evidence.

ICT system used by Coperforma

17.17. HOSC asked whether the ICT system used by Coperforma was fit for purpose.

17.18. Michael Clayton said that there were no concerns about the ICT system and he was confident that it provided all of the information that is needed in a suitable format for both Coperforma's operations team and its commissioners. Sally Smith added that HWLH CCG's Patient Transport Advisor will check whether the ICT system is fit for purpose when he visits Coperforma's operations team.

Reason for continued delays

17.19. HOSC asked why vehicles continue not to arrive on time.

17.20. Michael Clayton said that there are a large number of reasons for vehicles running late, for example, heavy traffic, breakdowns, weather or staff sickness. He said that these are underlying issues with patient transport and would occur regardless of whether the service is provided in house or by subcontractors.

17.21. Michael Clayton said that any provider should track each and every incident and be diligent about identifying the route cause. He said Coperforma had recorded each incident of lateness as a service exception and analyse it to discern whether there are lessons that can be learned which had led to service improvements.

Contingency plans

17.22. HOSC asked what contingency plans were in place in the event of another major issue such as the loss of a subcontractor, or the failure of the overall contract.

17.23. Wendy Carberry said that HWLH CCG had put in place contingency plans for a number of scenarios including if the service were to cease immediately, or if a single subcontractor failed. These plans are built around the way the service was delivered previously and HWLH CCG has had discussions with transport providers to make sure that arrangements can be put in place.

17.24. Michael Clayton added that Coperforma had planned to have surplus capacity in the first year of the contract as a contingency and this had made it possible to absorb some of the issues that have emerged since the contract started, for example the loss of two subcontractors. However, not all reasons for lateness can be resolved by having surplus capacity.

Scheduling of travel times

17.25. HOSC asked whether the travel times allowed for vehicles to reach patients was causing problems with performance, and whether sending vehicles to patients closer to them would improve travel times.

17.26. Michael Clayton agreed that scheduling was a key aspect of the PTS. When the contract was set up, Coperforma estimated the average journey time based on road information provided by third party sources. As part of the process, when a service exception is caused by a vehicle arriving late, Coperforma reviews its proposed journey time and compares it to the actual time it took. After three months of the service being in operation the original estimates now appear to have been optimistic, particularly around the coastal area. As a result, most of the estimated journey times built into the software used by Coperforma have been increased by nearly 60%, allowing drivers longer to reach their pick-up point. The settings in the system can also be changed to account for potential bad weather to allow more precise scheduling.

Procurement process

17.27. HOSC asked a number of questions about the procurement process, the additional costs of the contract to the CCGs, and whether Coperforma was willing to pay for patients who have missed appoints to see a consultant privately.

17.28. Alan Beasley noted that the procurement process had been subject to an independent report and it had been discussed at HOSC previously. He reiterated that the previous contract had come to a natural end so it was not the case that a decision was made proactively to outsource the contract.

17.29. Alan Beasley said that HWLH CCG agreed a fixed cost envelope as part of the contract but some additional costs have been incurred for management, oversight and scrutiny of the contract, for example, for the independent investigation into the procurement process.

17.30. Michael Clayton said he would look into whether it is feasible to pay for private consultants. He said that Coperforma has paid considerable sums to reimburse patients who have had to make their own travel arrangements. Alan Beasley said that HWLH CGG agreed a programme budget with Coperforma that included an agreement that Coperforma would reimburse additional transport costs incurred by healthcare trusts as a result of the PTS performance issues.

Contract specification

17.31. HOSC asked what weighting was given to performance during the procurement process; and whether the CCGs believe that the budget was enough, or the service provided was as good as could be expected within the financial envelope.

17.32. Alan Beasley said that the ratification report has been published in full and that describes the weighting and scoring system: finance was 20% of the overall score and 80% was issues around service quality, clinical safety etc. The report also says that no potential provider chose not to submit a tender due to the financial envelope.

17.33. He reiterated that the financial envelope for the new PTS contract was the same as the previous contract, but there was an expectation that increased demand for PTS services over the period of the contract would be absorbed by the new provider by making efficiencies. The

contract did not allow the provider to deliver this efficiency by increasing the eligibility criteria for patients to receive patient transport.

17.34. Alan Beasley accepted that the increased demand for a service with the same budget amounted to a reduced expense by the CCGs for each person using the service. He explained that there was an inbuilt 2% efficiency in all new NHS contracts and this would be the same for any other contract.

Contract management

17.35. HOSC asked what the level of failure would need to be for the contract to be terminated.

17.36. Wendy Carberry said the NHS contract encourages the CCG and provider to work together to try and make the service work for the local population. CCGs do not want to change service providers as it has an impact on patients, but HWLH CCG is using all levers within the contact, for example, it has served some contract performance notices and a breach notice on Coperforma.

17.37. Wendy Carberry said that the Key Performance Indicators (KPIs) in the contract are not set at 100%, so even if Coperforma meets all targets, there will still be some people who do not receive the service that the CCGs want; this is similar to the 95% target for A&E waiting times.

17.38. Wendy Carberry said that the feedback from a visit by HWLH CCG to patients and staff at the renal unit in Crawley was that the service was getting better and was comparable to the service offered to patients from Surrey by a different provider.

Coperforma shareholder

17.39. HOSC asked for comment on the Chair of Coperforma's position as a shareholder in a British Virgin Islands company.

17.40. Michael Clayton confirmed that the Chairman is an international investor who invests in hospital groups in China, USA and UK and that his details are on the Coperforma website.

Payment of Docklands Medical Services employees

17.41. HOSC asked for confirmation of when Docklands Medical Services employees will be paid.

17.42. Alan Beasley said that the matter was being treated by HWLH CCG with the utmost urgency. The CCG had funds available to make the payments but the payroll was being processed independently and it was the receipt of payroll information that would determine when staff were paid. Alan Beasley said he was working directly with the unions GMB and Unison who are collating the payroll information and engaging with the payroll provider.

Effect on emergency ambulance services

17.43. HOSC asked whether there had been an impact from the PTS issues on emergency ambulance services provided by South East Coast Ambulance Service NHS Foundation Trust (SECAmb).

17.44. Wendy Carberry said that she had not had any communication from SECAmb to say that there had been any effect.

17.45. The Committee RESOLVED to:

1) Request that Coperforma provide the number of critical incidents where no transport has arrived for a booked journey.

2) Request that HWLH CCG provide figures for the number of incidents being investigated as safeguarding concerns

3) Request that HWLH CCG provide comparative figures for the number of service users before and after the new PTS contract.

4) Request a further update on PTS at the 1 December 2016 HOSC meeting.

18. SUSSEX STROKE REVIEW

18.1. The Committee considered a report which provided an update on the Sussex Stroke Review, specifically relating to services provided by Brighton and Sussex University Hospitals NHS Trust (BSUH) to residents in central Sussex.

18.2. The report was introduced by Dr Peter Birtles, Urgent Care Clinical Lead, and Ashley Scarff, Director of Strategy, High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG).

Viability of other options

18.3. HOSC asked whether the preferred option to develop a fully compliant Hyper Acute Stroke Unit (HASU) with a co-located acute stroke unit (ASU) at Royal Sussex County Hospital (RSCH) was the only viable option and whether, as an alternative, it would possible to have a service where patients are stabilised locally before being transferred to a HASU.

18.4. Dr Peter Birtles said that all options were considered in significant detail but, taking into account a number of factors, the option being put forward was strongly favoured by clinicians because:

- centralising stroke units provided better outcomes as evidence suggests that, even if the journey time is 10-15 minutes longer, travelling to a properly resourced HASU is likely to result in a better outcome. Although the NICE guidelines recommend treatment of a stroke patient within an hour, in terms of actual outcomes the evidence suggests it is not as time critical as that;

- option 4 (the preferred option) would ensure that there was a stroke service caring for more than the 600 patients per year, which is the minimum number required to be able to gather sufficient clinical expertise to ensure that people have the best outcomes;

- interventional radiology is increasingly used for treatment of strokes and RSCH has a new radiology unit under development;

- neuro-surgeons need to be on site, and they are located only at RSCH where the intensive care unit is located – this cannot be located at two sites;

- guidance says that the HASU should be co-located with a major trauma site like the one being built at RSCH;

- only 50 HWLH CCG patients a year previously using the ASU at Princess Royal Hospital (PRH) would need to travel further. Patients in the east will generally go to Eastbourne District General Hospital and patients in the north will travel to Pembury Hospital.

Consideration of West Sussex stroke service proposals

18.5. HOSC asked how the proposed HASU at RSCH would align with services provided by Western Sussex Hospitals NHS Foundation Trust (WSHFT).

18.6. Ashley Scarff assured HOSC that HWLH CCG was working with colleagues in West Sussex CCGs and any future configuration of stroke services at WSHFT would not impact on the proposal for BSUH. However, the timing of the implementation of any WSHFT changes may be impacted.

18.7. Dr Peter Birtles said that having a single stroke site at RSCH would mean that no matter what configuration is chosen in West Sussex, RSCH will have above the minimum threshold of patients. However, it is only if the West Sussex HASU was to be located at Worthing Hospital that a HASU at PRH would be viable in terms of numbers of patients.

Capacity at RSCH

18.8. HOSC asked whether, in light of BSUH's Care Quality Commission (CQC) report which raised concerns about the capacity of the RSCH site, it was feasible to set up a HASU there.

18.9. Dr Peter Birtles said HWLH CCG considers the ongoing situation at BSUH at its monthly quality meetings. He said that most of the major problems at RSCH relate to its A&E Department and in a fully functioning stroke service patients would bypass A&E and be admitted directly to the HASU.

18.10. The Committee RESOLVED to:

1) note the report and its appendix;

2) agree that the change proposed is considered a 'substantial development or variation to services' requiring formal consultation with HOSC;

3) agree that a proportionate public consultation on this proposed change should be targeted at the areas particularly affected and on groups with special knowledge and interest in the issue; and

4) request that a report be circulated by email on the current performance of the stroke services provided by East Sussex Healthcare NHS Trust.

18.11. Cllr Mike Turner abstained from voting on whether the change proposed was a substantial development or variation to services.

19. <u>EAST SUSSEX HEALTHCARE NHS TRUST (ESHT) QUALITY IMPROVEMENT PLAN (QIP) - MATERNITY SERVICES</u>

19.1. The Committee considered a report which provided an update on the work undertaken to develop maternity services as part of East Sussex Healthcare NHS Trust's (ESHT) Quality Improvement Plan (QIP) and the current performance of the services.

19.2. The report was introduced by Dr Adrian Bull, Chief Executive, and Catherine O'Callaghan, Service Manager for Maternity, ESHT.

19.3. Dr Adrian Bull apologised for some incorrect figures supplied in the Births Before Arrival (BBA) statistics and agreed to provide the amended figures.

Number of transfers

19.4. HOSC asked whether 40% of patients having to be transferred from the Midwifery Led Unit (MLU) at Eastbourne District General Hospital (EDGH) to the obstetric unit at the Conquest Hospital was too high.

19.5. Dr Adrian Bull clarified that the 40% referred to those women transferred from the MLU who are having their first baby. Of the 320 women who started their birth at the MLU 62 were transferred, which is closer to 20%, and less than 10% of women having a second or third baby needed to be transferred. Of those 62 who did transfer, 52 transferred before they had gone into full labour, and the other 10 transferred in second stage labour after having been individually reviewed. These 10 women then spent considerable time at the Conquest Hospital before delivery or caesarean section.

19.6. Dr Bull said transferring patients is a managed and controlled process and the likelihood of transfer to the obstetric unit is part of the discussion clinicians have with women during the antenatal period. They will also be aware that when choosing to have their first baby at the MLU there is a reasonable chance they may be transferred to the obstetric unit.

Configuration of services

19.7. HOSC asked how many additional births would be necessary to support two viable consultant –led services in East Sussex; and whether a minimal consultant-led service could be returned to EDGH.

19.8. Dr Adrian Bull said the total number of births across both sites is 3,300 per year and the recommended minimum number for a single sustainable obstetrics unit is 2,500. Dr Bull said ESHT has agreed that it will continue to look at whether circumstances are changing and whether this means that there is a case for service reconfiguration.

19.9. Dr Adrian Bull disagreed that a minimal consultant-led service could be provided safely at EDGH as the low number of births would only support a part-time consultant service. One of the biggest risks to patients is to blur the lines between a MLU and an obstetric unit by having a part time consultant presence. This is because a MLU monitors emerging risks more closely than in an obstetric unit.

19.10. Dr Bull said that under the current maternity configuration, if an emergency transfer for a caesarean had to be made then it would indicate that the risk management protocols put in place at the MLU had gone badly wrong, and this has not happened over the past three years. He said that the MLU is an excellent option for women and those who go there have less need for intervention.

19.11. Amanda Philpott, Chief Officer, Eastbourne, Hailsham and Seaford Clinical Commissioning Group (EHS CCG) and Hastings and Rother Clinical Commissioning Group (HR CCG), said that the Better Beginnings maternity and paediatric reconfiguration was undertaken on the grounds of the quality and safety of services. The population projections carried out at the time went forward 20 years and estimated a 5% increase in the number of births; there would need to be a 40% increase to make two consultant-led sites viable. The current number of births, the current advice around safety, and difficulty in recruitment and retention of staff remain the same as they were at the time of the decision, and it would not be reversed whilst these circumstances persist.

19.12. Amanda Philpott added that the CCGs' remit is to keep services safe, high quality and, where possible, locally accessible. Consequently, the CCGs will always keep the number of births under review, as well as the advice and guidance about best practice for obstetric units.

Criteria for transfer

19.13. HOSC asked whether ESHT should review its criteria for transferring first time mothers to the obstetrics unit during the second stage of labour.

19.14. Dr Adrian Bull agreed about the need to review the criteria for the transfer of first time mothers and said that HOSC's comments would be fed in to that process.

19.15. Catherine O'Callaghan disagreed that second stage transfer decisions were bad midwifery practice. She said that the midwives at the MLU were highly trained and experienced; they make decisions throughout the labour process about whether a transfer is necessary using their clinical knowledge and judgement, including when issues arise during the second stage of labour.

19.16. Dr Adrian Bull clarified that transfers from the MLU to the obstetrics unit are managed transfers made in a controlled way for women who have been assessed as having a requirement for consultant input or the administration of additional pain relief; they were not emergency, last minute transfers.

Number of births at MLU

19.17. HOSC questioned whether the MLU was fully operational if only just over 300 births were taking place and the capital funding for improvements was not yet in place; and what was being done to improve the number of births.

19.18. Dr Adrian Bull agreed that there is potential to increase the number of births and suggested that the low birth rate was due to a perception in Eastbourne that all maternity services transferred to the Conquest Hospital following the Better Beginnings consultation; as well as a lack of the same level of local support and promotion of the MLU as the Crowborough Birthing Unit enjoys. He added that it was generally not understood that there was still a full obstetric led postnatal unit at EDGH and that women who delivered at Conquest Hospital could transfer back here for postnatal care if it is more local for them.

19.19. Dr Bull said that there are more than enough women who are eligible to give birth at the MLU to sustain the unit. ESHT is determined to change the perceptions which are discouraging women to use the service. He agreed that the number of births at the MLU should be included as one of the 'indicators of success' for the service.

19.20. Catherine O'Callaghan said that there is a working party from the MLU that is working with the Maternity Services Liaison Committee, patients, and staff to promote the MLU generally, which will help to increase the number of births.

Classification of BBAs

19.21. HOSC asked for clarification about the difference between an avoidable and unavoidable BBA.

19.22. Catherine O'Callaghan said that an avoidable BBA is where incorrect clinical triage advice is given over the phone to a woman, for example, being inappropriately told not to come to the MLU or obstetric unit. Most BBAs are classed as unavoidable and sometimes relate to women who had not attended antenatal care or booked with the Trust to deliver their baby. The 61 BBAs in 2015/16 will be reviewed to discover the reasons for them and whether there are any lessons to be learned, for example, asking community midwives to encourage women

during their antenatal period to book their delivery, or provide them with advice on accessing services sooner. Dr Bull said that ESHT was not a national outlier in terms of BBAs.

19.23. The Committee RESOLVED to:

1) Request revised BBA and 'transfer of women in labour' statistics taking into consideration the difference in transfer rates for mothers giving birth for the first time, comparative figure to the national rate, and if possible the percentage of BBAs that took place during transport;

2) Request further information about the impact of the reconfiguration – specific questions to be agreed by the Committee outside of the meeting.

20. HOSC FUTURE WORK PROGRAMME

20.1 The Committee RESOLVED to note their work programme.

The meeting ended at 1.20 pm.

Councillor Colin Belsey
Chair

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

Date of meeting: **1 December 2016**

By: **Assistant Chief Executive**

Title: **Sussex and East Surrey Sustainability and Transformation Plan**

Purpose: **To update HOSC with the progress of the Sustainability and Transformation Plan and to consider implications for East Sussex**

RECOMMENDATIONS

1) To consider and comment on the report.

2) To continue informal liaison with neighbouring HOSCs through the HOSC Chairs and Officers network and request a further update in March 2017.

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1 Background

1.1 In December 2015, the NHS shared planning guidance 16/17 – 20/21 outlined a new approach to help ensure that health and care services are built around the needs of local populations. To do this, every health and care system in England was tasked with producing a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the NHS England Five Year Forward View (5YFV) vision of better health, better patient care and improved NHS efficiency.

1.2 Local health and care systems came together in January 2016 to form 44 STP 'footprints'. The health and care organisations within these geographic footprints are working together to develop STPs which aim to help drive genuine and sustainable transformation in patient experience and health outcomes for the longer-term. Plans are also expected to demonstrate how the health system will achieve financial balance by 2020/21.

1.3 The NHS shared planning guidance (December 2015) explained that the success of STPs will depend on having an open, engaging, and iterative process that harnesses the energies of clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors, and local government.

1.4 In June 2016 HOSC received a report outlining the purpose and process of developing the STPs. The latest iterations of the plans were submitted to NHS England on 21 October. Most STPs have either already been published, or are in the process of being published. There has been some criticism nationally of the lack of publically available information earlier in the process, for example a recent report by the King's Fund which also noted the challenging timescale for developing STPs (previously circulated to HOSC Members).

1.5 If STPs propose any 'substantial developments or variations' to health services, relevant HOSCs would need to be consulted in the usual way according to health scrutiny legislation.

2 Supporting information

2.1 The local footprint which includes East Sussex is 'Sussex and East Surrey'. This comprises 23 partner organisations. The nominated Chair for this STP is Michael Wilson, Chief Executive of Surrey and Sussex Healthcare NHS Trust. Wendy Carberry, Accountable Officer of High Weald Lewes Havens Clinical Commissioning Group (CCG) is the nominated Senior Responsible Officer (SRO).

2.2 The Sussex and East Surrey STP will be published by 25 November and circulated in full to HOSC Members when available. An overview presentation will also be provided to HOSC

(appendix 1). This will be presented by Wendy Carberry as SRO, with input from local health and social care colleagues.

2.3 The development of STPs in the South East was discussed at a meeting of HOSC Chairs and Officers with the NHS England Regional Director and STP representatives on 18 November. HOSC Chairs wished to gain assurances regarding patient, public and stakeholder involvement in the plans and ongoing engagement with health scrutiny. Most STPs cover more than one HOSC area, necessitating liaison between HOSCs on scrutiny arrangements. It is suggested that this informal liaison continues in order that HOSCs are in a good position to undertaken any more formal scrutiny should this be required.

3. Conclusion and reasons for recommendations

3.1 HOSC is recommended to consider and comment on the report, to maintain informal liaison with neighbouring HOSCs, and to request a further update in March 2017.

PHILIP BAKER
Assistant Chief Executive

Contact Officer: Claire Lee, Senior Democratic Services Adviser
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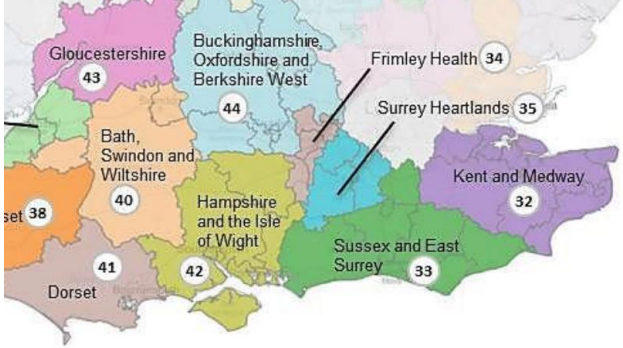
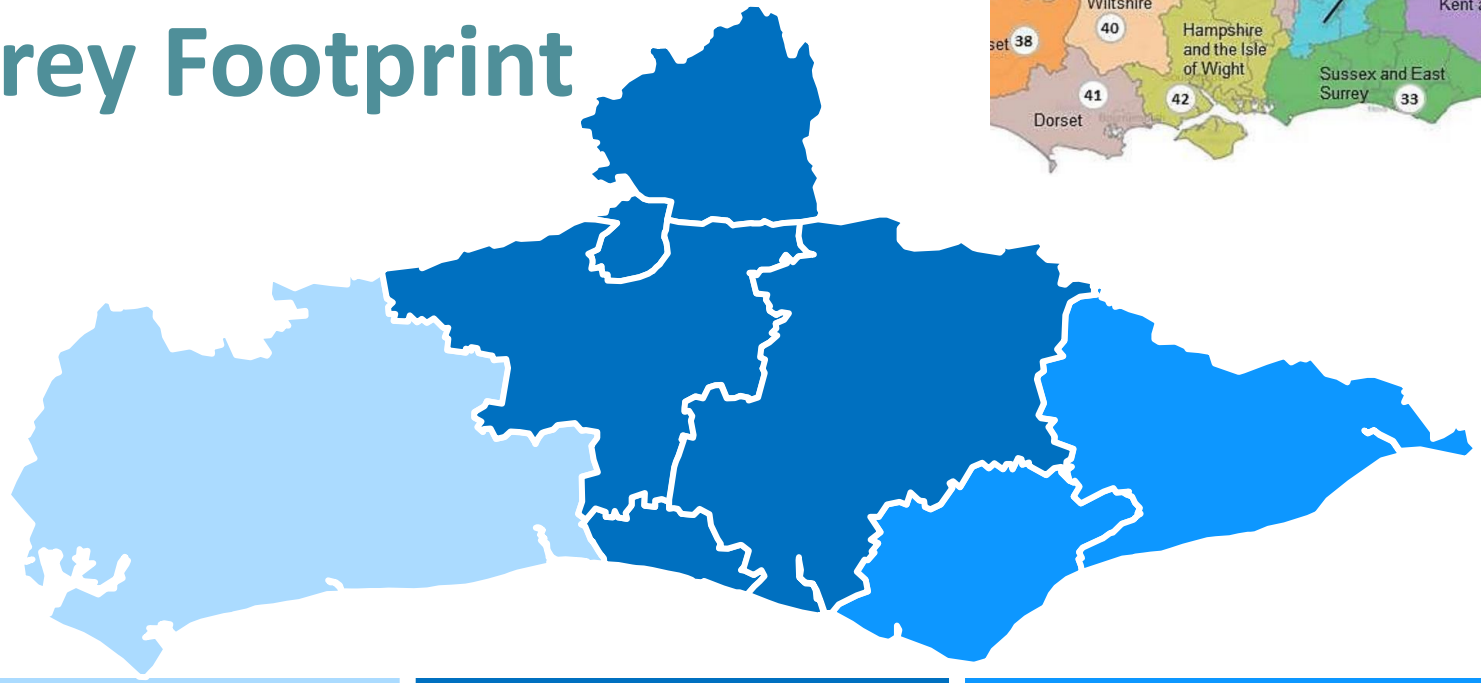
Sussex and East Surrey Sustainability and Transformation Plan

Wendy Carberry
November 2016

The Sussex and East Surrey Footprint





Coastal Care	Central Sussex & East Surrey Alliance (CSESA)	East Sussex Better Together (ESBT)

National context – What challenges are the NHS facing?

- **Health and Wellbeing Gap:** Quality of care can be variable, preventable illness is widespread, and health inequalities are high
- **Care and Quality Gap:** Patient needs are changing, new treatment options are emerging, and people are living longer with long-term conditions
- **Finance and Efficiency Gap:** Health and care funding is not increasing in line with increasing demand

What challenges do we face in our area?

- 2 acute hospital providers, SECAmb & 2 CCGs in Special Measures
- Acute hospital deficits at ESHT & BSUHT
- Long waits for planned care services
- Pressures on A&E, 18 weeks, Primary Care
- Pressures on Workforce
- Poor health outcomes (for example cancer)
- Estimated ‘do-nothing’ shortfall of £865m in 2020/21

The STP is our opportunity to tackle these challenges

The Sustainability and Transformation Plan is our opportunity to work together as NHS organisations and with local communities to:

- improve the health of our population
- improve the quality of our services
- improve our approach to prevention
- make the best use of the resources we have, including estates, workforce and finance

Doing nothing is not an option. As a footprint we are committed to learn from each other to achieve change at scale in order to deliver high-quality, cost-effective healthcare services

Where are we now?

Building from our June submission and feedback from NHS England, we now have:

- Established single system leadership systems across our three ‘places’
- Drafted STP-wide priorities: Short-term Winter Plans & medium-term provider sustainability
- Drafted strong place-based plans
- Identified dependencies on key enablers (estates, workforce, digital)
- Full STP submission (October), responding to NHS England feedback
- Preparing for wider engagement, review and support
- Appointed Programme Director to lead delivery of the STP

Our STP-wide Key Principles

1. Full **engagement** of local populations

2. Led by place-based **integrated care** in our 3 'places'

3. Focus on **prevention** and **proactive care** through **multidisciplinary** locality teams supported by a shift in investment towards **Primary Care and Community**

4. All providers in our footprint will **collaborate** to network services, share workforce and balance capacity across the system

5. Move at **pace** and support local organisations to go as fast as they can towards reaching our goals

Our initial STP-wide priorities

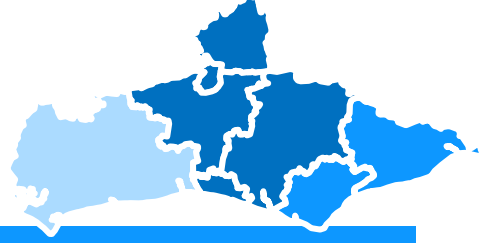
We recognise we can do more for our communities, faster, if we work on our priorities collaboratively:

1. **Urgent and Emergency Care -** Centres networked and linked with an ED and embedded in a primary care community of practice to enable a highly responsive service
   - Define operating model and STP-wide service specification for Urgent Care Centres and work with current providers on rapid improvements

2. **Frailty -** Co-ordinated care, organised to reflect complexity of needs and treat closer to home
   - Proactive care, integrated locality teams and personal resilience schemes.

3. **Primary Care -** Strengthened GP services through locality teams (or communities of practice) that co-ordinate care
   - Design primary care models according to the GP 5YFV and deliver the ten high impact changes.

We will lead the STP footprint with three 'Place-Based' plans



Coastal Care	Central Sussex & East Surrey Alliance (CSESA)	East Sussex Better Together (ESBT)

Each Place-Based area will be:

- Defined around local communities, empowered to co-design person-centred services and providing care led by GPs with support from a wide range of professionals.

- Represented through a 'Single Point of Leadership' who speaks on behalf of their place at the STP Programme Executive Group:
  - **Coastal Care** – Marianne Griffiths, Chief Executive, Wester Sussex NHS Foundation Trust
  - **CSESA** – Geraldine Hoban, Accountable Officer, Horsham & Mid Sussex CCG
  - **ESBT** – Keith Hinkley, Director of Adult Health & Social Care, East Sussex County Council

Place-based summary plans

Coastal Care

Initial Priorities:

- Develop Local Clinical Networks
- Tackle the challenge of the ageing population
- Redesign urgent care services
- New pathways for planned care
- Targeted service improvements for children to enhance physical and mental wellbeing

CSESA

Initial Priorities:

- Improve prevention and self care
- Better access to urgent care
- Continuity of care for patients with Long Term Conditions
- Coordinated care for frail and complex patients
- System-wide higher quality and performance

ESBT

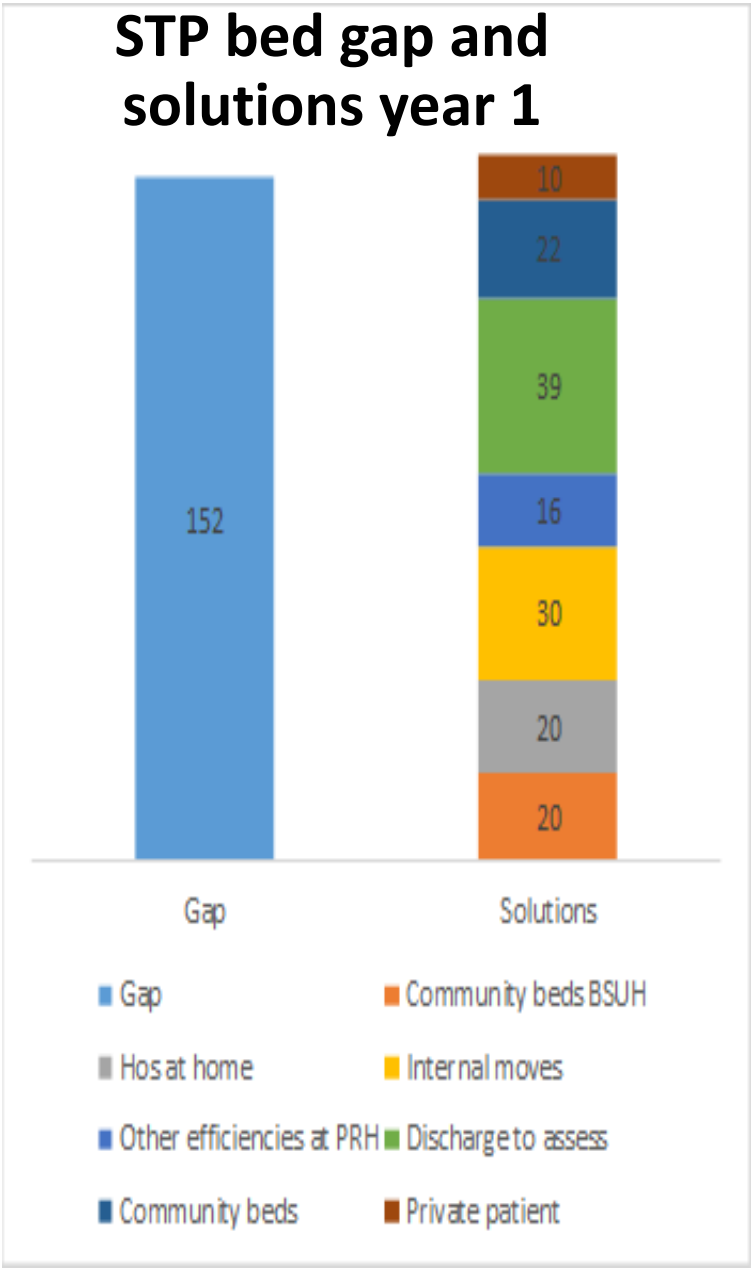
Initial priorities:

- Develop new Integrated Locality Teams
- Provide streamlined points of access for Health and Social Care services
- Develop new models for GP-led Urgent & Emergency Care
- Increase efforts to prevent illness and to promote healthy living and wellbeing

Immediate action: Winter plans

We currently have a bed capacity shortfall of around 150 beds. We have developed an immediate action plan to prepare for the winter, with particular focus on RSC, Eastbourne and Hastings, the hospitals under most pressure. Our solutions involve:

- Increasing capacity to look after patients at home to speed up discharge from hospital
- Using community hospital beds for patients who no longer need to be in the acute hospital
- Maximising available space at our existing sites



Longer-term provider sustainability plans

- As part of our STP we are working together as a footprint to support our acute provider organisations to achieve sustainability over time
- Alignment with our AC models will result in maximised access and use of services at all sites, including for integrated care models
- Partnership discussions are underway to build on existing and effective STP-wide networks to expand the range of services covered
- We will work with Specialised Commissioning to implement transformational QIPP schemes
- In the longer-term, we aim to map and deliver patient pathways for all sites through networks across sites and providers

STP wide Enablers

Workforce

We have developed a workforce action plan which is in place to:

1) Address the immediate workforce shortfall issues across our providers

2) Support the plans for winter pressures

3) Develop strategic workforce solutions for a sustainable future

We will shortly begin delivery of the plan in preparation for winter

Digital Transformation

We see digital transformation as a key enabler of our STP and aim to take learning from other footprints and implement digital solutions at an STP level to support the digitisation of both the Health and Care professional and the citizen journey.

Estates

Through our 'One public Estate' strategy we aim:

1) To drive up the efficiency of the use of estates assets across the whole STP footprint

2) To develop and deliver which enable the new models of care to flourish

We have also identified efficiency opportunities that could deliver significant savings, for example reduced running costs anticipated later in the 5 year planning horizon

Communications & Engagement Plan

Stakeholder input is central to reviewing and supporting our STP

- A working timed Communications & Engagement plan is being approved through the STP Board; with buy-in from local Communications & Engagement leads across the NHS and LA.

- Our approach will be to work openly with our communities; establishing meaningful and trusting relationships so that we can tackle the difficult issues together.

- CCGs will manage local engagement in close cooperation with the STP Board and with colleagues in local authority and public health.

Communications & Engagement Plan

Our plan will be delivered in three phases:

Phase one - Supporting publication of the STP:

Laying out the narrative for change and describing how all stakeholders will be involved in co-designing future work. All stakeholders will be informed of publication and on methods to feedback as appropriate.

Phase two – Development of the plan:

We need to continue engagement and dialogue with our communities to help us work to secure all our services over the winter period and to help us continue transforming our model to a patient-centred approach and with a far stronger focus on prevention and better community care.

Phase three - Delivery:

At this stage we expect to have robust channels of communication and to be able to demonstrate effective co-working with our stakeholders

What next?

- Continue/ramp up engagement with all stakeholders in order to best develop and deliver the STP
- Refine and plan delivery of our place-based plans
- Refine and plan delivery of STP-wide work stream plans
- Refine financial estimates
- Implement winter plans to respond to bed capacity shortfalls
- Identify and deliver immediate improvements to begin progress towards the STP

Wendy Carberry
November 2016

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

Date of meeting: **1 December 2016**

By: **Assistant Chief Executive**

Title: **East Sussex Better Together - Urgent Care Redesign Programme**

Purpose: **To inform HOSC of work to redesign urgent care services in Eastbourne, Hailsham and Seaford and Hastings and Rother as part of the East Sussex Better Together health and social care transformation programme.**

RECOMMENDATIONS

1) To consider and comment on the report.

2) To consider whether further scrutiny of this issue is required.

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1 Background

1.1 Urgent care is a term that describes the range of services provided for people who require same day health or social care advice, care or treatment. This is different from emergency care provided in emergency departments (A&E), other hospital departments, 999 and ambulances which are set up to respond to serious or life threatening emergencies.

2 Supporting information

2.1 Following a national review in 2014, NHS England set out very clear commissioning standards to ensure future urgent and emergency care services are integrated and offer a consistent service. These commissioning standards are informing how local health and social care partners in Eastbourne, Hailsham and Seaford and Hastings and Rother – through the East Sussex Better Together programme – look to best organise and provide local urgent care services.

2.2 The following services are included in the development of an integrated urgent care model:

- NHS 111
- GP (In Hours and Out of Hours)
- Walk-in Centres (in Eastbourne and Hastings)
- Activity at Accident and Emergency (A&E) departments
- Hospital Intervention Team
- Mental Health Crisis Support
- South East Coast Ambulance Service (SECAmb)
- Adult Social Care- Emergency Duty Service

2.3 The East Sussex Better Together Programme Director has provided a progress report with further details of the redesign programme – attached at appendix 1. This includes details of the public and stakeholder engagement which is informing the development of urgent care services.

3. Conclusion and reasons for recommendations

3.1 This report informs HOSC about the work underway in relation to urgent care and also presents an opportunity for the Committee to contribute to the work through raising questions or making comments. HOSC is recommended to consider and comment on the report and to determine whether further scrutiny is required.

PHILIP BAKER
Assistant Chief Executive

Contact Officer: Claire Lee, Senior Democratic Services Adviser
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East Sussex Better Together - Urgent Care Re-design Programme
Paula Gorvett, East Sussex Better Together - Programme Director

This paper provides a summary of the Urgent Care Re-design Programme along with a summary of the recent public engagement.

1.0 Context

Urgent care is a term that describes the range of services provided for people who require **same day** health or social care advice, care or treatment.

This is different from emergency care provided in our emergency departments (A&E), other hospital departments, 999 and ambulances which are set up to respond to serious or life threatening emergencies.

Following a national review in 2014, NHS England set out very clear commissioning standards to ensure future urgent and emergency care services are integrated and offer a consistent service. These commissioning standards are informing how we – through ***East Sussex Better Together*** – best organise and provide local urgent care services.

2.0 Introduction

Under East Sussex Better Together (ESBT), the overarching vision for urgent care is to embrace a system wide approach which will create a long term sustainable solution that delivers care in the most suitable environment wherever this is most appropriate. This vision, developed and informed by the outcomes of public and stakeholder events held since August 2014, will improve access to local urgent and emergency health and care services.

Identified as a priority from the outset, a dedicated ESBT Whole System Urgent Care work stream was established to oversee the transformation programme. The steering group, which comprised clinical and managerial leads across local providers and commissioners of urgent care services, was tasked to design and implement a new integrated delivery model of urgent health and social care and make recommendations for improvements to address clinical safety, quality of provision and effective use of resources across the system.

Following the development of the agreed case for change, extensive stakeholder engagement and co-design has been undertaken to identify options for how a transformed urgent care service might be provided across East Sussex.

This paper provides a summary of the progress to date, including a description of the proposed overarching service model and an outline of progress across each of the resulting workstreams underpinning our urgent care transformation programme.

2.0 Scope

At the outset of this work, it was agreed that the following services would be included in the scope as part of the development of an integrated urgent care model. This reflects the multiplicity of current service providers and existing contractual arrangements that are engaged in providing urgent care services for the local people of East Sussex:

- NHS 111

- GP (In Hours and Out of Hours)
- Walk-in Centres
- Activity at Accident and Emergency (A&E) departments
- Hospital Intervention Team
- Mental Health Crisis Support
- South East Coast Ambulance Service (SECAmb)
- Adult Social Care- Emergency Duty Service

In addition to the above, it was recognised that consideration of the Information Managements and Technology (IM&T) infrastructure to support integrated working and provision of care was required.

3.0 Service Model

A number of stakeholder events engaging with the public, voluntary sector, GPs, community services, local acute trusts, social services, housing, ambulance trust, mental health and local clinical commissioners were held in 2014 and 2015 to develop the service model.

Stakeholders told us they wanted consistency and confidence in the urgent care system. They requested clear links with primary care, the integrated locality adult teams providing community based health and social care services, crisis response, mental health, dental services, community pharmacists and voluntary services. Stakeholders described a hub and spoke model, which would effectively share multi-disciplinary teams to manage urgent care pathways both in the community and hospitals.

The outline model that was produced as a result of these engagement events was agreed by the ESBT Programme Board in December 2015 (Annex 1).

The proposed model and approach is entirely consistent with NHS England strategic planning guidance and the national model for urgent care published shortly thereafter. These cite that new integrated urgent care models should be developed to support urgent and emergency services, so that no one is working in isolation from expert advice 24 hours a day and identifies, as a priority, the provision of urgent care services in a coordinated urgent care centre.

Whilst it is evident that our proposed model is built on the principles of integration, given the complexity and far reaching nature of urgent care, the detailed design of our local system has been broken up into three key interrelated component parts:

1. The development of our A&E Departments into Integrated Urgent and Emergency Care Departments
2. The re-design and re-procurement of NHS 111 and the development of Local Clinical Hubs providing telephone assessment, triage and referral co-ordination service in line with recently published national specifications.
3. The provision of 24/7 access to same day general practice which includes the future provision of Primary Care Out of Hours (OOH) services and a review of our Eastbourne and Hastings Walk-in Centres (WICs)

An outline of the progress with the plans for each of the three component parts of the model redesign is summarised below.

4.0 Integrated Urgent and Emergency Care Department

Central to our whole system urgent care model is the enhancement of our A&E departments into fully integrated Urgent and Emergency Care departments through the introduction of a broader mix of staff to better manage people's wide ranging needs. This includes G.Ps, Physiotherapists, Nurse Practitioners (including Paediatric Nurses), Health Care Assistants, Mental Health Workers and Social Workers. These staff will work alongside our A&E consultants and emergency care staff at both hospital sites to ensure patients' needs are met as quickly as possible and they can seamlessly be referred on to appropriate community services to better support them on discharge.

In line with local feedback, the Urgent and Emergency Care department will have a more streamlined approach to managing patients more efficiently from presentation at the front door to supporting them through the system as required. A key element to the success of an integrated approach will be the rapid triage and assessment of the patient by a senior clinician and/or social worker, so that investigations and treatments can be started earlier, and planning for the safe discharge or transfer of patients to start in a timely way.

It was recognised from the outset that much of the work to develop integrated urgent and emergency care departments is achievable in the more immediate future through collaboration with local partners. Therefore in order to progress with the implementation of this approach to begin to enhance this part of the system, the following activities have been undertaken

- Review of the patients currently attending A&E by time of day and presenting condition to understand the demands on the service and levels of support required.
- Review of the skill mix of staff that is needed to better manage the level of demand and ensure our specialist emergency clinicians are able to focus on the emergency cases.

As a consequence, in order to focus our investment to best effect, additional funding has been agreed to begin to establish our integrated workforce and support the existing staffing complement and structures within our A&E departments. This includes recruitment to provide the following additional staffing capacity and skill mix:

- Enhanced Hospital Intervention Team to include social workers, therapists, nurses and mental health support workers.
- Dedicated Paediatric nursing team
- Expanded take home and settle team
- Non-clinical navigators to help signpost and support people to access local services
- General Practitioners

In addition, a review of the pathways to ensure patients are efficiency triaged, treated and referred to the appropriate onward setting is underway. This includes ensuring patients are effectively supported and navigated through the system in a seamless fashion, agreeing clearly articulated local urgent care pathways and the provision of robust alternatives in the community such as; community pharmacy advice for minor illnesses, extended primary care hours with access to emergency appointments and a 24/7 community based crisis response service.

It is anticipated that this work, together with the recruitment plans will be concluded by March 2017 to begin to provide a more streamlined, enhanced service that begins as soon as patients arrive at A&E.

5.0 NHS 111 / Local Clinical Hub Triage and Assessment

NHS 111 is the free NHS non-emergency number, available to everyone 24 hours a day, 365 days a year. It's the number to call to speak to a trained adviser, supported by healthcare professionals, where callers are asked a series of questions to assess symptoms and are directed to the best service to meet their needs.

Since inception, NHS 111 has been provided by a number of providers across the country in line with the national specification. The local NHS 111 service has been delivered by South East Coast Ambulance Service as part of a regional contract covering Kent, Medway, Sussex and Surrey (KSS). Originally contracted until March 2016, this has been extended until March 31st 2018 to allow time for a whole system redesign and new models of care to be developed in line with the national Integrated Urgent Care models as set out in NHS England commissioning standards guidance to CCGs. Across KSS, agreement has been reached that the re-procurement of the service will be split into 3 lots, with the East Sussex CCGs forming part of the Sussex and East Surrey NHS 111 re-procurement footprint.

The new national specification for the NHS 111 service is to provide a call handling and self-help service that is then integrated via technological solutions to local clinical hubs providing a comprehensive clinical triage and telephone assessment service. NHS 111 will therefore operate as the 'doorway' to access other urgent care services and provide a more streamlined assessment pathway, identifying patient need earlier in the pathway and routing calls to the most clinically safe and appropriate service for their need.

The preferred option for the development of our local East Sussex clinical hub is to develop and expand Health and Social Care Connect (HSCC) to provide the local clinical triage and telephone advice service and fulfil this role.

In line with this, we have established three clear project workstreams under this transformation umbrella:

1. To work with colleagues across Sussex and East Surrey to inform the re-procurement of the revised NHS 111 service in line with the nationally agreed standards.
2. To identify the technological requirements and solution to ensure necessary levels of integration between the new NHS 111 service and the local clinical hubs across Sussex and East Surrey.
3. To develop our local pathways to ensure the provision of effective timely clinical triage and assessment within HSCC as our local clinical hub.

Currently we are collectively working with CCG colleagues across Sussex and East Surrey to finalise the service model and specification for the new NHS 111 service in line with national standards by February 2017 to underpin re-procurement of the service within the originally agreed timescales. In addition, work continues at pace to further develop and refine our model for enhancing our local clinical assessment and triage services within these agreed timescales. The timeline for the required re-procurement of this service is currently under consideration to ensure robustness of approach across Sussex and East Surrey, and the new service model will be implemented from April 2018 at the earliest.

6.0 Primary Urgent Care Service (PUCS)

The third key component of our urgent care transformation relates to the redesign of primary care to provide consistent effective same day urgent care services. This relates to services currently provided by our General Practitioners within local practices, those provided by the Eastbourne and Hastings GP Walk-in Centres (WICs) and the existing GP Out of Hours (OOH) service provided by IC24, the latter two of which are provided via separate contractual arrangements with IC24. As with the NHS 111 service, the contract

end dates for each of these services have been extended to the end of March 2018 to enable a fully integrated approach to be achieved.

In order to inform our plans, engagement with and within localities has been undertaken. In line with existing local knowledge, feedback has told us that there are current challenges in the system which need to be considered in order to support primary care including:

- Challenged in-hours service provision making access difficult
- Fragmented service providers and delivery
- Increasing unscheduled demand
- Increase in complex cases
- Workforce challenges

In response, the proposed new model is for the provision of an integrated primary urgent care service in Eastbourne, Hailsham and Seaford (EHS) and Hastings and Rother (H&R) CCGs which seeks to uphold the NHS England Commissioning standard requirement that 'Integrated Urgent Care should aim to book face to face or telephone consultation appointment times directly with the relevant urgent or emergency service, whenever this is supported by local agreement. As networks and federations of GP practices develop, patients may be offered an alternative practice-based appointment within their GP network.'

The proposed new model for Primary Urgent Care Services outlines how patients will be able to access same day advice, guidance or treatment within the primary care setting and demonstrates the interface with both the NHS 111 service and the local clinical hub.

As described in section 7 below, this has been the subject of extensive local engagement, the outcome of which is currently being incorporated into our final plans. Once finalised and implemented, it is anticipated that this integrated service model will afford a number of benefits to patients and clinicians including:

- Patients will be able to directly access a triage appointment with their first call, leading to appropriate signposting or an appointment booked within a suitable time frame.
- Moving towards a Primary Care service that looks the same to the patient 24/7 (i.e. no in/out of hours nomenclature)
- GP capacity to manage demand and increase time to focus care on the management of long term and chronic conditions, and meet the needs of the general population.
- Ability to tailor the service and design it around identified needs, building on the good service already provided by the WICs, and enabling them to better manage demand and plan effectively.
- Provision of a pool of services to deal with needs that cannot be met by smaller GP practices and providing access to a larger multidisciplinary workforce.

As with NHS 111, we are working locally to incorporate and finalise the service model and specification for the new Primary Care Urgent Care Service by January for agreement in February 2017 to underpin re-procurement of the service within the originally agreed timescales. In the meantime, conversations continue with the Hastings Federation and IC24 to begin a piece of work to explore the potential to test the model in advance of the full roll-out.

8.0 Engaging with people about the re-design of Urgent Care

We have undertaken extensive engagement with local people to ascertain their views and what is important to them. Two extensive dedicated stakeholder engagement sessions were held on urgent care re-design in January and April 2015. The future provision of urgent care services has featured as a key interactive agenda item on three of our major Shaping Health and Care engagement events in both EHS and H&R CCG areas:

- **Autumn 2014** : Focusing on developing better ways of accessing urgent care and support
- **May 2015:** Exploring how the new model of accessing urgent care and support should work including, how we make the most of what is available in our communities to support our shared aims.
- **Spring 2016:** Urgent care – identifying what's important to local people?

Following these sessions, we have undertaken a more targeted engagement exercise to ask people how they think we could improve access and services for people as and when they need them on an urgent, same-day basis.

Throughout September 2016 we visited **8 locations** across the ESBT footprint and attended some **East Sussex wide community meetings.** We particularly **targeted views of parents of young children and people aged 20-29**, who are some of the highest users of urgent services.

A summary of the outcome of the engagement and a copy of draft report collating all the feedback is provided in Annex 2 for information. The survey questions and supporting information provided to respondents is attached as Annex 3.

9.0 Timescales and Next steps

As highlighted above, our urgent care transformation programme can be considered in three inter-related component parts. Whilst the development and enhancement of our A&E departments to provide integrated urgent and emergency care services has begun, the redesign of NHS 111 and our primary care urgent care services are subject to re-procurement. As such, the timetable anticipates that the service specification and final business case for the required re-procurement of NHS 111 and GP out of hours (our primary care urgent care work) will be concluded in January 2017 and feed into the wider Sussex and East Surrey NHS 111 re-procurement.

10.0 Recommendations

The Health and Overview Scrutiny Committee members are asked to note progress with the development and implementation on our integrated urgent care service model.

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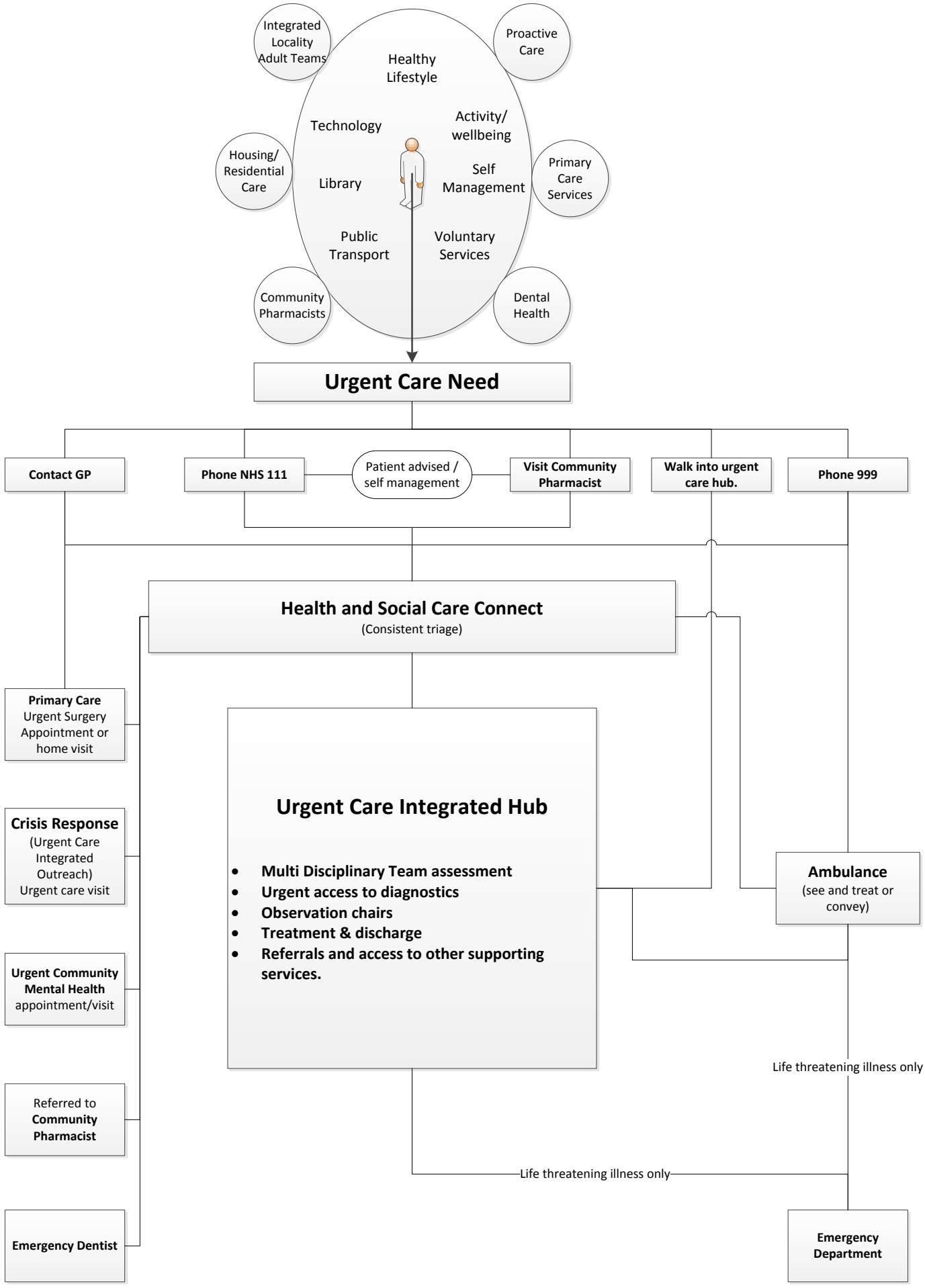
Outline Urgent Care Service Model

Annex 1



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

Improving urgent care

Public engagement report
August to November 2016

Jessica Town
Community Relations Officer
November 2016

Contents

Summary

Extensive public engagement was undertaken from August to November this year on what matters to people when they need same-day health or social care advice, care or treatment.

This report explains the background to the engagement, who we engaged with and how, and details the responses to questions about 111, the NHS telephone service, the GP walk-in centres at Eastbourne and Hastings, same day assessments and appointments, using technology (web chats and video calls) and community pharmacists.

People's responses to the questions and their comments will be built into our final service redesign plans which we anticipate will be agreed in January 2017 for implementation from April 2018 and beyond, ensuring we have a range of appropriate, high quality services available 24/7 to help people get the right advice, treatment, care in the right place, first time.

Introduction

What is urgent care?

Urgent care is a term that describes the range of services provided for people who require same day health or social care advice, care or treatment.

This is different from emergency care provided in our emergency departments (A&E), other hospital departments, 999 and ambulances which are set up to respond to serious or life threatening emergencies.

Why do we need to improve?

Following a national review in 2014, NHS England set out very clear commissioning standards to ensure future urgent and emergency care services are integrated and offer a consistent service. These commissioning standards are informing how we – through *East Sussex Better Together* – best organise and provide local urgent care services.

A focus for this engagement has been on services that people use most frequently on an urgent, same-day basis.

- same-day GP and nurse appointments
- the use of walk-in centres (Eastbourne and Hastings)
- the use of NHS 111 urgent telephone service
- utilising technology to support people's urgent, same-day needs.

Previous engagement

At our Shaping Health and Care public events in 2015 and the spring of 2016 there was a focus on urgent care services; attendees told us:

- It is important to be able to **access urgent care over the phone**.
- Access to services in the **evening or at the weekends** is important and the ability to **find advice** when you need it.
- It is particularly important to be able to **access a same-day appointment or an appointment within 48 hours**.
- People were clear about the importance of having the **right information about urgent services** and to have **confidence** these services offer **quality advice**.
- The role of **digital technology** was highlighted and improving the availability of this information and advice is important.
- There are **mixed views about the importance of seeing your usual GP**, or a GP in your practice, or the option to use a **video call**.
- The importance of **GP appointments** generally was prominent but people also discussed the value of other professionals in **providing support as part of an urgent care network** of support and services (for example pharmacies).
- The **timing and accessibility** of appointments is important.
- There should be **better access to patient records** both for patients and professionals and these should be shared between services.
- The importance of **self-care and proactive prevention** was highlighted (for example access to non-medical support from **community or voluntary organisations**) and **education** so local people understood the services available that can best support them.

What's happened already?

Initiatives already underway as part of the *East Sussex Better Together* programme include:

- 'navigators' in the emergency departments at Eastbourne District General Hospital and the Conquest Hospital, Hastings, help people register with a GP or dentist if they don't have one; signpost to community and voluntary services; talk to people about pharmacy services, and how they might get the support and/or treatment they need in the future
- extended hours for the 'take home and settle' team whereby Age UK East Sussex is able to return home with people from hospital up to 8pm
- Patient Online providing local people with access to view their medical records online, order repeat prescriptions and book appointments
- Health and Social Care Connect, a single access point for streamlined access to community-based services, seven days a week.

- the crisis response team established to support people in their own homes for up to 72 hours to either avoid hospital admission or facilitate discharge while longer term support arrangements are put in place.

What matters to you? – public engagement on urgent care August to November 2016

Who we sought to involve

Parents of young children and people aged 20 to 29 are more likely to use services on an urgent basis. This phase of the urgent care public engagement focused on these groups.

In addition, a public survey was more widely available on the *East Sussex Better Together* website and through our networks so that anyone with an interest could respond.

The questions we asked

There were seven questions in the 'What matters to you?' survey (online and hard copy). For the purposes of this report the responses have been collated under four key areas:

- NHS 111 service and GP walk-in centres
- same-day assessments and appointments
- using technology
- Community pharmacy.

What we did

The urgent care 'What matters to you?' survey was available online on the East Sussex Better website and publicised to all ESBT stakeholders. Hard copies of the survey were taken to the engagement events and meetings with community groups.

We held mini marketplace stands, collecting comments and surveys in **eight public locations** to ask people how they think we could improve access and services when people need them on an urgent, same-day basis.

We visited a variety of venues to talk specifically to parents and people aged 20-29. We went to **leisure centres, children's centres and the two GP walk in centres**, mainly in the **evenings and at weekends** in these locations:

Eastbourne **Hailsham** **Seaford** **Bexhill**

St Leonards **Hastings** **Battle** **Rye**

We also joined other **community groups** to ask people for their views and to encourage completion of the survey:

- **East Sussex Carers Forum** (hosted by Care for the Carers)
- **East Sussex Seniors Forum (ESSA)**
- **The Good Life Show** – a county-wide conference style event for people aged 50+
- **Learning Disability Partnership Board** – the Involvement Matters Team.

Over the coming weeks we will also be engaging with Gypsy and Traveller communities and homeless people.

What people told us

In total **497 surveys were completed**. The results provide us with information about what matters to people when they need urgent care advice or treatment for themselves or a family member.

NHS 111 and GP walk-in centres

We asked people what would make them *more likely* to use the NHS 111 telephone service. Respondents could identify multiple options and selected the top three factors as:

- If they had **confidence** a healthcare professional would respond **quickly**. (72% of people)
- If they had more **information about the possible options** for assistance when they call 111 (43%)
- If their **health record** was available to the 111 service. (42%).

Accessing services through NHS 111 and at GP walk-in centres

We talked to people about the GP walk-in centres in Hastings and in Eastbourne and explained we are considering changing the way these services are accessed. For example, instead of walking in and queuing to see a GP, you would call NHS 111 and be given a telephone assessment. If necessary you would then be offered an appointment on the same day without the need to queue.

We asked people what things are important in a service that assesses your needs on the telephone. Again respondents could identify multiple options and these were the results:

- **87%** of people said it is important to them to be able to receive advice, or be directed to a service locally, on the **same day when using the 111 telephone service.**
- **71%** of people said **being able to speak to a local healthcare professional** was important, should it be needed.
- **68%** of people said **a telephone service available 7 days a week, 24 hours a day** – was important.

- **42%** of people felt it was important to be able **to receive information about self-help, such as relevant online information, locations of pharmacies**, nearest available services and opening times.

Same-day assessments and appointments

Currently people may have to join a queue at a walk-in centre before they can be seen. We asked how helpful it would be if a same-day appointment could be booked (should this be needed) so they didn't have to queue.

- **95%** of people rated this 'helpful' or 'very helpful'.

We also asked how important it is to be able to walk in without booking or calling first and how helpful would it be if their own GP practice could direct them to an assessment service if they weren't able to offer a same-day appointment.

- **69%** of people rated it 'important' or 'very important' **to be able to walk in somewhere for an assessment** *without* the need to book first
- **82%** of people said it would be 'helpful' or 'very helpful' **if their own GP practice could direct them to an assessment service**, if they were not able to offer them a same day appointment.

Using technology: web-chats and video calls

We asked people what would make them want to use web chat typing or video calling (in addition to the 111 telephone service) to offer more ways to access urgent, same-day advice or care.

- **20%** of people surveyed would like to try an **online web chat or video call** to receive advice or an assessment.

These are the comments they made:

Communication in the services needs to be clear and advertise where these facilities are available. **It's useful for…**

- concerns about my baby/child
- unwell babies and children so they don't need to leave the home

- showing the clinician a rash
- whenever there is something visual about their concern
- for people with anxiety that prevents them from otherwise seeking advice
- reducing queues and time spent seeking advice
- helping those without transport or on low income
- offering an option when the GP practice is closed.

These are the things people are concerned about:

- **Accessibility** – broadband speeds, some concern that people have different needs; older people are far less likely to access a service in this way, so ensure the telephone option remains in place.
- **Having confidence** – people want to have confidence in these options, so that someone responds and that person will be a qualified professional. Also professionals operating the systems are properly trained; people don't want the focus to move from the patient to the technical aspects.

Community pharmacists

We asked people if they asked a pharmacist for advice.

- **77%** of people told us they **currently ask pharmacists for advice and/or remedies**, as well as medicines.
- **23%** of those surveyed said they **didn't use pharmacists or didn't know they could help.**

Comments and suggestions

As a result of the public survey, we collected in excess of 1,000 comments and a huge number of suggestions based on people's experiences about urgent care services; these comments will be on the *East Sussex Better Together* website.

Key themes included:

- People think **children** should be prioritised and would like to know paediatric **advice** is available on an urgent basis.
- **Identify people who have additional needs** and ensure routine examinations can be performed.
- Connecting with **large employers in the area** as a way of getting information out about local services that are appropriate for different needs and **education about healthy lifestyles**
- **Health records need to be shared** so urgent services know your medical history.

These messages came through clearly:

Communication is all important:

- Tell local people where they can go, for what types of problems.
- People need to understand the difference between urgent and emergency services
- Use clear language and no jargon.
- Advertise the information so people see it.
- Professionals need to communicate quickly and effectively with each other.

People were concerned about:

- **accessibility** (both eligibility and physical access)
- **good communication** (both out to the public and between professionals)
- **delays causing anxiety**
- **rural issues**; the difficulties people face when they don't live close to health care amenities
- the **misuse of services** and people not using the right services for their needs.

The things that people really value:

- their **community services** (diagnostics like x-ray, and minor injuries units in general)
- their **GP practice**
- high **quality services**, high standards of training for all staff.

These are the services or areas that people provided the most comments about:

Service / Area	Number of comments
Primary care (GP practices)	36
General comments about healthcare	29
NHS 111	15
Communication or/or education	15
Walk in Centres	13
Quality of services	10
Accessibility and equality	8
Concerns about people mis-using services	8
Emergencies / A&E department	8

A further 41 comments were also made about a wide range of issues, including finance, mental health, minor injury units, engagement, older people and technology.

What carers said

We know it's very important for carers to have access to a named GP in relation to the person they care for and that their long term and/or complex needs often have more significance in an urgent situation.

We attended the East Sussex Carers' Forum, hosted by Care for the Carers, and asked 'Do services meet your needs currently when you need advice urgently?' The feedback is below:

- Carers reported they have specific needs and are **often calling about complex and long term conditions.**
- **Delay is a significant problem** and can feel like a barrier to getting the help they need for the person they care for.
- **Crisis Response Team** – assistance from this team is accessed through their GP – or through 111 when their surgery is closed. Calling 111 and completing the assessment

process (also called telephone triage), elevates anxiety and causes frustration because it takes time to access the service they feel they need.

- **'Safe Spaces' cannot be used** if there are no staff available to supervise them, so they cannot access them. Safe Spaces are rooms in locations like hospitals, where somebody with a mental health condition can go to and be safe. The introduction of these rooms has significantly reduced the number of people being taken into Police custody unnecessarily.
- **Lack of clarity about what to do in a real emergency**, i.e. in a life-threatening situation. Some members of the group reported being told historically by health professionals, *not* to call for an ambulance. They are more likely to go through NHS 111 even when they feel the circumstances are becoming more serious. Breathing difficulties were given as the example. The difference between urgent and emergency need was clarified and the group were assured if they feel a situation is life-threatening, they should dial 999.

The group asked us to **promote the options and services** for when people need urgent advice, including what's available at evenings and weekends.

We also asked where they get their information and where they would like to see messages about support and services.

Carers told us to **place information where people go** – where people visit, physically, in their everyday lives. Places like:

- At **charities and community organisations** they visit, such as Care for the Carers.
- And in the community:

supermarkets
hairdressers
betting shops
rail stations
libraries
churches
healthcare settings - hospitals and GP practices
pharmacies
social care settings - day centres
residential care homes
community centre notice boards

There were also some other methods they recommended we use:

- Provide **community and voluntary organisations** with information so they can signpost.
- The group is also active **online, using websites that are helpful to carers** and resources that offer information about conditions to assist them in relation to the person they care for.

What the Involvement Matters Team (ITM) said

We talked to the IMT, a local forum for people with learning disabilities, at the East Sussex Learning Disability Partnership Board. The team forms part of the board alongside other stakeholders which include county council, parent-carers, commissioners of services, providers of services and representatives from community and voluntary groups.

We asked 'what's important to you, when you need a service urgently?' and the following comments were recorded.

- **I don't like waiting in a waiting room**. After a long while I get very anxious and I get upset.
- When I called NHS 111 **the person on the phone kept asking me questions that I didn't know the answers to** because I didn't have my helper with me. They couldn't understand me.
- The group agreed **when they see their usual GP, there is enough time allowed** for them to explain the issue and to make a decision about what to do next.

We also asked 'would you use technology to get information, or be assessed by a doctor?

The IMT members said **they do not use devices** like smart phones or tablets to seek advice or an assessment.

There will be further engagement with this the forum.

What happens next?

People's responses to the questions and their comments will be built into our final service redesign plans which we anticipate will be agreed in January 2017 for implementation from April 2018 and beyond.

We want to thank everyone who contributed their time and views for this phase of the *East Sussex Better Together* urgent care transformation programme. The results of the survey provide us with clear information about what matters to people when they need urgent same-day care for themselves or their families. Their views and experiences will help ensure we have a range of appropriate, high quality services available 24/7 to help people get the right advice, treatment, and care in the right place, first time.

Staying involved

We will continue to engage with local people through our Shaping Health and Care events to update on the developments as the plans are taken forward.

To stay up to date with progress of the design and work, or to be directly involved – contact us to let us know whether you would like to subscribe to emails or to talk about the different ways you can have your say. It's not all about meetings, you can be involved virtually as well:

The Engagement Team 01273 485300

Email: HRCCG.yoursay@nhs.net or EHSCCG.yoursay@nhs.net

Appendices

Copy of the brief with information about this programme

Copy of the survey.

The survey statistics, including all comments and equality data, will be on the *East Sussex Better Together* website.

Improving urgent care services

Introduction

Urgent care is a term that describes the range of services provided for people who require **same day** health or social care advice, care or treatment.

This is different from emergency care provided in our emergency departments (A&E), other hospital departments, 999 and ambulances which are set up to respond to serious or life threatening emergencies.

Following a national review in 2014, NHS England set out very clear commissioning standards to ensure future urgent and emergency care services are integrated and offer a consistent service. These commissioning standards are informing how we – through ***East Sussex Better Together*** – best organise and provide local urgent care services.

Any changes to these services will come into effect from March 2018 at the earliest, and we're seeking people's views now to help us get the design right.

Improving urgent care locally

Local urgent care services include:

- GP practices
- Walk-in centres at Eastbourne Station and Station Plaza, Hastings
- Pharmacies
- Mental health crisis support
- Adult social care – emergency duty service
- Out of hours GPs (clinics and home visits)
- Out of hours nursing and social care teams
- NHS 111
- NHS Choices website
- Health Help Now app
- East Sussex 1Space (East Sussex directory of care, support and wellbeing services).

We want to ensure we have a really good range of appropriate high quality urgent care services available 24/7 to help people get the right advice/treatment/care in the right place, first time.

To support this, we have been talking to local people, clinicians and partner organisations as well as taking into account national guidance and best practice.

From feedback to date we have learned:

- When people have an urgent care need they rightly expect high quality advice and treatment quickly but they find the current urgent care system confusing.

- It's not always clear where to go or which is the best service to contact so people end up repeating their 'story' a number of times before they reach the service that can offer the right help.
- It can be difficult to get same-day GP appointments.
- People want to easily access advice on how to self-manage minor illnesses through the internet or phone apps.
- People want the option to have telephone and video consultations with a clinician.
- Because the system is confusing, many people go to A&E for urgent care because they know they will be seen there. This puts pressure on our emergency services and costs more than treating minor illnesses and injuries at home or in the community.

Next steps

Both our local hospitals – Eastbourne District General and the Conquest – have A&E departments. We want to improve these departments by introducing a broader mix of staff to better manage people's wide-ranging needs. These staff will work alongside A&E consultants and emergency care staff at both hospitals to ensure patients' needs are met as quickly as possible and they can be referred on to appropriate community services to better support them on discharge.

Our consideration of improvements to the way other urgent care services are organised and accessed has focused primarily to two main services - NHS 111 and the walk-in GP service.

Any changes to these services will happen from March 2018 and we are seeking people's views now to help us get the service specification right.

1. NHS 111

111 is the free NHS non-emergency number, available 24 hours a day, 365 days a year. It's the number to call to speak to a highly trained adviser, supported by healthcare professionals; callers are asked a series of questions to assess symptoms and directed to the best service to meet their needs.

We want to improve and expand the range of services accessed through 111, making it the main point of access for local people who have an urgent health/social care need but do not know which service to contact.

This would involve:

- linking NHS 111 with local urgent care services so people could speak to a local healthcare professional should this be needed
- a local healthcare professional giving advice or, if needed, directly booking an appointment for people who need to be seen and/or treated by an urgent care clinician.

2. Eastbourne and Hastings GP walk-in centres

These health centres at Eastbourne Station and Station Plaza, Hastings, currently provide a walk-in service where people join a queue to be seen.

We want this service to be more effective for people who have an urgent care need and must be seen that day and are considering introducing a triage (assessment) system, which would be provided by local health care professionals and accessed via NHS 111.

They would discuss people's needs and symptoms on the telephone. If the assessment identified the need for them to be seen or treated the same day, an appointment would be booked, or another, appropriate service offered to meet their needs – including A&E or calling an ambulance if it's very serious.

Healthcare professionals managing the local assessment service would have information about all the options for meeting people's urgent health/social care needs, including home visiting for people who are housebound or unable to travel provided as part of the GP out of hours service outside of normal GP practice working hours.
Linked to the above and in response to earlier feedback, we are also exploring:

- how we might use **technology** to improve information and advice by offering confidential telephone consultations, online / web video consultations and web 'chat' with healthcare professionals; and
- how to improve the **information** about how to access local services; there are already many sources of self-help and service information, including NHS Choices and the Health Help Now app but what else might help people to help themselves when they have a minor illness or injury.

For more background information, engagement, and next steps see the Q&A. The questions we are asking the public are overleaf.

If you would like further information or to be kept up-to-date about the programme, email esbt@eastsussex.gov.uk or telephone 01273 485300.

What matters to you? Improving urgent care services questionnaire

Building on previous urgent care engagement, we want to communicate and engage more widely on our plans for urgent care. Any changes will come into effect from March 2018 and we're seeking people's views now to help us get the design right.

Urgent care is a term that describes the range of services provided for people who require same day health or social care advice, care or treatment. *This is different from the emergency care provided by our emergency departments (A&E), 999 and ambulances* **which are set up to respond to serious or life threatening emergencies.**

NHS 111 is the call to make to when you need help with urgent needs (including, for example, when your own GP practice is closed).

We are proposing to improve and expand the range of services that NHS 111 can access or refer you on to, making it the main point of access for people who have an out-of-hours urgent care need.

This will involve making sure, when you ring 111:
- you are advised or referred to the right service to meet your needs first time
- you can speak to a local healthcare professional should this be needed
- if needed, either an appointment can be booked for you to be seen by an urgent care healthcare professional on the same day, or you will be given advice about what you should do (for example, visit your local pharmacy, or attend A&E).

The survey closes 30 September 2016

Q1. What would make you more likely to use the 111 service?

Please select all the reasons that apply to you.

☐ If I could **have confidence** that a healthcare professional would respond to my enquiry quickly.

☐ If I have **more information** about the possible options for assistance once I have spoken to someone at 111.

☐ If my **health record** was available to the clinicians.

☐ If I could **type using a web chat** rather than telephoning.

☐ If I could **make a video call** rather than telephoning.

☐ I am not likely to use the 111 service.

Other (please specify)

GP walk-in centres

There are two centres locally providing walk-in GP appointments - at Station Plaza, Hastings and Eastbourne Rail Station. We are looking at how these services are best provided.

We are considering changing the way these services are accessed. For example, instead of walking in and queuing to see a GP, you would call NHS 111 and be given a telephone assessment. If necessary you would then be offered an appointment on the same day without the need to queue.

Q2: From the options below, what things are important to you in a service that assesses your needs on the telephone?

Please select all options that are important to you.

☐ To receive advice and/or treatment on the same day if needed.

☐ Having the telephone service available 7 days a week, 24 hours a day.

☐ Being able to receive information about self-help, such as relevant online information, locations of pharmacies, nearest services to you, opening times and more.

☐ Being able to speak to a local healthcare professional should this be needed.

Other (please specify)

Q3. How helpful would it be for you if you could be booked for a same-day appointment (should this be needed) so you didn't have to queue?

Note: If a healthcare professional assesses your need, they can direct you to the service which is best able to assist you. This may be to a pharmacy, a GP service or - as now - if it's very serious, to A&E or call for an ambulance.

☐ Very helpful ☐ Quite helpful ☐ Unsure ☐ Not very unhelpful ☐ Not at all helpful

Other comments:

Q4. What would make you want to use web chat typing or video calling (in addition to the 111 telephone service) to offer more ways to access urgent, same day advice or care?

Q5. How important is it for you to walk-in somewhere, without calling or booking first?

Note: By using a walk-in service you may be assessed and provided with an appointment later on, or directed to a service which is best able to meet your particular need.

☐ Very important ☐ Fairly important ☐ Unsure ☐ Not very important ☐ Not at all important

Other comments:

Q6. How helpful would it be to you if your own GP practice could direct you to an assessment service if they weren't able to offer you a same day appointment?

☐ Very helpful ☐ Quite helpful ☐ Unsure ☐ Not very helpful ☐ Not at all helpful

Other comments:

Q7. Do you currently ask pharmacists for advice and/or remedies – as well as medicines?

☐ Yes, often ☐ Yes, sometimes ☐ No ☐ I didn't know I could get advice from a pharmacist.

Other comments:

Q8. Which council area do you live in?

☐ Eastbourne Borough Council ☐ Hastings Borough Council ☐ Rother District Council ☐ Wealden District Council ☐ Lewes District Council ☐ None of these

Q9. Are there any other comments you would like to make about same day, urgent care services?

About you

We want to make sure that everyone is treated fairly and equally and that no one gets left out. That's why we ask you these questions. We won't share the information you give us with anyone else. We will only use it to help us make decisions and make our services better. If you would rather not answer any of these questions, you don't have to.

Q1 Are you.....? Please select one box

☐ Male ☐ Female ☐ Prefer not to say

Q2 Do you identify as a transgender or trans person? Please select one box

☐ Yes ☐ No ☐ Prefer not to say

Q3 Which of these age groups do you belong to? Please select one box

☐ 19 or under ☐ 30-39 ☐ 50-59 ☐ 70-79

☐ 20-29 ☐ 40-49 ☐ 60-69 ☐ 80 or over ☐ Prefer not to say

Q4 To which of these ethnic groups do you feel you belong? (source: 2011 census)
Please select one box

☐ White British
☐ White Irish
☐ White Gypsy/Roma
☐ White Irish Traveller
☐ White other*
☐ Mixed White and Black Caribbean
☐ Mixed White and Black African
☐ Mixed White and Asian
☐ Mixed other*
☐ Other ethnic group*
☐ Asian or Asian British Indian
☐ Asian or Asian British Pakistani
☐ Asian or Asian British Bangladeshi
☐ Asian or Asian British other*
☐ Black or Black British Caribbean
☐ Black or Black British African
☐ Black or Black British other*
☐ Arab
☐ Chinese
☐ Prefer not to say

*If your ethnic group was not specified in the list please describe your ethnic group.

The Equality Act 2010 describes a person as disabled if they have a longstanding physical or mental condition that has lasted or is likely to last at least 12 months; and this condition has a substantial adverse effect on their ability to carry out normal day to day activities. People with some conditions (cancer, multiple sclerosis and HIV/AIDS, for example) are considered to be disabled from the point that they are diagnosed

Q5 Do you consider yourself to be disabled as set out in the Equality Act 2010?

Please select one box

☐ Yes ☐ No ☐ Prefer not to say

Q6 If you answered yes to Q6, please tell us the type of impairment that applies to you.

You may have more than one type of impairment, so please select all that apply. If none of these apply to you please select other and give brief details of the impairment you have.

☐ Physical impairment
☐ Sensory impairment (hearing and sight)
☐ Long standing illness or health condition, such as cancer, HIV, heart disease, diabetes or epilepsy
☐ Mental health condition
☐ Learning disability
☐ Prefer not to say
☐ Other*

*If other, please specify

Q7 Do you regard yourself as belonging to any particular religion or belief?

Please select one box

☐ Yes ☐ No ☐ Prefer not to say

Q8 If you answered yes to Q8 which one? Please select one box

☐ Christian ☐ Hindu ☐ Muslim ☐ Any other religion, please specify
☐ Buddhist ☐ Jewish ☐ Sikh

Q9 Are you... Please select one box

☐ Bi/Bisexual ☐ Gay woman/Lesbian ☐ Other
☐ Heterosexual/Straight ☐ Gay Man ☐ Prefer not to say

If you have printed this survey you can send it to us using any envelope, by using this address: **Improving urgent care, Freepost, SEA2474, BN8 2ZZ**

Survey also online at
https://www.surveymonkey.co.uk/r/9Z9MLXK

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

Date of meeting: **1 December 2016**

By: **Assistant Chief Executive**

Title: **Patient Transport Service**

Purpose: **To consider an update on the Patient Transport Service in Sussex**

RECOMMENDATIONS

1) to consider and comment on the updates from High Weald Lewes Havens Clinical Commissioning Group (appendices 1 and 2)

2) to request a further report, focusing on progress with the transition to South Central Ambulance Service, in March 2017

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1 Background

1.1 The Patient Transport Service (PTS) is a Sussex-wide service that helps people access healthcare appointments. The service provides some 25,000 journeys per month for people who are unable to use public or other transport owing to medical conditions. The service is booked for people who meet certain medical criteria which would otherwise prevent them from getting to their appointment. PTS is free at the point of use for all eligible patients. It is a non-emergency transport service and is quite separate from emergency ambulance services which are commissioned separately.

2 Supporting information

2.1 On 1 April 2016 a new PTS went live across Sussex, provided by Coperforma. This followed a procurement process led by High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG) on behalf of the seven CCGs in Sussex.

2.2 In June HOSC received a report from HWLH CCG outlining problems which had been experienced with the delivery of the PTS service since the change of provider and how these were being addressed. Both the CCG and Coperforma acknowledged that performance had been unacceptable, with many patients experiencing severe delays or not receiving transport at all. There had been considerable media coverage of the problems experienced by patients and concerns had been raised with patient groups and elected representatives.

2.3 In September HOSC received a further update on the performance of the service. Performance data provided by Coperforma and feedback from patients and hospital Trusts analysed by the CCG indicated that the service had improved. However, it was acknowledged that this was not consistent or embedded across Sussex and some patients continued to experience problems with the service.

2.4 Since September a number of further issues have arisen in relation to one of Coperforma's sub-contractors, Docklands Medical Services (DMS) including disputes over payment and issues with Care Quality Commission (CQC) registration. As a result DMS is no longer providing a transport service in Sussex with alternative sub-contractors providing additional capacity to compensate.

2.5 On 1 November 2016 CQC published a report outlining findings from an unannounced inspection of Coperforma in July 2016, serving six requirement notices to the service to ensure improvements are undertaken. A full report of this inspection has previously been circulated to HOSC Members and is available on the CQC website. Areas for improvement included:

- The provider must ensure a robust system is in place for handling, managing and monitoring complaints and concerns.
- There must be robust systems in place to assess, monitor and improve the quality and safety of the services provided.
- The vehicles and equipment used by contracted services must be appropriate for safe transportation of patients, including wheelchair users
- Patients must receive timely transport services so they can access the health services they need from other providers.
- A manager must be registered with the Commission.
- CQC must be notified of safeguarding incidents and incidents affecting the running of the service.

2.6 Also on 1 November 2016, the Chairman was informed by letter from Wendy Carberry, Accountable Officer, HWLH CCG that South Central Ambulance Service NHS Foundation Trust (SCAS) would take over the contract for the PTS from April 2017. The transition from Coperforma will be phased over the next few months and be complete by April. The letter is attached at appendix 1.

2.7 As requested by HOSC, HWLH CCG has provided a further report (appendix 2) which provides an update on PTS performance, current service issues and the transition to SCAS.

2.8 Representatives of HWLH CCG will be in attendance at the HOSC meeting to take questions on the report.

3. Conclusion and reasons for recommendations

3.1 HOSC is recommended to consider the updates from HWLH CCG and question the attendees on the issues arising. The Committee will wish to consider whether everything possible is being done to ensure patients consistently receive an appropriate level of service now and during the transitional period, how the issues raised by CQC are being addressed and how ongoing risks are being managed.

3.2 HOSC is also recommended to request a further report, focussing on progress with the transition to SCAS, in March 2017.

PHILIP BAKER
Assistant Chief Executive

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East Sussex
BN7 2PB
Tel: 01273 485300
Email: HWCCG.HWLHCCGEnquiries@nhs.net

Via Email

01 November 2016

Dear Counsellor Colin Belsey,

I am writing to let you know that South Central Ambulance Service NHS Foundation Trust (SCAS) has agreed to take over the contract for the Sussex Patient Transport Service**.** In order to minimise disruption to patients who use the service, the transfer will be phased over the next few months, with SCAS taking complete responsibility from April 2017.

Patients do not need to do anything. They should continue to book their transport in their normal way and should not notice any difference in the service. However, over the next few months, SCAS will gradually take over more and more of the service.

SCAS has 40 years' experience, and currently provides the PTS service across the whole of the South Central region, including Hampshire and the Thames Valley (Berkshire, Buckinghamshire and Oxfordshire). It was recently named preferred bidder to take over the patient transport service for Surrey, Hampshire and Hounslow from April 2017. It is rated good by the CQC, who specifically highlighted the care that SCAS staff provide to patients using the Patient Transport Service, rating it as outstanding.

As you know, since 1st April 2016 the Sussex PTS has been managed by Coperforma, which took over the contract following a competitive procurement and tendering process. The start of the new contract saw unacceptable levels of performance, both in making bookings and with the transport itself. The service has improved, although the improvements are not consistent across the whole of Sussex and some patients continue to experience problems.

Recently, however, there have been a number of issues between Coperforma and some of its subcontractors, which have raised concerns about the sustainability of the service. In September, the CCGs stepped in to pay staff of Dockland Medical Services, a subcontractor of Coperforma, after the company stopped providing the patient transport service for Sussex patients.

The CCGs will now work with SCAS on a detailed plan for transfer. There is a great deal of work to be done, but we believe that the managed transfer is best for patients and for staff. They been through a period of uncertainty and we will now be able to resolve that.

Yours sincerely

Wendy Carberry,
Chief Officer
NHS High Weald Lewes Havens Clinical Commissioning Group;

On behalf of-

Amit Bhargava,	Clinical Chief Officer, NHS Crawley CCG
Marie Dodd,	Acting Chief Officer, NHS Coastal West Sussex CCG
Adam Doyle,	Chief Officer, NHS Brighton & Hove CCG
Geraldine Hoban,	Chief Officer, NHS Horsham & Mid Sussex CCG
Amanda Philpott,	Chief Officer, NHS Eastbourne, Hailsham & Seaford and NHS Hastings and Rother CCG

East Sussex Health Overview and Scrutiny Committee (HOSC)
Update on the Patient Transport Service in Sussex - 1st December 2016

Summary

- Feedback from provider trusts whose patients use the service, and from patients themselves, remains constant in telling us that the service is improving across Sussex.
- Docklands Medical Services (DMS), a transport subcontractor, is still not providing a service in Sussex and ex South East Coast Ambulance Service NHS Foundation Trust (SECAmb) staff employed by DMS, continue to be available for work.
- The Clinical Commissioning Groups (CCGs) are looking at alternative options for this DMS staff group.
- The additional capacity sourced by Coperforma to mitigate the loss of DMS is maintaining service delivery.
- The CCGs have worked with Coperforma and the unions to put in place a mechanism coordinated by GMB to pay DMS staff any outstanding payments via a third party payroll. This has ensured staff have now been paid standard pay up to November 2016.
- CCGs are utilising the powers available within the NHS standard contract and enacting these where Coperforma's performance falls below what is expected.
- Coperforma has agreed to step down from the contract following a no fault termination. In order to minimise disruption to patients, the transfer will be phased over the next few months, with South Central Ambulance NHS Foundation Trust (SCAS) taking complete responsibility from April 2017.
- The Sussex CCG's posted a Voluntary Ex Ante Transparency Notices (VEAT) in the Official Journal of European Union (OJEU) on 4th November 2016 as part of a transparent process to communicate our intention to directly award a 3+1 year contract to SCAS.
- The CCGs will now begin to develop a detailed transition plan with SCAS and Coperforma.

Quality and CQC issues

The Care Quality Commission (CQC) announced on 1 November 2016, that it would continue to monitor the PTS while the service is in transition and published its full report on the service provided by Coperforma Ltd following an unannounced inspection in July 2016. The CQC told the company that it must sustain significant improvements to the service in Sussex and served six requirement notices to the service to ensure improvements are undertaken. A full report of this inspection has been published on the CQC website.

Areas for improvement include:

- The provider must ensure a robust system is in place for handling, managing and monitoring complaints and concerns.
- There must be robust systems in place to assess, monitor and improve the quality and safety of the services provided.
- The vehicles and equipment used by contracted services must be appropriate for safe transportation of patients, including wheelchair users.
- Patients must receive timely transport services so they can access the health services they need from other providers.
- A manager must be registered with the Commission.
- CQC must be notified of safeguarding incidents and incidents affecting the running of the service.

Patient safety

- The work of the Patient Safety Group, led by a GP, with representatives from HealthWatch, local authority safeguarding, hospital trusts to oversee patient safety and experience has been on-going.
- Members of the group continue to visit hospitals, speaking to patients and front line staff to get their feedback on the service.

Performance

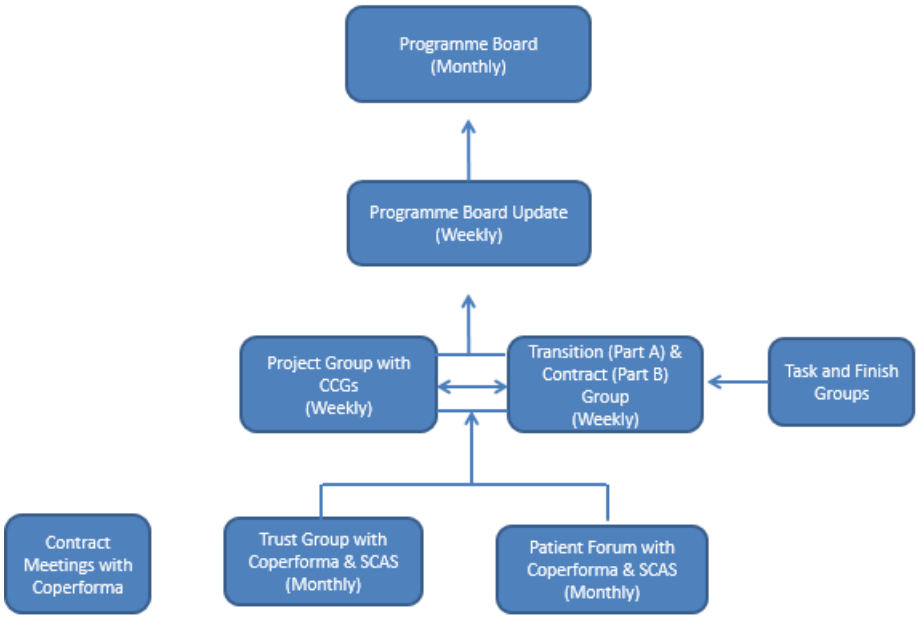
- The feedback we are receiving from patients and staff tells us that the service level is being maintained with the latest patient user survey shows patient satisfaction at 4.1 out of 5.
- The CCGs and CSU are awaiting feedback from Coperforma regarding the data anomalies found and continue to use the contract levers available to them to manage this.
- The CCG recently visited Coperforma and performed a full quality audit on the policies and processes. A report will be available in early December 2016.

Transition

The Sussex CCG's posted a VEAT in OJEU on 4th November 2016 as part of a transparent process to communicate our intention to directly award a 3+1 year contract for the provision of non–emergency patient transport across Sussex to SCAS. No challenges in response to the VEAT were received and the Sussex CCG's will now begin the process of negotiating the detailed terms and conditions of that contract with SCAS. This contract will be in place prior to the 1st April 2017 commencement date.

On behalf of the seven Sussex CCG's, NHS High Weald Lewes Haven CCG has signed a Memorandum of Agreement with SCAS to allow for the immediate planning of the operational transfer of services from Coperforma to SCAS in a phased and managed way over the coming months. This phased transfer will be complete by the contract "go live" date of 1st April 2017. An executive level PTS Programme Board including membership from each CCG has been established to provide oversight and scrutiny of this process.

PTS Transition Governance Structure



New PTS management team for CCGs

In addition to the CCGs Specialist PTS Advisor, a new Programme Manager for PTS and a PTS Programme Director have been deployed to oversee the transition.

Conclusion

HOSC is asked to review this update from the Sussex CCGs and raise any matters they have regarding the PTS during and beyond the transitional period.

Work Programme for Health Overview and Scrutiny Committee

Future work at a glance

Updated: 23 November 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.

Issue	*Objectives and summary*	*Organisation giving evidence*
23 March 2017		
Sussex and East Surrey Sustainability and Transformation Plan (Provisional)	To consider an update on the NHS Sussex and East Surrey Sustainability and Transformation Plan (STP) and its implications for healthcare in East Sussex.	Wendy Carberry, Senior Responsible Officer (and Chief Officer, High Weald Lewes Havens Clinical Commissioning Group)
Patient Transport Service (Provisional)	To consider an update on the performance of the Patient Transport Service (PTS) focussing on the progress with the transition to South Central Ambulance Service NHS Foundation Trust (SCAS).	High Weald Lewes Havens Clinical Commissioning Group
Central Sussex Stroke Review	To consider recommendations from the HOSC Review Board in relation to proposals to reconfigure acute stroke services provided by Brighton & Sussex University Hospitals NHS Trust.	High Weald Lewes Havens Clinical Commissioning Group

Other HOSC work
This table lists additional HOSC work ongoing outside of the main committee meetings or potential agenda items under consideration.

Issue	***Objectives / Evidence***	***People / HOSC timescale***
Ambulance services	Joint South East Coast area HOSC Sub-Group to scrutinise SECAmb's response to the findings of the recent CQC inspection and the Trust's wider recovery plan	HOSC Chair, Vice Chair and officer – first meeting December 2016
Mental health services	Regular meetings with Sussex Partnership NHS Foundation Trust and other Sussex HOSCs to consider the Trust's response to CQC inspection findings and other mental health issues, including ongoing reconfiguration of dementia inpatient beds in East Sussex. CQC re-inspection September 2016 – report due late 2016	Last meeting: 8 July 2016 Next meeting: January 2017 TBA HOSC Chair, Vice-Chair and officer
Regional NHS liaison	Regular (approx. 4 monthly) meetings of South East Coast area HOSC Chairs with NHS England Area Team and other regional/national organisations as required e.g. NHS Improvement, NHS Property, CQC	Last meeting: 18 November 2016 Next meeting: 16 March 2017 HOSC Chair and officer
ESHT CQC re-inspection	CQC re-inspected ESHT during October 2016 – report likely to be available in early 2017	Potential agenda item – 23 March 2017
Quality of cancer care	Consider the reasons for the performance of East Sussex CCGs in the NHS England's league table rating NHS performance on cancer.	Initial research – potential information request to CCGs
Pain management services	Information request on pain management services to Hastings and Rother Clinical Commissioning Group (HR CCG) and Eastbourne, Hailsham and Seaford Clinical Commissioning Group (EHS CCG).	November 2016 – awaiting response.
Equipment returns	Potential information request to BSUH re. the ability to return equipment for people who live in East Sussex but are treated in West Sussex.	Initial research – potential information request TBC.

If you have any comments to share about topics HOSC will be considering, as shown above, please contact:
HOSC Support Officer: Claire Lee, 01273 335517 or claire.lee@eastsussex.gov.uk

Acronyms

A&E – Accident and Emergency department
ASC – Adult Social Care
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
NHSE – NHS England
NHSI – NHS Improvement
SCAS – South Central Ambulance Service NHS Foundation Trust
SECAMB – South East Coast Ambulance Service NHS Foundation Trust
SPFT or SPT – Sussex Partnership NHS Foundation Trust
TBC – to be confirmed

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