

## **HEALTH OVERVIEW AND SCRUTINY COMMITTEE**

**THURSDAY, 21 SEPTEMBER 2017**

**10.00 AM COUNCIL CHAMBER, COUNTY HALL, LEWES**

**MEMBERSHIP -** East Sussex County Council Members  
Councillors Colin Belsey (Chair), Phil Boorman, Bob Bowdler,  
Angharad Davies, Ruth O'Keeffe (Vice Chair), Sarah Osborne and  
Andy Smith

District and Borough Council Members  
Councillor Janet Coles, Eastbourne Borough Council  
Councillor Mike Turner, Hastings Borough Council  
Councillor Susan Murray, Lewes District Council  
Councillor Bridget Hollingsworth, Rother District Council  
Councillor Johanna Howell, Wealden District Council

Voluntary Sector Representatives  
Geraldine Des Moulins, SpeakUp  
Jennifer Twist, SpeakUp

### **AGENDA**

1. **Minutes of the meeting held on 29 June 2017** (*Pages 7 - 14*)
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. **Urgent Care** (*Pages 15 - 38*)
6. **Sussex and East Surrey Sustainability and Transformation Partnership** (*Pages 39 - 56*)
7. **Clinically Effective Commissioning** (*Pages 57 - 68*)
8. **HOSC future work programme** (*Pages 69 - 90*)
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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13 September 2017

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Next HOSC meeting: 10am, Thursday, 30 November 2017, County Hall, Lewes

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



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## HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Lewes on 29 June 2017

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### PRESENT:

Councillors Colin Belsey (Chair), Councillors Bob Bowdler, Angharad Davies, Ruth O'Keeffe, Peter Pragnell and Sarah Osborne (all East Sussex County Council); Councillor Janet Coles (Eastbourne Borough Council) and Councillor Susan Murray (Lewes District Council)

### WITNESSES:

#### **East Sussex Healthcare NHS Trust (ESHT)**

Catherine Ashton, Director of Strategy, Innovation and Planning  
Hazel Tonge, Deputy Director of Nursing

#### **High Weald Lewes Havens Clinical Commissioning Group (CCG)**

Ashley Scarff, Director of Strategy and Deputy Chief Officer  
Sam Tearle, Senior Strategic Planning & Investment Manager

#### **Eastbourne, Hailsham and Seaford CCG / Hastings and Rother CCG**

Jessica Britton, Chief Operating Officer

#### **East Sussex County Council**

Keith Hinkley, Director of Adult Social Care and Health

### LEAD OFFICER:

Claire Lee, Senior Democratic Services Adviser

#### 1. MINUTES OF THE MEETING HELD ON 23 MARCH 2017

1.1 The Committee agreed the minutes were a correct record of the meeting held on 23 March 2017.

#### 2. APOLOGIES FOR ABSENCE

2.1 Apologies for absence were received from:

- Cllr Phil Boorman (substitute: Cllr Peter Pragnell)
- Cllr Bridget George
- Cllr Joanna Howell
- Cllr Andy Smith

- Cllr Mike Turner
- Jennifer Twist

2.2 The Chair noted that Julie Eason had resigned her position due to new work commitments. He thanked her for the contribution she had made to the Committee over the years and wished her well in her new endeavours.

2.3 The Chair welcomed the new Members of HOSC and thanked Cllrs Frank Carstairs, Tania Charman, Alan Shuttleworth and Bob Standley for their contributions during the course of their time on HOSC.

### 3. DISCLOSURES OF INTERESTS

3.1 There were none.

### 4. URGENT ITEMS

4.1 Jessica Britton, Chief Operating Officer, Eastbourne, Hailsham and Seaford Clinical Commissioning Group (EHS CCG) and Hastings and Rother Clinical Commissioning Group (HR CCG) informed HOSC that the East Sussex Better Together (ESBT) programme had won the award for *fostering commissioner and provider collaboration in transforming health services* at the National Healthcare Transformation awards on 28 June. The ESBT programme was also nominated for the I-Rock Project in Hastings, a mental health programme for young people.

4.2 Jessica Britton said that the award demonstrated that the ESBT programme was truly bringing together health and social care. She thanked HOSC for its support over the past three years.

4.3 The Committee congratulated everyone involved in ESBT for their achievement.

### 5. CONNECTING 4 YOU PROGRESS UPDATE

5.1. The Committee considered a presentation providing an update on the progress of the Connecting 4 You health and social care transformation programme in the High Weald Lewes and Havens (HWLH) area of East Sussex.

5.2. Keith Hinkley, Director of Adult Social Care and Health, East Sussex County Council; Ashley Scarff, Director of Commissioning and Deputy Chief Officer, and Sam Tearle, Senior Strategic Planning & Investment Manager, both from High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG), answered questions from HOSC Members.

#### **The key achievements of the Connecting 4 You programme**

5.3. Ashley Scarff said that Connecting 4 You (C4Y) has helped improve multi-agency working, with both Sussex Community NHS Foundation Trust (SCFT) and the East Sussex County Council (ESCC) Adult Social Care Department aligning their services towards the four “Communities of Practice” and improving community care pathways. Keith Hinkley said that the key improvement of C4Y has been to align operational services so that they are able to provide unified case management for patients.

5.4. Ashley Scarff outlined some new services that have been introduced as part of C4Y that have resulted in a reduction in hospital admissions, including:

- Consultant Geriatricians who proactively outreach into local communities to support old and vulnerable people;
- Community Diabetes Service, with significant focus on education for patients to manage that long term condition;
- Joint Musculoskeletal Service with Eastbourne, with Hailsham and Seaford Clinical Commissioning Group (EHS CCG) that is piloting a self-referral service for people with physiotherapy needs, for example, chronic back pain. This is receiving extremely positive feedback from patients and clinicians.

5.5. Keith Hinkley added that the High Weald Lewes Havens (HWLH) area is receiving new joint health and social care services such as Health and Social Care Connect (HSCC) and the Joint Community Reablement teams that are being delivered across the whole of East Sussex.

### **Progress of C4Y**

5.6. Ashley Scarff explained that the health and social care budgets have been aligned and the C4Y Programme Board receives a combined financial plan that shows the aggregated budget for the whole health and social care economy in the HWLH area. However, at this stage they are not pooled in the same way as they are for the East Sussex Better Together (ESBT) Alliance, which has an agreed Strategic Investment Plan (SIP) for 2017/18.

5.7. Sam Tearle explained that a detailed timeline of the C4Y programme will be presented to the C4Y Programme Board on 19 July; it will include how the SIP and the Multi-Specialty Community Provider (MCP) model for C4Y will be progressed. He said that the pace of the programme will increase over the summer and into autumn.

5.8. Keith Hinkley added that strategic investment planning for the HWLH area is flagged in ESCC's State of the County document that was agreed by Cabinet in June. He said that it is expected that decisions about the SIP, alongside the design of the MCP model, will be made towards the end of 2017. It will be difficult to develop more integrated services until the MCP model is agreed.

### **C4Y within wider Sussex and East Surrey Sustainability and Transformation Partnership (STP)**

5.9. Ashley Scarff explained that Horsham and Mid Sussex CCG and Brighton & Hove CCG are also looking at a MCP model of integrated care. The three CCGs comprise the footprint within the Sussex and East Surrey Sustainability and Transformation Partnership (STP) called Central Sussex and East Surrey Area (CSESA) South and have considerable commonality. They share the same community healthcare provider – SCFT – as well as a shared mental health provider – Sussex Partnership NHS Foundation Trust (SPFT) – and all three use the acute hospital services of Brighton & Sussex University Hospital NHS Trust (BSUH) for some or all of their residents. There is also an imperative for the CCGs to work together due to financial and capacity pressures on the acute system, especially in Brighton & Hove, and pressure from NHS England to work together at scale and in the most efficient way possible.

5.10. Ashley Scarff explained that from the CCGs perspective it was the right decision for HWLH CCG to withdraw from ESBT. If HWLH CCG had continued with ESBT, he explained, the process of providing integrated health and social care might be further ahead, but only for 10-15% of the CCG's population. He added that HWLH CCG recognises the need to maintain a

pace of change but the best approach involves making the most appropriate connections with other CCGs and providers.

5.11. Keith Hinkley said that there is an ongoing review across the whole STP of governance arrangements, including in the CSESA South footprint, that is due to be completed in October. This means that further work might need to be undertaken in the autumn on the governance arrangements of C4Y, which could impact on the planned development of a SIP and MCP model.

### **Consultation on C4Y**

5.12. Ashley Scarff explained that local people will have seen the C4Y engagement programme that has been visible at various forums and meetings held in several locations within the programme's footprint.

5.13. He agreed with the Committee that engagement, feedback and insight from front line staff was critical. The CCG Board is constantly being fed the opinions healthcare providers and of GPs – who are an integral part of the structure of CCGs. C4Y events have also been held, including one in January where team leaders from health, social care and voluntary sector providers were involved.

### **Definition of self-management**

5.14. Ashley Scarff explained that self-management forms a key part of the C4Y strategy and refers to helping people, especially those with long term or complex conditions, manage their own conditions in order to help keep them away from reactive, hospital care. This is good for the individual, carer, family, and the healthcare system as whole, because healthcare professionals are not reactively responding to a crisis at the most costly point in the healthcare pathway.

5.15. Keith Hinkley added that there is a national and international evidence base about the gains in the health of a population as a whole if people have a better understanding of, and ability to manage, their own health, for example, being able to access their case records, or access healthcare professionals, via an online portal.

### **Streamlined point of access**

5.16. Keith Hinkley explained that ESCC manages the streamlined point of access – Health and Social Care Connect (HSCC) – on behalf of the whole health and social care system. HSCC has drawn together health and social care practitioners in to a single place for patients and health and social care professionals to connect with the healthcare system and be guided to the most appropriate point within it.

5.17. Keith Hinkley said that significant investment has been made to the clinical and practitioner input within HSCC so that the right decisions about the urgency of a patient's need, and the appropriate care for them, are made at a very early point in the patient's contact with the healthcare system. He added that feedback is very positive but there remain areas of improvement, for example, improving response times to calls.

5.18. He said that HSCC has drawn together multiple points of access but will not become a single point of access due to the complexity of health and social care, and the fact that many patients will continue to contact their GP in the first instance. Therefore, the key to making HSCC work is ensuring that all practitioners – including GPs – understand the need to refer patients to HSCC so that they can enter the healthcare system at the appropriate point. Training for staff is underway so that they are aware of HSCC.

5.19. The Committee RESOLVED to;



- 1) note the report;
- 2) request a further update on Connecting 4 You in the autumn containing a timeline of key events for the transformation programme;
- 3) request an additional report on Connecting 4 You for March 2018; and
- 4) request a visit to the Health and Social Care Connect (HSCC) centre in Eastbourne.

## 6. END OF LIFE CARE

6.1. The Committee considered a report on the progress of East Sussex Healthcare NHS Trust (ESHT) End of Life Care (EOLC) project.

6.2. Catherine Ashton, Director of Strategy, and Hazel Tonge, Deputy Director of Nursing, both from ESHT, answered questions from HOSC Members.

### **New EOLC team structure**

6.3. Hazel Tonge explained that the new EOLC team structure – including the Senior Nurse who will coordinate and oversee the EOLC service across both hospital sites – came together in May and is currently focussed on making sure the right governance arrangements are in place to ensure both the Conquest Hospital and Eastbourne District General Hospital (EDGH) team work to the same standards. There is currently not enough available data to demonstrate success of the new arrangement, but in two months' time there should be. The two teams have, however, said that they are now functioning as one team, have access to the same specialist support, and are supporting each other.

6.4. Hazel Tonge explained that EOLC Practice Development Facilitators have trained 1,065 acute ward staff on the new Individualised Care Plan. A patient's individualised care plan includes symptom controls and their preferred plan for death, and also includes where to refer them within the healthcare system.

### **Culture and leadership**

6.5. Hazel Tonge explained that staff have told her that there is a very different culture in the organisation than there was two years ago. Staff now feel secure enough to seek support and raise concerns – for example, through weekly nurse meeting groups – or access counselling should they require it. The NHS Staff Survey results reflect this observation.

### **Extending the service to 24/7**

6.6. Hazel Tonge said that she has written a draft options paper for the ESHT Board to consider setting out the advantages and disadvantages of maintaining a 5 day service or moving to a 7 day one. The Trust Board will consider it during July and decide on the necessary financial support.

### **Identifying patients in the last year of their life**

6.7. Hazel Tonge said that ESHT's priority currently is to identify those patients in the last days of their life. The EOLC teams are working with non-palliative teams, such as cardiology and gastroenterology, but the process is not yet complete. There is an awareness and engagement workstream in place to raise clinicians' awareness of palliative care, but raising awareness is a nationwide challenge – which is why so much national guidance is written on the subject.

6.8. Jessica Britton said that the ESBT Alliance is developing an EOLC Strategy. This involves ESHT working with CCGs to develop a system where staff from primary, community and acute care can share information about patients who are in the last year of their life, with their consent. The EOLC Strategy will also develop awareness raising programmes and training courses to assist clinicians to identify those patients in the last year of their life. Further details of the strategy are likely to be available by next year.

6.9. Catherine Ashton said that ensuring patients' EOLC needs are tracked is a key part of the ESBT Alliance's EOLC Strategy. The purpose is to avoid having to provide reactive hospital care, and to ensure that when a patient visits hospital they have a GP's care plan in place that has been worked through with them and is easily accessible to hospital staff.

6.10. Hazel Tonge added that a case manager is assigned to patients who are identified as requiring long term health or social care. The case manager supports them to maintain wellness by making sure the appropriate health and social care workers are informed about the patient's needs and this should include palliative care needs.

### **Involvement of chaplaincies and hospices**

6.11. Part of the EOLC service's five year strategy involves bringing together all sectors – CCGs, carers, chaplaincy service, voluntary sector, and hospices – to support people with palliative care. ESHT now has formal arrangements in place with both hospices in East Sussex, for example, as part of the EOLC service's new "one team" approach, the Consultant in Specialist Palliative Care is providing two morning or afternoon sessions per week to develop care standards and training at the hospices.

6.12. Hazel Tonge agreed that the chaplaincy service is important for providing spiritual support to patients – including to those who are not religious. There are both paid and voluntary chaplains operating in ESHT. The chaplains need to know which patients in the Trust are identified as being EOLC patients and are provided with a list of patients that they can visit and see whether they want spiritual support. They also provide support beyond EOLC for carers and relatives of deceased patients.

### **Ensuring consistency of EOLC care**

6.13. Catherine Ashton explained that it is difficult issue to ensure a named member of staff provides EOLC due to the difficulty in predicting when palliative care is required. There is, however, a recognition that the Palliative Care teams need to ensure that the handover information about patients within the teams needs to be really thorough. This will result in a team of people who know the palliative care needs of a group of patients and so will all know who it is they are seeing and what their needs are.

### **Living wills**

6.14. Hazel Tonge explained that ESHT has an advance care planning system in place that includes discussing living wills with patients. This has received positive feedback from families.

6.15. Hazel Tonge added that it depends how the patient presents on admission whether or not they will be asked if they have an advance care plan. Usually patients will present at a hospital with an acute condition and treating that is the clinicians' priority. However, some patients, or their families, will proactively identify that they have an advance care plan in place, and in those situations the clinician may ask about a living will.

6.16. Hazel Tonge advised HOSC that there is a public event in July that will ask people for feedback about advance care planning and living wills. Jessica Britton added that the CCGs have not done specific engagement work on living wills, but will work with colleagues from

provider organisations to raise the profile of them in the future. Living wills are gaining a high profile nationally, with more national guidance including reference to them.

### **Referral flow chart**

6.17. Hazel Tonge confirmed that the referral flow chart for ward staff should be shared with patients, but she could not guarantee all patients see it, as it is not something that she audited.

### **EOLC plans in the C4Y area**

6.18. Ashley Scarff said that Sussex Community NHS Foundation Trust (SCFT) is the provider of community services in the HWLH area and it has in place a well regarded EOLC pathway.

6.19. He said that developing the ability for organisations to share care records is particularly important to improving EOLC as it will allow organisations to access to patient information in a sensible and reasonable manner.

6.20. He added that a system-wide piece of work to improve support for families and carers beyond the death of their loved one is also very important, been raised at broader engagement events held by HWLH CCG. He said that there is a risk that a carer may suppress their own health and social care needs to look after a dying loved one, so it is important that health and social care systems are in place to support them after the death of the patient.

6.21. The Committee RESOLVED to:

- 1) note the report;
- 2) request a future update at the March 2018 meeting;
- 3) request confirmation by email about how widely referral flow charts are shared with patients; and
- 4) request that the audit against NICE QS 144: Care of dying adults in the last days of life is provided by email.

## **7. HOSC FUTURE WORK PROGRAMME**

7.1 The Committee RESOLVED to note the work programme.

The meeting ended at 11.45 am.

Councillor Colin Belsey  
Chair

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

**Date of meeting:** 21 September 2017

**By:** Assistant Chief Executive

**Title:** Urgent Care

**Purpose:** To update HOSC on developments in urgent care services, including:

- redesign of the urgent care system as part of the East Sussex Better Together programme;
- the Sussex-wide redesign and re-procurement of NHS 111;

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## **RECOMMENDATIONS**

**1) To consider and comment on the report.**

**2) To consider what 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 accident and emergency departments (A&E), other hospital departments, 999 and ambulances which are set up to respond to serious or life threatening emergencies.

1.2 Following a national review in 2014, NHS England set out clear commissioning standards to ensure future urgent and emergency care services are integrated and offer a consistent service. In March 2017, NHS England and NHS Improvement published the *Next Steps on the NHS Five Year Forward View* which highlighted the importance of delivering integrated urgent care services to help address the fragmented nature of out-of-hospital services. This national guidance is informing how local health and social care partners look to best organise and provide local urgent care services.

### **2 Supporting information**

#### **East Sussex Better Together urgent care redesign**

2.1 In December 2016 HOSC received a report from health and social care partners in Eastbourne, Hailsham and Seaford and Hastings and Rother outlining work underway through the East Sussex Better Together (ESBT) programme to redesign the urgent care system in this part of the county.

2.2.1 The report focused on three areas:

- the enhancement of A&E departments in Hastings and Eastbourne 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. It was anticipated that this work would begin to provide a more streamlined, enhanced service that begins as soon as patients arrive at A&E.
- The provision of 24/7 access to same day general practice which included the future provision of Primary Care Out of Hours services and a review of the Eastbourne and Hastings Walk-in Centres. The proposed new model for Primary Urgent Care Services outlined how patients would be able to access same day advice, guidance or treatment within a primary care setting.

- the redesign and re-procurement of NHS 111 (see below). This was seen as very much linked with the two areas above and part of an integrated approach to urgent care.

2.3 HOSC requested a progress report on the ESBT urgent care redesign programme in September 2017. This report is attached at appendix 1.

## **NHS 111**

2.4 NHS 111 is the free NHS non-emergency number, available to everyone 24 hours a day, 365 days a year. The December 2016 report to HOSC outlined plans to undertake a Sussex-wide procurement exercise to appoint a future provider for this service in line with a new national specification. This new national blueprint for the NHS 111 service is to provide a call handling and self-help service that is then integrated with local clinical hubs which will provide a comprehensive clinical triage and telephone assessment service. NHS 111 will therefore operate as the 'doorway' to access other urgent care services which are more locally based. In East Sussex the intention was to expand the existing county-wide Health and Social Care Connect service to provide the local clinical hub and triage service.

2.5 The re-procurement of NHS 111 is being led by Coastal West Sussex Clinical Commissioning Group (CCG) on behalf of all Sussex CCGs. The team leading this work has approached all the Sussex HOSCs to provide an update and seek HOSC input to the ongoing work. A specific update on NHS 111 is included at annex 3 of appendix 1.

## **East Sussex Healthcare NHS Trust (ESHT) – Urgent Care and Patient Flow**

2.6 Over the past two years HOSC has been scrutinising various aspects of ESHT's Quality Improvement Programme, developed following Care Quality Commission (CQC) inspections of the Trust. In March 2017 the committee received a report on the most recent CQC inspection (October 2016) which identified the significant progress made by ESHT and the key areas requiring ongoing focus. One of the areas rated 'requires improvement' was urgent care and both hospitals were rated 'inadequate' for the 'safe' domain of urgent care.

2.7 In response to CQC findings and service pressures the Trust had established an urgent care and patient flow project. The aim of the project was to ensure that patients on the urgent and emergency care pathway are treated in the right place at the right time, first time by the right staff. HOSC requested more information on this work which, due to the significant overlap and integration with the wider ESBT urgent care redesign programme, is incorporated into the report at appendix 1.

## **3 Urgent care outside ESBT**

3.1 Other than the redesign of NHS 111 which is Sussex-wide, much of this report focuses on developments in the ESBT area, linked to the A&E and acute hospital services provided by ESHT. Urgent care is also an area of focus for the Connecting 4 You programme in the High Weald Lewes Havens area. This area primarily links into A&E and acute hospital services provided in Brighton, Haywards Heath and Tunbridge Wells. HOSC will receive a further update on Connecting 4 You in November 2017 which will present an opportunity to consider the range of service development programmes underway in this area.

## **4. Conclusion and reasons for recommendations**

4.1 This report provides HOSC with an update on developments in relation to urgent care. HOSC is recommended to consider and comment on the report and to determine what further scrutiny is required.

**PHILIP BAKER**  
**Assistant Chief Executive**

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## **East Sussex Better Together – Urgent Care Redesign Programme Update** **Mark Angus, East Sussex Better Together – Urgent Care System Improvement Director**

**This paper provides a summary update on the progress being made on the East Sussex Better Together Urgent Care Re-Design Programme, including an update on the 111 transformation and re-procurement programme.**

### **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, NHS England set out very clear commissioning standards in September 2014 to ensure future urgent and emergency care services are integrated and offer a consistent service.

In March 2017, NHS England and NHS Improvement published the *Next Steps on the NHS Five Year Forward View (FYFV)*, which highlighted the importance of delivering functionally integrated urgent care services to help address the fragmented nature of out-of-hospital services. The aim of the FYFV is to provide care closer to people's homes and help tackle the rising pressure on all urgent care services (primary and hospital) and emergency admissions.

In the next steps FYFV publication there are 10 nationally set key deliverables in relation to urgent and emergency care for 2017/18 and 2018/19 and these are set out in annex 1 of this report.

The nationally set commissioning standards and key deliverables are informing and shaping how we – through **East Sussex Better Together** – best organise and provide local urgent care services.

### **2.0 Introduction**

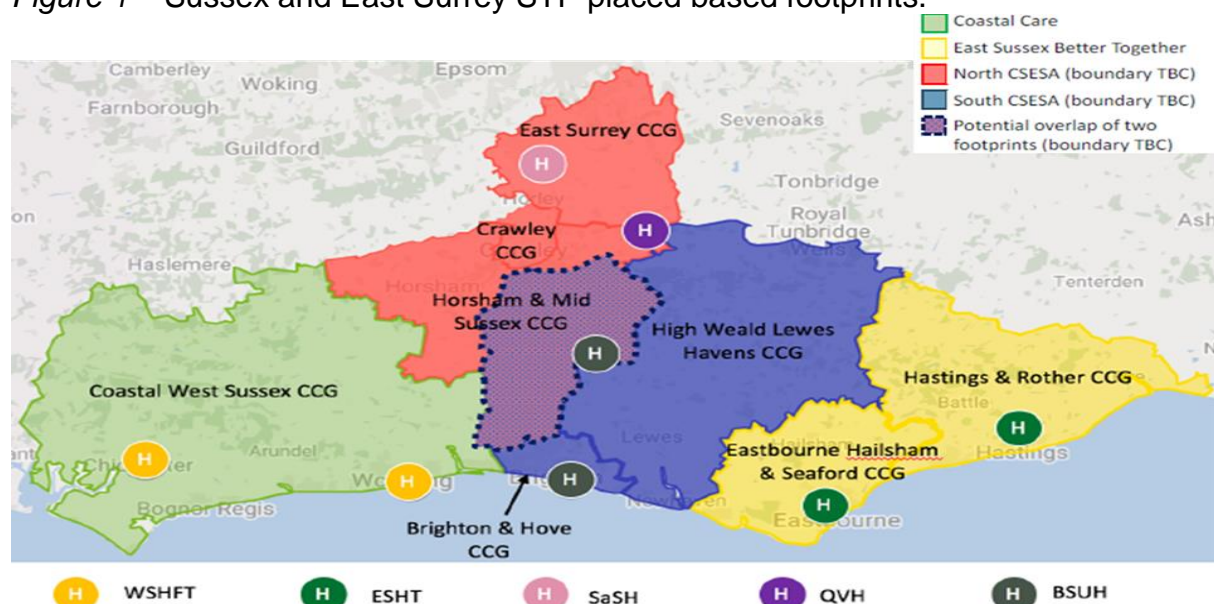
Under East Sussex Better Together (ESBT), the overarching vision for urgent care is to adopt an integrated system-wide approach creating a long term sustainable solution for local people. The model is designed to increase efficiency and productivity of our urgent care system, providing access to the right care in the right place, first time.

The ESBT<sup>1</sup> urgent care re-design and transformation programme is framed within the wider place based Sussex and East Surrey Sustainability and Transformation Plan (STP). The STP place based footprint for Sussex and East Surrey is set out in the Figure 1 below.

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<sup>1</sup> ESBT includes the areas covered by Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG

Figure 1 – Sussex and East Surrey STP placed based footprints.



The ESBT Whole System Urgent Care transformation programme has been led by clinical and managerial leads across local providers and commissioners of urgent care services. It has been informed by patient experience and feedback. Together we have co-designed and progressed the implementation of a new integrated delivery model of urgent health and social care to improve clinical safety, quality of provision, patient experience and ensure that resources are used effectively across the system.

Following on from the previous paper submitted to the Health Overview and Scrutiny Committee (HOSC) in December 2016, this paper provides a summary update on the progress made to date, including updates on each of the component workstreams underpinning the ESBT urgent care transformation programme.

### 3.0 Scope

The following services are included in scope as part of the development of an integrated urgent care model:

- 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, the importance of the Digital Information Management and Technology (IM&T) infrastructure as a key enabler to support integrated working and provision of care is recognised within the programme.

#### **4.0 Service Model**

As previously reported a number of stakeholder events have been held in East Sussex to develop the local urgent care service model. These events engaged with the public, voluntary sector, GPs, community services, acute trusts, social services, housing, ambulance trust, mental health services and local clinical commissioners. The outcomes of these engagement events were shared with the HOSC in December 2016.

The service model, attached as annex 2, was agreed by the ESBT urgent care programme board and reflects the commissioning standards for Integrated Urgent Care published in September 2015 by NHS England and it is congruent with the national Integrated Urgent Care Service Specification, which was published recently in August 2017.

Key principles of the model design have been identified as follows:

- The intention is to offer an integrated 24/7 urgent care service.
- There will be a single-entry point via NHS 111 to fully integrated urgent care services, recognising that access to urgent GP appointments remains unchanged.
- A clinical hub (staffed centrally, virtually or a mixture of both) to support people accessing the right service for them, will offer access to a wide range of clinicians such as GPs, pharmacists, dental and mental health services and specialists, and will offer advice to patients and healthcare professionals.
- Clinicians will have a robust accurate directory of services which will enable them to refer patients to the appropriate local service.
- Patients requiring access to face to face Primary Care Urgent Services will be referred from the clinical hub.
- These services will be co-located with hospital emergency departments, which our local stakeholders identified as their preferred location for integrated urgent care hubs.

The three components of the local system model redesign are set out below:

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 referrals co-ordination service in line with recently published national specifications;
3. The provision of 24/7 access to same day general practice (GPs), 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 update on the progress that has been made on the three components since the December 2016 report to the Health and Overview Scrutiny Committee (HOSC) is summarised below together with an update on the nationally announced Ambulance Response Programme.

## **5.0 Integrated Urgent and Emergency Care Department**

The enhancement of our A&E departments into fully integrated Urgent and Emergency Care departments is central to the Integrated Urgent Care model and this will be delivered through the introduction of enhanced triage and streaming of patients so they are seen by the service that is right for their needs. This will be enabled by the introduction of a broader mix of staff to better manage people's wide-ranging needs. This approach will ensure that services are better aligned to patients' needs and improve access to A&E for the patients who require this level of care.

*During the course of 2017 progress has been made in developing and enhancing our A&E departments as follows:*

In April 2017, the Department of Health announced that all systems must have co-located primary care streaming services at Trusts with type 1 A&E<sup>2</sup> departments by October 2017. The development of this service is to help address the increase in A&E attendances. East Sussex Healthcare NHS Trust successfully bid for £1.685m from national funds to support the development of the estates re-design costs required to support primary care streaming at both the Conquest and Eastbourne District General Hospitals (EDGH). The estates works are progressing and the plan is that space to accommodate the new primary care service will be available by the end of October 2017.

In support of the primary care streaming model the role of GPs in A&E has been piloted at EDGH and the learning from this pilot has informed the service model that has been developed to support primary care streaming. The aim is to have the primary care streaming service operational at both hospitals by the end of October 2017. It is important to note that this service is being established to more effectively manage existing A&E demand and should not be seen as an alternative to patients continuing to access their own GP. The most significant challenge to establishing the new service is the recruitment of such a highly specialised and scarce workforce.

East Sussex Healthcare NHS Trust has also developed plans to establish enhanced ambulatory care services as part of the modernisation of the front door service model (people that arrive at the Integrated Urgent and Emergency Care Department). This will enable ambulatory patients (patients who may need to be treated but not admitted to hospital), who require specialist assessment, to be streamed away from A&E and be seen by the relevant specialists rapidly and assessed, treated and discharged on the same day.

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<sup>2</sup> A type 1 A&E = A consultant led 24-hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.

In addition, a re-designed acute and frail medical assessment model for those patients who only require a short period of time in hospital to be assessed and treated is also being developed. This new service model should be in place at EDGH by the end of November 2017 and, subject to capital funding and building works, will be developed at Conquest Hospital by Spring 2018. Development of this service model will ensure that patients are seen by specialist doctors and an integrated hospital intervention team and where possible assessed, treated and discharged within 72 hours, therefore significantly reducing the length of stay required and helping people get home sooner where appropriate.

Progress has been made within the acute hospitals in implementing nationally recognised good practice in the management of patient pathways including: the development of improved multi-disciplinary team (MDT) working and decision making at ward level; regular weekly senior MDT review of all patients with a length of stay of more than 7 days; and the establishment of an integrated discharge team bringing health and social care staff together to manage complex supportive discharge arrangements for people more effectively.

During 2017 there has been investment into a number of key teams to support and improve patient management and discharge planning including the following:

- Community falls and fracture liaison team to identify patients at high risk of falls and implement falls prevention solutions.
- Crisis response team to provide up to 72 hours emergency support as an alternative to A&E and emergency admission.
- A pilot started in August 2017 using the aforementioned crisis response teams to support the discharge of patients who would benefit from being assessed in their own homes rather than whilst they are in an acute bed, referred to as a 'discharge to assess' model.
- An enhanced Hospital Intervention Team in the acute hospitals to assess and organise either urgent packages of care or prescribe home aids/support in order to avoid hospital admissions from the A&E department or to enable patients to be managed as a short stay patient with a length of stay of less than 48 hours.
- The development of integrated support workers (ISWs) across adult social care and health to support people in their own homes to avoid admission and to provide step down care to reduce the time patients have to spend in an acute hospital or community bed. Plans are progressing well towards recruiting 100 ISWs by April 2018.

In respect of urgent and emergency liaison mental health services for adults and older adults in acute hospitals, the current on-site service provision at our acute hospitals is limited to 9 hours a day 5 days a week. The local system is therefore working closely with the Sussex STP colleagues to develop a bid to secure national transformation funding to develop 24/7 acute mental health liaison cover in our A&E departments, as set out in the national Mental Health Five Year Forward View.

## **6.0 NHS 111/Local Clinical Hub Triage and Assessment**

The model for a new NHS 111 service has been designed across the Sussex and East Surrey footprint in line with the NHS Five Year Forward View and the redesign of the urgent and emergency care services. NHS England published in August 2017 a National Integrated Urgent Care Service Specification which sets out the outcomes expected for a NHS 111 and integrated clinical assessment services.

The national service specification mandates a combined service model for GP out of hours and NHS 111 services to integrate access to urgent care services by April 2019. This new service will significantly reduce the number of handoffs (being passed between services) that patients currently experience and provide the gateway for patients to access face to face urgent care services across Sussex.

In establishing the new model the preferred option identified is to continue working collectively with Sussex STP colleagues to refine our local Health and Social Care Connect (HSCC) service model<sup>3</sup> and continue to develop the HSCC as an enhanced local clinical service for complex calls within the agreed timescales. In order to underpin the implementation of a new NHS 111 service the developments to our local HSCC model will need to be aligned to the NHS 111 procurement timescales.

In order to deliver these service changes, it is vital that developments are made with the supporting technology to enable patients successful access to services as well as routing of calls to alternative services. We are currently working with our digital colleagues across Sussex as well as locally to deliver these improvements in technology.

A detailed update on the NHS 111 transformation and procurement process is included as annex 3 to this report. It should be noted that this is relevant to the whole of East Sussex, not only the area covered by ESBT.

## **7.0 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 date for GP OOH services has been extended to the end of March 2019 to enable a fully integrated approach to be achieved.

Both WICs contracts have been extended to September 2018 to enable full engagement with all stakeholders to ensure the most appropriate service for the local population is secured to ensure sustainable provision of primary care urgent services.

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<sup>3</sup> Health and Social Care Connect (HSCC) offers both the public and professionals a single point of access for adult health and social care enquiries, assessments, services and referrals.

As well as stakeholder engagement and the review of current services to inform future provision, projects are being undertaken to help to address some of the current challenges identified by stakeholders as reported in the paper received by the HOSC in December 2016 as follows:

- Challenge1: Challenged in-hours service provision making access difficult
  - Within the national General Practice Forward View (GPFV) plans are required to provide extended access service for bookable Primary Care appointments for 50% of the population by March 2018 moving to 100% coverage by March 2019. The CCGs are currently undertaking a pre-market engagement exercise to identify potential providers of the extended access service. This service will give patients the ability to pre-book appointments after 6.30pm and on Saturdays and Sundays where appropriate.
- Challenge 2: Fragmented service providers and delivery
  - Care navigator training is being offered to all GP practices starting January 2018. This may be on a practice or locality basis. This will enable the navigation of patients to the most appropriate service within the practice or to the most appropriate service within the local area.
- Challenge 3: Increasing unscheduled demand
  - Focus groups with members of the public are being undertaken and an information pack will be produced to help patients understand the full range of healthcare options available to best meet their need.
- Challenge 4: Increase in complex cases
  - Support for practices to use alternative methods of consultation where appropriate e.g. remote consultations, on-line advice and guidance, skype and CCG wide training in the Year of Care programme to encourage patient empowerment and a more holistic approach to a patient's needs.
- Challenge 5: Workforce challenges
  - Ongoing development of skill mix within the practice primary care teams. Primary Care investment within the GPFV, together with additional investment as part of ESBT, is being used to support transformational and innovative workforce changes and upskilling staff within the Primary Care teams to ensure patients can access the most appropriate clinician for their need.

## **8.0 Urgent Treatment Centres (UTCs)**

The *Next Steps on the Five Year Forward View* document, published in March 2017, described a process to end the confusing array of Urgent Care Centres, Minor Injury Units, Walk-In-Centres and other forms of urgent care provision outside of A&E's.

The national requirement is to create a more standardised offer for patients, which will be known as Urgent Care Treatment Centres (UTCs). UTCs will provide a more standardised, consistent offer including:

- A service open 12 hours a day, seven days a week, integrated with local urgent care services;
- Treatment by clinicians with access to diagnostic facilities that will usually include an X-ray machine: and
- Appointments that will be bookable through NHS 111 as well as GP referral.

The national expectation is that the first 150 facilities will be designated by December 2017 with detailed plans to be agreed by 31<sup>st</sup> March 2018 that will ensure all other systems designate their UTC facilities by no later than 1 December 2019.

The ESBT urgent care programme is currently considering where the development of UTCs and other recent nationally mandated developments sit within the locally agreed service model and will publish its plans early in 2018. We will ensure stakeholder engagement in this programme.

## **9.0 Ambulance Response Programme (ARP)**

The national ARP aims to achieve a more equitable and clinically focused response, meeting patient needs in an appropriate timeframe through better allocation and distribution of resource.

A new series of national standards, indicators and measures has been developed to assist with the governance of the new ambulance operating model that has been developed through the ARP.

SECamb participated in phase 2 of the national project, and implemented the Nature of Call (NoC) and Dispatch on Disposition (DoD) aspects of the ARP on the 18<sup>th</sup> October 2016.

NoC is a set of questions used to try and identify life-threatening calls before the main triage assessment occurs, and DoD is a method of dispatching resources when it has been identified that they are required.

The 999 service is currently developing the implementation plan for the remaining phase of the ARP for 22<sup>nd</sup> November 2017.

## **10.0 Meeting the workforce challenge**

One of the most significant challenges faced by the ESBT urgent care transformation programme is the ability to develop, attract and retain the workforce required to deliver the new service model. The strategy and plan to meet this challenge is therefore an important element of the urgent care re-design programme.

The East Sussex Better Together Workforce Strategy was published in October 2016 which set out the three priority workstreams in terms of focusing workforce

planning support. Urgent Care was agreed to be one of these three priority areas along with Primary Care and Integrated Locality Teams.

The workforce strategy also confirms that targeted workforce plans responding to the needs of specific ESBT initiatives would be undertaken rather than having one overarching workforce plan. This approach was agreed due to the complexity and wide ranging aspects of the ESBT programme for creating integrated care services, with the majority at different stages of development.

This approach has also been reflected in supporting commissioners with the design of the three key components of the local urgent system model redesign. Workforce plans are therefore, at different stages for each of these initiatives.

Each of the workforce plans however, face similar challenges in terms of the national workforce supply issues and how these impact specifically to East Sussex as a place to attract and retain staff, which has its own local challenges such as poor transport links, age demographic perceptions and the draw for staff to work in Brighton or London.

The key urgent care recruitment 'hot spots' are considered to be:

- GPs (in terms of their role in the ESBT Whole System Urgent Care transformation programme)
- Hospital Consultants
- Unregistered nursing staff
- Allied Health Professionals
- Social Workers

ESBT is developing an integrated Recruitment and Retention plan that focuses on addressing these 'hot spots'. For example, the following are an illustrative list of the actions being taken by ESBT Alliance partners to resolve the skills gap in urgent care:

- GP Fellowship role (a joint appointment whereby the Fellow spends 2 days per week in Urgent Care)
- Overseas recruitment campaign
- Recruitment to a Trust Associate Specialist grade
- Offering training placements in urgent care
- Introducing new roles such as Physician's Assistant, Doctor's Assistant, Nurse Associate
- Maximise the benefits from social media in recruitment and to promote ESBT as an innovative and good place to work
- Promote East Sussex as a place to live and work
- Retention initiatives to retain experienced/older workers
- Rotational posts, so that staff experience and become skilled in more than one area
- Talent management and succession planning
- Values based, coaching approach to leadership

## 11.0 Engaging with people about the re-design of Urgent Care

As previously reported to HOSC we have undertaken extensive engagement with local people to ascertain what is important to them at our bespoke stakeholder events and our East Sussex Better Together Shaping Health and Care Events in 2015 and 2016. This was supplemented with a widespread survey and extensive and focussed engagement with diverse public groups and individuals during August to November 2016. We have also undertaken specific engagement work in local GP practices to understand how people access services and what is important to them. East Sussex Healthwatch has also undertaken engagement on reasons for people accessing urgent care and we collect ongoing feedback through our East Sussex Better Together Public Reference Forum. Outcomes of all of this work have directly shaped and informed the urgent care model design principles.

Whilst the significant requirements as set out in the national Five Year Forward View are broadly consistent with the agreed ESBT urgent care service model it is important that the views of the public and key stakeholders continue to be considered as we take these developments forward locally. Therefore, a further programme of engagement with the public and key stakeholders will be taken forward during the remainder of 2017 and throughout 2018

## 12.0 Timescales and next steps

As highlighted above, we have made good progress on our local plans and this is resulting in improvement for local people, in particular the development and enhancement of our A&E departments to provide integrated urgent and emergency care services, with further implementation planned. The redesign of NHS 111, in line with national requirements, our primary care urgent services and the requirement to establish a new Urgent Treatment Centre standardised service offering are subject to procurement or re-procurement procedures being followed. This has previously been reported to HOSC and the summary of milestones and timelines are set out below in Table 1:

*Table 1: Summary of milestones and timelines:*

<b>Key Milestones</b>	<b>NHS 111 Procurement Timetable</b>	<b>GP OOH Procurement Timetable</b>	<b>WICs Procurement Timetable</b>
Implementation	April 2019	April 2019	October 2018
Current contract end dates	March 2019	March 2019	September 2018
Business Case to be completed	September 2017	September 2017	October 2017
Procurement process	March 2018 - March 2019	March 2018 – March 2019	November 2017- October 2018

In addition to the above there is a requirement for systems to ensure that Urgent Care Centres are designated and operational by no later than December 2019 and system plans to achieve this including procurement requirements are required by no later than 31 March 2018.



## **Recommendations**

The Health and Overview Scrutiny Committee members are asked to note progress with the development and implementation of our integrated urgent care service model. Further progress reports can be submitted to the HOSC as requested.

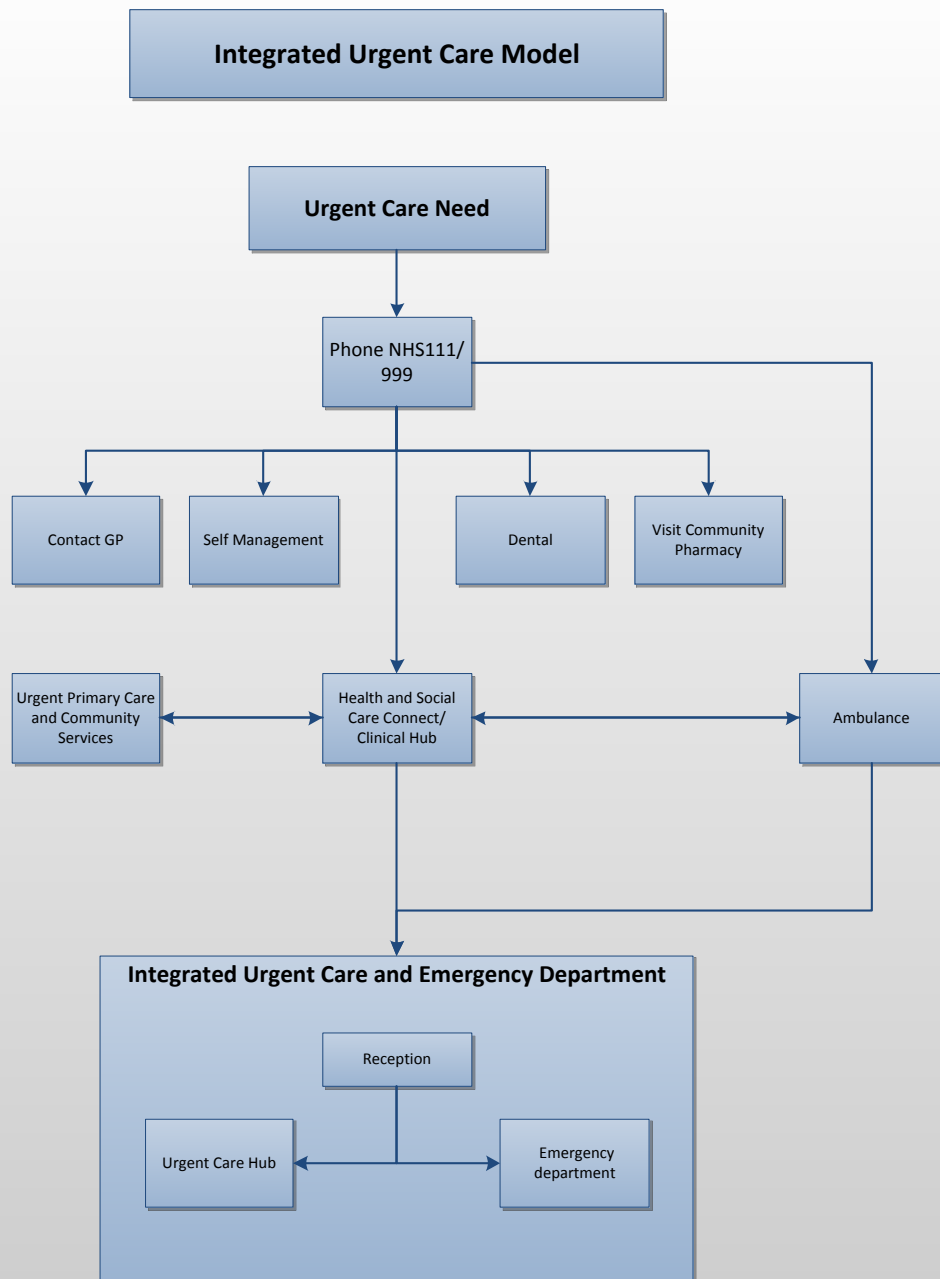
**Contact Officer: Mark Angus – ESBT Urgent Care System Improvement  
Director, Tel. No 01273 403547  
Email: <mailto:mark.angus@nhs.net>**

## Annex 1 – Next Steps of the NHS Five Year Forward Views: 10 deliverables 2017/18 and 2018/19.

- Every hospital must have comprehensive **front-door clinical streaming** (ensuring that patients who attend A&E and can be seen by primary care clinicians are identified) by October 2017, so that A&E departments are free to care for the sickest patients, including older people;
- By October 2017 every hospital and its local health and social care partners must have adopted good practice to enable appropriate **patient flow** (ensuring that patients are cared for in the right place and the right time), including better and more timely hand-offs between their A&E clinicians and acute physicians, 'discharge to assess', 'trusted assessor' arrangements, streamlined continuing healthcare processes, and seven-day discharge capabilities;
- Hospitals, primary and community care and local councils should also work together to ensure people are not stuck in hospital while waiting for **delayed community health and social care**;
- Specialist **mental health care in A&Es**: 74 24-hour 'core 24' mental health teams, covering five times more A&Es by March 2019, than now;
- Enhance **NHS 111** by increasing from 22% to 30%+ the proportion of 111 calls receiving clinical assessment by March 2018 so that only patients who genuinely need to attend A&E or use the ambulance services are advised to do this. GP out of hours and 111 services will increasingly be combined. By 2019, NHS 111 will be able to book people into urgent face to face appointments where this is needed;
- NHS 111 online will start during 2017, allowing people to enter specific symptoms and receive advice on management;
- Roll out **evening and weekend GP appointments to 50% of the public by March 2018 and 100% by March 2019**;
- Strengthen support to care homes to ensure they have direct access to clinical advice, including appropriate on-site assessment;
- Roll-out of standardised new '**Urgent Treatment Centres**' (UTC), which will be open 12 hours a day, seven days a week, integrated with local urgent care services;
- Implement the recommendations of the **Ambulance Response Programme** by October 2017, putting to an end to long waits not covered by response targets.

Web Link: <https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/>

## Annex 2 – East Sussex Better Together Urgent Care Service Model



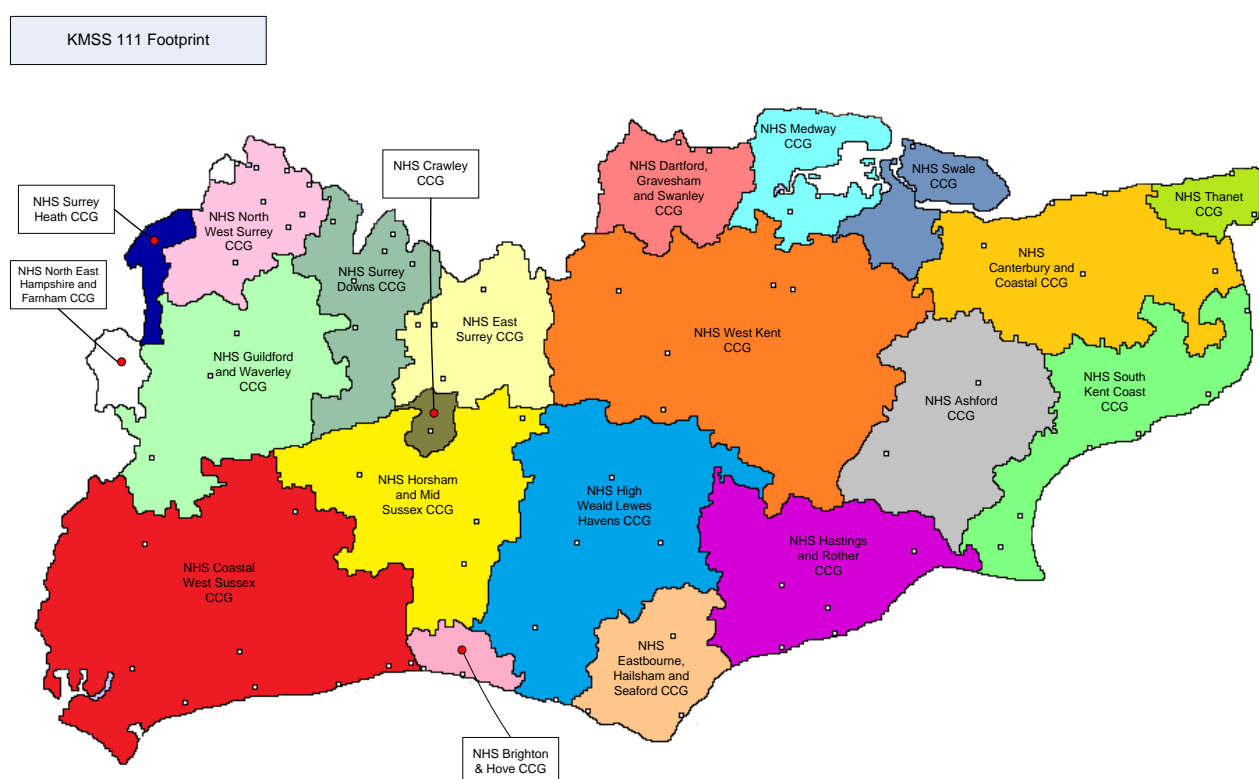
## Annex 3 – NHS 111 Transformation and Procurement Programme

### 1. Background

**NHS 111** - is the non-emergency number that people should call if they need medical help or advice but feel it's not a life-threatening situation. There are experienced call handlers and clinicians who are available to assess a person's needs and situation and direct them to the best local services for the care they need. The NHS 111 service is currently provided by South East Coast Ambulance service (SECamb).

**GP Out of Hours (OOH)** – the service is provided by Integrated Care 24 (IC24) and works with our local GPs to provide out of hours' services to our local population.

The original contract for the NHS 111 service was a South East regional contract for Kent, Medway, Sussex and Surrey (KMSS) and consisted of 21 CCGs. The original contract expired on 31 March 2017. Out of the 21 CCGs across Kent, Medway, Sussex and Surrey (KMSS), 17 CCGs agreed to a two-year contract extension with South East Coast Ambulance service (SECamb) until 31 March 2019. This includes the area covered by East Sussex. NHS Swale CCG is the lead commissioner for this service across our area and our local CCGs are involved in this process.

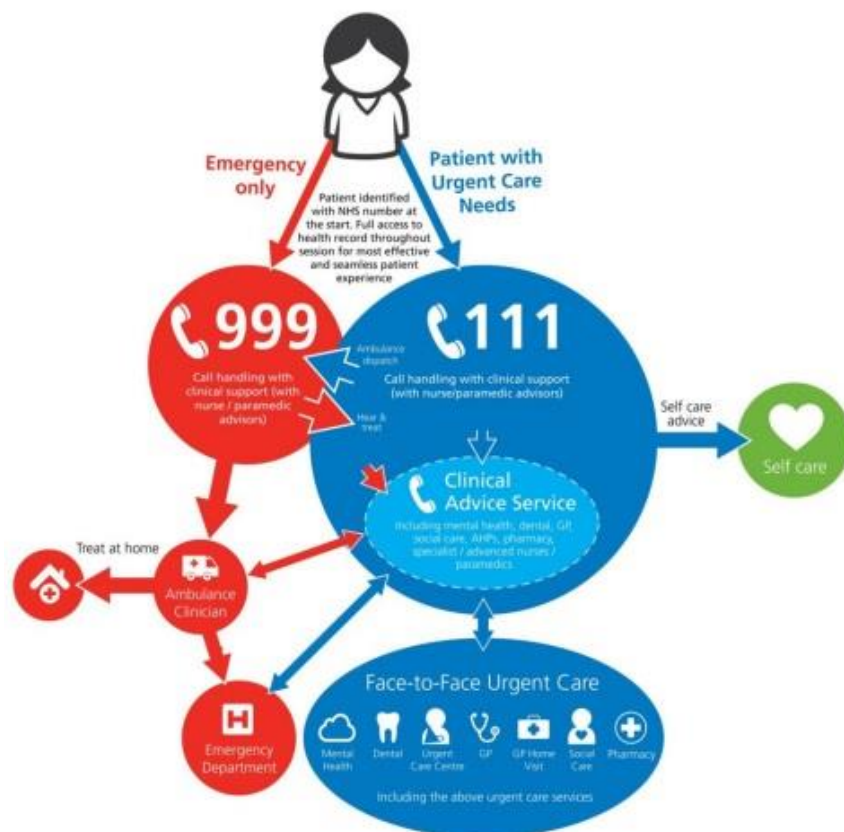


## 2. 111/Integration of Urgent Care Transformation Programme

In line with the NHS Five Year Forward View the redesign of urgent and emergency care services is developing across the Sussex and East Surrey STP footprint. The integration of urgent care services will provide the Sussex population (1.69m people) with an integrated seamless service for their urgent care needs and this includes the NHS 111 service.

The Urgent and Emergency Care Route Map was published in November 2015 as part of the Keogh Review. Included in the report was the deliverables for NHS 111 and the development of integrated Clinical Assessment Services (CAS).

The CAS modelling is seen as pivotal to bring urgent care services together with an Integrated Urgent Care model and the NHS 111 service is integral within its design - as shown below:



## **2a. Programme Objectives**

The objectives of this programme are:

- To re-procure NHS 111 supported by an integrated Clinical Assessment Service (CAS) with all seven pan-Sussex CCGs
- To detail the options for the design and locations of face to face urgent and emergency care services and procure services as part of the wider urgent care model in line with the national recommendations, best practice and local need
- Ensure that our patients and public, providers, voluntary sector and social care partners are co-designers and formally consulted (as required) on the service model options
- Agree and seek the relevant approval to the chosen service model
- Decommission current services as appropriate
- Procure and implement the new service model
- Ensure the CCGs and local health economy remains on a sound financial footing in the future
- Ensure that the urgent and emergency care model complements and aligns with the aspirations for the Sustainability and Transformation Plan (STP)
- Ensure key lessons learned from other large scale procurements in Sussex (for example Patient Transport Services), but also around the country are followed :-
  - Do not allow the programme to become isolated from the business / services / organisations (need to ensure all stakeholders are aware, understand and support the proposed approach).
  - A phased rollout rather than a big bang approach will be the approach for the go live of this service
  - Transition planning is key and should be tested and robustly challenged
  - As part of the transition planning, there should be specific planning around transfer of key data between the old and new providers. Business critical data should be identified and failure to transfer should be a go / no go issue.
  - Resourcing for procurement should not be underestimated. Key roles should be identified and filled with clear understanding of the requirements for each role and the time commitment required to deliver. The programme will use external sourcing for specialist roles where this cannot be met appropriately from within the organisation(s).

## **2b. Redesign Principles**

In aligning to the national recommendations, a number of principles are suggested:

- The NHS 111 service will be part of an urgent and emergency care system that is able to meet the needs of the whole population, within the resources available, delivering improved quality and patient experience
- The patient will experience a service that is working as one integrated and whole system although provided by multiple agencies
- The patient will be seen at the right time, by the right person with the right skills to manage their needs, in the right place
- The patient will not experience any delay in receiving the most appropriate interventions through the whole pathway being able to respond to unpredictable fluctuations in demand
- Provide highly responsive urgent care services outside of the Accident and Emergency Department (A&E) so people no longer choose to attend A&E when they do not need to
- A single point of access to urgent care services
- Provide improved access to GPs or nurses working from community bases equipped to provide a much greater range of tests and treatments
- Empower ambulance services to make more decisions to treat more patients and allow them to make referrals in a more flexible way
- Provide better support and education for people to self-care and to enable a greater use of pharmacists
- Improved utilisation of the voluntary sector.

## **3. The Model**

Plans for achieving the vision of an integrated urgent care system will be enabled by progressing procurement of NHS 111 as a single point of entry supported by an integrated Clinical Assessment Service (CAS). A wider, joined-up approach to designing NHS 111 and the CAS will provide a more integrated, effective approach to these services.

The CAS will provide clinical advice to patients contacting NHS 111 or 999 and services, which enable patients to speak to a GP as well as providing clinical support to clinicians, such as ambulance staff and emergency technicians so no decision is made in isolation, as detailed within the Integrated Urgent and Emergency Care Commissioning Standards.

This system will be supported by being functionally integrated with all the local urgent care models that are in development with further support of the model to be achieved by the technical integration of IT systems enabling the sharing of single patient records and the transfer of calls to available services to avoid re-triage at each step. The procurement will include the telephone triage aspects of the current

out of hours' service. The face to face out of hours' service will be delivered locally but will be informed by the outputs from this model.

The model is developed in order to support navigation of patients away from Emergency Departments, when attending with symptoms appropriate for primary care intervention. It should be noted that although emergency services within the A&E departments are not part of this review, they should be positively affected by the programme, as patients attending these departments that do not require this level of expertise should be directed and treated appropriately elsewhere within the urgent care system.

The component parts of the Integrated Urgent Care Service are shown below, aspects of this will be delivered through the NHS 111 / Clinical Assessment Service (CAS) procurement and other functions will be delivered locally.

<b>Key Principles of the new model</b>		
	<b>Current model</b>	<b>Proposed model</b>
<b>Contract</b>	<p>One organisation providing NHS111 for all of Kent, Surrey and Sussex</p> <p>OOH services for Sussex and East Surrey - IC24</p> <ul style="list-style-type: none"> <li>•Area 1: Coastal West Sussex CCG</li> <li>•Area 2: Brighton &amp; Hove CCG</li> <li>•Area 3: Hastings &amp; Rother CCG, Eastbourne, Hailsham &amp; Seaford CCG and High Weald Lewes &amp; Havens CCG</li> <li>•Area 4: Crawley CCG, Horsham &amp; Mid Sussex CCG and East Surrey CCG</li> </ul>	<p>A single contract with responsibility for 24/7 integrated service for NHS 111 across Sussex, and possibly larger. This may be delivered by a single organisation or (more likely) by a group of organisations working together. Access to face to face services would be delivered locally.</p> <p>A single contract, with a clearly designed specification, would make it easier for CCGs to hold providers to account for delivering the right outcomes and care for patients.</p>
<b>Clinical support</b>	Heavily reliant on GPs for clinical support. Recruitment of GPs is increasingly difficult as there is a shortage of GPs nationally.	A range of clinical skills is available (nurses, paramedics, pharmacists and GPs) who could be used flexibly to provide clinical support. This means callers would be directed to the most appropriate clinician for what they need.
<b>Assessment</b>	People who require a GP urgently have to speak to at least two people (typically more) before they can get definitive clinical advice or an appointment.	People would be directed to the most appropriate service; usually by the first person they speak to.
<b>Appointments</b>	Some direct bookings –but patients	Direct bookings for appointments for



	usually need to hang up and call a different number to make an appointment with the appropriate service	identified services.  Patients who needs are identified as best et by their GP (in hours) will be transferred to their GP surgery reception and then the processes of the practice will be used to arrange an appointment
<b>Medical history</b>	Services have limited access to special patient notes for people with complex health and/or social care needs, and no access to routine medical history for NHS111 or OOH	Those involved directly in patient care would have consistent access to special patient notes and routine medical history for patients using the service
<b>Equity of access</b>	Access to OOH services is different depending on where people live	Access to OOH services would be the same, regardless of where people live and patients would have more choice
<b>Professional contact</b>	Currently unclear and inconsistent access to clinicians and other professionals	One place for all professionals to go to request advice, information and contact
<b>Signposting</b>	Currently signposting to information or appropriate services is limited (5%)	Increase of signposting (where appropriate and safe) and advice lines with existing conditions e.g. diabetes, cancer

#### 4. Communication and Engagement

A stakeholder mapping has been undertaken to ensure we communicate and engage properly with all relevant stakeholders, including patients and the public. The communications and engagement plan, for the programme, aims to engage and fully communicate the NHS 111/ Integrated Urgent Care programme. It will build people's trust and confidence not only in the 111 service but also in integration of urgent care services.

It will ensure the appropriate information and guidance is available in the right place, at the right time for both internal and external audiences.

##### Objectives

- To communicate and engage with patients and the public around the re-procurement of the pan-Sussex 111 service - **Public**
- To raise positive awareness of the 111 re-procurement and the changes GPs, Partners and Providers will see – **Clinical Services**
- To communicate and engage internally with staff across the seven CCGs, five acute trusts, three community trusts and two mental health trusts about their

role to support the 111 communications and engagement activity – **Internal Chairs, Executives, Managers and Staff**

- To enhance patients' confidence and engagement with the 111 service and ensuring their voice and experience informs the design and procurement process - **Lay Members, Patients and Public**
- To ensure patients have the information and support to make informed choices about their health care and to encourage patients to use the appropriate services depending on their health care needs – **Public**
- To increase positive awareness and understanding of the NHS 111, pharmacies and the minor injuries unit – **Public**

## 5. Next Steps and Recommendations

The timescales for the programme are as follows:-

<b><u>Stage 1: Service Redesign</u></b> <ul style="list-style-type: none"> <li>• Soft market testing and development of technology options</li> <li>• Process mapping and pathways</li> <li>• Business analysis &amp; financial modelling</li> <li>• Agreement of operating model and blueprint</li> <li>• Completion of Project documentation</li> <li>• Business case and service design signed off</li> </ul>	November 2016 – September 2017
<b><u>Stage 2: Procurement Readiness</u></b> <ul style="list-style-type: none"> <li>• Further patient engagement</li> <li>• Approval of service specification</li> <li>• Procurement Documentation</li> <li>• Clinical engagement</li> </ul>	September 2017- December 2017
<b><u>Stage 3: Procurement - the procurement approach is still to be confirmed</u></b> <ul style="list-style-type: none"> <li>• Commencement of Pre-Qualification Questionnaire (PQQ) and Invitation to Tender (ITT) procurement process</li> <li>• Decision regarding appropriate procurement process (most capable provider, open tender)</li> </ul>	January - September 2018
<b><u>Stage 3: Deployment</u></b> <ul style="list-style-type: none"> <li>• Development of deployment and mobilisation plan, stakeholder list &amp; benefits realisation plan</li> <li>• Engagement of incoming and outgoing providers in order to facilitate seamless transfer</li> <li>• Management of go-live activities, floor walking support, bug-fix and post go-live evaluation</li> <li>• Management of deployment to steady state and withdrawal, based on agreed criteria</li> <li>• Production of a project exit report detailing actions, issues and lessons learned</li> </ul>	September – April 2019
<b>Go Live</b>	1 April 2019

The recommendations to the Health Overview and Scrutiny Committee are as follows:

- **To note the progress that has been made to date with the NHS 111 Transformation and Procurement programme and related next steps.**
- **To receive a further update on the NHS 111 procurement process in December 2017**

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

**Date of meeting:** 21 September 2017

**By:** Assistant Chief Executive

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

**Purpose:** To provide HOSC with an update on progress of the Sustainability and Transformation Partnership.

---

## **RECOMMENDATIONS**

- 1) To consider and comment on the report.**
  - 2) To provisionally request a further update in March 2018, to be determined by the Chair dependent on progress.**
- 

## **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 and deliver STPs which aim to help drive 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 local footprint which includes East Sussex is 'Sussex and East Surrey'. This comprises 24 partner organisations – NHS commissioners and providers and top tier local authorities. Since they were established STPs have been renamed Sustainability and Transformation Partnerships, reflecting the move from planning to delivery and the importance of engagement across the partners and more widely. STPs are not legal entities in themselves and have no decision making powers - each partner organisation remains sovereign.

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

## **2 Supporting information**

2.1 The first iteration of the Sussex and East Surrey STP was published in November 2016. The published documents are available on Clinical Commissioning Group (CCG) and Trust websites, for example: <http://www.highwealdleweshavensccg.nhs.uk/our-programmes/sussex-and-surrey-sustainability-and-transformation-plan/>

2.2 In December 2016 HOSC received an overview presentation which outlined three 'place-based plans' which formed the basis of the STP. Two of these included parts of East Sussex – East Sussex Better Together (which covers Eastbourne, Hailsham and Seaford and Hastings and Rother CCG areas) and the Central Sussex and East Surrey Alliance (CSESA), which incorporates the Connecting 4 You programme in High Weald Lewes Havens (HWLH) CCG. The CSESA area has subsequently been divided into two – north and south – with HWLH falling into the CSESA South 'place' with Brighton and Hove CCG and part of Horsham and Mid-Sussex CCG.

2.3 The place-based plans focus on integration of health and social care services in localities, developing community services, proactive management of long term conditions and increased emphasis on prevention and self-care.

2.4 Overlaying the place-based plans are a number of other workstreams being undertaken at STP footprint level, notably workforce planning and reviewing the capacity and sustainability of acute hospital services.

2.5 HOSC last had an update on the progress of the STP in March 2017. At that time the STP was undergoing a 'review and refresh' to ensure it was adding value to local work and was focussed on the right priorities, with appropriate governance arrangements. The review of acute services was also progressing with support from external consultants undertaking analysis of hospital capacity and future demand. Some outcomes from this work were expected over the summer. HOSC will want to understand how these areas of work have progressed since March.

2.6 The nominated Chair for this STP is Michael Wilson, Chief Executive of Surrey and Sussex Healthcare NHS Trust, who is also the provider Senior Responsible Officer (SRO). Wendy Carberry, Accountable Officer of High Weald Lewes Havens CCG is the nominated CCG SRO and she will provide HOSC with an update on STP progress – slides attached at appendix 1.

2.7 Most STPs cover more than one HOSC area, necessitating liaison between HOSCs on scrutiny arrangements. Informal liaison is continuing between HOSC Chairs and Officers in Sussex and Surrey in order that local HOSCs are in a good position to undertake 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 and to provisionally request a further update in March 2018, to be confirmed by the Chair dependent on progress and the availability of new information for HOSC to consider.

**PHILIP BAKER**  
**Assistant Chief Executive**

Contact Officer: Claire Lee, Senior Democratic Services Adviser  
Tel. No. 01273 335517  
Email: Claire.lee@eastsussex.gov.uk

# Sussex and East Surrey

# Sustainability and Transformation Partnership

September 2017



## What is the STP?

### The STP is a partnership

- A new way of working together across health and social care
- 24 organisations - CCGs, providers and local authorities, building on local plans
- Aims to:
  - Ensure no part of the system operates in isolation
  - Improve health and wellbeing
  - Improve health and care services
  - Make the best use of available resources
- Not one, single, separate plan
  - It is a way of aligning the plans of all the partners



## Why do we need an STP?

Same as the drivers for ESBT, but strengthens joint working across a wider area

### **Health and wellbeing gap**

- Growing and aging population, more long term conditions
- Significant health inequalities across the area

### **Care quality gap**

- Primary care recruitment, access and facilities
- Secondary care access, outcomes and recruitment

### **Finance and efficiency gap**

- Becoming harder to keep up with rising costs
- £900m gap by 2020/21 if we do nothing

## Progress so far

- **Scale of change** needed is not easy; it will take time
- We have been **developing relationships and processes** for working together
- **On-going commitment** from NHS partners and councils have agreed to work in partnership
- **Established clinical board** – senior professionals from all partners to oversee shape of future services
- New **executive chair** and national support to be confirmed during September

## Role of local authorities

- All four councils committed to working with the NHS to improve health and social care outcomes
- Recognition that STP is an NHS governance framework with councils being democratically accountable through their Members to local residents
- Principle of places fundamental to councils and integrated working and formal agreements need to be built around places and their populations
- Work from the places can then be aggregated to the STP footprint where this will add value

## Place based plans

### **Community-based, integrated health and care services**

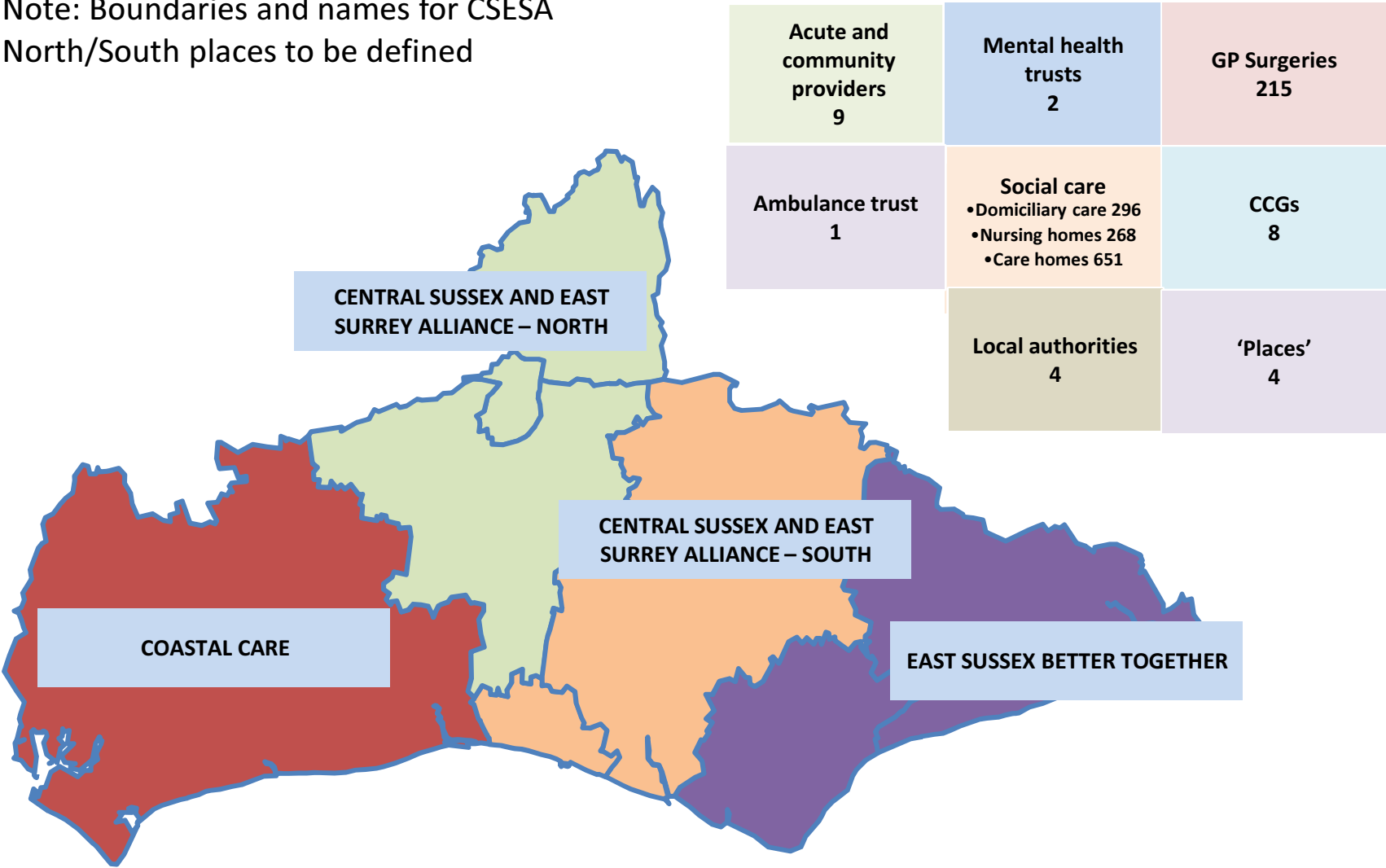
- Each plan based on local needs, but with shared aims:
  - Help people to stay well
  - Support people to manage conditions and retain independence
  - Avoid unnecessary hospital visits

### **The four places:**

- Coastal Care
- Central Sussex and East Surrey Alliance – North
- Central Sussex and East Surrey Alliance – South
- East Sussex Better Together (ESBT)

# Sussex and East Surrey

Note: Boundaries and names for CSESA  
North/South places to be defined



## Place based plans – next steps

- Plans developed locally
  - Led by CCGs and LAs, with local involvement
- Place based plans feed into and shape the STP
  - Form cornerstone, with other plans shaped around them
- East Sussex Better Together (ESBT), one of the four places, is already well developed as work began in August 2014. The ESBT Alliance is working in shadow form in 17/18, creating the conditions for a single health and care entity in future, taking a whole population/whole system approach that includes the integration of community-based services
- Work on other place based plans developing rapidly

## Commissioning reform

- Commissioners working together to make it easier to:
  - commission services jointly
  - commission integrated health and care
  - delegate commissioning functions to the right level
- Also enables CCGs to better share risks, resources and expertise
- CCGs would remain accountable to local community, with own governing body
- Plans being developed now, aiming for CCG approval in autumn 2017, and for implementation in April 2018.

## Acute services strategy

- With better community provision in place, we will need to ensure we have the right acute services for the future
- Work commenced earlier this year to review demand and capacity over the coming years
  - Significant challenges if demand and length of stay continue to rise at current rate
- Need to assess acute avoidance of place based plans and opportunities for hospitals to work more closely together
- Clinicians will then lead development of acute services strategy with input from local communities
- Will take time. No decisions without public and patient involvement



## Improving services

STP partnership taking collective action on service priorities:

### **Urgent and emergency care**

- Reducing demand – easier to see or access advice from GP
- Extending and standardising urgent treatment centres
- Faster ambulance and A&E times with prompt discharge

### **Mental health**

- Joined up approach to deliver 7-day services, integrated with physical health, and better mental health promotion
- Integrated health and care model for enduring ill health

### **Cancer care**

- Implementation of delivery plan with Sussex and Surrey cancer team

## Enabling workstreams

Working with partners to coordinate plans in three key areas:

### **Workforce**

- Recruit, retain and develop the right staff with the right skills

### **Estates**

- The right buildings and facilities in the right places
- Using all our property and facilities as effectively as possible

### **Digital**

- IT systems to support high quality, integrated care

## Closing the gap in our finances

- If we do nothing, we face a £900m gap by 2020/21, and many organisations struggling to maintain financial plans
- We must take the opportunity of the STP to work together:
  - Integrated community-based care
  - Focus on supporting people to stay healthy
  - Less - but better - use of acute hospitals
- Also, to be efficient as possible, for example reducing:
  - Reliance on expensive agency staff
  - Costs of ineffective treatments and wasted medicines
  - Duplicated back-office costs
- Collaboration gives best chance of better health and better services within available resources

## Clinically effective commissioning

- Clinical board leading work to look at all treatments and procedures commissioned across all eight CCGs to reduce unwarranted clinical variation
- Links into Rightcare and Get it Right First Time initiatives
- Considerable variation between CCGs at present. Aim is to:
  - ensure only clinically effective treatments commissioned, in line with evidence and NICE guidelines
  - deliver best value for money for public and fairness for patients
- Clinicians involving patient and public reps in discussions
- CCG Governing Bodies will make decisions

## Involvement and accountability

- STP is a partnership and way of working
  - No power to make decisions on behalf of partners
- Decision making continues to sit with individual boards
  - This cannot change without legislation
- Partners continue to be responsible for involving local people
  - Many elements of STP already shaped by local people
- Plans that make up STP do not currently include any proposals that would require consultation
- But we will be keeping staff, patients and public involved
- No decisions without formal consultation where appropriate

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

**Date of meeting:** 21 September 2017

**By:** Assistant Chief Executive

**Title:** Clinically Effective Commissioning

**Purpose:** To provide HOSC with an overview of a new regional NHS initiative, 'Clinically Effective Commissioning'.

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## **RECOMMENDATIONS**

- 1) To consider and comment on the report.**
  - 2) To agree what, if any, further scrutiny of this issue is required.**
- 

## **1 Background**

1.1 Clinically Effective Commissioning is a new regional NHS initiative which aims to improve the effectiveness and value for money of healthcare services by ensuring that commissioning decisions across the region are consistent, that they reflect best clinical practice, and that they represent the most sensible use of limited resources.

1.2 The aim is to apply sound clinical decision making within mutually agreed policies. The intention is to ensure equality of access, improved clinical outcomes, better patient experience and efficient demand and capacity management across the system. In addition, supporting processes are being put into place to make it easier for clinicians to work within clinical policies where they exist.

## **2 Supporting information**

2.1 Clinically Effective Commissioning is a regional initiative which is being led locally by CCGs. South East Coast HOSC Chairs have agreed that scrutiny of this programme should initially be conducted by individual HOSCs, and a similar report is being presented to Brighton and Hove, West Sussex and Surrey HOSCs. As Clinically Effective Commissioning progresses, and should substantive plans for changing services be identified, it may be necessary to further explore whether these plans are better scrutinised individually or jointly.

2.2 Further information on the programme is attached at Appendix 1 and will be presented to HOSC by Wendy Carberry, Accountable Officer of High Weald Lewes Havens CCG on behalf of all three Sussex CCGs.

## **3. Conclusion and reasons for recommendations**

3.1 HOSC is recommended to consider and comment on the report and to agree any further scrutiny required. HOSCs are likely to become more involved in scrutinising aspects of this work-stream as it develops.

**PHILIP BAKER**

**Assistant Chief Executive**

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# Clinically Effective Commissioning (CEC)

CEC Programme Team  
August 2017

# How do we address waste and achieve best value?

---



CEC focussed on planned care (rather than urgent care)

In order to help the whole system balance resources and demand there is a need to:

1. Decide what the system will and won't do (e.g. medicines, procedures or other treatments) based on a defensible and clinically led decision making process
2. Enact those choices in formal policies, embed them in systems and communicate our decisions widely
3. Keep those policies up to date and under continuous review to ensure they reflect clinical evidence as it emerges and the needs of our local populations
4. None of these discussions undermine the hard work of clinical redesign which is also required, but these hard decisions will create the space in which redesign can occur

## Key assumptions:

- As a system we have identified all areas of waste and have addressed them via savings schemes – if examples of pure waste are located these are being addressed as an absolute priority
- We recognise that there is no more money likely to be forthcoming – we need to manage within the resources we have been allocated
- Managers can do a lot to implement change and identify the issues and challenges, but ultimately as a clinically led organisations, it is the membership of the CCG which need to decide the priorities for the local population – led by our clinical leaders

# Why this is good practice, even if there weren't financial challenges

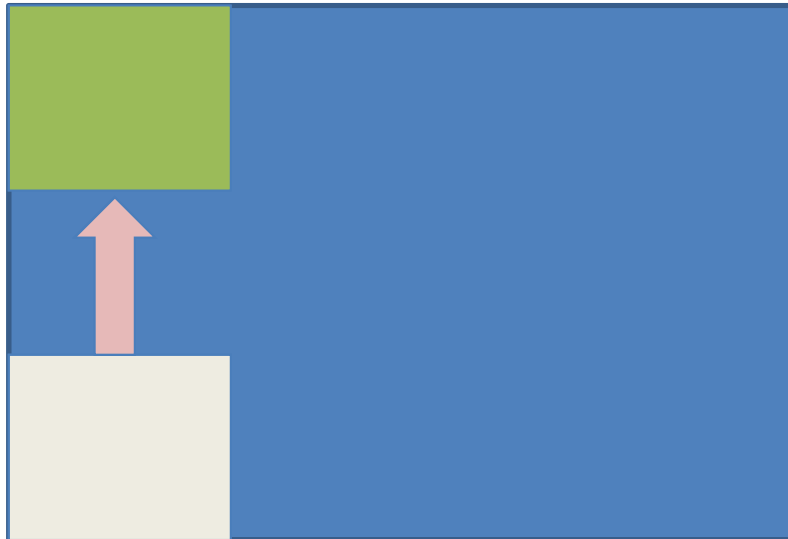
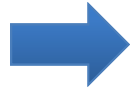


Resources required for the innovation



Implementation of high value innovation e.g. troponin in heart disease funded by reduced spending on lower value intervention in the cardiovascular programme budget and control of innovation of uncertain value.

Innovation adopted



Resources freed by reducing lower value activity



## **CCG commissioned, STP oversight**

There are 8 CCGs in the STP – they commissioned the work as it is core business for CCGs, but ultimately as the implementation needs the whole system to play a role, so CEC is a key work programme for the STP

## **CEC Programme is governed as follows:**

- Decisions to change must be made by the CCGs – clinical policies are 'owned' by each CCG – so each must come to their own decision, but work in common to arrive at the same result by:
- Overseeing the work via the CEC Programme Board (all 8 CCGs are represented)
- Reporting weekly and monthly progress and issues

## **STP oversees and reviews**

- STP executive monthly – highlight report
- STP clinical board – advises on clinical issues which may have wider system impacts

# Three CEC Objectives



## 1. Common Policies - Objective

There are 8 CCGs in the STP – and there are at least 5 main versions of each clinical policy (this means that Patients referred to the same hospital for the same treatment are subject to different threshold policies).

The different policies mean that patients get different access and outcomes. If a common, revised policy can be established there will be:

- **Greater equality of access to treatments across the whole STP footprint**
- **It will be cheaper for CCGs to maintain currency of common policies**

All policies are being reviewed and detailed assessment of evidence supporting the policy and the degree of difference between each policy is being assessed.

Latest information on what the 8 CCGs spend with local acute hospitals indicates that there is substantial variation in numbers of treatments per 100k population – which indicates that there is non-clinical variation which could be addressed to release resources.

In other locations, improved policies and increased effort on end-to-end processes and compliance has stopped 5 - 15% of the activity, which could release £3-6m in a full year after implementation of the total programme

# Three CEC Objectives



## 1. Common Policies – Progress

A first group of policies are being finalised – these are policies where most CCGs already had an existing policy and there is strong evidence body of clinical evidence exists to support a common policy which will set a threshold for treatment.

- **STP clinical board has agreed that most of the policies are uncontroversial**
- **all CCGs have had multiple rounds of drafts to review.**
- **Final drafts to be provided to CCGs in August for decision making within CCG processes**

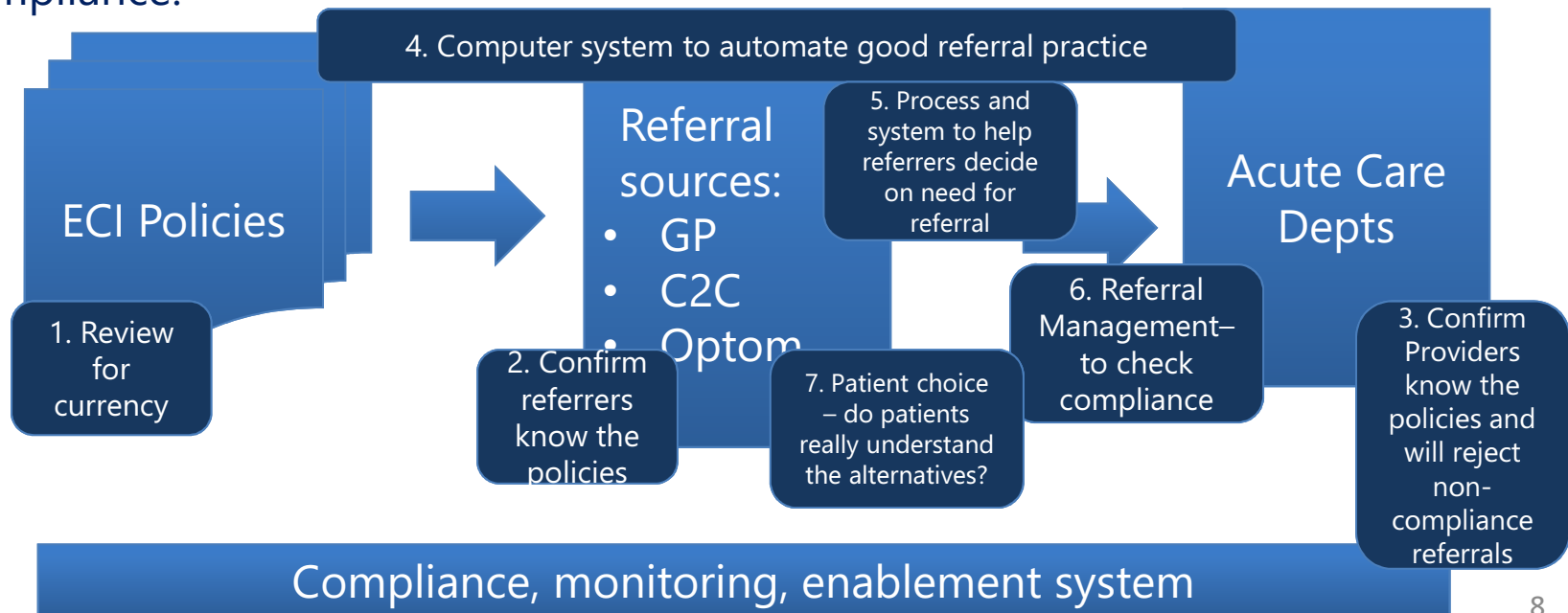
A second group of policies is being reviewed and developed. These are more complex, as CCGs have different existing policies, or there is more clinical debate required to find the appropriate standard.

- Four clinical evidence review workshops have been booked for September – to bring acute providers, GPs, patient reps and others together to discuss the evidence base and as far as possible agree on an outline common policy
- If new policy proposals represent a significant change, then engagement and consultation processes will follow to ensure CCGs involved and engage all relevant stakeholders

## 2. Improved processes - Objective

There are 8 CCGs in the STP each of which have differing approaches to ensuring end to end compliance with existing policies. This leads to differing effectiveness of the thresholds – as in some cases there is evidence of significantly differing use of medicines and procedures, despite similar or identical policies.

There are significant advantages in the CCGs working together to develop best practice approaches and in some cases co-developing new processes and systems to aid compliance.





## 2. Improved processes - Progress

Each stage of the process has been analysed for each CCG.

The CEC programme has developed project outlines for 12 initial projects to improve each step of the process. Not yet been approved for implementation as there are key stakeholders who have yet to be involved.

- **PID 1:** Set up STP wide process to update, maintain and upload policy changes onto GP systems.
- **PID 2:** Help referrers work within the process (link to the introduction of supporting software e.g.. DXS)
- **PID 3:** Implement decision support tools to standardise GP referral
- **PID 4:** Harmonise uptake of E-referral (ERS) across Provider Trusts and support GPs to adopt
- **PID 5:** Standardise GP dashboard to review variation in GP referral patterns
- **PID 6:** Shared decision making and PDA processes to help patients make more fully informed decisions about their care
- **PID 7:** Align IFR processes to harmonise with prior approvals arrangements at Trusts
- **PID 8:** Advice & Guidance – Secondary care assistance to GP referrers – opportunity for common approach
- **PID 9:** Promote common approach to ‘referral hub’ function for validation of prior approvals.
- **PID 10:** Implement easy to use prior approval system in the four principal acute Trusts (BSuH, SaSH, ESHT, WSHFT). Capture C2C referrals.
- **PID 11:** Coding and costing optimisation supporting standardised reporting and compliance processes
- **PID 12:** Audits to demonstrate quality and compliance

## 3. Accelerating savings

There are 8 CCGs in the STP and an emerging cost pressure in 2017-18 for the Commissioners' budgets

Working across the CCGs, we aim to identify a range of opportunities which can be rapidly assessed and put in place across the system to improve the financial position.

This work takes place in the context of the Capped Expenditure Process, which required the whole system to demonstrate that all possible options has been considered then prioritised for further development based on criteria also developed in the project.

There are a small number of options which CCGs believe could be pursued in 2017-18 most of which involve the 8 CCGs working more closely together to share best practice and take advantage of the scale offered by the STP.

Further work to take place in August to gather more options, quantify the opportunities and examine the timescales for delivering sustainable change.

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

**Date of meeting:** 21 September 2017

**By:** Assistant Chief Executive

**Title:** HOSC Work Programme

**Purpose:** To consider the committee's work programme and minutes of the various joint HOSC working groups

---

## RECOMMENDATIONS

- 1) To agree the work programme.
  - 2) To note the minutes of the joint HOSC working groups; and
  - 3) To agree any specific questions or lines of enquiry that the sub-group members should raise on behalf of HOSC at future meetings.
- 

## 1 Background

1.1 The work programme contains the proposed agenda items for future HOSC meetings and is included on the agenda for each committee meeting.

1.2 The work programme also lists a number of ongoing joint HOSC sub-groups set up to meet with and scrutinise NHS organisations that provide services across multiple local authority areas. The minutes of the most recent meetings of these working groups are included as appendices to this report.

## 2 Supporting information

2.1 The work programme is attached as appendix 1 to this report. It contains the proposed agenda items for the upcoming HOSC meetings, as well as other HOSC work going on outside of the formal meetings, including the joint HOSC sub-groups.

2.2 Each Joint HOSC sub-group has between one and three representatives from East Sussex HOSC. Joint HOSC working groups have been set up to scrutinise the following issues:

### Ambulance Services

- A joint South East Coast area HOSC sub-group set up to scrutinise South East Coast Ambulance Service NHS Foundation Trust's (SECAmb) response to the findings of the recent Care Quality Commission (CQC) inspection and the Trust's wider recovery plan. Meets approximately 4 times per year. Membership: Cllr Belsey and Cllr O'Keeffe. Most recent minutes attached at **appendix 2**.

### Brighton & Sussex University Hospitals NHS Trust (BSUH)

- A joint working group with West Sussex and Brighton and Hove HOSCs set up to scrutinise BSUH's response to the findings of recent CQC inspections and the Trust's wider recovery plan. Meets approximately 4 times per year. Membership: Cllrs Belsey, O'Keeffe and Howell (substitute: Cllr Murray). Most recent minutes attached at **appendix 3**.

### Mental health services

- A Joint Sussex HOSC sub-group to scrutinise Sussex Partnership NHS Foundation Trust (SPFT) response to the findings of recent CQC inspections and the Trust's wider quality improvement plan. It also considers other mental health issues, including the ongoing reconfiguration of dementia inpatient beds in East Sussex. Meets approximately 3 times per

year. Membership: Cllrs Belsey, O'Keeffe and Osborne. Most recent minutes attached at **appendix 4**.

2.3 The HOSC work programme will be updated and published online following this meeting. A link to the forward plan is available on the [HOSC webpages](#).

### **3 Conclusion and reasons for recommendations**

3.1 The work programme sets out HOSC's work both during formal meetings and outside of them. The minutes of the joint HOSC meetings will help to inform all HOSC Members and the public about the issues being scrutinised.

3.2 HOSC members are asked to agree the work programme (subject to the addition of other items identified during the meeting), note the minutes of the HOSC sub-groups, and ask HOSC sub-group representatives to raise any specific identified issues with the relevant NHS organisations at future sub-group meetings.

**PHILIP BAKER**

**Assistant Chief Executive**

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# Work Programme for Health Overview and Scrutiny Committee



## Future work at a glance

Updated: **September 2017**

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

<i><b>Issue</b></i>	<i><b>Objectives and summary</b></i>	<i><b>Organisation giving evidence</b></i>
<b>30 November 2017</b>		
Connecting 4 You update	An update on the progress of the Connecting 4 You programme in the High Weald Lewes Havens area of East Sussex, including a timeline for Connecting 4 You.	High Weald Lewes Havens Clinical Commissioning Group
<b>29 March 2018</b>		
Connecting 4 You Update	A further update on the progress of Connecting 4 You programme.	High Weald Lewes Havens Clinical Commissioning Group
Stroke Services	An update on the performance of stroke services provided by Brighton and Sussex University Hospital NHS Trust following reconfiguration.	High Weald Lewes Havens Clinical Commissioning Group/Brighton and Sussex University Hospitals NHS Trust

## Other HOSC work

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

<b>Issue</b>	<b>Objectives / Evidence</b>	<b>People / HOSC timescale</b>
Patient Transport Service	Email update on performance requested following the contract transfer to South Central Ambulance Service from April 2017.  Performance update circulated at the end of Quarter 1, further performance update requested for Quarter 2.	Email circulated to HOSC members in August 2017, Q2 update requested for October 2017
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 and Vice Chair Last meeting: 26 June 2017 Next meeting: 17 October 2017
Reconfiguration of Maternity and General Surgery	A meeting to discuss the performance of maternity and general surgery at East Sussex Healthcare NHS Trust (ESHT) since their reconfiguration. Meeting will also include a visit to the midwife led unit at Eastbourne District General Hospital	All HOSC Members Meeting: 14 September 2017
Brighton & Sussex University Hospital NHS Trust	Joint Sussex HOSCs Sub-Group to scrutinise Brighton & Sussex University Hospitals NHS Trust (BSUH) response to the findings of the recent CQC inspections and the Trust's wider recovery plan	Cllrs Belsey, O'Keeffe and Howell (Sub: Cllr Murray) Last meeting: 30 March 2017 Next meeting: 4 October 2017
Mental health services	Regular meetings with Sussex Partnership NHS Foundation Trust (SPFT) 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.	Cllrs Belsey, O'Keeffe and Osborne Last meeting: 1 August 2017 Next meeting: November/December 2017 TBC
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	HOSC Chair and officer Last meeting: 24 July 2017 Next meeting: December 2017/January 2018 TBC
Quality of cancer care	Consider the reasons for the performance of East Sussex CCGs in the NHS England league table rating NHS performance on cancer.	Briefing note by EHS/HAR CCGs circulated to HOSC Members, further update requested for November

GP Access	Initial research on GP Access in East Sussex underway, including vacancies, registration and electronic access	Further action TBC based on research.
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**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](mailto:claire.lee@eastsussex.gov.uk)

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**South East Coast Ambulance Service NHS Foundation Trust –  
Regional HOSCs Sub-Group**

**Monday 26<sup>th</sup> June 2017, 2pm-4pm**  
SECAMB HQ, Nexus House, Crawley

**MEMBERS**

**Brighton & Hove HOSC**

Cllr Ken Norman (Chairman)  
Karen Amsden (Officer)

**East Sussex HOSC**

Cllr Colin Belsey (Chair)  
Cllr Ruth O’Keeffe (Vice-Chair)  
Claire Lee (Officer)

**Kent HOSC**

Cllr Sue Chandler (Chair)  
Vice-Chair (TBC)  
Lizzy Adam (Officer)

**Medway HOSC/Children’s OSC**

Cllr Wendy Purdy (Chair, HOSC)  
Cllr David Royle (Chair, Children’s OSC)  
Jon Pitt (Officer)

**Surrey Wellbeing and Health Scrutiny Board**

Cllr Ken Gulati (Chairman)  
Cllr Sinead Mooney (Vice-Chair)  
Andrew Spragg (Officer)

**West Sussex HASC**

Cllr Bryan Turner (Chairman)  
Cllr Dr James Walsh (Vice Chairman)  
Helena Cox (Officer)

**1. Introductions**

Cllr Bryan Turner chaired the meeting and invited everyone to introduce themselves.

**2. Apologies**

Apologies had been received from Cllr Ruth O’Keeffe, Cllr Ken Gulati, Dr James Walsh, Cllr Wendy Purdy (Cllr Teresa Murray substituted), Cllr David Royle, Cllr Sue Chandler (Cllr Mike Angell substituted), Helena Cox.

**3. Care Quality Commission (CQC) re-inspection**

3.1 Daren Mochrie, the new SECAMB Chief Executive, confirmed that CQC had undertaken a re-inspection w/c 15 May. This had involved 40-50 inspectors looking at 999, emergency services, Hazardous Area Response Team (HART) and 111.

3.2 The Trust has yet to see a draft report but initial feedback was better than the previous year and there were no surprises. CQC saw clear evidence of improvements, robust plans and a Programme Management Office in place, and

recruitment to the new Senior Leadership Team underway. They were particularly positive about 111, which has seen significant improvements since last year, and about care given by staff across the Trust.

### 3.3 CQC's key areas of ongoing concern were:

- **medicines management** – there is now a robust plan and a new Chief Pharmacist but the Trust still needs to be doing more at speed.
- **recording of 999 calls** (audio recording - important for immediate review or later audit). There have been technical issues in being able to record appropriately which are now almost resolved. This issue does not affect 111.
- the need for speedier roll out of **electronic clinical records** and concerns about whether all details are being captured from paper records. There will be wider benefits from going electronic in passing information to hospitals and GPs and minimising any loss of records. It will also make audit and research easier. The Trust is working on connectivity with the wider system.
- appropriate recording and acting on **serious incidents** (SIs).

### 3.4 The following issues were covered in response to questions:

- CQC felt staff engagement was much better across the Trust and received positive feedback from unions and governors regarding the Trust's direction of travel. Daren and other senior staff have been getting out to meet staff and spending time on shift with crews. He has not been picking up significant bullying issues but recognises Trust leadership could be better at communicating and engaging with staff. The recruitment of a stable leadership team will also help with staff confidence.
- Professor Lewis's report on bullying and harassment is due by the end of July and will probably raise engagement issues. Daren assured Members that the Trust intends to embrace its findings and recommendations.
- The move to a single Trust HQ may enable more development of teamworking and this may include a social element.
- One of the areas the Trust is reviewing in detail is recording of SIs and use of Datix, which can be a good system for incident and risk management. SECAMB has found difficulties getting Datix working but now has a new Datix manager who has started addressing the issues. This is in addition to doing wider work on learning from incidents which is making progress.
- There was an aspiration to move out of special measures within 18 months – 2 years and CQC and NHS Improvement are keen to support trusts to move on but also to ensure that progress is sustainable. The Trust will look at the outcome of the latest inspection and the next steps from that point. If remaining in special measures the Trust will take advantage of the additional support this brings.
- CQC's process for sharing its findings will be as before – a formal report and Quality Summit probably in early September. HOSC Chairs will be invited.
- The roll out of ipads to staff has been done incrementally to ensure staff are trained and they are used properly. Their primary use is for the clinical record and this is the initial focus.
- SECAMB uses 5 or 6 private contractors to provide additional capacity at times of peak demand via an agreed framework, not ad hoc arrangements. The Trust monitors their performance and has been reviewing how appropriate assurance of standards is obtained. CQC also regulates private contractors but at a different

level to NHS Trusts and the Commission is currently looking at how they regulate these providers.

**Action: HOSCs to be informed when Prof. Lewis's report is available.**

#### **4. Quality Improvement Plan (QIP) progress**

4.1 Jon Amos, Interim Director of Strategy & Business Development, advised that SECAMB is starting to incorporate initial feedback from the recent CQC re-inspection into the QIP and will fully update it when the formal report is received. The key areas of challenge had already been highlighted and discussed in item 3 above.

4.2 The following additional points were made in response to questions:

- The additional time allocated to complete some actions reflects a balance between fixing immediate issues raised by CQC and then tackling wider issues which subsequently emerge. New issues have been added to the QIP as they are picked up by the Trust's governance systems and it is positive that these are being picked up internally.
- The medicines management issues are not related to significant concerns about the use of drugs. CQC are highlighting how the Trust can improve safe and consistent management, storage and efficient use of drugs. This is challenging for SECAMB as drugs are held in many diverse locations. The Trust now has a medicines optimisation plan, which includes ensuring legal requirements are met in relation to controlled drugs.
- The most challenging and long term actions are around meeting performance targets because this is partly linked to demand outstripping resource and some targets being outdated. In addition, embedding cultural change and sustainable change to management of medicines and SIs will take time.

#### **5. Performance**

5.1 Jon Amos introduced the paper which provided data for the period to the end of May 2017 and which would also be considered by the Trust Board this week.

5.2 The following headlines were highlighted from each section of the report:

##### **Finance and workforce**

- SECAMB has moved from 4 to 3 on financial rating which is linked to a reduction in use of agency staff and ensuring there are the right skills in place internally. The move to Crawley may be helping with recruitment of entry level roles, some of which now have a waiting list. But some specialist roles remain difficult to recruit. The increased vacancy rate reflects a recent increase in establishment as new permanent roles have been created.
- A new on line appraisal and 121 system will be rolled out to all staff by autumn 2017 – this will help to ensure they are recorded rather than relying on people uploading paper versions. Ipad's can be used as part of this and the new team leader role will include time to do appropriate supervision on shift with staff. It will also roll out to volunteers in the next 18 months. The Trust is also changing how training is recorded to a rolling basis rather than starting from scratch each year.

### **Operational performance**

- Performance reflects the improvement trajectory agreed with commissioners and regulators. This trajectory has a slight dip in Q2 reflecting the introduction of the new CAD which will have a short term negative impact but long term gains.
- Activity is up on last year but not as much as expected.
- Ongoing challenges around hospital turnaround. Good progress has been made with some Trusts which has demonstrated the benefit of strong focus – SECAMB will be sharing this work more widely. The impact of handover delays has been estimated at 7-8% effect on performance.
- There was a dip in May on the call pick up target, driven by committing time to training on the new CAD – each member of staff needs a week's training in a short period of time. Expect this to pick up quickly as new system comes in.
- 111 - slight dip in call answer performance in May – also reflected nationally, which may reflect bank holiday weekends but there was good planning for these. An increase in late evening calls may be related to Ramadan and the Trust will be looking to reflect this in future plans.

### **Clinical effectiveness**

- ROSC performance is good but this does not seem to be translating into people surviving to hospital discharge. This may be a data issue which is being investigated with commissioners – there have been changes to the way data is obtained and it has required manual follow up for patients who have survived as there is no consistent recording across Trusts. There may also be variation in outcomes between acute hospitals. Some areas are starting to develop specialist centres for cardiac services and when the data is clearer SECAMB will discuss with clinical networks.
- Stroke – performance is slightly less timely on getting people to hospital but SECAMB is increasingly taking people longer distances to specialist centres.
- Clinical outcome data lag will reduce as electronic record comes in.

**Action: group to receive follow-up information on the investigation into cardiac survival to discharge data.**

### **Quality and safety**

- The increase in the number of incidents is positive due to increased reporting.
- Complaints are significantly down – this is linked to the transfer of PTS in Surrey to SCAS.
- Timeliness of response to complaints has improved significantly – almost at target. The process is much improved.
- Safeguarding referrals – some changes are linked to PTS changes.
- Level 3 safeguarding training is slightly behind plan – there is a process in place to improve but this does impact on front line resource – an extra day has been allocated for training this year.
- The complaints category 'concerns about staff' is often related to staff attitude. Trusts do a lot of work around how best to communicate in stressful situations, but there can be alcohol involved or a mismatch between expectations and reality e.g. Trusts don't always dispatch an ambulance and need to explain how this approach is better for people.

- Clinical audit is mostly internally led by the medical department (separate from front line), but is checked by the external audit firm.

## **Finance**

- Challenging year: £15m (7% of turnover) is needed in efficiencies to put additional resources where needed. SECAMB is further behind acute trusts on making efficiencies so there may be some easier savings still to achieve. The Trust is working with regulators and commissioners to assist on areas like handover delays and performance trajectories and ensuring efficiencies can be made safely.
- Savings targets are set by regulators and the Trust will make the case as needed to regulators for flexibility in return for improvements.
- The Trust has a 2 year contract with commissioners to April 2019 but is discussing amendments to this.

## **6. Surge management plan**

6.1 Jon Amos advised that review and revision of the draft plan continues and that trials were undertaken during recent hot weather. The aim is to prioritise limited resources appropriately during peaks and making this more of a routine procedure as needed. It represents a significant change to past ways of working.

6.2 Jon confirmed that the plan will go to the Board once finalised and can be brought to the HOSCs group at the same time.

**Action: Surge Management Plan to be brought to future HOSCs Sub-Group meeting when available.**

## **7. Strategy**

7.1 Jon Amos explained that the paper would be considered at a part 2 Board meeting this week but is also being shared with stakeholders for any general feedback. It sets out the general direction for the Trust but there will be a further detailed delivery plan to add an additional layer e.g. as the national ambulance response programme is finalised and other information becomes available.

7.2 Jon clarified that there would not be a formal consultation on the strategy but that it had drawn on a lot of work with CCGs and patient groups. It does not represent a major change of direction, more a reassertion and communication of the Trust's existing direction of travel.

7.3 It was noted that SECAMB covers 4 STP areas which is challenging, but is less complex than the 22 CCGs areas also covered by the Trust.

**Action: any comments on the draft strategy to be sent to Jon Amos, particularly in relation to any local issues.**

## **8. Next meeting**

8.1 It was agreed to arrange a further meeting in early October to coincide with the release of the CQC report. This would be the primary focus of the meeting, along with updated QIP and performance report. A tour of the building will also be included.

**DRAFT**

**Joint Sussex HOSC Working Group: Brighton and Sussex University Hospitals NHS Trust (BSUH) Quality Improvement**

**Thursday 30 March 2017**

**Attendees (HOSCs):**

Cllr Dee Simson, Chair (BH HOSC), Cllr Kevin Allen (BH HOSC), Cllr Lizzie Deane (BH HOSC), Cllr Colin Belsey (ES HOSC), Cllr Ruth O'Keeffe (ES HOSC), Cllr Edward Belsey (WS HOSC), Cllr Bryan Turner (WS HOSC)

**Attendees (BSUH):**

Lois Howell, Director of Clinical Governance  
Pat Keeling, Consultant (supporting BSUH with outpatient performance)

**1. Apologies**

1.1 Cllr Johanna Howell (ES HOSC), Cllr Dr James Walsh (WS HOSC) and Dominic Ford (BSUH).

**2. Notes of the last meeting 14.2.17**

2.1 In regard 2.2, bullet point 1 Mr Turner wished he had challenged Mr McEwan's comments regarding 'Adult Social Care (ASC) funding cuts causing exit lock from A&E' and that Mr McEwan was unable to provide evidence to substantiate that statement.

**3. Outpatients**

3.1 Pat Keeling gave a presentation on outpatient performance at BSUH (see separate slides). Since the CQC inspection BSUH had been working to improve certain aspects of the patient journey through outpatients, members were updated on the progress that had been made.

3.2 **GP referral management** – backlog in the numbers of referrals had averaged around 2,000-3,000 per week during the first half of 2016, additional staff had removed the backlog and following the implementation of a digital link in September 2016 numbers had fallen below 1,000 per week. The digital link at reduced referral management from 8 days to 1 day and had been great for staff morale. The next stage was to move to an e-referral system and process within 24 hours.

3.3 **Consultant Triage Times** - in relation to some unacceptable referral triage times, work was underway looking into nuances with particular consultants. The target was to move to referrals being triaged within 48 hours.

3.4 **Patient 'Did Not Attend' (DNA) rates** - DNAs were down to 6.6% which was better than the national average and the trust was trying to get everything right first time. Appointment letters had been sent asking patients to ring to book an appointment and then patients couldn't get through. Patients were now being telephone and given a choice with appointments. Two way texting had begun on 6 March which was beginning to have an impact and was good for offering appointments too. It was planned that digital barcoded letters

would be offered, which was saving some trusts approximately £1.5m a year. Continuous improvement was expected but at a lesser rate than had been experienced so far.

**3.5 30 Minute Wait Time** – 26.51% of patients were waiting longer than 30 minutes wait to see a consultant and again there was a need to get things right first time. Individual audits would take place as the year progressed on routine OD appointments. It was asked if digitalisation gave a truer picture of how long patients were waiting. Members were informed that a patient admin system was due to be introduced in October which would track patients across the hospital on a particular day. It was asked if this work would assist the CQC when they revisiting the hospital. Members were informed that previous figures could not be repeated and that the Trust was doing a deep dive with a number of variables being look at, in addition to working with the outpatient nurse forum. A lot of money was being lost for patients who did not attend approximately £160 per patient. It was hoped that by using two way texting this would allow patients to be slotted in. Members highlighted the need to use publicity to make the public aware.

**3.6 Clinics which over run** – Members noted that Rheumatology was high in percentage terms compared to others. The issues had been identified as reception staff leaving after contracted which contributed to a loss of effective follow on appointments. This would continue to be monitored.

**3.7 Reduced number of missing follow up appointments** - There had been an issue of forms not being processed at the end of clinics with receptionists not picking up or consultants filling them in. Work had been done with consultants the numbers were coming down. The new module which was being launched in October was anticipated to help but the CQC expected no missing forms when they re-inspected the Trust. There was a sustained improvement across the Trust.

**3.8** Members were pleased that things were going in the right direction and supported the planned digitalisation. It was asked if the current team were able to take this work forward. An officer had been brought in who would identify and map processes which could then be digitalised. In turn information management strategies would be looked at to strategically align with all Trust strategies. However, there were constraints with Wi-Fi access in some buildings and that infrastructure would not be put into buildings which would be redeveloped. Although, it was commented that it was important to get digital systems in place regardless of buildings. Two way texting was hoped to be in all departments by the end of April and that a procurement/business case would be needed before letters could be digitalised. Members were informed that it was not possible to estimate the savings that would be gained by digitalisation although savings would be made through two way texting for all outpatients and looking at diagnostics. Digitalised forms for inpatient booking and theatres from October may be more of a challenge for some clinicians.

**3.9** Other digital pathways included a digital fracture clinic where clinicians use Skype to talk to patients; integrated discharge team to follow-up digital approaches; digital signatures for consultants in order to catch up on admin. Infrastructure was a big theme both buildings and digital.



#### **4. Quality and Safety Improvement Plan (QSIP)**

4.1 Lois Howell presented an update (papers attached). There was an emphasis to remind staff of the improvement that had been made. Work was continuing with staff and wards, with mock inspections undertaken. These inspections had been with supported from NHSI, WSHT, SECamb, Sussex Police, CCGs, Healthwatch and BSUH staff. There was a focus on what must do's/should do's.

4.2 Members noted for the following points from Ms Howell's presentation:

- There had been considerable improvement in the four hour access targets and ambulance handover times – for the week ending 8 January the four hour target was 74.3% although only 20% of ambulance turnovers were within 15 minutes
- For the week ending 26 March the four hour target was 86.5% with increased attendance, which was much better performance. 45% within 15 minutes, 86% delayed more than 30 minutes, 8% more than an hour which was to do with space in hospital, although delayed transfers of care have reduced
- 94% occupancy rate in March – aiming for 85% - good patient flow was key
- The national target for 18 week waiting time is 92% in February BSUH was at 82.1%, an improvement. The Trust is now 136 out of 154 in this regard nationally.
- Cancer performance target of 31 days, the Trust was 62 day below national standard. The Trust was treating people in backlog and expected to be compliant in April.
- There was a focus on people and to talk positively on what has been done.
- Routine and continual improvement regarding the one patient experience panel working with Healthwatch. People were being invited to apply to be on the panel with training provided.
- It was asked if what was being done was sustainable going into next winter. Members were informed that there would be pressures but there was potential to have 40 beds at Newhaven and look at movement between PRH & RSC recommissioning 75 extra short stay beds so patients would not need to go to wards.
- An infusion suite was being created at PRH so that patients did not need to be in a hospital bed when received treatment.
- Regarding Hospital at Home, members were informed that the Community Trust was struggling to appoint to those roles and that through turnover there had been a net loss. However, there had been some successful recruitment days.
- Part of the problem at PRH was affordable accommodation for staff, with more available in Brighton. There was a small supply of suitable accommodation Haywards Heath.
- Cleaning had been outsourced but was to be brought back in-house as the standard wasn't good enough.
- Over the past 18 months extra recruitment had been an issue so the Trust was embarking on an apprentice scheme, NVQ etc and enhancing the NHS Band 4 role.
- It was asked if anything could be done regarding the loss of a nursery bursary. Help was need for affordable and suitable accommodation and help

with travel to Haywards Heath. The take-up for nurse's houses had not been great as they were one step up from university accommodation.

## **5. Update on management arrangement with Western Sussex Hospitals NHS Foundation Trust**

5.1 Members received an update on management arrangements at the Trust and were provided with staff briefings which had just been issued (attached). NHS Trusts were legally obliged to have a Chief Executive, Head of Finance, Chief Nurse and Medical Directors. The management team at WSHT would divide roles between the two Trusts. Evelyn Barker had a one year contract currently with BSUH.

## **6. Quality Account 2016/17**

6.1 Lois Howell provided members with the main headlines from the Trusts previous Quality Account and the nine targets for coming year (presentation attached). There had been mixed performance regarding the Trusts previous years Quality Account. The Medical Examiner has tasked all Trusts to review deaths in hospitals in order to learn effectively. An engaged workforce would continue to be an area of focus for the coming year.

6.2 Members noted that the target within the Enhanced Recovery Programme for Orthopaedics had not been met and in terms of reducing hospital required infections the Trust had not achieved targets regarding C-difficile and MRSA.

6.3 Focus for the coming year was:

- Three Patient Experience Projects – Patient Experience Panels/Booking Hub/Mouth care matters
- Three Patient Safety Projects – Safety Huddles/Improving care for the deteriorating patient – Sepsis and Acute Kidney Injury (AKI)
- Three Clinical Effectiveness Projects – Urgent Care Centre/Ward supplies system/Fractured neck of femur surgical pathway

6.4 Through the discussion members were informed that regarding 'Mouth care matters' there was an aspiration to eliminate rather than reduce numbers of lost and broken dentures. Work would be done in the run up to surgery to ensure that patients had not had a change in condition over the 18 week referral to treatment target.

6.5 It was agreed that individual HOSCs would contact the Trust to respond to the Quality Account consultation.

## **7. Date of next meeting**

7.1 It was agreed the next meeting should be held in July to focus on a 3Ts update and CQC re-inspection update. Members also asked to use this opportunity to meet new directors.

## Meeting between Sussex Health Scrutiny Committees and Sussex Partnership NHS Foundation Trust

01 August 2017 1pm to 3pm

### Note of the meeting

#### In attendance

- **Sussex Partnership NHS Foundation Trust (SPFT):** Dr. Rick Fraser, Medical Director; Sam Allen, Chief Executive Officer; Simone Button, Chief Operating Officer; Sally Flint, Chief Finance Officer; Sue Esser-Bowerman, Director of HR and OD
- **Brighton & Hove Health and Wellbeing Overview & Scrutiny Committee:** Giles Rossington (Scrutiny Officer)
- **East Sussex Health Overview & Scrutiny Committee:** Cllr Colin Belsey (Chair), Cllr Ruth O'Keeffe (Vice-Chair) and Harvey Winder (Scrutiny Officer)
- **West Sussex Health & Adult Social Care Select Committee:** Mr Bryan Turner (Chairman), Ms Hilary Flynn (HASC Member) and Helena Cox (Scrutiny Officer)

#### 1. Apologies for absence

1.1 Apologies for absence were received from Cllr Ken Norman, Dr James Walsh and Dan Charlton.

#### 2. Notes of the last meeting

2.1 The notes of the last meeting were agreed as a correct record.

#### 3 Sussex and East Surrey Sustainability and Transformation Partnership (STP) Mental Health Workstream

3.1 The following key points were made during the introduction of the report and in response to questions:

- The Mental health workstream is one of several workstreams being undertaken by the STP. The aim of the workstream is to determine how the voluntary sector, local authorities and NHS can work better together to meet the needs of patients, carers, families and local communities. There has been a positive buy-in from service users, carers, and other stakeholders so far.
- The workstream's 'Case for Change' will go to the STP Executive Board next week. There will be a workshop held after then to provide stakeholders with an overview of the Case for Change.
- The publication of research carried out as part of the workstream shows a mortality gap of up to 26 years between patients with and without mental health issues. Mental health receives 7% of healthcare funding but 20% of acute A&E admissions are people with mental health illnesses. This demonstrates the importance of mental health care to the whole healthcare system and SPFT is working to highlight this gap in the media.

- The health system will need to be recalibrated to meet the increased need and reduced resources. This will involve a shift away from acute care to community care. To help with this transition, SPFT is prioritising securing funding for and implementing a 24/7 community crisis care, which will help patients avoid acute or A&E admissions. The current service only runs to 10pm, after which time patients are advised to go to A&E. this is a commissioning gap and has been highlighted nationally by the CQC.

4.2 It was agreed that HOSC/HASC Members would be invited to the upcoming SPFT workshop about the Clinical Case for Change.

#### **4. Clinical Strategy**

4.1 The following key points were made during the introduction of the report and in response to questions:

##### **Single point of access**

- SPFT's proposed single access point will help provide patients with access to the right services at the right time. It will also help SPFT to achieve collaborative working with other providers by accurately signposting patients to services that are not provided by SPFT – 50% of commissioned mental health services in Sussex are provided by SPFT and the rest of funding goes to other providers.
- Jonathan Beder was leading the single point of access workstream and was liaising with partners and stakeholders. A business case will be developed during the next six months.

##### **CAMHS**

- An increasing number of young people are presenting with neurological issues, such as ADHD and autism, which require additional time to treat properly. This is due in part to the considerable reduction or closure of other services, such as educational psychologists in schools, school, and youth services, resulting in the use of CAMHS as the only available point of contact.
- The I-rock service in Hastings is proving effective as a youth service model and is being rolled out across Sussex. It provides advice on wellbeing, education, employment, housing and mental health. It was designed with young people and has a 100% satisfaction rating. This lower tier of mental health advice will help to reduce the burden on CAMHS.
- As part of the STP and placed-based plans, plans are underway to develop a collaborative programme with schools to identify high risk children – such as those with parents with mental health problems – and provide them with treatment early in order to prevent illness in adulthood. This will include providing training to teachers so that they can identify symptoms and help signpost children to the right place.
- There are recruitment issues in CAMHS, particularly with nurses and consultant psychiatrists; these are national issues.
- Waiting time figures have gone back up – after a recent decline – to just below 95% of patients seen within the national waiting time limits.

- There has been less investment by CCGs in CAMHS in West Sussex compared to the national average.

### **Additional funding for mental health services**

- As a result of extra government funding for mental health services, SPFT is being commissioned by NHS England to provide perinatal services. This is a popular service to work for, however, and SPFT staff will often want to transfer to it, reducing staffing levels elsewhere in the trust. This is compounded by wider recruitment problems caused by falling numbers of trainees and graduates, and the tendency of up to 50% of clinical psychology graduates to emigrate to Australia, Canada and New Zealand once they reach consultant level due to the pay and lifestyle quality.
- It is difficult to explain to staff the concept of ring-fenced money being provided for services, like the perinatal service, that are given high importance by NHSE when there is not enough resource to deliver the existing core service.
- There are increasing retention issues caused by the decision in the 1980s/90s to grant staff 'mental health officer' status meaning that they can retire aged 55 on a full pension, which many are now reaching.
- SPFT is getting better at retaining its workforce and NHSE is conducting a survey into what would keep staff in Sussex. This will help SPFT to determine how it can better retain staff.
- The Clinical Strategy includes proposals to develop new career paths and roles that will help retain permanent staff and reduce the need for agency staff.

### **Discovery College**

- A number of people have recently graduated from the discovery colleges as Peer Workers for others aged 12-21 years.

#### **4.2 It was agreed:**

- 1) that HOSC/HASC members would be invited to future discovery college graduations
- 2) SPFT would welcome the consideration of CAMHS at future HOSC/HASC meetings

## **5. Review of older people's mental health and dementia services**

### **5.1 The following key points were made during the introduction of the report and in response to questions:**

- There is an additional review of estates for older people in Sussex ongoing in tandem with this review as many dementia inpatient wards are in standalone units in need of capital investment. Standalone units are not as safe and are more expensive because they require more staff – as there are no staff from adjacent wards to provide cover – and they are hard to recruit to because they offer fewer career opportunities.

- The medium to long term solution in East Sussex is to have all older people mental health inpatient wards on the same site as physical healthcare services in the Conquest Hospital.
- The plan is to self-fund the building reconfigurations, but creative PFI work is also being considered, as well as working with other trusts as part of One Public Estate, e.g., in Worthing.
- More detail about what services will need to be reconfigured will be available by December.

5.2 It was agreed to request a report on the review of inpatient services for older people in Sussex at the next meeting.

## **6. Thematic Review of Homicides**

6.1 The following key points were made during the introduction of the report and in response to questions:

- The “Making Families Count” event was very effective and received strong staff feedback. A second event is planned for the future.
- The trust has sent out a couple of stakeholder briefings on the independent inquiry reports to press officers of various organisations.

6.2 It was agreed that HOSC/HASC officers and Members would be added to the distribution list for future stakeholder briefing for items of media interest.

## **7. Delayed transfers of care (DToC)**

7.1 The following key points were made during the introduction of the report and in response to questions:

- The BBC put in a recent FoI request on the length of stay of patients awaiting discharge over the past five years. One patient from SPFT was awaiting discharge for three years from an inpatient unit, which was the longest length of stay in the country. SPFT will issue a press statement on 2 August in anticipation of the BBC story.
- SPFT is working with the whole health and care system to improve discharge of patients from mental health beds; E Sussex ASC department has been very helpful in this regard. Since the FoI, improvements have been made to DToC and the longest current stay is 9 months.
- The aim is to reduce DToC by 4.5% by September. There were 33 DToC patients in beds July, these were not all older people or acute beds and included 5 of the 7 patients in the Learning Disability Assessment Treatment Centre. These patients are very difficult to find placements for nationally.
- Finding placements for inpatients with drug and alcohol addiction remains an intractable issue in Brighton & Hove, as few organisations or private landlords are prepared to provide them with placements. Patients who have been in an institutional setting want independence along with wraparound support but there is a shortage of quality supported housing that can provide this. This was exacerbated when Brighton & Hove CCG disinvested in SPFT provided

housing and bought new units that could be provided at a lower cost. There may be opportunities to work with housing associations, and it is important to get the issue on the agenda again.

## **8. Care Quality Commission**

8.1 The following key points were made during the introduction of the report and in response to questions:

- SPFT is expecting a review of its well-led domain shortly; the trust has received a data request from the CQC that is likely to be a pre-cursor to inspection. A follow-up inspection of the September 2016 inspection was expected, but the election and rollout of the new inspection regime have delayed it until now.
- Improving mandatory and statutory training levels was a must-do action of the CQC. The trust is now improving and sustaining its mandatory training levels through better monitoring and reporting.
- Variations in the quality of services across Sussex was another issue, and this is being addressed through more local leadership via the eight Care Delivery Services (CDS).
- The trust has also issued guidance on setting out the key minimum requirements to do each job safely and well.
- SPFT has very resilient cyber security. It is one of the few trusts with Cyber Essentials accreditation.
- The trust conducted a fire safety review following the Grenfell Tower fire and used it as an opportunity to ensure staff were receiving their statutory Clinical Risk Assessment training.
- The Executive Team vacancies of Director of Corporate Governance, Director of Strategy and Chief Digital and Information Officer are expected to be filled soon.

8.2 It was agreed that the most recent Mandatory and Statutory Training report to the Board of Directors would be circulated to Members.

## **9. Date of the next meeting**

9.1 It was agreed to hold another meeting in early-December 2017.

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