HEALTH OVERVIEW AND SCRUTINY COMMITTEE

THURSDAY, 30 NOVEMBER 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
Councillors 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 21 September 2017** *(Pages 7 - 18)*

2. **Apologies for absence**

3. **Disclosures of interests**

   Disclosures by all members present of personal interests in matters on the agenda, the nature of any interest and whether the member regards the interest as prejudicial under the terms of the Code of Conduct.

4. **Urgent items**

   Notification of items which the Chair considers to be urgent and proposes to take at the appropriate part of the agenda. Any members who wish to raise urgent items are asked, wherever possible, to notify the Chair before the start of the meeting. In so doing, they must state the special circumstances which they consider justify the matter being considered urgent.

5. **Connecting 4 You update** *(Pages 19 - 44)*

6. **Cancer Performance in East Sussex** *(Pages 45 - 60)*

7. **Kent and Medway review of stroke services** *(Pages 61 - 112)*

8. **HOSC future work programme** *(Pages 113 - 132)*

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

PHILIP BAKER
Assistant Chief Executive
County Hall, St Anne's Crescent
LEWES BN7 1UE

22 November 2017

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Next HOSC meeting: 10am, Thursday, 29 March 2018, County Hall, Lewes

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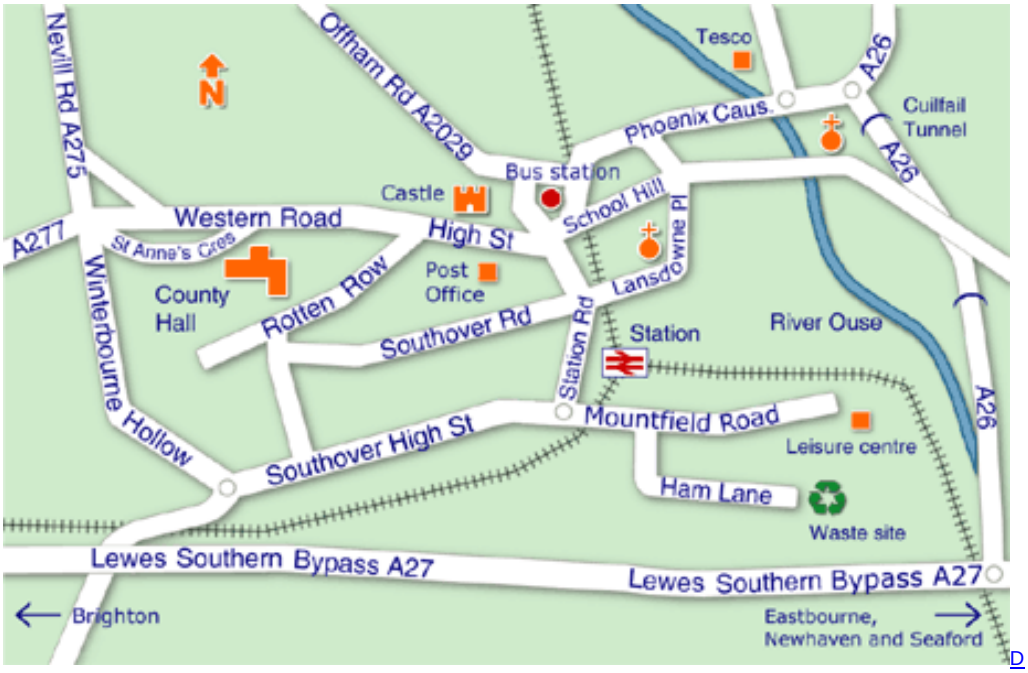

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HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Lewes on 21 September 2017

PRESENT:

Councillors Colin Belsey (Chair), Councillors Phil Boorman, Bob Bowdler, Angharad Davies and Ruth O'Keeffe (all East Sussex County Council); Councillor Janet Coles (Eastbourne Borough Council), Councillor Mike Turner (Hastings Borough Council), Councillor Susan Murray (Lewes District Council), Bridget Hollingsworth (Rother District Council), Councillor Roger Thomas (Wealden District Council), Geraldine Des Moulins (SpeakUp) and Jennifer Twist (SpeakUp)

WITNESSES:

Dr Adrian Bull, Chief Executive, East Sussex Healthcare NHS Trust
Joanne Chadwick-Bell, Chief Operating Officer, East Sussex Healthcare NHS Trust
Jessica Britton, Chief Operating Officer, Eastbourne, Hailsham and Seaford Clinical Commissioning Group (CCG) / Hastings and Rother CCG
Wendy Carberry, Chief Officer, High Weald Lewes Havens CCG
Ashley Scarff, Director of Strategy and Deputy Chief Officer, High Weald Lewes Havens CCG
Mark Angus, Urgent Care System Improvement Director, East Sussex Better Together Alliance
Colin Simmons, 111 Programme Director (Sussex), NHS Coastal West Sussex CCG
Dr Shivam Natarajan, Clinical Lead, Clarity Consulting

LEAD OFFICER:

Claire Lee, Senior Democratic Services Adviser

8. MINUTES OF THE MEETING HELD ON 29 JUNE 2017

8.1 The Committee agreed the minutes of the meeting held on 29 June 2017 as a correct record.

8.2 The Chair thanked Dr Adrian Bull, Chief Executive of East Sussex Healthcare NHS Trust (ESHT), for the tour of the Midwife-Led Unit and Cardiology at Eastbourne District General Hospital (EDGH) and the seminar on the progress of reconfigurations to the Trust's General Surgery and Maternity services.

9. APOLOGIES FOR ABSENCE

9.1 Apologies for absence were received from Cllr Johanna Howell (substitute: Cllr Roger Thomas), Cllr Sarah Osborne, and Cllr Andy Smith.

9.2 The Chair welcomed Geraldine Des Moulins as the new member of HOSC representing the voluntary sector.

10. DISCLOSURES OF INTERESTS

10.1 There were no disclosures of interest.

11. URGENT ITEMS

11.1 There were no urgent items.

12. URGENT CARE

12.1 The Committee considered a report providing an update on developments in urgent care services, including redesign of the urgent care system as part of the East Sussex Better Together (ESBT) programme; and the Sussex-wide redesign and re-procurement of NHS 111.

12.2 Mark Angus, Urgent Care System Improvement Director, East Sussex Better Together; Jessica Britton, Chief Operating Officer for the two ESBT Clinical Commissioning Groups (CCGs); Adrian Bull, Chief Executive, and Joanne Chadwick-Bell, Chief Operating Officer, of East Sussex Healthcare Trust; and Colin Simmons, Programme Director for 111 Transformation, provided answers to questions raised by HOSC Members.

Urgent Care Treatment Centres

12.3. Mark Angus explained that the development of Urgent Care Treatment Centres (UTCs) is a national requirement that is being undertaken locally through the East Sussex Better Together (ESBT) Whole System Urgent Care transformation programme. NHS England (NHSE) requires that detailed urgent care plans are developed by March 2018 and the plans are in place by 1 December 2019.

12.4. Mr Angus said that commissioners within ESBT were currently working out where UTCs will be located based on three potential options:

- co-locating UTCs with the A&E Departments and the new Primary Care Streaming Services at Eastbourne District General Hospital (EDGH) and the Conquest Hospital;
- developing existing walk-in centres to the higher UTC specifications, including diagnostic facilities like an X-ray machine; or
- building new UTCs, although limited access to capital funds makes this option more challenging.

12.5. Jessica Britton said that there will likely be two UTCs in the ESBT area and confirmed that there were no current plans for the development of one in Seaford. She added that in addition to UTCs the transformation programme will include the development of a range of urgent primary and community services available across the ESBT area – including extended opening hours for GP surgeries, and a re-developed Out Of Hours (OOH) GP Service.

Paediatric Urgent Care

12.6. Mark Angus said that the ESBT Whole System Urgent Care transformation programme include provision for paediatric care, but commissioners would need to be confident that any provider would be able to provide the service safely and effectively.

12.7. Joanne Chadwick-Bell added that A&E Departments on both hospital sites have specialist paediatric nurses that can support children with urgent or emergency care need. There are also paediatric units on both sites for children who require more specialist consultant support and there are no plans to change this configuration.

Primary Care Streaming Service

12.8. Joanne Chadwick-Bell said that the Primary Care Streaming Service is due to commence as a pilot from October. ESHT has received a number of CVs from GPs interested in the position and one full-time GP has been appointed so far to the EDGH A&E Department. The Trust is negotiating funding for the role and will be employing GPs directly to help with their indemnity insurance. The service will be divided into shift patterns of four hours at a time to make it easier for GPs to carry out the role part-time if they wish, and ESHT will employ a bank of GPs to help fill the role in a similar way to an out of hours service. The benefits of the service and the level of investment required to run it will be closely monitored over the winter period.

Extended Access Service

12.9. Mark Angus said that there is current pre-market engagement being undertaken to understand the potential to develop extended primary care access services including the potential to establish extended access service hubs, in accordance with the national requirement to extend patients' access to bookable appointments for primary care. He confirmed it would be unlikely that people would see their own GP at these hubs, but the results of public engagement work suggest that people's views on the importance of seeing their own GP is mixed, whilst access to primary care expertise is of key importance.

Ambulatory Care Unit

12.10. Dr Adrian Bull confirmed that a new consultant has been appointed to the Ambulatory Care Unit at the Conquest Hospital who starts in early-October.

Patient Care Plans

12.11. Dr Adrian Bull said that a fully transparent care plan is an aspiration within the NHS and there are many areas where good progress is being made, for example, for people receiving palliative care in the last year of their life there has been a major effort to ensure that the details of those plans are put on the extended summary care record. He explained that all clinicians currently have access to a patient's summary care record but the extended summary care record can only be accessed by certain clinicians mainly in acute settings. There has recently, however, been significant progress in rolling extended summary care records to primary care.

Training for palliative care

12.12. Dr Bull agreed that working with specialised nurses trained in palliative care is important. He said ESHT is working across ESBT area to look at how the patient needs of those 20-30% of palliative care patients requiring care for conditions other than cancer can be met.

The Trust has been in contact with both hospices in East Sussex about doing more to raise awareness and both have indicated that they are open to the idea.

Communication strategy

12.13. Jessica Britton said that under the new urgent care system, patients should be able to call NHS 111 once and be signposted to the right help that they need without needing to find out for themselves where they need to go. Once it is in place, the new 111 service will be promoted to reflect its increased importance as the first point of contact for people requiring urgent care, however, because of this there is no plan to do a major advertising of individual new urgent care services. Joanne Chadwick-Bell added that a communications plan for the winter period is about to be published asking patients to call 111 for all healthcare needs unless it is an emergency.

12.14. Joanne Chadwick-Bell explained that the Primary Care Steaming Service in A&E departments involves the extension of skill sets available at an existing service and are not new services in themselves, and as a result there is no plan to advertise it as a new service.

Capacity, recruitment and retention of urgent care staff

12.15. Mark Angus and Joanne Chadwick-Bell said that GP recruitment it is a significant challenge and area of concern both locally and nationally and explained how the Whole System Urgent Care transformation programme is looking to alleviate the issue:

- a single, better co-ordinated OOH contract rather than the current arrangement of a separate walk-in centre and OOH contract that can lead to both services vying for the same GP workforce;

- exploring the use of technology such as Skype that could allow GPs to provide OOH services remotely;

- using a wider skill set within the workforce, e.g., advanced nurse practitioners with the right training can deal with a number of primary care presentations instead of GPs; and

- incentives to work in a primary care setting, for example, offering joint acute and primary care roles for GPs who want more of a ‘portfolio career’.

12.16. Colin Simmons said that ensuring the OOH workforce has sufficient capacity will require other healthcare workers to be involved in urgent care. He said that many OOH contacts are around requests for repeat prescriptions, so capacity for OOH can be enhanced by developing the 111 service so that when a patient calls 111 they can be asked whether their query is a pharmaceutical one and transferred to their local pharmacist, who can provide the repeat prescription for them.

12.17. Dr Adrian Bull said that workforce recruitment and retention is one of the biggest challenges across ESHT and effects all departments. He agreed that there is merit in exploring the idea of recruiting a senior Associate Consultant to draw in other junior doctors and consultants. He explained that ESHT has had ongoing discussions with Brighton & Sussex Medical School to see how the Trust can better link up with their training programme and improve the academic attraction of ESHT for all clinicians.

NHS 111

Scope of NHS 111 procurement

12.18. Dr Bull explained that the scope of the NHS 111 procurement is for a service that will respond to calls from the public, assess the medical need of the caller, and pass the caller on to the relevant service. Colin Simmons added that under the new procurement model, NHS 111 service will include clinical assessment carried out by clinicians via a Clinical Assessment Service (CAS).

12.19. Dr Bull explained that under the new urgent care system NHS 111 will remain the number to call for urgent medical assessment and will have clinical expertise on site to provide this assessment. On the other hand, Health and Social Care Connect (HSCC) will be there for more complex patients – or a GP on behalf of a patient – to call when they require a mix of clinical and social need, for example, physiotherapy, reablement, district nursing or social care assistance.

Indemnity insurance

12.20. Dr Bull clarified that GPs who are employed by private OOH companies, such as IC24, have different indemnity requirements than if they are employed directly by the NHS. This issue has been recognised and is being rectified through the 111 procurement for those individual who will work within 111 and the CAS. It is also being resolved for GPs due to begin working in the Primary Care Streaming Service by ESHT employing the GPs who work in A&E.

Privacy and electronic patient records

12.21. Jessica Britton said that over the past 4 years the CCGs have been mindful of people's concerns about information sharing and it has been discussed extensively at patient engagement events. The consistent message is that patients want their information to be appropriately shared where it is helpful to meet their treatment needs. This feeds into the development of how to use technology within the boundary of good information governance.

12.22. Dr Adrian Bull said that the 111 re-procurement work has included a survey on patients' attitudes towards the sharing of records. Colin Simmons added that any provider of the NHS 111 service will have to follow the information governance guidelines around data protection, security and audits. Any procurement specification will also make clear who should have access to that data, i.e., clinicians having access to summary care records, rather than all employees being able to access them.

Access to 111

12.23. Joanne Chadwick-Bell said that the 111 call handler will quickly pick up whether the caller does not speak English and will transfer them to a language line. This is a national standard and already available. Access for the deaf community is recognised as a major challenge nationally and NHS England is working with providers on solutions. There are schemes such as signing over Skype that are being trialled by some OOH services.

Call handler career progression

12.24. Colin Simmons confirmed that NHS England's national career blueprints for call handlers will be known before the new 111 provider is appointed. The outline of the national career blueprints – setting out what career progression will look like for a call handler becoming an advanced call handler – will be published early in 2018.

12.25. The Committee RESOLVED to:

1) note the report;

2) consider a further update on urgent care at the June 2018 committee meeting;

3) provide a written update on 111 in January 2018 and a further update in 2 October meeting;

4) request a report on GP access in March 2018; and

5) request confirmation as to the number of GPs to be employed as bank staff for the A&E Primary Care Streaming Service.

13. SUSSEX AND EAST SURREY SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP

13.1 The Committee considered a report providing an update on the most recent developments with the Sussex and East Surrey Sustainability and Transformation Plan (STP).

13.2 Wendy Carberry, Senior Responsible Officer for the STP provided a presentation and answered questions from Members of HOSC.

Effect of STP on Connecting 4 You

13.3. Wendy Carberry said that the CCGs in the Central Sussex and East Surrey Area (CSESA) South plan to merge some back-office functions by April 2018. She confirmed that this will not affect the implementation of High Weald Lewes Havens Clinical Commissioning Group's (HWLH CCG) Connecting 4 You (C4Y) programme – which is the model of care for the HWLH population – or its constituent services such as Communities of Practice, the frailty pathway, and the Golden Ticket dementia pathway. She argued that these services are starting to come together rapidly and the C4Y programme is not as far behind other placed-based plans as it may appear.

CSESA boundary

13.4. Wendy Carberry confirmed that the boundary between CSESA North and South has been fixed. The North will comprise Horsham and Mid Sussex, Crawley and East Surrey CCGs and the South will comprise Brighton & Hove and HWLH CCGs. She said that some functions will be carried out jointly with Brighton & Hove CCG, some with the other CCGs in the CSESA area, and some across the whole STP.

Funding for healthcare

13.5. Wendy Carberry explained that there is no specific extra money that will be provided to deliver the placed-based plans such as C4Y or ESBT. Dr Bull added that the predicted funding gap by 2020 is based on comparing the trend for healthcare funding with the trend for

increasing healthcare needs. The prediction is that the increase in healthcare need is much greater than the expected funding increases but funding itself will not decrease relative to the current levels, so there is no expectation that CCGs will have to reduce spending below current levels. He said that the health and social care organisations must align themselves in such a way as to reduce future demand by using existing resources better. The challenge and tension at the moment, however, is to protect investment in community based care to reduce future demand whilst also addressing significant funding challenges in acute care.

Use of ICT in healthcare

13.6. Dr Adrian Bull said one of the main initiatives across the NHS is to improve the adoption rate of new technologies that help clinicians deliver healthcare. The NHS will increasingly need to support the development of apps and other ICT that will enable patients to take control of their patient records so that expert patients can manage their own conditions, such as diabetes. NHS Digital is encouraging this through an accreditation programme for new healthcare apps, such as those that remind you when to take prescription medicine, which are listed on its website. Dr Bull added that technology can also be used to help detect diseases, for example, a handheld device that has been rolled out to all GP practices in East Sussex to detect atrial fibrillation and is being rolled out elsewhere.

STP Engagement plans

13.7. Jessica Britton clarified that there are no STP plans currently being developed that would require a formal consultation on the grounds that they were a substantial variation to services. ESBT and C4Y programmes have involved local people in engagement and consultation every step of the way, for example, through Shaping Health and Care events and the development of the Health and Wellbeing Stakeholder Group – which will have representation on the ESBT Strategic Commissioning Board from December.

STP ensuring patient choice

13.8. Wendy Carberry confirmed that patient choice is enshrined in the NHS Constitution and would be adhered to during the development of services as part of the STP or the place-based plans in East Sussex.

Impact on STP of NHS England's rating

13.9. Wendy Carberry confirmed that the STP was rated by NHS England "requires greatest improvement". This was in part due to the size and complexity of the STP, significant financial pressures, a number of NHS providers in special measures, and four CCGs in special measures. She said that the STP will be rated on an annual basis and the current rating forms the baseline score.

13.10. Wendy Carberry explained that the STP works closely with NHS Improvement (NHSI) and NHS England (NHSE) and the STP considers that it is on the trajectory to improvement. The STP is in discussions with NHSE about what support it can provide to help overcome the STP's challenges, after which point the STP's Executive Chair role will be appointed to.

13.11. Dr Adrian Bull added that he is confident that the right plans are emerging from the STP but there is a real challenge to make the necessary changes on the scale required to address the current significant financial challenges that already exist across the STP. He said that at the

moment there is no quick solution, but he was confident that the STP will be where it needs to be in the next 3-5 years.

STP Acute Strategy

13.12. Dr Adrian Bull said that it has been agreed that there will be no single overarching strategy for acute care. Instead, acute providers will continue to develop their strategies for the placed-based plans of which they are part, whilst at the same time BSUH will develop a strategy for tertiary care. BSUH will work alongside ESHT and the other providers to ensure that the tertiary strategy complements their place-based strategies. BSUH has committed to develop this tertiary strategy in consultation with partners before Christmas 2017. Dr Bull added that a commitment to joint approach towards elective care has been agreed across the STP but it has not been defined how it will be done yet.

Purpose of STPs

13.13. Dr Adrian Bull that the purpose of STPs is to enable the NHS to meet the healthcare demand of local populations within existing resources. He argued that this can be done by providing better care for patients in the community and avoiding more costly acute admissions. This will also benefit the patient and provide them with better care because it will prevent their condition deteriorating to the point where they need to go to hospital. Describing them as purely money saving exercise is, therefore, overly simplistic.

13.14. The Committee RESOLVED to:

1) note the report;

2) request an update on the STP in either March 2018, or when the Chair considers that it has progressed to the stage where a report would be worthwhile. If a report is not appropriate for March 2018, the reasons why will be provided.

14. CLINICALLY EFFECTIVE COMMISSIONING

14.1 The Committee considered a report providing an update on Clinically Effective Commissioning.

14.2 Ashley Scarff, Deputy Chief Officer and Director of Strategy, High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG); and Dr Shivam Natarajan MS FRCS, Clinical Lead from Clarity Consulting, answered questions from the Committee.

Reason for reviewing procedures with limited clinical effectiveness

14.3. Dr Shivam Natarajan explained that there are approximately 2,500 hip and knee operations in the STP area per year. Out of those, 150 were for revisions of previous operations which means that they were either not done appropriately or properly.

14.4. An initial knee operation costs £5-10k but a revision costs £110k. The Clinically Effective Commissioning (CEC) programme is looking at the first point in the surgical pathway at which these unnecessary revisions can be prevented, which is to ensure that the policies of all CCGs in the STP area are clear about who the appropriate people are who should receive the surgery

and when the appropriate time is in the clinical pathway for them to receive it. This has two benefits: appropriately giving the right person the knee operation will avoid the unnecessary expense of complications, and by having the right people have the surgery additional people who do require the surgery can receive it in a timely manner.

14.5. Dr Natarajan explained that the appropriate thresholds for patients to receive each type of surgery will be set out in STP-wide policies that are in line with the Royal College guidelines and clinical best practice, for example, the current policies for a hysterectomy differ across each CCG, with some saying patients may have one after six months of conservative management and others after 12 months. However, the clinical evidence says there should be three stages/ types of conservative management that should be tried if possible before major surgery. The policy being developed, therefore, says that patients should go through three stages of conservative management before going to surgery. Changing the eligibility for surgery to fit with clinical best practice is not a purely financial exercise but in the interest of good patient care; and may result in more surgeries for some CCGs, or a greater number of surgical procedures for some illnesses.

14.6. Dr Natarajan added that Clinically Effective Commissioning will also tie into other clinical work such as Get it Right First Time and the STP's acute care workstream by highlighting the various avoidable variations in care and eliminating waste. Within the STP only half the surgeons involved with hip and knee replacements are carrying out 30 or more knee or hip operations per year the remaining half are only doing a handful. This variation in quality that this causes should be avoided and is something that could be addressed through this other work, for example, agreeing as part of the acute care workstream to do knee operations in only three major centres of excellence. Ashley Scarff clarified that this process would not result in a limitation in choice but balance choice with quality and better outcomes. Choice is enshrined in the NHS Constitution and the CCGs will uphold that.

Shared Decision Making

14.7. Dr Natrarajan explained that shared decision making has only recently become a formal process within the NHS – although it has been practiced individually by clinicians beforehand. It involves the clinician explaining to the patient the reasons why they should or should not opt for a surgical procedure, for example, the potential complications and the rate at which these complications occur, and the patient's current need for surgery compared to other treatments. This provides patients with the ability to take a judgement based on the positive and negatives of having, or postponing, surgery.

14.8. The policies will also make it clear when during the clinical pathway the shared decision should be made based on national guidelines. This is because it is not always possible to make a shared decision at the primary care stage as the GP may have insufficient knowledge about the illness. In these cases the shared decision may be taken with a specialist clinician following appropriate assessments and investigations.

14.9. Dr Natarajan said that patients will be informed about their rights with regards to shared decision making through a revision of the patient information leaflets.

Procedures chosen for further investigation

14.10. Dr Natarajan said that Clarity Consulting reviewed 150 procedures across the STP area and shortlisted 50 for further investigation across general surgery, eye, musculoskeletal, obstetrics and gynaecology. They were shortlisted as these surgical procedures had a lot of activity that contained the largest variations in the number of surgeries per CCG. Once these 50 procedures have been reviewed it will be rolled out as far as possible across other procedures. Dr Natarajan confirmed that East Sussex CCGs are an outlier in 10 to 15 of these 50 procedures, either because more surgeries are performed here than the STP average, or they are performed at a higher cost than national guidelines recommend.

Accelerated Savings

14.11. Dr Natarajan explained that Accelerated Savings is a piece of work over and above the clinical policy rationalisation work. The Accelerated Savings workstream is looking at other areas of waste within the system, for example, improvement in procurement processes for acquiring knee replacements (prosthesis) where all 8 CCGs procure prostheses from the same few vendors at 8 different prices between £400 and £2,000. This variation in cost does not reflect the variation in clinical outcome, where data shows that the £2,000 prosthesis has poorer results than the £400 one in some studies. Dr Natarajan said that about 50 areas were looked at during August as part of Accelerated Savings and around 10 were identified as areas where improvements could deliver significant benefits across the STP, including procurement optimisation, medicines management and patient transport system inefficiencies. Ashley Scarff clarified that this is the beginning of the process and no decisions have been made yet.

Involvement of CCGs in Clinically Effective Commissioning

14.12. Dr Natarajan explained that there has been a high level of clinical engagement during the CEC project and GPs have been involved at several levels including as CCG Chairs; at four workshops involving multi-disciplinary teams, including GPs; and through a GP engagement exercise where members of the CEC project attended local GP meetings or clinical reference groups to communicate to GPs about the CEC project.

14.13. The Committee RESOLVED to:

1) note the report;

2) request a further update at the March 2018 Committee meeting; and

3) to provide details of the 10 possible areas for improvement to be pursued during 2017/18 as part of the Accelerated Savings process.

15. HOSC FUTURE WORK PROGRAMME

15.1 The Committee considered its work programme and the notes of the three joint HOSC working groups set up to meet with and scrutinise NHS organisations that provide services across multiple local authority areas.

15.2 The Committee RESOLVED to:

1) note the report;

2) note the minutes of the working groups; and

3) add a report on cancer care performance to the 30 November agenda.

The meeting ended at 1.05 pm.

Councillor Colin Belsey
Chair

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Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date:	**30 November 2017**
By:	**Assistant Chief Executive**
Title:	**Connecting 4 You update**
Purpose:	**To update HOSC on progress of the Connecting 4 You health and social care transformation programme in the High Weald Lewes Havens area.**

RECOMMENDATIONS

HOSC is recommended to consider and comment on the report from High Weald Lewes Havens Clinical Commissioning Group.

1. Background

1.1 Connecting 4 You is the health and social care transformation programme led by High Weald Lewes Havens (HWLH) Clinical Commissioning Group (CCG) and East Sussex County Council in the HWLH area.

1.2 HWLH CCG patient flows differ considerably from those of the other East Sussex CCGs. Although HWLH CCG residents receive the majority of primary and community services within East Sussex, the great majority of people access secondary care services from out of county providers – particularly from hospitals in Brighton, Hayward's Heath and Tunbridge Wells. This means that HWLH CCG has to contribute to planning for better integration and co-working across three health systems: East Sussex; Brighton & Hove and Mid Sussex; and West Kent.

1.3 HWLH area and the Connecting 4 You programme form part of the Central Sussex and East Surrey Alliance (CSESA) place based plan area within the Sussex and East Surrey Sustainability and Transformation Partnership (STP). The CSESA area has more recently been sub-divided into two 'places': CSESA South, which covers HWLH, Brighton & Hove and part of Horsham & Mid-Sussex CCGs; and CSESA North which covers the remainder of Horsham & Mid-Sussex, Crawley and East Surrey CCGs.

1.4 In October 2017 it was announced that the four Sussex CCGs in the CSESA area have agreed to come together to establish an alliance with a single leadership team and operating model. This aims to strengthen and streamline the commissioning functions for the four CCGs. Adam Doyle (current Accountable Officer for Brighton & Hove CCG) has been appointed as the joint Accountable Officer for all four CCGs. Managing Directors have also been appointed for each of the north and south sub-areas – in the south this will be Wendy Carberry (current Accountable Officer for HWLH CCG). The four CCGs will remain statutory bodies, retaining their Governing Bodies and accountability for commissioning for their local populations. The Central Sussex Commissioning Alliance expects to go live from January 2018.

2. Progress update

2.1 HOSC last received an update on the progress of Connecting 4 You in June 2017. At the time the committee requested further detail on timelines and milestones for the programme. In particular the committee wished to understand how the development of a Strategic Investment Plan (SIP – bringing together health and social care spending into a single plan) and the multi-speciality community provider (MCP) model for integrating services would be progressed.

2.2 HWLH CCG has supplied a further update as requested which is attached at appendix 1. As well as providing an overview of the programme's objectives, timescales and progress the report focuses in more detail on some specific areas of service development:

- **Urgent care transformation and readiness for winter pressures** – this section complements the report received by HOSC in September on urgent care developments in the rest of East Sussex under the East Sussex Better Together programme, and the Sussex-wide re-procurement of NHS 111. The report focuses on developments in the urgent care systems which connect to Brighton and Sussex University Hospitals NHS Trust (hospitals in Brighton and Hayward's Heath) and Maidstone and Tunbridge Wells NHS Trust (which includes the hospital at Pembury).
- **Dementia Golden Ticket** - this section outlines how the care pathway for people diagnosed with dementia has been redesigned and how the new pathway is being rolled out across HWLH.
- **Lewes Health Hub and Primary Care Home** – this section outlines how the 'communities of practice' model for integrated community care is being developed in the Lewes area.

2.3 Representatives from HWLH CCG will present the update to HOSC.

3. Conclusion and recommendation

3.1 HOSC members are invited to consider and comment on the HWLH CCG report.

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Update on the progression of the Connecting 4 You Programme

High Weald Lewes Havens CCG – November 2017

1. Background

High Weald, Lewes and the Havens (HWLH) is a large area without an acute hospital meaning that patients have to travel to one of three neighbouring ones. This complex patient flow has not always been recognised by local services. HWLH has an older than average population, high levels of frailty and pockets of poverty and health inequalities. Often patients struggle to understand their health and care services, as different organisations are responsible for different stages of their care.

Coupled with this complex geography and demographics there is also the backdrop of unprecedented financial challenges as well as unsustainable pressure on all parts of the health and social care system due to ever increasing demand and universal workforce recruitment difficulties again across the whole system from care homes to therapists to hospital doctors and general practitioners.

In recognition that no single organisation will be able to address these challenges and meet the needs of the population of HWLH a strong partnership approach is needed. In response the Connecting 4 You (C4Y) Programme was initiated in 2016 building upon developments done at an East Sussex level in preceding years, to transform the delivery of health and social care services across the HWLH Clinical Commissioning Group (CCG) area. This enabled the focus of integration of services to be developed at a bespoke and targeted level with relevant stakeholders.

C4Y is a partnership led by East Sussex County Council (ESCC) and HWLH CCG and covers the whole population of HWLH. The partnership includes;

- Primary Care
- Healthwatch East Sussex
- ESCC Adult Social Care and Children's Services
- Public Health
- Sussex Community NHS Foundation Trust (SCFT)
- Sussex Partnership NHS Foundation Trust (SPFT)
- Third and Voluntary Sector
- Wealden and Lewes District Councils

2. Introduction

At the meeting of the East Sussex HOSC in June 2017 there was a presentation given detailing the development of the Connecting 4 You (C4Y) Programme. It was noted that the building blocks of C4Y were firmly in place and HOSC Members requested an update on the 'delivery' of the programme later in 2017.

This report has been produced in response to that request and is split into four sections. The first section offers a high level update in regards to the development of the comprehensive C4Y Programme Plan, to stakeholder engagement, the progression of the accountable care model for HWLH and the C4Y governance arrangements.

The report then details three main areas as examples where significant progress can be seen in terms of tangible deliverables. These include;

- Urgent care systems and readiness for winter pressures; a range of initiatives to ensure integration of the whole system and that it is best able to respond to the current and increasing demands on the health and social care system across the HWLH area of East Sussex.
- The Dementia Golden Ticket – the expansion of an award-winning transformational new model of care
- The development of the Lewes Health Hub and Primary Care Home; the true integration of health and social care services in Lewes, delivering a 'community of practice'.

3. Progression of the Connecting 4 You Programme

3.1 Engagement with the public and wider stakeholders

There continues to be a high priority placed upon ensuring regular and meaningful engagement with the general public and wider stakeholder groups such as the East Sussex Seniors Association (ESSA) and Patient Participation Groups (PPGs).

The C4Y Programme has supported the development of the new Countywide Partnership and Engagement forum and will have a formal representative on the group. The important next step is to determine how the patient and service user experience and perspective that will be captured by this new forum will be used to meaningfully inform the development of the C4Y Programme and its component projects.

In September 2017 as part of the wide ranging and ongoing engagement for the programme, a C4Y Shaping Health and Social Care event was held in Crowborough. This was very well attended with around 60 participants.

The first part of the event was used to update on some key current transformational initiatives including;

- Re-procurement of 111
- Development of Urgent Treatment Centres
- GP Out of Hours service
- Initiatives to pro-actively support those living with frailty

These were well received with widespread support and also useful challenges in regards to specific details such as the pressing need to ensure widespread access to a patient's summary care record throughout the whole health and social care system.

The second part of the event was an opportunity for participants to offer feedback on their experience of using services, both positive and negative, to help shape the focus and development of all aspects the C4Y Programme.

A follow up C4Y Shaping Health and Social Care event is being planned for early 2018 in the Havens area. Discussions have already commenced with the C4Y partner agencies to determine if there are any key initiatives they would like to use the event to engage with the public on.

During 2018 there will also be opportunities for members of the public and wider stakeholders to engage on more localised issues both directly and through partner organisations to help support the development of the four Communities of Practice (COPs) across HWLH.

It is recognised that many people are unable to attend such events due to work, family and caring commitments. Therefore there is a commitment to ensure that effort is made to try to increase the range and number of the general public participating at C4Y engagement events, partner engagement activities and also to develop other, including 'virtual,' methods of engagement. Healthwatch East Sussex have offered their support in achieving this.

3.2 NHS Five Year Forward View new models of care and accountable care systems - Formation and development of the Multi-speciality Community Provider (MCP) Alliance for the HWLH.

A Multispecialty Community Provider model (MCP) is described as a new type of integrated provider system serving the whole population. It combines the delivery of primary care and community-based health and social care services.

Connecting 4 You (C4Y) is a transformational programme and it has been determined that this is best delivered by the adopting the (MCP) as described in the NHS Five Year Forward View. It is perceived that this will allow the flexibility to both progress the four 'communities of practice' and to develop the best fit model to deliver accountable care across the region and the multiple hospital systems in adjacent areas that serve the HWLH population.

During March 2017 senior representatives from ESCC, SCFT, SPFT and HWLH CCG met to consider the development of the C4Y MCP Alliance and in particular make initial agreements about the form and shape. Given the complex geography across HWLH, not least the fact the area is served by four acute hospital trusts, the decision was made to focus on functional delivery ahead of organisational form but to initially adopt a 'virtual' MCP Alliance model.

Membership has been widened to now include;

- The Third and Voluntary Sector (represented via Speak Up)
- Lewes and Wealden District Councils
- Healthwatch East Sussex

It was agreed that a focus on 'frailty' should be the priority for 2017-18 across HWLH. Not only is this identified as a cross cutting priority for all of the organisations represented it was also seen as an ideal opportunity to develop the new ways of integrated working including the formation of the four communities of practices within HWLH which in turn would help determine the optimum alliance configuration for an HWLH accountable care system or MCP.

During 2018 the initial 'virtual' MCP Alliance arrangements will be reviewed with a view to determining the best form for more formal arrangements.

3.3 Sustainable Transformation Partnership (STP) and the Central Sussex Alliance

Increasingly CCGs within STP regions across the country are working more closely together on particular issues where it makes sense to do so at a larger scale. It is recognised that by streamlining processes, CCGs can work more efficiently and effectively that helps avoid duplication and ensures there is more consistency in services and quality across a larger area.

Within the Sussex and East Surrey STP, four CCGs – High Weald Lewes Havens (HWLH), Brighton and Hove, Crawley and Horsham and Mid Sussex – have agreed to work closer together in the form of the NHS Central Sussex Commissioning Alliance.

The Alliance will be organised into two places – North covering Crawley and Horsham and Mid Sussex CCGs; and the South covering HWLH and Brighton and Hove CCGs.

There are no plans to merge CCGs as this would require a change of law given they are statutory bodies and the Governing Bodies of each organisation will remain responsible for commissioning healthcare for their local populations.

The Alliance will look at ways in which it makes more sense to do things at a larger scale. For example:

- Performance management of the large cross boarder contracts such as those with the acute hospital trusts
- commissioning pathways for urgent care
- Specialist secondary care services such as stroke and cancer care.
- IT, finance and 'back office' functions

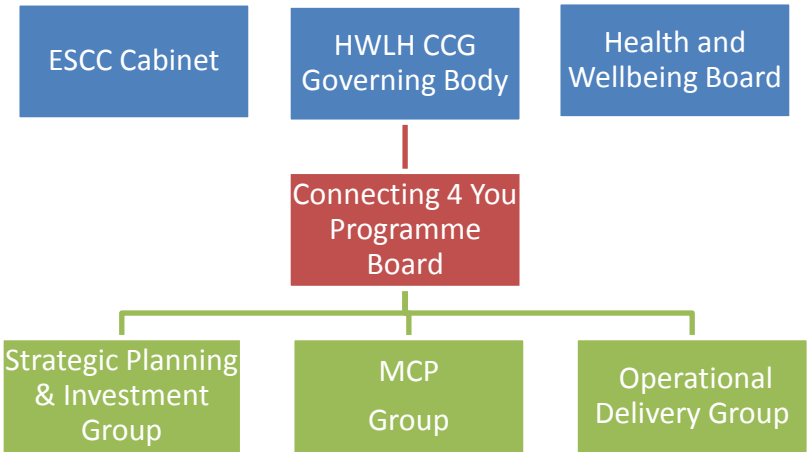
It is important to highlight that this does not change the focus or importance of the Connecting 4 You programme and its shared population as there is still a clear need to transform services and develop better ways of working together on a local or 'Community of Practice' level. To accelerate this work a series of localised 'co-design' workshops are being arranged for November and December 2017 and ESCC Public Health colleagues have offered valuable help in planning and delivering these.

3.4 Governance arrangements

The governance arrangements for the C4Y programme are now firmly in place and the sub-groups fully operational with membership that spans the Connecting 4 You partnership.

The three C4Y sub-committees report into and are accountable to the C4Y Programme Board which is the over-arching governance body for the C4Y Programme and its members are all senior representatives from the partner organisations. This includes representation from the third sector as well as Healthwatch East Sussex. It is here that key decisions fed up from the sub-committees are ratified as well as the focus on the mitigation of key exceptions and significant blockages to the programme.

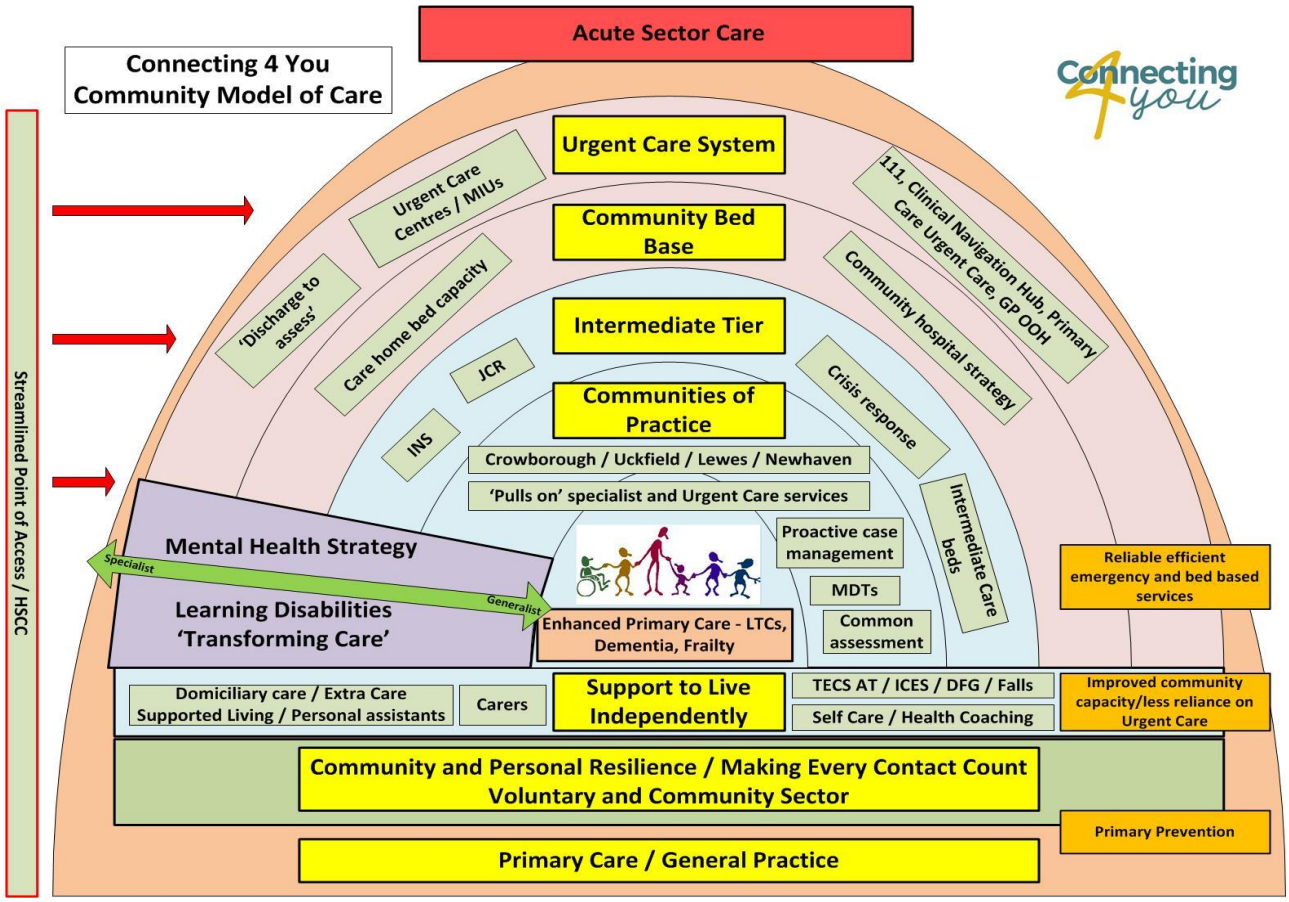
The C4Y governance structure is depicted below;



3.5 C4Y Programme Plan

Considerable work has been undertaken to develop the C4Y Programme plan, building on key East Sussex wide enabling developments such as Health and Social Care Connect and then determining the means to deliver effective integrated heath and social care to the population of HWLH working with the different hospital systems that cover this area.

The plan details all of the transformation projects across C4Y partner organisations that make up the C4Y Programme plan over the next 3-5 years. These are grouped into categories that align to the C4Y Community Model of Care as depicted by the diagram below. The yellow boxes in the model describe the fundamental building blocks of the integrated health and social care system for HWLH.



The plan presents comprehensive detail, including risks relating to each project, that is updated on a monthly basis. Attainment of each project to the plan is set around six universal gateways that all require target completion dates.

This is jointly owned plan for the C4Y partners who all have opportunity to identify key transformational initiatives to add to the programme plan as well as contribute to the delivery of planned programme activities.

The C4Y partnership, the programme and associated governance is the means by which the planning and application of the Better Care Fund and Improved Better Care Fund for HWLH are developed, agreed and monitored.

The C4Y Operational Delivery Group manages the programme through comprehensive monitoring that highlights;

- Attainment or slippage in regards to all six gateways for each project included in the plan
- A summary of all risks threatening the attainment of milestones
- Highlight Reports that provide detail of each project.

The following sections of this report highlight a number of key areas of focus and development of integrated working to improve services for the people of HWLH.

4. Urgent Care and Readiness for Winter Pressures

4.1 Background

Patients access urgent care services when they feel they cannot wait for a GP appointment and need to be seen without delay. Perhaps the most common perception of an urgent care service is the hospital Emergency Department (ED). However patient needs can often met more appropriately, and quickly, in other parts of the urgent care system. It is clear that patients can find the current array of options at times confusing and inconsistent across health and social care systems, and as such default to the ED. The C4Y urgent care programme will offer an integrated urgent care system with a single point of entry via NHS 111 as a viable alternative to presenting at A&E or dialling 999 when it is not an emergency. This model will offer a range of options to the public, including standardised Urgent Treatment Centres, urgent primary care in and out of hours, and other community services, as well as high quality Emergency Departments, whichever service is most appropriate for them.

4.2 The Planning Context

As the majority of HWLH inpatients are placed in acute hospitals outside the county (see table 1), the C4Y partnership includes representation from Brighton and Sussex University Hospitals NHS Trust (BSUH); and Maidstone and Tunbridge Wells NHS Trust (MTW), as well as Sussex Community NHS Foundation Trust (SCFT) who hold the contract for community services (including the three community hospitals) with the CCG area

Table 1: 12 month's inpatient activity up to August 2017

12 months inpatient activity up to August 2017

		BSUH	MTW	ESHT	Total
Eastbourne, Hailsham and Seaford (EHS)	No.	3,218	271	45,932	49,421
	%	6.51%	0.55%	92.94%	
Hastings and Rother (H&R)	No.	1,365	589	44,317	46,271
	%	2.95%	1.27%	95.78%	
HWLH	No.	15,442	10,702	5,502	31,646
	%	48.80%	33.82%	17.39%	
East Sussex Total	**No.**	**20,025**	**11,562**	**95,751**	**127,338**
	%	**15.73%**	**9.08%**	**75.19%**	

This marked difference is even more noticeable with Emergency Department attendance, as seen in table 2.

Table 2: 12 months A&E activity up to August 2017

12 months A&E activity up to August 2017

		BSUH	MTW	ESHT	Total
EHS	No.	3,260	186*	49,745	53,005
	%	6.13%	0.35%	93.52%	
H & R	No.	593	633	50,076	51,302
	%	1.16%	1.23%	97.61%	
HWLH	No.	21,352	8,870	4,585	34,807
	%	61.34%	25.48%	13.17%	
East Sussex Total	**No.**	**25,205**	**9,503**	**104,406**	**139,114**
	%	**18.12%**	**6.83%**	**75.05%**	

* Includes one set of suppressed numbers so could be up to an additional 4 patients here

As a result, the CCG, and C4Y partners including ESCC Adult Social Care, SCFT, and SPFT actively feature in the planning and delivery of three systems: East Sussex Healthcare NHS Trust (ESHT); BSUH; and MTW; as well as the STP-wide NHS 111 programme board and Urgent and Emergency Care Network (chaired by the CCG chair, Dr Elizabeth Gill). Through these Boards, comprised of Executive officers from each health and social care organisation, plans have been put in place to ensure urgent care services meet the needs of patients, particularly during the build up to, and during, the Christmas and winter periods. Input form SCFT and SPFT, who span a number of health and social care systems, ensures a consistent response to the planning and delivery of multiagency services. Specific pieces of work are as follows

4.3 C4Y Urgent Care programme

4.3.1 Primary Care steaming at the Emergency Department front door.

Using local data, up to a third of patients attending Emergency Departments (EDs) in Sussex could be more appropriately, and swiftly, seen by a GP. This is in line with national projections. This year, as part of the Five Year Forward View, all CCGs and Acute Hospitals with EDs were asked to put in place streaming at the front door to steer appropriate patients towards a primary care physician. This will: reduce the pressure upon the ED; reduce the need for a wider array of diagnostic tests; reduce costs due to a lower PBR tariff; and, most importantly, direct patients to the most appropriate care for their needs. Recognising that a significant number of people from HWLH attend the Royal Sussex County Hospital (RSCH) in Brighton and Princess Royal Hospital (PRH) in Haywards Heath, both part of BSUH, the CCG led on the planning and delivery of this service, which went live on 31 October. Through membership of the ESHT and MTW boards, the CCG also received assurance that similar streaming is in place in those hospitals attended by HWLH patients.

4.3.2 Delayed Transfer of Care (DTOCs) reduction

Over the last 12 months DTOCs have risen significantly across the country, and this has been particularly felt in BSUH and ESHT. Most noticeably, data showed that East Sussex had a greater proportion of DTOCs relative to other CCGs in BSUH. East Sussex patients were more likely to experience delays to discharge than their counterparts in Brighton and West Sussex. Over the summer the CCG worked with Adult Social Care and SCFT through the C4Y programme to put in place a programme of activity to reduce DTOCs. At the time of drafting, there are 6 patients experiencing delays of an average 7 days, which is down from a high of 27 patients in September with and average delay of 28 days. This has led to an additional focus on delays in the community hospitals, with similar reductions.

4.3.3 Admission Avoidance/Discharge to Assess

During the DTOC programme, it became clear that a number of delays were due to patients who, though medically ready, were not leaving hospital because they were awaiting further assessments, for example for Occupational Therapy, Continuing Health Care, or further social services intervention. The CCG has been working with Adult Social Care, SCFT and the Joint Community Rehabilitation (JCR) teams to develop a Discharge to Assess programme which will support patients in their homes, ensuring they spend as little time in hospital as possible and are assessed in their regular surroundings (which research suggest results in them ultimately needing a reduced package of care) and can be managed by the multi-agency Communities of Practice, which were established as part of the new community services contract with SCFT, which went live in November 2015. A full business case will go to the C4Y programme board in December, and subject to approval mobilisation will take place in January 2018.

4.3.4 Let's Get You Home campaign

A number of discharges are delayed due to patients and/or their families taking time to accept a package of care, or care home option, made available to them. As well as reducing flow in the acute hospital, this also impacts on patient safety, as research has shown the longer patients stay in acute settings when medically ready to leave, the longer their convalescence is likely to take. Recognising that this can be a difficult time for patients and their carer, the CCG led on a Sussex-wide policy and information campaign for staff, patients and carers to reduce these delays. This was successfully run at the start of 2017, and is currently being repeated across Sussex in time for Winter 2017/18.

4.3.5 Enhanced Health Care in Nursing Homes

During the year, and particularly in winter, EDs see a significant number of conveyances from Care Homes. Last winter the CCG piloted an initiative with a number of nursing homes which included 'ward rounds' from local GPs and the creation of agreed care plans which could be accessed by the GP Out of Hours Service in the event of the resident displaying concerning symptoms. The evaluation showed 35 fewer conveyances to hospital over the Christmas period than the previous year. Therefore the CCG is now rolling out an enhanced programme, including training for care home staff and medication reviews, to all care homes in HWLH by April 2018.

4.3.6 Community Geriatricians

This is an initiative that commenced in the Havens and was immediately well received whilst showing a clear link to a reduction in non-elective admissions to acute hospitals. community geriatricians are patient facing and provide expert advice to GPs, community hospitals and care homes as to how best to treat and support those living with moderate to severe frailty and have complex co-morbidities. The community geriatricians are employed by the acute hospital trusts serving HWLH hence offering a vital link between these and community services.

This service has now been expanded to the rest of HWLH and has been enhanced further by the support of community pharmacists who can carry out poly-pharmacy reviews to ensure that complex medication regimes are not increasing the risk of a person falling.

4.3.7 Winter resilience

As every year, the CCG and ESCC have contributed to the planning for winter in all three health and social care systems which they face. These plans have been subjected to desktop testing facilitated by NHS England, and will ensure that HWLH patients receive the best possible response regardless of which system they access treatment and care from. The C4Y programme has provided a vehicle for community and primary health and social care services in HWLH to engage with acute providers and the voluntary sector to ensure this consistent response.

4.3.8 Next steps

During 2017/18 the Connecting 4 You programme will continue to develop an urgent care programme which meets the needs of residents. C4Y Shaping Health and Social Care events, regular contact with Patient Participation Groups, online surveys, and the involvement of patients and carers in project design and implementation are all ways in which patients and public are involved in this programme of work.

5. The Dementia Golden Ticket – An award-winning new model of care

5.1 Context

A diagnosis of Dementia can be devastating and can severely affect families, relationships and the quality of life, which they all experience. There are expected to be 2,620 people of all ages living with dementia in High Weald Lewes Havens (HWLH) and approximately a quarter of hospital beds are occupied by someone who has a dementia. The total cost of the disease is higher than the cost of cancer, strokes and heart disease combined.

As with other diseases, it makes a difference if dementia can be identified and treated as early as possible. Evidence also proves that a psycho-social model of support can help people with a diagnosis (and their families) to live as well as possible with the condition; this is why the Department of Health's National Dementia Strategy was titled 'Living Well'.

5.2 The Case for Change

Local clinical enquiry, including a Quality Impact Assessment undertaken, indicated that the existing HWLH dementia pathway fell short of meeting the needs of patients and carers and did not provide adequate support or quality of care. This cumulative picture was leading to dementia patients presenting in acute and emergency settings, in what was considered to be an avoidable poor state of health. As such, the system was viewed as ill-equipped to support patients and carers with a dementia.

Based on these findings, the CCG engaged in an extensive clinical review and stakeholder engagement exercise. It formalized a partnership with Sussex Partnership NHS Foundation Trust (SPFT), Primary Care, Community Services and the Voluntary Sector and established a clinically-led committee to support the co-production of The Dementia Golden Ticket model of care. This wholly new approach to dementia care and support, involved an extensive re-design of dementia care across the system, with a focus on integrated and holistic care (of both the person with dementia and their family carer) and a shift from Secondary Care interventions to pro-active Primary Care management and post-diagnostic support. It also included a range of psycho-social interventions to help people live as well as possible, for as long as possible with the condition.

Having successfully piloted the model of care at Buxted Medical Centre, the CCG was able to demonstrate with some assurance, compelling evidence that The Dementia Golden Ticket approach improves outcomes for patients and carers, delivers economic benefits to the health and social care system and is preferred by the workforce, to the historical dementia pathway.

Externally, it has been commended as a model of best practice, winning a number of awards and interest continues to grow about its applicability at scale, including nationally.

5.3 Implementation and Mobilisation

Further work and refinement, together with the completion of a Primary Care Education package in partnership with Brighton and Sussex Medical School (BSMS), now sees the partnership framework in a state of mobilisation to roll-out the model of care in a phased approach based on 'Waves' of implementation in Primary and Community Care. There is a 2 year incremental model of delivery in Secondary Care due to workforce implications. This approach was approved by the CCG's Governing Body as the most supportive method of rolling out a new model of care and the safest means of managing the transfer of patients from Secondary to Primary Care.

As of the 02 October 2017, 5 Practices went live with The Dementia Golden Ticket with Wave 2 launching in January 2018 (an additional 3 Practices), with plans for another 5 to roll-out from April 2018. The remainder will come on stream, quarterly thereafter.

5.4 What's already different and in place in The Dementia Golden Ticket model of Care:

- A new GP referral pathway, making it easier and more streamlined to refer to Secondary specialist services.

- A new Memory Assessment and Management Service undertaking comprehensive assessments and diagnosis in peoples' own homes (SPFT)

- A Dementia Guide Service, providing contact within 2 days after diagnosis, face to face contact within 10 days and on-going practical and emotional support to the person and family living with dementia. (East Sussex County Council Carers Engagement and Respite Service)

- GP surgeries (signed up to the Locally Commissioned Service) delivering post-diagnosis review within 10 days of diagnosis, 6/12 review meetings and weekly, proactive 'Blip' Clinics. All appointments under the framework are up to 40 minutes long.

- Advanced Care Planning documents have been developed for The Golden Ticket model of care and are mandated to be completed by the GP Practice and Dementia Guide Service, within 6 months' of diagnosis.

- 7 weekly Memory Wellbeing Cafes in Ringmer, Buxted, Crowborough, Peacehaven, Ticehurst, Newick and Uckfield. (Know Dementia)

- 3 Leisure Centres providing weekly Dementia Exercises Classes in Peacehaven, Lewes and Uckfield, rising to 4 in January 2018, to include Crowborough. (Freedom and Wave Leisure)

- 3 Weekly Musical Activity Sessions, in Lewes, Uckfield and Newhaven, rising to 5 localities in 2018. (Know Dementia)

- Free Transport for those people that need it, to access community interventions coordinated by the ESCC Transport Hub.

- 2 hour daily 'Hotline' from Primary to Secondary Care for direct and timely support of the Primary Care workforce. (SPFT)

- 2 half day Education Package delivered in partnership with BSMS, to enable identification of a Lead Primary Care Practitioner and GP for every practice rolling out The Dementia Golden Ticket. Next education package to support Wave 3 scheduled for January and March 2018.

5.5 What benefit is this new approach and support providing to people and the health and social care system:

Patient and carer benefit

- Additional time allocated to this patient group (with appropriate multi-agency support) will help to deliver an enhanced quality of service.
- A shift from acute provision to community-based care, closer to home.
- A model of care which meets the holistic needs of the family situation; improving quality of life, independence and patient and carer experience.
- Patients and carers access good quality and timely information, advice and support, which enable them to self-manage the condition, for as long as possible.
- Carers will receive support, as well as equal access to psycho-social interventions, which enables them to continue in their caring role, for as long as possible.
- Advance Care Planning will be the norm instead of the exception; resulting in improved condition management, and patients and carers having their wishes and preferences respected.
- Practices know their patients (and their families) best and are therefore best-placed to manage their condition.
- Self-reported improvement in patient and carer wellbeing.
- Reduced carer crisis leading to inappropriate admissions to care settings.

Primary Care benefit

- A Primary Care Practitioner-led service, which would previously have relied on GP appointments, will release GP capacity to see more non-dementia patients. This contributes to Primary Care sustainability in the longer term.
- Meeting the holistic needs of the patient and carer will reduce overall GP consultation time and release capacity back into the practice.
- Practices will have the capability to treat all physical health problems 'through the lens of dementia' and to manage the patients' needs holistically.
- Primary Care staff (and other inter-disciplinary workers) feel equipped and empowered to manage slow declining dementia in the community.
- The system will re-orient from reactive crisis response to planned and proactive care; which will enable practices to re-organise the way they see patients and assist with overall resource management.

Secondary Care benefit

- Secondary Care resources are aligned to the most specialist and complex case-work; with additional capacity aligned to support Primary Care in a timely and responsive way.
- The new Memory Assessment and Management Service will provide a higher quality comprehensive assessment in peoples' own homes, delivering the diagnosis in the best possible way, e.g. in people's own homes.
- The multi-disciplinary specialist team will meet twice weekly, to proactively manage and support the most complex cases.
- The system will re-orient from reactive crisis response to proactive care, which will assist with overall resource management.

System benefit

- Primary Care Review and 'Blip' clinics, utilising the 'eyes and ears' of the community and support circle, will maximise opportunities for preventing deterioration and crisis, and thereby reduce admittance to inappropriate care settings.
- There will be a wider spread of dementia knowledge and awareness.
- Easy accessibility to patient information and ability to share information electronically as part of the integrated team.
- Clarity of roles and responsibilities across multi-agencies in the dementia care pathway will prevent patients and carers 'falling through the gaps' and being 'funnelled' through a system of inappropriate and costly care. This should improve patient and carer experience.
- Patients, carers, and health and social care professionals know where to go and who to contact when the person with dementia and/or carer gets into difficulty. This heightened awareness will result in a proactive, integrated and timely response from services, which will help to avoid crisis and admittance to inappropriate care settings.
- Reduced District General Hospital (DGH) admissions.
- Reduced acute dementia bed admissions.
- Reduced carer crisis leading to inappropriate admissions to care settings.
- Delaying/reducing care home usages (based on standardised national evidence base for earlier intervention). An increase in discharges back to original place of residence.
- In year 1 there is a total anticipated system benefit of £74k, rising to £929k in year 2 and £1,452k in year 3. Not all of this benefit is immediately cash releasing.

5.6 Governance and Partnership

Oversight of implementation of The Dementia Golden Ticket model of care across HWLH is by an Executive Steering Group for Dementia and a Joint SPFT Implementation Steering Group and progress is reported to the C4Y Programme Board.

As ambitions to recruit Admiral Nurses (specialist Nurses of Carers of people living with Dementia) progresses, a partnership Steering Group including multiple Agencies, (including the Voluntary Sector), will be developed.

5.7 Awards

The Dementia Golden Ticket model of care has won the following accolades:

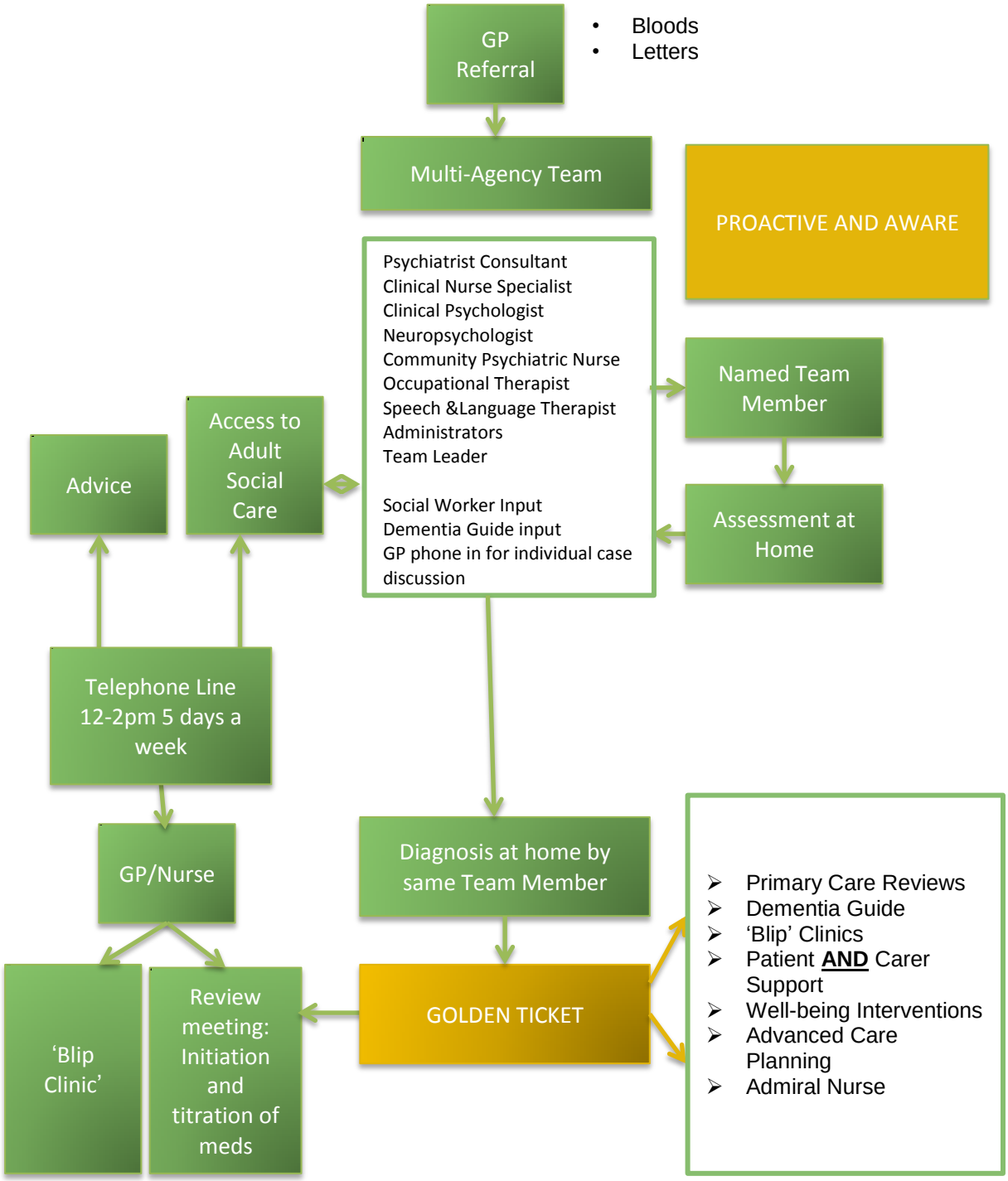
- The National Primary Care Awards 2016 - Winners of 'Pathway Innovation of the Year Award'

- National Dementia Care Awards 2016 - Shortlisted in top 5 for 'Outstanding Dementia Care Innovation'

- The Dementia Golden Ticket Pilot won Gold in the Sussex Partnership NHS Foundation Trust 'Partnership in Practice', award for effective partnership working across groups, within an integrated team, with patients and carers, other teams and organisations. It also won Silver in the 'Team' Category.
- The Dementia Golden Ticket won the Health Foundation's Innovation for Improvement Programme Award.

It is currently Shortlisted in the Primary Care Team category of The BMJ Awards (22 November 2017) and GP Awards (30 November 2017) for Primary Care innovation. The Dementia Golden Ticket has been showcased nationally and internationally, as a model of best practice.

5.8 The Dementia Golden Ticket – Full Model of Care



6. Lewes Health Hub and Lewes Primary Care Home: Premises and Care Model

Central to the C4Y Programme are the four 'Communities of Practice' (CoP); Crowborough, Uckfield, Lewes and the Havens. These are seen as the foundation for transforming integrated community care in HWLH, serving populations of 30,000 – 50,000. CoPs were a key component of the reprocurement of community services now provided by SCFT. CoPs bring together primary care, community services, ASC, SPFT and the third and voluntary sector. Lewes practices are at the forefront of developing this integrated way of working and are part of a national vanguard programme that describes this as 'Primary Care Home'.

6.1 Lewes Health Hub

In December 2014, NHS England announced the availability of £1bn over four years to improve access and the range of services available in primary care, through investment in premises, technology, the workforce and support for working at scale across practices.

Clinical Commissioning Groups (CCGs) were invited to submit recommendations to NHS England to support the funding of improvements and developments in practices.

The recommendations were required to demonstrate the following:-

- Increased capacity for primary care services out of hospital
- Commitment to a wider range of services to reduce unplanned admissions to hospital
- Improving seven day access to effective care
- Increased training capacity

An application from the three Lewes practices to create the 'Lewes Health Hub' was approved by the CCG, and submitted to NHS England on 30th June 2016. On 28th October 2016 confirmation of the success of bid was received.

The proposal is for the relocation of three Lewes GP practices from their existing, challenged premises, into a purpose-built health campus on the North Quarter Development in Lewes. In addition to the new practice premises, the accessible location will provide a catalyst for change to health and social care provision for the town of Lewes.

Integration of the three practices and community services will enable more flexible seven-day working, increase resilience, and enable the patients of Lewes to access a broader range of services within a core mandated primary care services, and enable the use of practice pharmacist, paramedic and nurse specialists working at scale. In addition, the close working will be engendered with ease of access to the associated facilities providing community, social and third sector services that will be situated within the wider health campus, providing more joined up care for the patients within Lewes.

The North Quarter development is being undertaken by Lewes District Council in partnership with Santon, the premises development arm of a South African Pension Company. The development is to be carried out in three phases, with the Health Hub being part of the first phase which is currently projected to be completed by March 2019.

It is envisaged that additional space within the primary care facility will enable the practices to extend the current training programmes and increase from 4 GP trainees with additional medical school and nurse training. Paramedic practitioner training, practice nurse training and physician assistants will also be included within the training programmes.

6.2 Lewes Primary Care Home

Following a thorough consultation process of all GPs of River Lodge, St Andrews and School Hill there has been a unanimous agreement to proceed to a merger of all 3 practices.

The three practices seek to shape their Clinical Model on 'Primary Care Home', a model that brings together a range of health and social care professionals to work together to provide enhanced personalised and preventative care for their local community.

Within this model staff come together as a complete care community – drawn from GP surgeries, community, mental health and acute trusts, social care and the voluntary sector – to focus on local population needs and provide care closer to patients' homes. Primary Care Home shares some of the features of the multispecialty community provider (MCP) - its focus is on a smaller population enabling primary care transformation to happen at a fast pace, either on its own or as a foundation for larger models.

This focus will drive locally owned, bottom up change that is sustainable beyond the end of the New Model of Care (NCM) programme in 2017/18, making the programme value for money and truly transformational.

The scheme has been accepted as one of the second wave of 'Primary Care Home' sites supported by the National Association of Primary Care (NAPC) to develop a model of integrated care aligned with a multispecialty community provider as described in the NHS 5 Year Forward View.

Evolving general practice in this way will allow a focus on patient's needs to give individualized care and integrate with other providers of care and well-being in the wider local health community to provide a single point of access for health and social care needs whilst continuing to retain the long-term continuity that patients have come to appreciate in Lewes by working in care teams which will focus on specific cohorts of patients.

Multidisciplinary teams will focus on patient groups with different care needs supported by patient advisors who are able to direct patients to the most appropriate pathway and patient navigators who are able to provide advice and support.

Patient Groups

- Children & Young People
- Working Age Adults
- Older People

Care Needs

- Complex Needs
- Long Term Conditions
- Generally Well

Types of care

- Ongoing Care
- Elective Care
- Urgent Care

Continuous care teams

By creating small groups of GPs supported by patient navigators these teams will retain the long-term continuity that patients value at the same time as giving daily access for patients with ongoing needs. More complex needs can be helped by proactive case management.

Acute team

Integrating existing acute care in general practice with minor injuries and minor ailments services. This team can triage patients to the most appropriate member of staff utilising Nurse Practitioner, Paramedic and GP roles.

Multiagency Team

Complex patients requiring specialist case management are supported by dedicated case managers. Multidisciplinary teams including community nurses, palliative nurse specialists, community psychiatric nurse, social worker, Occupational therapy, community physiotherapy and GP's meet to provide a holistic integrated approach to ensure health and social care needs are met.

Long-term condition team

'One stop shop' aimed at seeing patients for all routine medication and chronic disease reviews at one appointment. Routine blood testing and blood pressure monitoring with support from specialist nurses and community pharmacists to provide expert advice on long term conditions.

Nursing Team

Providing an integrated approach to patients requiring nursing care both in the practice and in the community. Bringing together existing separate teams to provide a co-ordinated approach.

Specialist teams

Patients can be provided with advice when specialist input is required providing services not part of the GMS contract such as travel advice, vaccinations, contraception with coils and implants, sexual Health, dermatology and substance misuse. Over time these can be extended and integrate secondary care roles into the organisation

Redesigning the delivery of acute, chronic and preventive health care and integrating it more closely with the parallel process of social care, community well-being, public health and secondary care will create a truly transformed and sustainable landscape. This aligns fully with the five year forward view to enable a growing and aging population to maximise their health and well-being.

7. Next Steps

Presented above are three key work streams that are fully transformational and demonstrating tangible benefits to the health and social care system for the people of HWLH, to offer assurance that the C4Y Programme is active and demonstrating success.

There is full recognition that we are facing economic challenges that are far more stark than those health and social care have faced over the last ten years. Through the C4Y governance forums there is a strong and continual focus on what transformational initiatives need to be implemented as quickly as possible to offer swift and real mitigation in regards to the current pressures throughout the system.

Below is an outline of some of the further transformational initiatives that are actively being developed. All of them have a clear focus on reducing the number of people admitted to acute hospital and better outcomes for the individual.

- Falls; there is currently a scoping exercise underway to identify the gaps in interventions that help prevent falls and also one that help ensure the maximum possible reablement for those that have fallen.
- East Sussex Fire and Rescue Service Home Safety Checks; following the successful initiation in the Havens this service is being expanded into the Crowborough area. This is targeted at those living with frailty and the focus is to mitigate trip hazards and other aspects of a person's home environment that could put them at risk.
- Hospice in the Weald training scheme; This is offered to Care Home staff to better manage end of life care in residential settings thus greatly reducing the number of people who are admitted to die in an acute hospital.

- Integrated Support Solutions; This is an initiative being led by ESCC and aims to bring together a range of currently 'stand-alone' interventions that are all focused on keeping people living independently at home for as long as possible resulting in far more holistic single assessment of a person's needs. This has strong potential to add synergy to the range of interventions being developed to help better support those living with frailty in the community.
- 111/Out of Hours procurement. This is a Sussex wide procurement, which has been the subject of a previous presentation to the HOSC. The local response to the 111 programme will be developed by C4Y, whether in or out of hours.
- The further development of Minor Injuries Units and their alignment with services HWLH patients access outside of East Sussex, including Walk-in Centres, Urgent Care Centres, and EDs. The HWLH MIUs, provided by SCFT, are important clinical assets used by the patient population. As part of the C4Y programme the MIUs will be supported to increase the activity they see and to integrate more fully with primary care both in and out of hours.
- Frailty pathways. HWLH patients currently benefit from a community geriatrician service working with BSUH and MTW. This will be developed in conjunction with the Communities of Practice to ensure a full programme of support to the frail elderly across the CCG area.

Author;

Sam Tearle

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November 2017.

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

Date of meeting: **30 November 2017**

By: **Assistant Chief Executive**

Title: **Cancer Performance in East Sussex**

Purpose: **To update HOSC on cancer performance in East Sussex.**

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 In early 2017, NHS England published ratings providing a snapshot of how well different areas of the country were diagnosing and treating cancer and supporting patients. Cancer performance was assessed across all Clinical Commissioning Groups (CCGs) in England, with each CCG being given one of four headline ratings based on their performance across four cancer targets. The results were published on MyNHS. The four targets are:

- Cancer diagnosed at early stage (within stage 1 or stage 2);
- People with urgent GP referral having first definitive treatment for cancer within 62 days of referral;
- One-year survival from all cancers; and
- Cancer patient experience.

1.2 The headline rating for both Eastbourne, Hailsham and Seaford (EHS) and Hastings and Rother (HR) CCGs was *Inadequate*. High Weald Lewes Havens (HWLH) CCG received a rating of *Requires Improvement*.

1.3 In response to these assessments, HOSC requested an initial briefing, which was circulated to the committee by email in May, on what was being done to improve cancer care in the two CCG areas rated as inadequate. In September the committee requested a follow up report be provided for this meeting's agenda, and that it include an update on cancer performance across the whole of East Sussex.

2 Supporting information

2.1. Two reports covering the ESBT (EHS and HAR) and Connecting 4 You (C4Y – HWLH CCG) areas of East Sussex are attached as appendices 1 and 2. Paragraph 2.1-2.7 of the report attached as appendix 1 sets out how EHS and HR CCGs are improving their performance against the key targets, including by supporting and raising awareness amongst GPs about cancer diagnosis and referrals, and raising community awareness.

2.2. Appendix 2 sets out how HWLH CCG is improving its performance against these targets.

Cancer waiting time targets

2.3. The NHS Constitution includes maximum referral time targets for patients with suspected (and diagnosed) cancer. NHS acute trusts' performance is measured against these targets on a monthly basis; they include:

- Two week wait from urgent GP referral to first appointment.
- 31 days from diagnosis (date of decision to treat) to first treatment (start date)
- 62 days from urgent GP referral to first treatment (start date).

East Sussex Healthcare NHS Trust (ESHT)

2.4. The main provider of cancer care diagnosis and treatment for the ESBT area is East Sussex Healthcare NHS Trust (ESHT). The report attached as appendix 1 shows that ESHT is meeting the two week waiting time and 31 days from diagnosis targets. It is not, however, currently meeting the 62 days from urgent referral to treatment target of 85% (see appendix 1 paragraph 3.2). The 62 day target is the same target that CCGs were measured against as part of the national assessment.

2.5. A Cancer Improvement Plan is in place for ESHT containing a number of recommendations for the Trust to take forward during the next year. These are set out in paragraph 3.3 of appendix 1.

Brighton & Sussex University Hospital NHS Trust (BSUH)

2.6. There are three NHS Trusts that receive suspected cancer referrals for residents in the HWLH area; Brighton and Sussex University Hospital NHS Trust (BSUH), Maidstone and Tunbridge Wells NHS Trust (MTW), and ESHT.

2.7. Performance by BSUH against the NHS constitutional standards is set out in paragraph 3.2 of appendix 2. The Trust is meeting the two week and 31 days target, but not the 62 day referral to treatment target.

2.8. Details of the BSUH recovery plan are set out in paragraph 3.3 and 3.4 of Appendix 2.

Maidstone and Tunbridge Wells NHS Trust (MTW)

2.9. MTW performance across the NHS constitutional standards has been variable over the past 12 months. The 2 week wait standard has been achieved in 9 of the past 12 months, the 31 day standard in 6 of the past 12 months and the 62 day standard has not been achieved at all in the past 12 months.

2.10. NHS Improvement has asked MTW to put together a trajectory to meet the 62 day standard by December and MTW has developed a recovery package in partnership with West Kent CCG. This is set out in paragraph 3.8 of appendix 2.

3. Conclusion and reasons for recommendations

3.1 This report provides HOSC with an update on the performance of NHS commissioner and provider organisations in relation to cancer care targets. HOSC is recommended to consider and comment on the report and to determine what further scrutiny is required.

PHILIP BAKER
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East Sussex Better Together: Cancer Performance

A progress update for the East Sussex Health and Overview Scrutiny Committee November 2017

1. Background

1.1 In July, NHS England published 2016/17 ratings providing a snapshot of how well different areas of the country are diagnosing and treating cancer, and supporting patients.

1.2 Based on data published over the course of the last two years, a Clinical Commissioning Group Improvement and Assessment Framework (IAF) has been published and this provides an initial baseline rating for six clinical priority areas; of which one is cancer.

1.3 The ratings, which are broken down by local Clinical Commissioning Groups (CCGs) and published on MyNHS, show areas in need of improvement, and also highlight areas of best practice.

1.4 The headline ratings by CCG for cancer performance in 2016/17 showed that local improvement is needed to maximise outcomes for local people as Eastbourne, Hailsham and Seaford CCG (EHS and Hastings and Rother CCG (HR) were both rated as inadequate in this regard.

1.5 The table below shows 2016/17 performance by IAF cancer target:

CCG	Cancers diagnosed at an early stage	Suspected cancer urgent referral to having first definitive treatment with 62 days	One year survival from all cancer	Cancer Patient Experience – average score given by patients asked to rate their care on a scale of 1-10 (10 being best)
EHS	44.2%	75.3%	68.8%	8.8
HR	49.8%	69.5%	67.1%	8.5
England average	50.72%*	81.88%**	69.6%*	8.7*

*Data taken from cancer dashboard https://www.cancerdata.nhs.uk/dashboard#?tab=Overview

**NHS England, September 2017 (month only) 62 day performance, England average

1.6 The data presented from 2016/17 showed that both CCGs require improvement in cancers diagnosed at an early stage, people with urgent (suspected cancer) GP referral having their first definitive treatment within 62 days of referral and one year cancer survival from all cancers.

1.7 The following sections of this paper provide information on current performance and action being taken to ensure sustainable improvement locally. It should be noted that data on the 62 day target is available on a monthly reporting cycle. The latest 62 day target performance is for September 2017 and is:

September 2017, 62 day performance	**Target 85%**
HR CCG	85.42%
EHS CCG	75.3%
East Sussex Healthcare NHS Trust (ESHT)	80.8%
England average	81.88%

1.8 Around the country the 2016/17 CCG IAF performance varies. More locally, the performance rating for each of the Sussex CCGs, Crawley, Coastal West Sussex, Brighton and Hove and High Weald Lewes Havens, was requires improvement. For Horsham and Mid Sussex CCG the rating was good.

1.9 Secondary care diagnosis and treatment for the East Sussex Better Together area is predominantly provided by ESHT. However, patients may also be referred to other providers such as Brighton and Sussex University Hospitals NHS Trust (BSUH) and Maidstone and Tunbridge Wells NHS Trust (MTW). This report includes details of ESHT performance. High Weald Lewes Havens (HWLH) CCG will include BSUH and MTW performance in their report as part of this agenda item.

2. Cancer diagnosed at an early stage

2.1 When a patient is diagnosed with cancer, the extent of the cancer is determined by stage – 1, 2, 3 or 4 with 1 being at an early stage and 4 being advanced cancer. This staging is recorded by secondary care providers. Providers are working to improve the quality of their data and, at ESHT data completeness has increased from around 20% of all patient staging being recorded last year, to 40% this year. The CCGs are working with ESHT to ensure data completeness increases further.

2.2 There is a range of ways to increase awareness and improve early diagnosis of cancer. Nationally there are the screening programmes for bowel, cervical and breast cancers and these programmes are offered across both CCGs. Additionally, the national Be Clear on Cancer programme aims to improve early diagnosis of cancer by raising public awareness of signs and symptoms of cancer, and to encourage people to see their GP without delay: this summer there were both respiratory and skin cancer campaigns.

2.3 Both CCGs are implementing the June 2015 National Institute for Health and Care Excellence (NICE) guidance for Suspected Cancer: Recognition and Referral (NG12). This is part of delivering earlier diagnosis for cancer patients and hence

improved survival. This guideline includes recommendations on the symptoms and signs that warrant investigation and referral for suspected cancer. The (previous) 2005 guidance indicated around 5% of patients referred would actually have a cancer diagnosis. The evidence base has developed since then and the 2015 guidance uses a threshold of 3%. Lowering the threshold for referral does mean an increase in referrals into secondary care for some types of cancer and it should help to improve the number of patients diagnosed earlier – at stages 1 or 2 rather than 3 or 4.

2.4 GP education in cancer awareness and symptoms has also been a focus for both CCGs. There was an East Sussex wide cancer GP Update event in November 2015, an HR event in July 2016 and an EHS one in June 2017. The agenda for each of these events had a heavy focus on NG12 and generally raising awareness of signs and symptoms of cancer to support earlier diagnosis.

2.5 Further to this, in order to address significant health inequalities, the CCG has established the Healthy Hastings and Rother (HHR) Programme. The programme aims to address health inequalities by improving the health and wellbeing of people in the most disadvantaged communities in Hastings and Rother and reducing the life-expectancy gap between the most affluent and most deprived communities.

2.6 Cancer is one of the main causes of premature death and a key contributor to inequalities in life expectancy in Hastings and Rother. Cancer incidence and prevalence rates are both significantly higher than England, with colorectal and lung cancers in particular showing worse outcomes. As such, as part of the overall HHR programme, a Cancer Quality Improvement Programme has been established to focus resource and action where it is most needed and most likely to have a positive impact on people's lives. Initiatives include:

- **Cancer Quality Improvement Service (CQIS):** A Cancer Research UK (CR UK) Primary Care Facilitator is working to enhance primary care cancer-related performance. GP practices are supported to review their data and develop practice cancer action plans.

- **Locally Commissioned Service (LCS):** GP practices have taken part in a scheme to increase uptake of national cancer screening programmes by identifying patients who did not attend screening and inviting them to do so.

- **Cancer Awareness Roadshow:** The CR UK roadshow was held in Hastings and St Leonards (the more deprived locality of Hastings and Rother) in July 2016.

- **"Speed dating" for GPs and consultants:** This event, led by CR UK, brought together GPs and secondary care clinicians to focus on improving diagnosis and referral. Further events have been planned.

- **Community Approaches to Promoting Early Awareness of Cancer:** Following a tender process, Unique Improvements, a not-for-profit organisation, working with disadvantaged communities to find local solutions to problems using a community asset-based approach, have been commissioned to promote public awareness of symptoms and the need for early presentation. They are building on community assets, recruiting, training and supporting teams of local volunteers to take action in their own communities.

- **Population survey of cancer awareness using the Cancer Awareness Measure (CAM):** Over 2000 people from a representative sample of residents aged 45-74 years completed face-to-face interviews. The results have informed the public awareness work of Unique Improvements.

2.7 Following the success of the focused work in Hastings and Rother, and in addition to the local roll out of national programmes, this learning will be shared across to the EHS CCG area in order to understand where to target additional work as appropriate.

3. Cancer Waiting Times

3.1 The NHS constitutional (maximum) waiting time targets for suspected (and diagnosed) cancer patients include:

- Two week wait from urgent GP referral to first appointment (2WW).
- Two week wait from general breast symptoms (where cancer is not initially suspected) GP referral to first appointment.

- 31 days from diagnosis (date of decision to treat) to first treatment (start date) (31 day).
- 31 days for subsequent treatments for new cases of primary and recurrent cancer where an anti-cancer drug regimen or surgery is the chosen treatment modality.
- 31 days for all subsequent treatments for new cases of primary and recurrent cancer where radiotherapy is the chosen treatment modality.

- 62 days from urgent GP referral to first treatment (start date) (62 day).
- 62 days from a cancer screening service to first treatment.
- 62 days from a consultant's decision to upgrade the urgency of a patient they suspect to have cancer to first treatment.

3.2 For the ESBT area, the main provider for suspected cancer referrals is ESHT. ESHT have made considerable improvements over the last year with performance against the NHS constitutional cancer waiting times targets. The targets are now

being met sustainably with the exception of the 62 days from urgent referral to treatment – see table below showing ESHT 2WW, 31 day and 62 day targets over the last year. Plans are in place to improve performance in this area and achieve the 62 day target.

ESHT Cancer Waiting times performance

Target	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May17	Jun 17	Jul 17	Aug 17	Sept 17
2WW (93%)	97.2%	98.7%	98%	97.1%	98.4%	98.1%	96.8%	96%	96%	95.4%	94.7%	96.4%
31 day (96%)	98.7%	99.5%	98.3%	99.5%	98.8%	97.1%	98.1%	96.8%	98.9%	95.3%	97.7%	96.8%
62 day (85%)	82.5%	78.3%	84.1%	78.6%	69.9%	76.3%	76%	72.4%	73.4%	74.7%	81.6%	80.8%

3.3 The ESHT Cancer Improvement Plan is regularly reviewed and the CCGs continue to work proactively with ESHT to ensure the actions in the plan continue to secure improvement and ensure sustainability of cancer services delivery. Following the most recent review, there are a number of key actions that ESHT will address during the next year, including:

- Tumour site pathway reviews: urology; head and neck and lower gastrointestinal have taken place, with lung next.

- Strengthening links with tertiary centres via joint Patient Tracking List (PTL) weekly meetings: links with BSUH, MTW and Guy's and St. Thomas' Hospitals Trust (who are the tertiary centre for lung cancer patients) are all established. This will support patient pathways between ESHT and the respective tertiary provider and help with achieving the targets.

- Continued review of trigger points used on PTLs to ensure the patient pathway is proactively managed.

- Development of a strategy for radiology to ensure capacity can meet demand and enable direct access referrals (in line with NICE guidance for Suspected Cancer: Recognition and Referral NG12).

- Order Comms (an electronic requesting system) for radiology has now been rolled out to all GPs in both CCGs and should be rolled out in ESHT by the end of December 2017.

- Reviewing the breast cancer pathway to ensure full implementation of one-stop clinics and most appropriate follow up pathways.

- The CCG funded the purchase of endo-bronchial ultrasound (EBUS) equipment enabling ESHT to set up a local service for patients who previously had to go to Brighton or London. The local service commenced in June 2017.

- ESHT have been partially successful in two bids made to NHS Improvement: firstly (awarded £98k) to enable additional capacity in computerised tomography (CT), gynaecology and urology. Secondly (£85k) for improved patient tracking functions including improving data sharing between clinical IT systems.

3.4 As noted above, the 62 day target continues to be a challenge and a number of initiatives are in place to support improvement where this may relate to patient choice. For example, initiatives to help patients understand the importance of their appointments, such as the patient leaflet that GPs and ESHT give to patients who are referred on the suspected cancer 2WW pathway, and the recruitment of a nurse whose role is to contact patients who decline an appointment to talk through and help where possible. Examples of where this has helped include: talking more about the reason for the referral and what the patient can expect; understanding the patients personal issues so enabling arranging suitable appointments; liaising with care homes so that appointments are made when staff can be released to accompany patients; arranging transport; or simply a phone call the day before an appointment as a reminder.

3.5 Some issues such as workforce are more complex to address and reflect a national picture. This includes a lack of histopathologists, oncologists and dermatologists to fully support improvement.

4. One year survival from all cancers

4.1 The England average for one year survival rates from all cancers is 69.6% (2013). This is an increase from 60.6% in 1999. The 2016/17 CCG IAF shows that EHS are at 68.8% and HR at 67.1%.

4.2 For comparison, other Sussex CCGs have the following one year survival rates: HWLH CCG 69.9%; Brighton and Hove 69.4%; Crawley 66.7%; Horsham and Mid Sussex 71.5% and Coastal West Sussex CCG 67.1%.

5. Patient satisfaction Survey

5.1 The National Cancer Patient Survey is carried out annually by Quality Health Ltd commissioned by the Department of Health (DoH). In 2016 the cohort of patients identified by the DoH was those with a primary cancer diagnosis admitted as an in-

patient or daycase during the period 1st April 2016 to 30th June 2016. For ESHT this represented an initial sample size of 914 of whom 613 patients returned surveys; a 73% response rate compared to the national average of 67%.

5.2 There have been considerable improvements in recent years and despite some continued challenges, the outcome of the 2016 patient satisfaction survey is relatively positive, with EHS achieving 8.8 and HR 8.5 out of 10. There is variation nationally and the average is 8.7.

5.3 ESHT cancer services team has reviewed the results of the survey and have identified a few areas that were below the national average and therefore have developed an action plan to improve these. For example, only 75% of ESHT patients recalled being told that they were entitled to free prescriptions compared with 80% of respondents nationally. Action will be taken forward by the Cancer Services team in conjunction with the Clinical Nurse Specialist teams.

5.4 It should be noted that that were many areas of the survey where ESHT compare similarly or favourably to the national average. For example, 93% of ESHT patients were given the name of their clinical nurse specialist; 77% were asked what name they wished to be known by (national average is 68%); and 97% felt that their GP had been given enough information about their condition and treatment compared to the national average of 97%.

6. Conclusion

6.1 There is much positive action in hand to continue to improve the experience and outcomes of people diagnosed with cancer and we will to continue to implement action and monitor cancer performance to ensure improvements across all of the targets.

6.2 Our focus remains on improving the CCG IAF targets and ensuring we continue to meet the NHS Constitution targets as well as ensuring action to achieve the 62 day target.

6.3 As part of this we are working within the new Surrey and Sussex Cancer Alliance to support implementation of the cancer related recommendations in the NHS Five Year Forward View and the Department of Health Independent Cancer Taskforce Report: Achieving World-Class Cancer Outcomes 2015. These all support improvement in the four cancer targets in the CCG IAF.

Lisa Elliott
Senior Performance and Delivery Manager
NHS Hastings and Rother & NHS Eastbourne Hailsham and Seaford CCGs

November 2017

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Update on Cancer Issues and Performance for the East Sussex Health and Overview Scrutiny Committee

High Weald Lewes Havens CCG – November 2017

1. Background

1.1 NHS England published 2016/17 ratings providing a snapshot of how well different areas of the country are diagnosing and treating cancer and supporting patients.

1.2 Based on data published over the course of the last two years, the **Clinical Commissioning Group Improvement and Assessment Framework** provide an initial baseline rating for six clinical priority areas, including cancer.

1.3 The ratings, which are broken down by local Clinical Commissioning Groups (CCGs) and published on MyNHS, show areas in need of improvement, but also highlight areas of best practice.

1.4 The headline rating for High Weald Lewes Havens for 2016/17 is 'Requires Improvement' with the following associated figures:

1.5 The table below shows performance by IAF cancer target:

CCG	Cancers diagnosed at an early stage	Suspected cancer urgent referral to having first definitive treatment with 62 days	One year survival from all cancer	Cancer Patient Experience – average score given by patients asked to rate their care on a scale of 1-10 (10 being best)
HWLH	51.1%	77.5%	69.9%	8.7
England average	50.72%*	81.88%**	69.6%*	8.7*

*Data taken from cancer dashboard https://www.cancerdata.nhs.uk/dashboard#?tab=Overview

**NHS England, September 2017 (month only) 62 day performance, England

1.6 The performance rating for other Sussex CCGs which require improvement include: Crawley; Coastal West Sussex; and Brighton and Hove. Horsham and Mid Sussex CCG was rated good. Eastbourne, Hailsham and Seaford and Hastings and Rother were inadequate.

1.7 The CCG has patient flow into 3 Trusts for suspected cancer referrals; Brighton and Sussex University Hospital NHS Trust (BSUH) [host commissioner Brighton and Hove CCG], Maidstone and Tunbridge Wells NHS Trust (MTW) [host commissioner West Kent CCG] and East Sussex Healthcare NHS Trust (ESHT) [host commissioner Eastbourne, Hailsham and Seaford CCG]. In this report, details of BSUH and MTW performance are included. The accompanying EHS/HR report will include details of performance for ESHT.

2. Cancer diagnosed at an early stage

2.1 There is a range of ways to increase awareness and improve early diagnosis of cancer. Nationally there are the screening programmes for bowel, cervical and breast cancers. Also the national Be Clear on Cancer programme: this summer there were both respiratory and skin campaigns

2.2 In addition to national campaigns, the CCG also has a Cancer Research UK Primary Care Facilitator working to enhance primary care cancer related performance. GP practices are supporting to review their data and develop practice action plans. Practices are also encouraged to attend local education events and to encourage their patients to attend local awareness events.

2.3 The CCG is pursuing funding for a Macmillan GP to support primary care, if secured, it is envisaged that the Macmillan GP will work in partnership with our Cancer Research UK Primary Care Facilitator to reduce the CCGs incidence of cancer diagnosis on emergency presentation. National trends for diagnosis on emergency presentation are downwards and the data for HWLH CCG follows this and in Q4 2016 16% of first admissions were for emergency presentation (England value was 17.9%)

2.4 The CCG is implementing the June 2015 NICE Guidance for Suspected Cancer: Recognition and Referral (NG12). The (previous) 2005 guidance used a range of percentage risks of cancer with few corresponding with a positive predictive value of lower than 5%. The evidence base has developed since then and the 2015 guidance uses a threshold of 3%. This does mean an increase in referrals in some tumour sites to secondary care and should help to improve the number of patients diagnosed earlier – at stages 1 or 2 rather than 3 or 4.

2.5 At BSUH the implementation of NG12 has been divided into two phases. Phase 1 (tumour site groups (TSG's) include breast, brain/CNS, children and young people, cancer of unknown primary, haematology, head and neck, lung, sarcoma – soft tissue, sarcoma – bone, skin and urology) was launched on the 6th November by BSUH. There continue to be discussions between BSUH and CCGs on the implementation of phase 2 which includes gynaecological, lower gastrointestinal (GI) and upper GI. These TSG's form phase 2 implementation because of problems with ongoing ultrasound capacity at the Trust for gynaecological, and lower and upper GI are a speciality that has continued to be challenged in constitutional standards and patients exceeding 52 weeks due to endoscopy capacity and surgery lists. The joint CCG and BSUH Planned Care and Cancer Board have been asked to agree a date for phase 2 implementation across the BSUH system at their November meeting. It has been recommended to the Board that this be no later than 31st December.

2.6 Post all phases of NG12 going live, there will be another phase of work monitoring the impacts and outcomes for patients and ongoing development to improve pathways particularly in light of the

forthcoming 28 day standard which aims to speed up route to diagnosis and treatment by shortening the length of timed pathways.

2.7 At MTW the implementation of NG12 is ongoing. Direct access radiology for suspected cancer as per NG12 is being provided by the Trust and a separate referral form provided to practices so it is clear that this is a 2 week response not a routine timeline. The Trust is also intending to provide direct access for oesophago-gastro-duodenoscopy (OGD) for upper GI cancer pathways and for occult blood tests for colorectal cancer pathway for 2018/19. West Kent CCG is working closely with the Trust to agree the pathways. Revised referral forms for all pathways are due to go live at the end of November.

3.Cancer waiting times

3.1 At BSUH there have been considerable improvements over the last year with performance on the NHS constitutional cancer waiting times targets with the targets now sustainably being met with the exception of the 62 days from urgent referral to treatment, although this has been showing an improving trend. This target continues to be a challenge and in September 2017 the compliance was 75.3% against the 85% target. It is expected the Trust will be compliant by December 2017. High Weald Lewes Havens CCG supports this through weekly patient tracking list (PTL) attendance.

3.2 The table below shows performance for the NHS constitutional standards for BSUH

Target	Oct'16	Nov'16	Dec'16	Jan'17	Feb'17	Mar'17	Apr'17	May'17	Jun'17	Jul'17	Aug'17	Sept'17
2WW*	95.11%	94.04%	93.93%	90.68%	93.25%	93.41%	93.41%	94.08%	94.65%	94.82%	93.82%	95.06%
31D**	97.22%	96.36%	95.83%	95.9%	94.02%	97.30%	98.04%	98.84%	100%	98.32%	98.76%	97.22%
62D***	78.4%	78.23%	68.42%	82.09%	64.46%	79.29%	74.29%	82.89%	69.42%	67.52%	76.30%	75.32%

* 2 week wait from urgent GP referral to first appointment; target 93%

** 31 days from diagnosis (date of decision to treat) to first treatment (start date); target 96%

*** 62 days from urgent GP referral to first treatment (start date); target 85%

3.3 The BSUH Recovery Plan is reviewed at quarterly meetings and the Brighton and Hove CCG Macmillan Primary Care Nurse and Macmillan GP are working together with BSUH in partnership to continue to develop this further. A recent update on work as part of recovery package includes the following:

- Treatment summaries for GPs and patients have been developed with guidance from Macmillan began being piloted from October and following this they will be rolled out to oncology
- Formal holistic needs assessments (HNAs) have been developed for use at the beginning and end of treatment. Current work with CNS and support workers is ongoing to develop the HNA process. There will be an emphasis on self-care but also making sure patients know where / who to contact if an issue arises
- Generic health and wellbeing packs are being created to be handed out at HNAs
- Cancer Health and Wellbeing Event held at the Amex on the 21st November – the event is open to all people living locally who are living with or after cancer. It's a chance to find out about the wide range of support services available to those affected and their friends, family and carers. It is

suitable for people at all stages throughout cancer treatment. Macmillan, BSUH and Martlets hospice have been closely involved with developing the content for the event

3.4 The 62 day target continues to be a challenge and in October 2017 BSUH secured £210K from NHS England to support delivery of 62 day compliance. The planned spend of this money is spread across the following:

- Pathology (£65K) – money is being used to drive turnaround process improvements. The impact of money spent to date is reduced PTL numbers and better management of patients through pathology i.e. swifter turnaround times. There will be continued streamlining and monitoring of pathology process and reporting time i.e. not an increase in numbers of treatments but a process improvement as part of the 62 day pathway

- Radiology (£49K) – money to be spent to drive turnaround process improvements. The expected improvement in turnaround times for the imaging stage of the pathway (targeting lower GI and head and neck). Not a specific increase in number of treatments but an expected positive impact on performance

- Endoscopy (96K) – money to be spent to treat additional endoscopy patients between January and March. It is expected that an additional 286 endoscopy patients will be seen which equates to 17 additional sessions per month (11 patients per session)

3.5 BSUH have also been involved in developing the Surrey and Sussex Cancer Alliance Cancer Awareness and Earlier Diagnosis (AEDI) bid submitted in October 2017 for Cancer Transformation Funding from NHS England which outlines 2 key programmes for funding; implementation of recovery package (a series of intervention which when delivered can greatly improve outcomes for people living with and beyond cancer) and stratified follow-up (an approach involving steering individuals onto the best pathway to address their specific needs). Unfortunately, the bid was not successful because as a system the 62 day constitutional target has not been achieved; this was not a pre-requisite for the bid. The Surrey and Sussex Cancer Alliance have been informed that the bid can be reconsidered when the system achieves the 62 day standard.

3.6 At MTW performance across the NHS constitutional standards has been variable over the past 12 months. The 2 week wait standard has been achieved in 9 of the past 12 months, the 31 day standard in 6 of the past 12 months and the 62 day standard has not been achieved at all in the past 12 months. All targets continue to be a challenge, particularly the 62 day standard, this target continues to be a challenge and NHS Improvement have asked MTW (as they have done with all Trusts falling short on this standard) to put together a trajectory to meet the target by the end of December. Failure to meet the 62 day target at present is largely attributable to diagnostic capacity, particularly radiology and endoscopy. In relation to pathways, urology is currently posing the greatest challenge because the surgical treatment element is commissioned by NHS England from Medway NHS Foundation Trust for all of Kent and Medway. This issue has now been escalated via the West Kent CCG quality team to NHS England as a concern and to request help in supporting an action plan for urology.

3.7 The table below shows performance for the NHS constitutional standards for MTW

Target	Oct'16	Nov'16	Dec'16	Jan'17	Feb'17	Mar'17	Apr'17	May'17	Jun'17	Jul'17	Aug'17	Sept'17
2WW	93.42%	95.05%	95.33%	95.32%	95.32%	94.94%	90.98%	93.13%	93.04%	96.61%	91.49%	90.46%
31D	99.19%	93.44%	96.12%	90.55%	92.8%	98.56%	88.12%	92.80%	92.50%	93.69%	96.83%	97.37%
62D	72.73%	63.30%	71.53%	63.55%	61.48%	73.08%	59.29%	68.70%	73.58%	70.49%	82.73%	76.40%

* 2 week wait from urgent GP referral to first appointment; target 93%

** 31 days from diagnosis (date of decision to treat) to first treatment (start date); target 96%

*** 62 days from urgent GP referral to first treatment (start date); target 85%

3.8 The MTW recovery package has been developed in partnership with West Kent CCG, the lead commissioner for this Trust. A recent update on work as part of recovery package includes the following:

- Increased 2 week wait capacity in breast and urology
- 'Straight to test' pathway introduced for colorectal referrals resulting in 80% of patients having their colonoscopy within 2 weeks
- Consultant upgrade for lung patients who have positive findings on chest x-ray
- Daily 'huddles' to track patients which has resulted in improved engagement with clinical teams
- Weekly PTLs with referring Trusts to support patient pathways between the two providers and help with achieving the 38 day transfer target
- MTW submitted a successful bid to the NHS England Radiotherapy Linear Accelerator Replacement Programme for £1.8M. The monies are being spent replacing 2 linear accelerators (LINAcs) for radiotherapy, the first of which is due to go live in November 2017
- New fixed-site PET Scan facility with additional capacity opened 31st August 2017
- Detailed demand and capacity work for all tumour sites
- Detailed action plans developed by whole teams, clinically led
- Strengthened MDT coordinator team
- Successful bids for Cancer Transformation Funding to support additional capacity for radiology reporting, admin support for breast follow-ups, nurse capacity for "straight to test" in upper GI

3.9 MTW as part of the Kent and Medway Cancer Alliance have also been involved in developing a bid for the 'Living With and Beyond' (LWAB) element of the Cancer Transformation Funding from NHS England which was submitted in October 2017. Unfortunately, the bid was not successful because as a system the 62 day constitutional target has not been achieved; this was not a pre-requisite for the bid. The Kent and Medway Cancer Alliance have been informed that the bid can be reconsidered when the system achieves the 62 day standard.

4. One year survival from all cancers

4.1 The England average for one year survival rates from all cancers is 70.4% (2014). This is an increase from 60.9% in 1999. The 2016/17 CCG IAF shows that for HWLH CCG one year survival is 69.9%; up from 60.3% in 1999.

4.2 Other Sussex CCGs have the following one year survival rates: Eastbourne, Hailsham and Seaford 68.8%, Hastings and Rother 67.1%, Brighton and Hove 69.4%, Crawley 66.7%, Horsham and Mid Sussex 71.5% and Coastal West Sussex CCG 67.1%.

5. Patient satisfaction survey

5.1 Despite the challenges faced by our Trusts, the outcome of the patient satisfaction survey is relatively positive, with HWLH CCG achieving 8.7 out of 10.

6. Conclusion

6.1 HWLH CCG continues to monitor cancer performance and at BSUH and MTW to ensure improvements across all targets. HWLH CCG will continue to work with the lead commissioners at each Trust including ESHT to achieve this as well as with the Trust directly where appropriate.

6.2 HWLH CCG will focus on CCG IAF targets as well as each of the NHS Constitutional targets.

6.3 HWLH CCG will work with the new Surrey and Sussex Cancer Alliance to continue to work towards implementing the cancer related recommendations in the NHS Five Year Forward View and the Department of Health Independent Cancer Taskforce Report: Achieving World-Class cancer Outcomes 2015. The CCG will also engage with MTW to support their involvement as part of the Kent and Medway Cancer Alliance.

Tammy-Ann Sharp
Programme Manager – Planned Care and Cancer
NHS High Weald Lewes Havens CCG

November 2017

Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date of meeting:	**30 November 2017**
By:	**Assistant Chief Executive**
Title:	**Kent and Medway Review of Stroke Services**
Purpose:	**To provide HOSC with an overview of the review of stroke services underway in Kent and Medway and to consider the potential implications for East Sussex residents.**

RECOMMENDATIONS

1) To consider and comment on the report.

2) To agree that the proposed reconfiguration of stroke services in Kent and Medway is likely to constitute a 'substantial development or variation' to services for East Sussex residents requiring formal consultation with HOSC.

3) To authorise the Chair, in consultation with the committee, to make arrangements with the other affected HOSCs for the formation of a joint HOSC to respond to the NHS consultation, should this be required before the committee's next meeting.

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1 Background

1.1 Acute stroke services in Kent and Medway are currently provided from seven hospital sites including Tunbridge Wells Hospital (Pembury) and William Harvey Hospital (Ashford), the two sites which are also accessed by East Sussex residents.

1.2 NHS organisations in Kent and Medway, through the area's Sustainability and Transformation Partnership (STP), have been reviewing how acute stroke services are provided across the area with a view to making changes to improve care. It is intended to present information to NHS England imminently, asking for their agreement to initiate public consultation on proposed service changes, subject to formal agreement by the relevant Clinical Commissioning Groups (CCGs) and consultation with affected HOSCs. The aim is to begin consultation early in 2018.

2 Supporting information

2.1 The NHS proposal would see a move away from the seven acute hospitals in Kent and Medway all providing acute stroke services to a smaller number (potentially three) of the hospitals providing hyper acute stroke units (HASUs), co-located with acute stroke units. This would mean not all hospitals would provide acute stoke care.

2.2 The CCGs believe that the proposed service model will improve quality of care and significantly improve patient outcomes. Further information on the process which has been followed to date and the proposed service model is set out in the following appendices:

- Appendix 1: Letter to HOSC Chair
- Appendix 2: Summary of Service Models and Hurdle Criteria
- Appendix 3: Kent and Medway Stroke Delivery Model

2.3 Representatives from High Weald Lewes Havens CCG and Kent and Medway STP will be available to take questions from HOSC on the information provided.

3. Impact on East Sussex

3.1 Significant parts of East Sussex fall into the catchment area for stroke services provided at hospitals in Kent, particularly a large part of High Weald Lewes Havens CCG area, but also part of Hastings and Rother CCG area. Further information on catchment populations and the number of stroke patients from East Sussex treated in Kent in recent years is set out in appendix 4.

3.2 The total East Sussex population falling into the catchment areas for Tunbridge Wells and William Harvey Hospitals is approximately 90,000. The total number of stroke patients from East Sussex who received acute stroke care at hospitals in Kent in 2016/17 was 90.

3.3 At this stage the shortlisted options for the configuration of services on fewer hospital sites have not yet been agreed. This means it is not yet possible to assess the potential impact of specific options on East Sussex residents, for example, whether the proposed options would involve the continued provision of acute stroke services at Tunbridge Wells Hospital or William Harvey Hospital.

3.4 Due to the significant patient flow from its area, High Weald Lewes Havens CCG has formally joined the joint CCG committee which will make decisions on proposed options and, ultimately, the final configuration of services.

4. HOSC role

4.1 Under health scrutiny legislation, NHS organisations are required to consult HOSCs about a proposed service change which would constitute a 'substantial development or variation' to services for the residents of the HOSC area. When a proposed service change is considered 'substantial' by more than one HOSC, there is a legal requirement that the affected committees form a joint HOSC to respond to the NHS consultation. Individual HOSCs may retain the power to refer the change to the Secretary of State for Health if it is ultimately not considered to be in the best interests of health services for the residents of the HOSC's area.

4.2 There is no national definition of what constitutes a 'substantial' change. Factors such as the number or proportion of patients affected, the nature of the impact and the availability of alternative services are often taken into account in coming to an agreement between the HOSC and the NHS on whether formal consultation is required.

4.3 In this case it is not yet possible to make a firm decision on whether the proposed changes to stroke services in Kent and Medway will constitute 'substantial' change for East Sussex residents, as the specific options are not yet available. However, given the substantial portion of East Sussex which falls into the catchment area of affected services, and the potential impact on travel for patients and families it seems likely that any set of options could constitute a substantial change to the services currently used by the county's residents. HOSC has previously considered changes to acute stroke services provided by East Sussex Healthcare NHS Trust and Brighton and Sussex University Hospitals NHS Trust to fall into the category of substantial change.

4.4 HOSCs in Kent and Medway have indicated the proposed changes will constitute substantial change for their residents. The HOSC in Bexley is also considering the proposals. It is therefore very likely that a joint HOSC will be required. On the current NHS timetable, this would need to be established early in the new year, before the next meeting of East Sussex HOSC in March.

5. Conclusion and reasons for recommendations

5.1 On the basis of the information currently available, HOSC is recommended to agree that the proposed changes to stroke services in Kent and Medway are likely to constitute a

‘substantial development or variation’ to services for East Sussex residents requiring formal consultation with the committee. Further information will be provided to HOSC’s next meeting to enable formal confirmation of this judgement.

5.2 As other HOSCs are also likely to consider the proposals to be substantial change for their residents, HOSC is recommended to authorise the Chair, in consultation with the committee, to make arrangements with the other affected HOSCs for the formation of a joint HOSC to respond to the NHS consultation, should this be required before the committee’s next meeting.

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PHILIP BAKER
Assistant Chief Executive

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

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NHS
Kent and Medway STP

To:
Cllr Belsey
Chair
Health Overview Scrutiny Committee
East Sussex County Council,
County Hall,
St Anne's Crescent,
Lewes,
East Sussex BN7 1UE

Michael Ridgwell
STP Programme Director
Magnitude House
New Hythe Lane,
Aylesford,
Kent ME20 6WT

12/10/2017

Dear Cllr Belsey,

Re.: Kent and Medway Review of Stroke Services

I am writing to you in my capacity as the senior responsible officer (SRO) for the review of stroke services in Kent and Medway to update you on the work we are undertaking and ask how you would like us to work with you.

You may be aware that we have been reviewing how acute stroke services are provided in Kent and Medway. Our proposal would see a move away from the seven acute hospitals in Kent and Medway all providing acute stroke services to a smaller number of the hospitals providing hyper acute stroke units (HASU)s, collocated with acute stroke units. This would mean not all hospitals would provide acute stoke care but we firmly believe that through developing HASUs we will significantly improve outcomes for patients. This view is supported by clear research evidence that demonstrates the potential benefit to patients of delivering care in the way we are proposing. Information on the service model we are looking to adopt, and the hurdle criteria that are being used for the initial evaluation of our long list of options, is included in the paper included with this letter.

There are also a number of patients from outside Kent and Medway that use local services. I have included a paper that details patient flows into Kent and Medway from neighbouring CCG areas. This also makes an assessment of the size of the neighbouring populations, from which these patients come, that look to Kent and Medway hospitals for stroke services. We think this provides a useful context for your considerations on how you wish us to engage and consult with you.

We shortly hope to be in a positon to present information to NHS England asking for their agreement to initiate consultation, subject to formal agreement by the CCGs and consultation with the health and overview and scrutiny committees. Our hope is to get out to consultation early in 2018. Kent and Medway CCGs are setting up a joint CCG committee with delegated responsibility to take forward the stroke review. Bexley CCG and High Weald, Lewes and Havens CCG will also be members of the CCG joint committee.

With regard to working with and consulting with the HOSCs, the Kent and the Medway committees have established a joint committee (JHOSC). The intention is meet with the JHOSC in November to provide an update and more detail on the next steps and then again in January to consult on the

proposals we are looking to publicly consult on and our consultation plan. We would welcome your guidance on how you would like us to engage and consult with you as we progress the stroke review. I have also copied in Cllr Purdy who is chairing the JHOSC and the HOSC officers from the two councils should you wish to liaise with them directly.

We would be very happy to discuss further or present to the HOSC if this would be helpful.

Yours sincerely,

Michael Ridgwell
Programme Director
Kent and Medway STP

Cc:
Ashley Scarff, Director of Commissioning and Deputy Chief Officer
Claire Lee, Support Officer, East Sussex County Council
Lizzy Adams, Scrutiny Research Officer, Kent County Council
Jon Pitt, Democratic Services Officer, Medway Council
Cllr Purdy, Chair, Kent and Medway Joint HOSC

KENT AND MEDWAY SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP

Service Models and Hurdle Criteria – Stroke Service

Introduction

1. This paper summarises the service models and hurdle criteria that have been developed for stroke services through the Kent and Medway Sustainability and Transformation Partnership (STP). Changes to stroke services have implications for the patients from High Weald Lewes Havens (HWLH) CCG who look to Kent and Medway providers for the provision of stroke care.
2. The service models and hurdle criteria were developed by the local care and hospital care workstreams. These have built on patient, public and carer insight over recent years about what is important to people about local services, with clinical leadership and involvement in the design and thinking, and some ongoing testing and discussion with wider stakeholder audiences and groups across Kent and Medway. The development and progress of the design phase has been regularly reported to the STP Clinical Board, the Patient and Public Advisory Group (or its predecessor the Patient and Public Engagement Group) and onwards to the STP Programme Board. The draft service models have been presented to the South East Coast Clinical Senate[1] and their feedback has been taken into account in preparing the final versions that are now being presented.

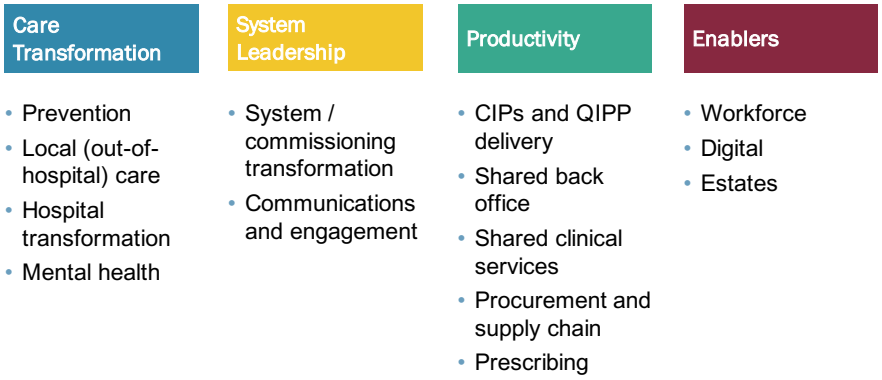
Context

3. Sustainability and Transformation Plans were proposed in the annual NHS planning guidance Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21 issued in December 2015[2]. This outlined the triple aim of the plans was to address: health inequalities; quality failings and under-performance against NHS Constitution targets; and financial challenges.
4. The further development of Sustainability and Transformation Plans, and a further recognition that these arrangements are about collective system leadership through the change of name to Sustainability and Transformation Partnerships, was outlined in Next Steps on the Five Year Forward View[3] published in March 2017. The October STP submission outlined the key themes of transformation that are being pursued across Kent and Medway. These were identified as follows:

[1] Clinical Senates have been established to be a source of independent, strategic advice and guidance to commissioners and other stakeholders. This includes reviewing proposed changes through bringing together a range of healthcare professionals with patients to review proposals presented to them. This is also part of the NHS England service change assurance process.

[2] https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

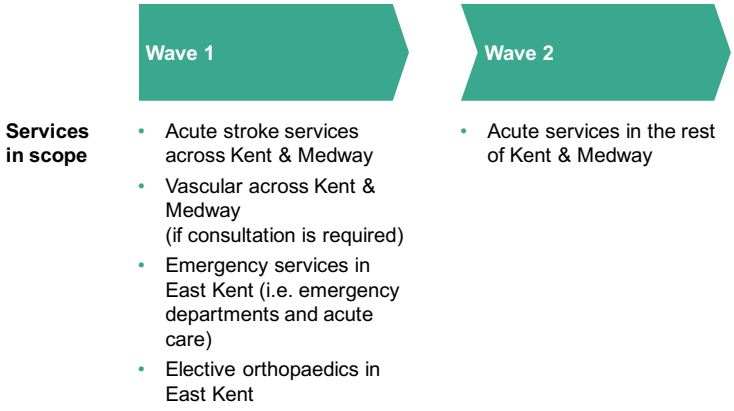
[3] https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf



5. Workstreams were established to take forward each of the above areas, comprising clinicians, leaders and practitioners from across Kent and Medway NHS and local authority organisations. They have been meeting since the autumn of 2016 and test and discuss their work with both the programme's Patient and Public Advisory Group (including its precedessor the PPEG) and the programme's Partnership Board as part of an ongoing programme engagement infrastructure.

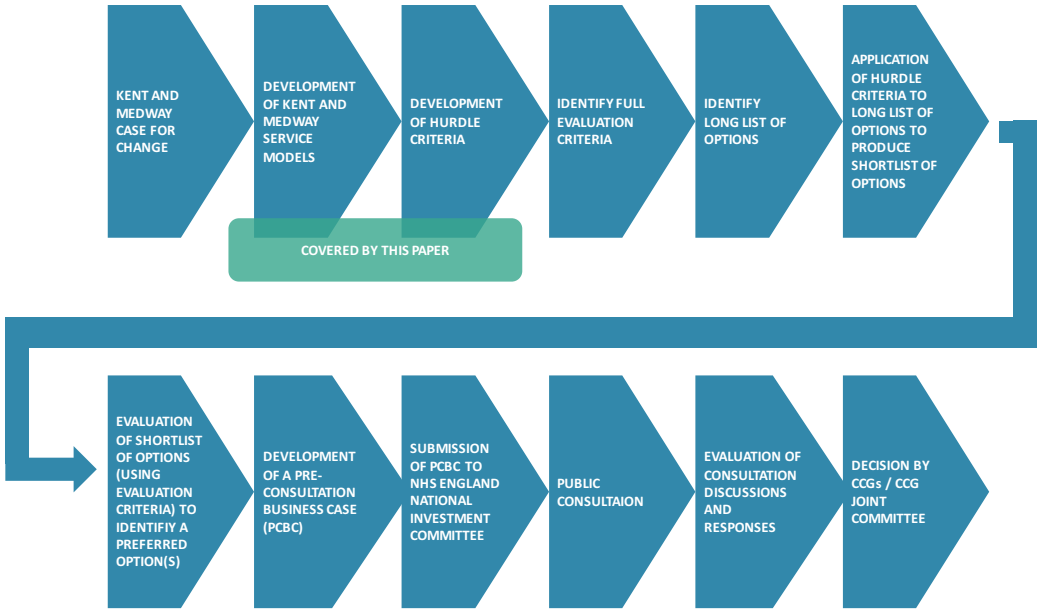
6. The STP Programme Board took stock of the progress being made by these workstreams in February 2017. It was recognised that different parts of the Kent and Medway area were at different stages in relation to their readiness and development.

7. The STP stocktake concluded from an analysis of patient flows within Kent and Medway that there are negligible potential activity flows from East Kent to the rest of Kent and Medway. It was proposed that it is possible to consult on service changes in East Kent around urgent and emergency care alone, though the impact on future options in the rest of Kent and Medway will need to be considered. Therefore, two waves of public consultation are proposed to be undertaken within a clear strategic framework for all of Kent and Medway:



8. It is envisaged that any consultation on the reconfiguration of stroke services will take place in early 2018, subject to agreement from NHS England and consultation with relevant health overview and scrutiny committees.

9. In moving to consultation we are following a process that covers a number of stages as outlined in the following diagram (as outlined in the process diagram this paper covers the proposed service models and hurdle criteria for stroke services):



Case for change

10. The Kent and Medway STP Clinical Board has prepared a technical case for change[4] which has been used to prepare a more accessible public facing case for change to support engagement with patients, carers, local communities and stakeholders[5].

11. These documents outline the strategic rationale for why change is needed. While there is much to be proud of about health and social care services in Kent and Medway, there are several issues that we need to tackle; there are long waiting times for some services and the quality of care is not always as good as it could be. We also need to focus on reducing the need for health and social care through self-management, ill health prevention and earlier diagnosis. The following provides a summary of the case for change:

	Case for change	Our ambition
Health and wellbeing	• Our population is expected to **grow by 414,000 people** by 2031. Growth in the number of over 65s is **over 4 times greater** than those under 65; an aging population means **increasing demand for health and social care**. • There are **health inequalities** across Kent & Medway; in Thanet, one of the most deprived areas of the county, for example, a woman living in the best ward for life expectancy in Thanet can expect to live **almost 22 years longer** than a woman in the worst. The main causes of early death are **often preventable**. • Over **500,000 local people live with long-term health conditions**, many of which are preventable. And many of these people have multiple long-term health conditions, dementia or mental ill health.	• Create services which are able to meet the needs of our changing population • Reduce health inequalities and reduce death rates from preventable conditions • More measures in the community to prevent and manage long-term health conditions
Quality of care	• There are over 1,000 people who are **in hospital beds who could be cared for elsewhere if services were available.** Being in a hospital bed **for too long is damaging for patients** and increases the risk of them ending up in a care home. • We are **struggling to meet performance targets** for cancer, dementia and A&E. This means people are not seen as quickly as they should be. • Many of our local hospitals are in 'special measures' because **of financial or quality pressures** and numerous local nursing and residential homes are **rated 'inadequate' or 'requires improvement'**.	• Make sure people are cared for in clinically appropriate settings • Deliver high quality and accessible social care across Kent and Medway • Reduce attendance at A&E and onward admission at hospitals • Support the sustainability of local providers
Sustainability	• We are **£110m 'in the red'** and this will rise to **£486m by 20/21** across health and social care if we do nothing. • Our **workforce is ageing** and we have difficulty recruiting in some areas. This means that **senior doctors and nurses are not available** all the time and there are high numbers of temporary staff across health and social care.	• Achieve financial balance for health and social care across Kent and Medway • To attract, retain and grow a talented workforce

SOURCE: Kent and Medway 5yrFV

[4] http://kentandmedway.nhs.uk/wp-content/uploads/2017/03/Kent-Medway-Case-for-Change-technical-doc-FINAL-UPDATED.pdf
[5] http://kentandmedway.nhs.uk/wp-content/uploads/2017/04/Kent-Medway-Case-for-Change-UPDATED-APRIL-17.pdf

12. The position outlined in the case for changes provides further details of the challenges against the triple aims of STPs (as outlined in Point 3), namely:

    i. health inequalities – there continue to be significant health inequalities within Kent and Medway, with the main causes of early death often being preventable:

    ii. quality failings and under-performance of NHS Constitution targets – with large numbers of patients not supported in the most appropriate setting of care, widespread non-delivery of NHS Constitution targets and a significant number of organisations facing quality challenges; and

    iii. financial challenges – a net over-performance on £110m in 2015/16 on the NHS total system budget which is projected to rise to £486m by 2020/21.

13. The challenges outlined above, and in more detail in the case for change, impact detrimentally on the health and lives of the population we service and on the sustainability of NHS and social care services. The strategic remit of the STP is to address these challenges.

Stroke services

14. More detailed information on the stroke service model is included in Appendix 0.

15. In 2015/16 approximately 2,500 acute stroke patients were supported in the seven acute hospitals in Kent and Medway. Currently all of these hospitals provide acute stroke care and, following the immediate acute episode, patients are either discharged without further rehabilitation or discharged back to their home with a community rehabilitation package or to a new home, such as a residential care home, that is suitable for their needs.

16. In 2015/16 only half of all patients were admitted within four hours and this performance is below the national average. In addition:

    i. all hospitals only provide five-day stroke consultant face-to-face cover;

    ii. none provide seven-day consultant ward rounds;

    iii. less than 50% of patients receive thrombolysis within 60 minutes; and

    iv. performance against Sentinel Stroke National Audit Programme (SSNAP) is variable and inconsistent.

17. Currently patient volumes are too small to deliver clinical sustainability hyper acute stroke units on all seven acute hospital sites. In particular, there are significant challenges that cannot be met with the current service model with all seven hospitals providing acute stroke care. We need to ensure there is 24/7 consultant availability with a minimum of six trained thrombolysis consultant physicians on rota and consultantled ward round seven days a week. This will be supported by a multi-disciplinary team including nurses, physiotherapists and occupational therapists.

18. In order to achieve the above we need to consolidate stroke services on fewer sites to ensure there are sufficient volumes of patients supported on each site to sustain the staffing numbers. For Kent and Medway this means delivering a combined hyper acute stroke unit and acute stroke unit service on a smaller number of sites. In practice for Kent and Medway this means developing hyper acute stroke units that support volumes of more than 500 patients and less than 1,500 confirmed stroke patients.

19. Alongside the acute stroke provision it is recognised that we need to develop robust early supported discharge and rehabilitation services.

20. Information is included in Appendix Π on the number of patients from outside of Kent and Medway that receive stroke care from local hospitals.

Hurdle criteria

21. As with the clinical models, the hurdle criteria has been developed through the hospital care workstream, with clinical and patient engagement, and then reviewed and signed-off by the STP Clinical Board prior to being approved by the STP Programme Board.

22. Through consideration of the service models we will identify a long list of options around potential service changes. As outlined in the process diagram at Point 11, these will be evaluated using the hurdle criteria. An option must meet the requirements of each of the hurdle critieria or it will be rejected. This means that through assessing the long list of options by applying the hurdle criteira a shortlist of options will be generated. This shortlist of options will go forward to more detailed evaluation. The following hurdle critieria are proposed:

Criteria	Description in relation to application against long list of options for stroke services
Is the potential configuration option clinically sustainable?	• Does it deliver key quality standards? • Does it address any co-dependencies? • Will the workforce be available to deliver it? • Will there be sufficient throughput or catchment population to maintain skills and deliver services cost effectively?
Is the potential configuration option implementable?	• Will the option deliver financial and clinical sustainability within a medium-term timeframe by 20/21? This statement is based upon a system wide view
Is the potential configuration option accessible?	• Can the population access services within a window of 120 minutes from call to needle?[6]
Is the potential configuration option a strategic fit?	• Does it implement the outcome of other recent consultations or designation processes?
Is the potential configuration option financially	• Must not increase the 'do nothing' financial baseline *(given the need for capital investment at any resulting sites which is of similar quantum, noting*

[6] Using 95% accessing services within 60 mins (off-peak) as a proxy

sustainable?	*more at PFI sites, this will be considered in detail at evaluation stage)*

Summary

23. As indicated at the start of this paper it is envisaged that consultation will take place in 2018 on stroke service provided in Kent and Medway. This paper provides an update and information on the service model and hurdle criteria that have been used to provide the initial assessment of options.

Kent and Medway Stroke Delivery Model

February 2017

Introduction and purpose of service delivery model template

- A number of services have been prioritised as for early consideration by the K&M hospital care working group. This pack forms one of a series service delivery model templates for the priority services.
- The aim of this pack is to consider the key issues the service is facing within the hospital context, its current in-hospital model of care and aspirational future model among other relevant context.
- The pack follows the structure of:
  - A summary slide outlining key information from each section; then
  - Each section, with a summary slide up front followed by evidence slides
- The pack has been created with expert input from across Kent & Medway, and has been developed by the K&M Hospital care workstream before being signed off by the Clinical Board.
- The Acute medical care template focuses on the model for acute medicine in the acute hospital with future medical models using the assumptions made by local care about preventing acute hospital admission and facilitating appropriate timely discharge.

The STP outlined the aspiration for Hospital Care model which prevents ill health, intervenes earlier and delivers excellent, integrated care closer to home

Care Transformation workstreams

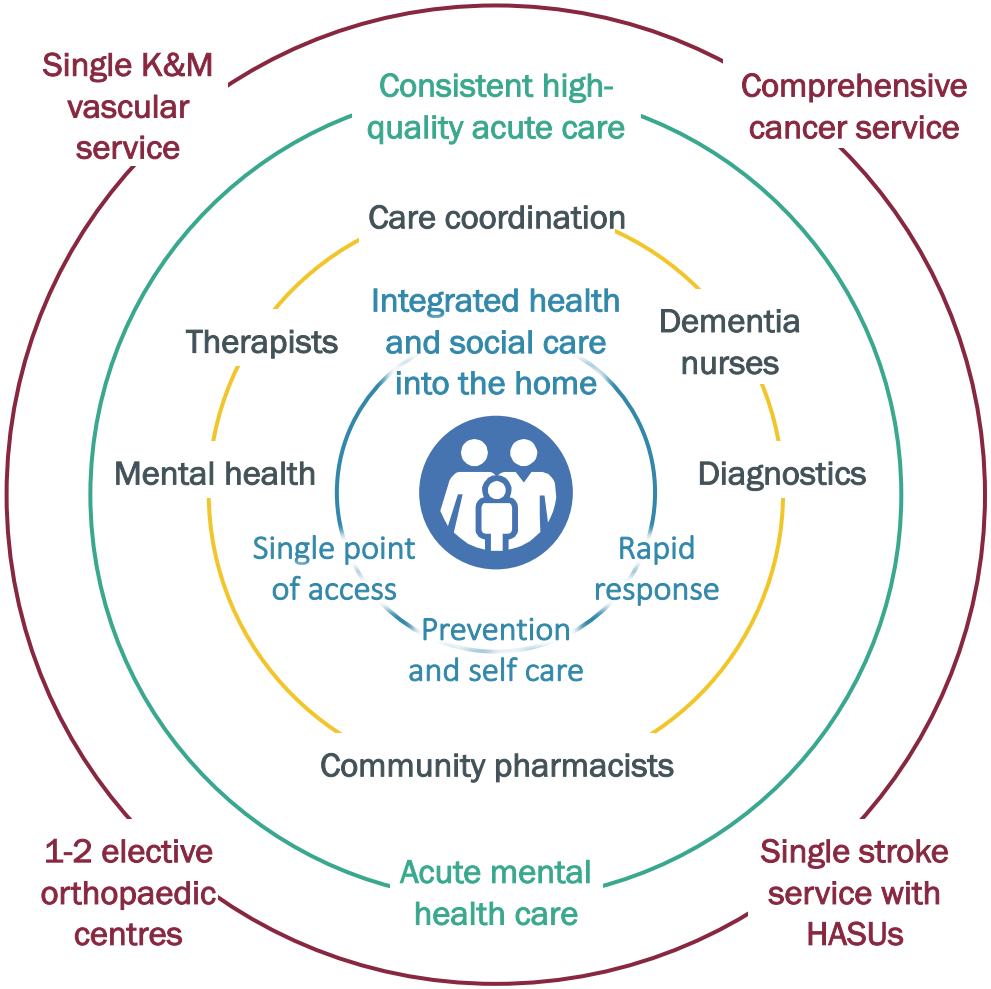
Prevention
Enlisting public services, employers and the public to support health and wellbeing

Local Care
A new model of care closer to home for integrated primary, acute, community, mental health and social care

Hospital Care
Optimal capacity and quality of specialised, general acute, community and mental health beds

Mental Health
Bringing parity of esteem, integrating physical and mental health services, and supporting people to live fuller lives

Kent and Medway Future Care Model



Source: K&M STP

The focus of this template will be on Hospital Care

Summary contents

1. Who is the population being served?
   - 2,487 patients (FY 15/16)
   - Services currently provided at all 7 acute hospitals
2. What are the issues in the case for change which need to be addressed?
   - Only half of all patients admitted within 4 hours and performance is below national average
   - All 7 hospitals only provide 5 day stroke consultant face to face cover; none provide 7 day consultant ward rounds, less than 50% of patients receive thrombolysis within 60 mins
   - Patient volumes are too small to deliver clinical sustainability/ Performance against SSNAP is variable and inconsistent
3. What is the service delivery model today?
   - 7 combined HASU/ASU stroke units across Kent & Medway
   - Patients receive their Hyper-acute, acute and acute rehabilitation in these units
   - Patients are then discharged without further rehab, discharged back to their home with a community rehabilitation package or to a new home such as a residential care home that is suitable for their needs/ Rehab pathways are variable across K&M
4. What is the proposed service delivery model for the future?
   - Consolidation onto fewer sites; 3 sites is the optimum when measured against the agreed critical criteria.
   - Deliver a combined HASU and ASU service on each of the 3 sites
   - Develop robust early supported discharge and rehabilitation services
5. What are the co-dependencies and building blocks?
   - A&E /Emergency Medicine
   - Acute and General Medicine
   - Elderly Medicine
   - Respiratory Medicine
   - Critical Care (adult)
   - General Anaesthetics
   - Acute Cardiology
   - X-ray and Diagnostic Ultrasound
   - CT Scan
   - Acute Mental Health Services
   - Therapy; SLT/OT and Physiotherapy
   - Physiotherapy
   - Urgent GI Endoscopy[1]
   - MRI Scan[1]
   - Acute Inpatient Rehabilitation[2]
6. What are the minimum thresholds for staff in clinical standards?
   - HASU requirements; 24/7 consultant availability with minimum 6 trained thrombolysis physicians on rota and consultant led ward round 7 days a week, 2.9 WTE Nurse (80:20 registered unregistered per bed ,Per 5 beds; 1 Physiotherapist, 0.68 Occupational Therapist, 0.34 S&L therapist, 0.20 Clinical Psychologist, 0.15 Dietician [3]
   - HASU Volume requirements; >500 and < 1500 confirmed stroke patients
7. Engagement – to date and required
   - Over the last 2 years EKHUFT has engaged with key stakeholders internally and externally through a series of EKHUFT and East Kent Strategy Board events.
   - West Kent have not carried out engagement to date

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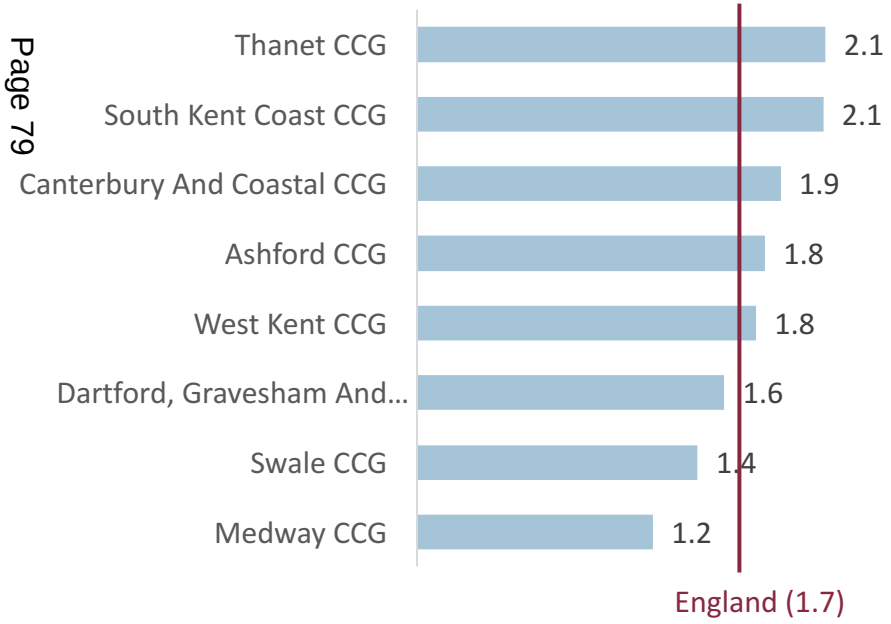
7. Engagement – to date and required

- 2,487 patients (FY 15/16)
- Services currently provided at all 7 acute hospitals

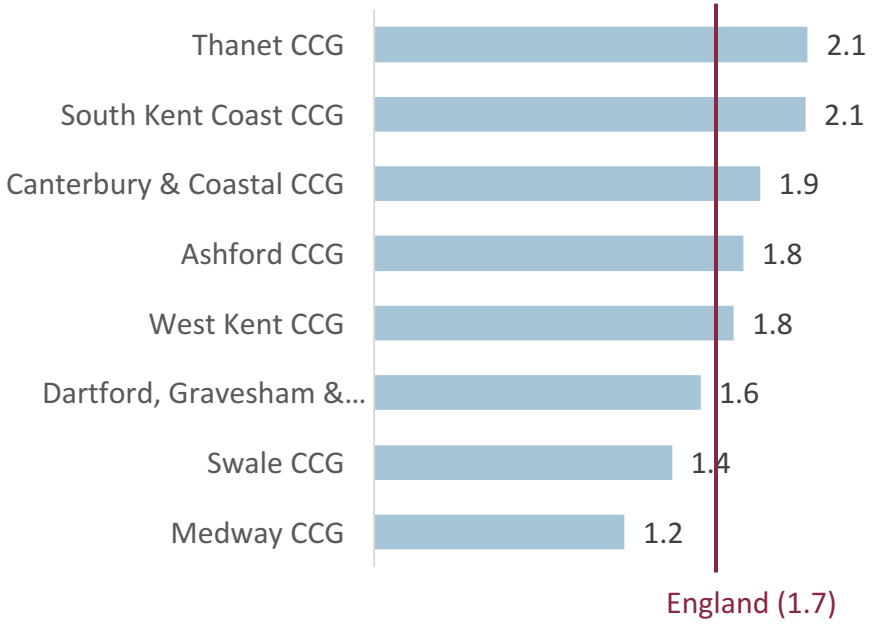
Background

- The total Kent and Medway population is 1.81 million
- On average, prevalence is 1.7% for stroke & 2% for Atrial fibrillation for the Kent & Medway population
- Prevalence varies across CCG and reflects population demographics
- "At risk" groups include:
  - patients with hypertension, atrial fibrillation and diabetes
  - black ethnic populations
  - elderly

Stroke prevalence, %

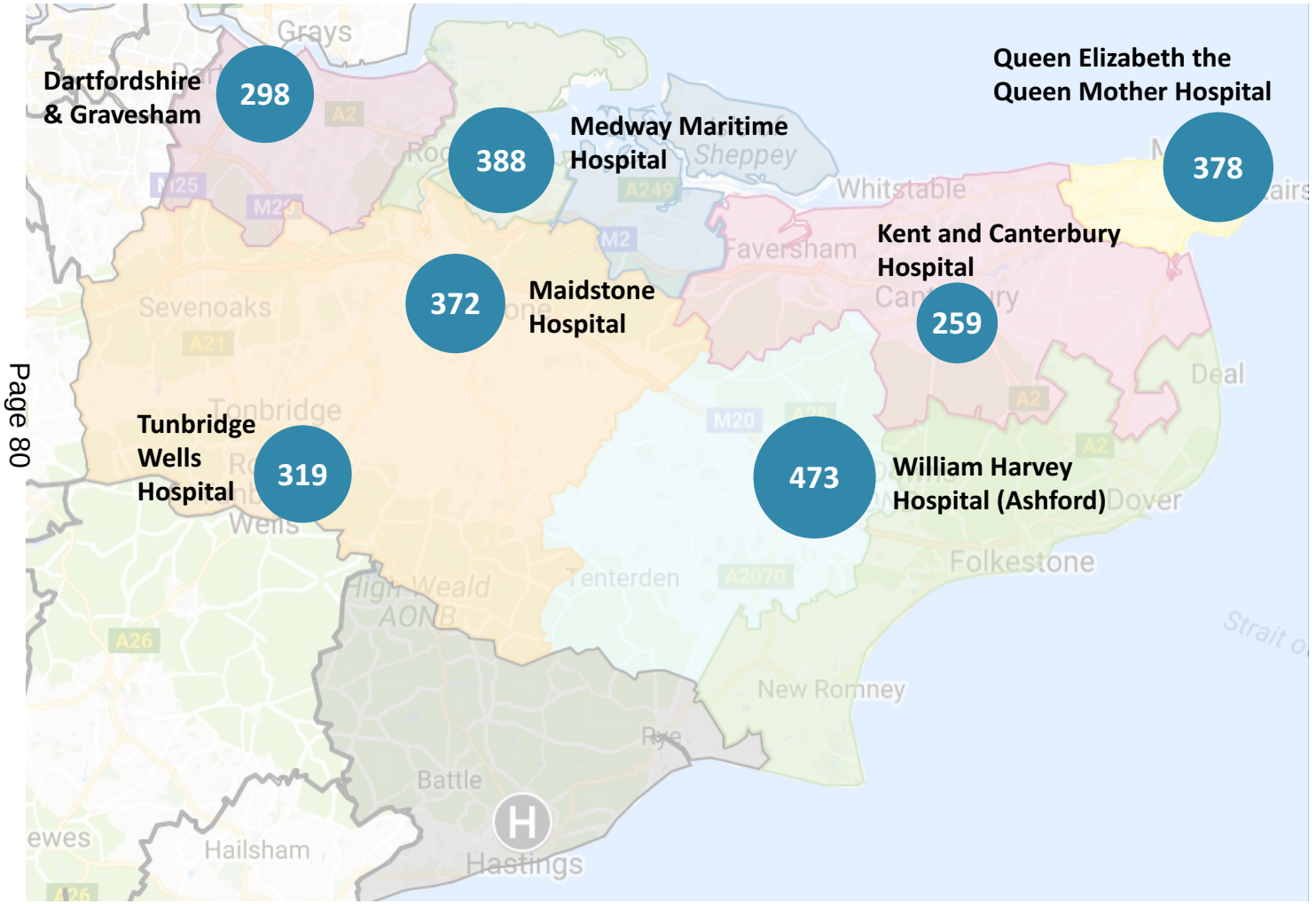


Atrial fibrillation prevalence, %



* SSNAP Apr 2015 – Mar 2016 ** CCG Stroke Profiles Public Health England 2014. **QOF 2015/16)**

Who is the population being served?



- At present, stroke is delivered at all 7 acute sites.
- Patients flow into K&M from east Sussex and South London

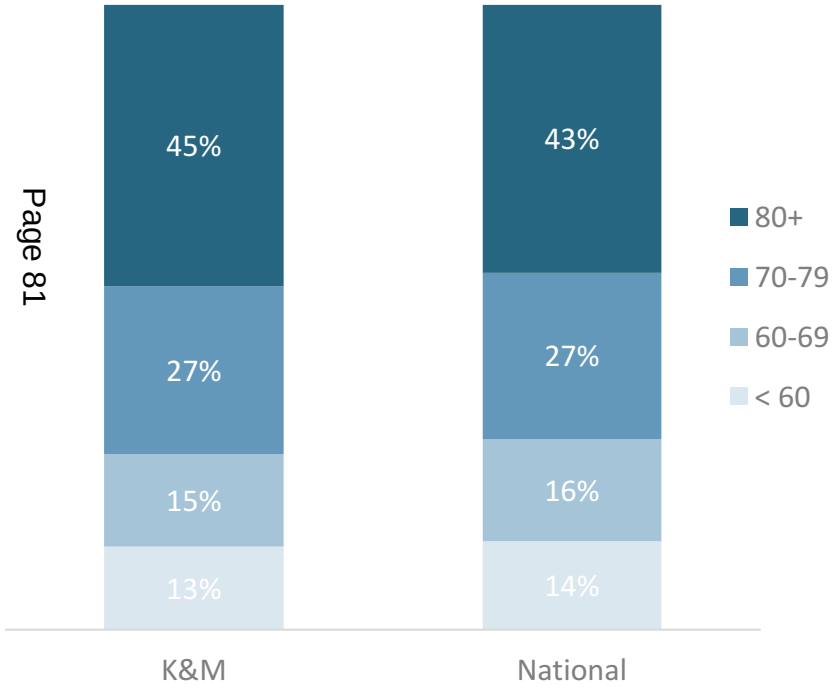
Notes
70 patients per year from South London (into DVH)
65 patients per year form East Sussex
72 hour cohort refers to the processes of care in the first 72 hours of stroke, beyond which patients enter into post-acute stroke care processes

Source: SSNAP clinical audit Apr 15– Mar 16

Stroke incidence

- There are approximately 2,500 confirmed stroke patients per annum treated in the 7 acute hospitals.*
- Public health analysis identifies that based on the current preventative measures and pattern of stroke incidence locally and nationally this figure will not significantly change over the next 10 years, including projected population growth across Kent and Medway.
- Incidence increases with age – although the overall profile is very similar to England

Stroke incidence by age bucket*, %



Stroke activity by site

Site	2012/13	2013/14	2014/15	YoY growth
Darent Valley Hospital	343[1]	324	337	4%
Medway Maritime Hospital	368	417	393	-6%
Maidstone Hospital	294	321	320	0%
Tunbridge Wells Hospital	375[2]	325	298	-8%
William Harvey Hospital	440	473	477	1%
Kent & Canterbury Hospital	292	366	380	4%
Queen Elizabeth the Queen Mother Hospital	319	346	354	2%
Total K&M	**2,431**	**2,572**	**2,559**	-1%

Notes: [1] 70 patients per year from Bexley, South London (into DVH)
[2] 65 patients per year form East Sussex

Source: *SSNAP clinical audit, Apr 2015 – Mar 2016

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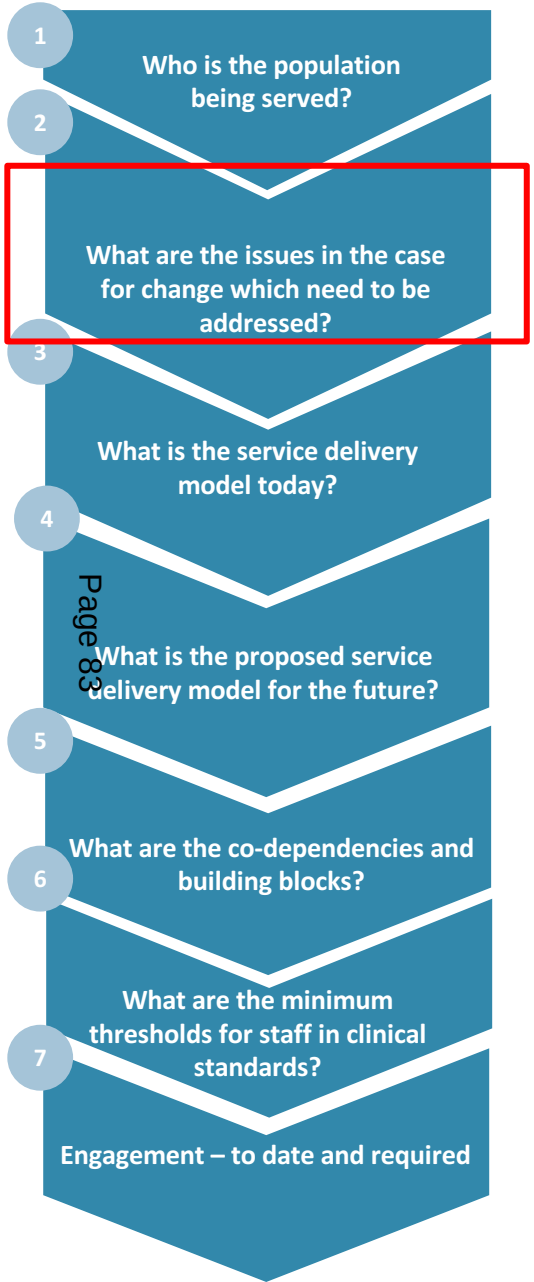

- Only half of all patients admitted within 4 hours and performance is below national average
- All 7 hospitals only provide 5 day stroke consultant face to face cover; none provide 7 day consultant ward rounds, less than 50% of patients receive thrombolysis within 60 mins
- Patient volumes are too small to deliver clinical sustainability/ Performance against SSNAP is variable and inconsistent

What are the issues in the case for change which need to be addressed?

1 **Delays in direct admission and limited availability of 7 day services**

- Generally < 50% of all patients are being admitted within 4 hours and performance is below national average
- Significant workforce gaps across the services therefore 7 day stroke consultant ward rounds not available across any of the hospitals currently
- 7 day therapy service not consistently available across all units

Difficult to access to treatment within the recommended timeframes

- In most hospitals, less than 50% of patients receive thrombolysis within 60 mins and are below the national average
- Fewer patients receive speech and language therapy communication assessment within 72hrs of clock start
- Very limited 7 day therapy assessments undertaken

3 **Patient volumes are too small to deliver clinical sustainability**

- Recommended patient volumes fall between 500 and 1,500 confirmed stroke admissions per year but patient volumes in each acute hospital are below the 500* patient threshold
- No hospital is achieving patient volumes recommended for clinical sustainability

Source: SSNAP clinical audit Apr 15– Nov 16, K&M Case for Change – Stroke * 2016 RCP standards

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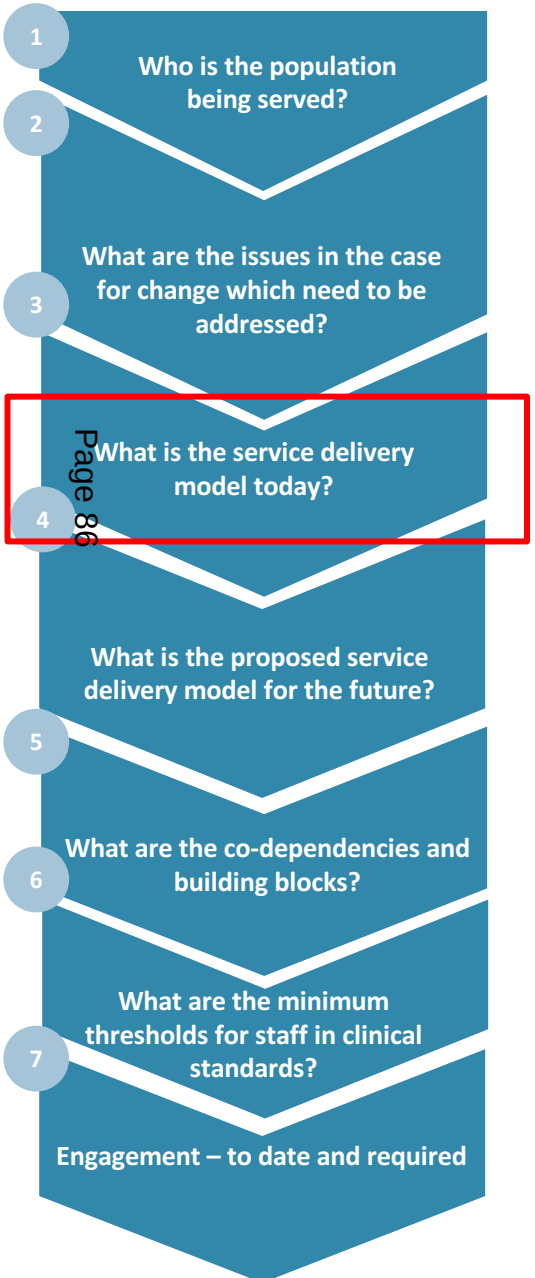

- 7 combined HASU/ASU stroke units across Kent & Medway
- Patients receive their Hyper-acute, acute and acute rehabilitation in these units
- Patients are then discharged without further rehab, discharged back to their home with a community rehabilitation package or to a new home such as a residential care home that is suitable for their needs/ Rehab pathways are variable across K&M

What is the current service position?

Below national average | Equivalent to national average | Above national average

Aims	National recommendation/Target	D&G	MFT	MH	TWH	WHH	KCH	QEQM	National
Rapid and accurate diagnosis	Imaging within one hour of admission	50%	50%	55%	56%	61%	59%	69%	48%
Direct admission	Patients admitted directly onto a specialist stroke unit within four hours	41%	43%	56%	41%	53%	51%	60%	58%
	Patients stay in the stroke unit for 90% of the inpatient episode	84%	79%	87%	67%	84%	88%	85%	84%
Immediate access to treatment	Thrombolysis within 60 mins	42%	16%	43%	59%	60%	38%	48%	59%
	Speech and language therapy communication assessment within 72 hours of clock start	22%	67%	35%	39%	24%	26%	37%	39%
Specialist centres with sufficient numbers of patients and expert staff	Assess patients by specialist stroke consultant and within 24 hours.	62%	55%	61%	73%	81%	86%	91%	79%
	Assess patients by stroke trained nurse and therapist within 24 hours.	91%	87%	91%	88%	87%	91%	89%	88%
Multidisciplinary teams	MDT assessment, to include specialist physicians, nurses , therapists. A wider group of specialist is increasingly advised including clinical psychology, dietetics.	Partial	Partial	Partial	Partial	N [1]	N [1]	N [1]	
24 hour access, 7 days a week	7 day stroke consultant ward rounds*	N	N	N	N				
	OOH access to consultant assessment for thrombolysis*	Y	Y	Y	Y	Y	Y	Y	
	7 day stroke trained nurse and therapist cover	Partial	Partial	N	N	N [3]	N [3]	N [3]	
Patient volumes that deliver clinical sustainability	> 500 and <1500 confirmed stroke admissions	N	N	N	N	N	N	N	
SSNAP performance Q1 2016 (Apr-Jun)	Target: A	D	D	B	D	C	D	C	

Notes: [1] Only available 5 days a week
[2] OOH rota is networked across 3 sites with the use of telemedicine; rota is fragile given combined contribution to HCOOP rota simultaneously
[3] Do not meet national guidelines

Source: K&M Case for Change stroke, South East Coast Clinical and Quality standards for stroke, SSNAP audit (April 2015-Mar 2016)

What is the current service model for stroke rehabilitation?

East Kent:

- Assessment for a patients rehabilitation needs and the start of their rehabilitation begins as soon as a patient arrives into the Stroke Unit (joint HASU/ASU) until they are discharged. This team is made up of physiotherapists, occupational therapists, speech therapists, and nursing and medical staff.
- The options for patients once discharged from the Stroke Units are:
  - Discharged home with no further requirement for rehabilitation
  - Discharged and referred into ESD (Early Supported Discharge / with beds at Westview in Tenterden and Broad Meadow in Folkestone)
  - Discharged and referred into the East Kent Community Stroke Team
  - Discharged and referred into specialist Neuro-Rehabiltation service at K&CH
  - Discharged and referred for further in-patient rehabilitation at a Community Hospital (To be confirmed)

DGT:

- Rehabilitation starts from day one, with a plan for treatment such as methods of feeding, communication and other aspects of care, drawn up by the rehabilitation team. This team is made up of physiotherapists, occupational therapists, speech therapists, and nursing and medical staff.
- The options for patients once discharged from the Stroke Units are:
  - Discharged home with no further requirement for rehabilitation
  - Discharged and referred into ESD (Early Supported Discharge)
  - Discharged and referred into the Gravesend community neuro-rehabilitation service
  - Transferred to the Sapphire Unit for inpatient rehabilitation at Gravesend Community Hospital

What is the current service model for stroke rehabilitation?

MTW:

- Assessment for a patients rehabilitation needs and the start of their rehabilitation begins as soon as a patient arrives into the Stroke Unit (Joint HASU/ASU)
- Patients continue to receive rehabilitation until they are discharged from the Stroke Unit.
- Both stroke units combine HASU/ASU and inpatient rehabilitation (ie all inpatient rehabilitation occurs within the Acute Trust).
- The options for patients once discharged from the Stroke Units are:
  - Discharged home/placement with no further requirement for rehabilitation
  - Discharged and referred into ESD (Early Supported Discharge) – West Kent only
  - Discharged and referred to community neurorehab team

MFT:

- **TBC**

What are the service delivery models: Evidence base

	Source/Publication	Date	Key Points
1	K&M Stroke Review Literature review by K&M Public Health teams	2015	• Hyperacute stroke units are clinically effective • Some evidence of cost effectiveness
2	National stroke Strategy	2007	Recovery significantly influenced by; • Seeing a stroke Consultant within 24 hours; • Having a brain scan within 24 hours of admission; • Being seen by a stroke trained nurse & one therapist within 72 hours of admission; • Being admitted to a dedicated stroke unit • A nutritional assessment & swallowing assessment within 72 hours; • Being given antiplatelet therapy within 72 hours; • Receiving adequate food and fluids for the first 72 hour.

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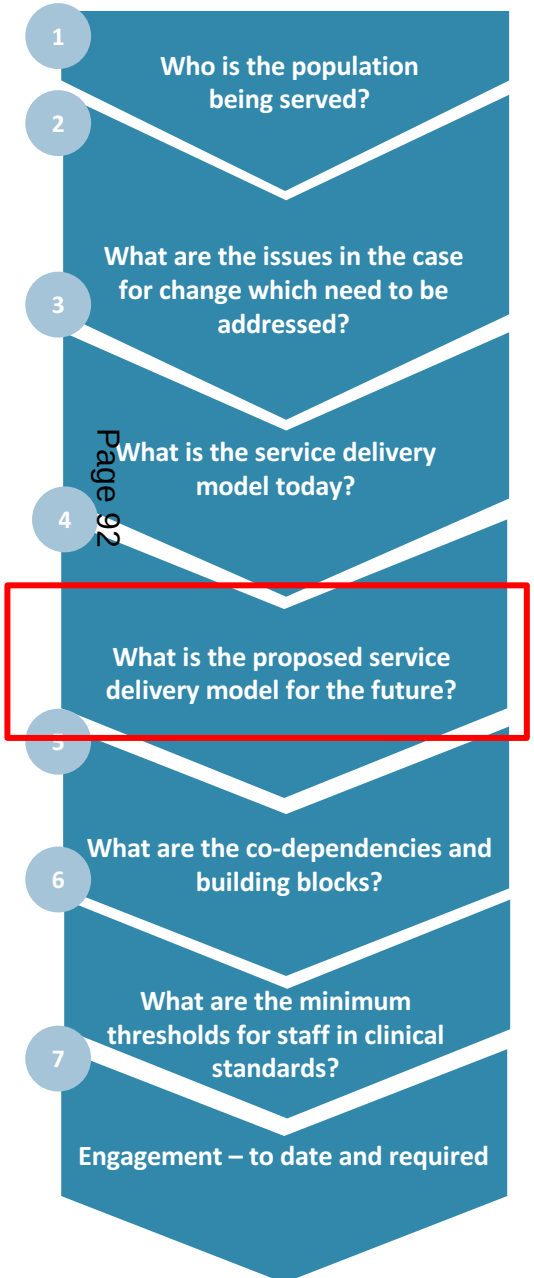

- Consolidation onto fewer sites; 3 sites is the optimum when measured against the agreed critical criteria.
- Deliver a combined HASU and ASU service on each of the 3 sites
- Develop robust early supported discharge and rehabilitation services

What is the proposed model for the future?

TODAY

- All seven units deliver acute Stroke Care
- The units operate combined HASU/ASU models although the specific beds are not always identifiable
- 7 day medical ward rounds only operate in TWH, not always consultant led (on a 1:3 rota)
- Consultant assessment is available in all units over the weekends via telemedicine rotas
- 7 day therapy only available in MFT
- No unit meets the recommended workforce across any profession

FUTURE

- 7 day specialist consultant led stroke service available (able to respond to twice daily ward rounds requirement Autumn 2017)
- Consolidate onto 3 sites; that meet the critical criteria inc travel times
- Combined HASU and ASU units
- Direct access from ambulance transfers to the service ? Stroke assessment unit
- Early Supported Discharge available for min 50% of pts
- Improved rehabilitation services available.
- Development of a centre able to deliver thrombectomy on one of the three sites to provide across K&M
- Co-located with critical co-dependencies that improve patient outcomes and support staff

Source: Kent & Medway Review of Stroke Services (2015 /2016).

What are the implications of not meeting the standards: Patient outcomes

Not delivering the standards does not provide the ability for **a step change** in outcomes.

It minimises the opportunity to potentially improve mortality, length of stay and functional ability.

There is no opportunity to reduce the nature and level of complications ie associated infections/complications such as pneumonia

No opportunity to address the clearly evidenced risks associated with low nursing levels on patient mortality

- London review showed a 17% reduction in 30 day mortality

Reduction in Length of stay

- 7 % reduction in patient length of stay (London Review)

- **Clinical senate advised that compliance with the standards delivers an improvement in;
  - 6 and 12 month modified Rankin scale outcomes (useful as it breaks down disability in to easily understood and captured outcomes).
  - The percentage of stroke patients returning home
  - Reducing the percentage of patients being discharged to a residential / nursing home;
  - Increasing the percentage of patients having their 6 and 12 monthly reviews
  - Increasing the percentage of patients returning to work
- Patients and carers outcomes relating to quality of life scores (although not currently being collected at a national level) such as Euro-QOL, SF-36, the Stroke Impact Scale, and the Stroke Carer Burden Scale

Source: Impact of centralising acute stroke services in English metropolitan areas on mortality and length of hospital stay: difference-in-differences analysis (*BMJ* 2014;349:g4757)

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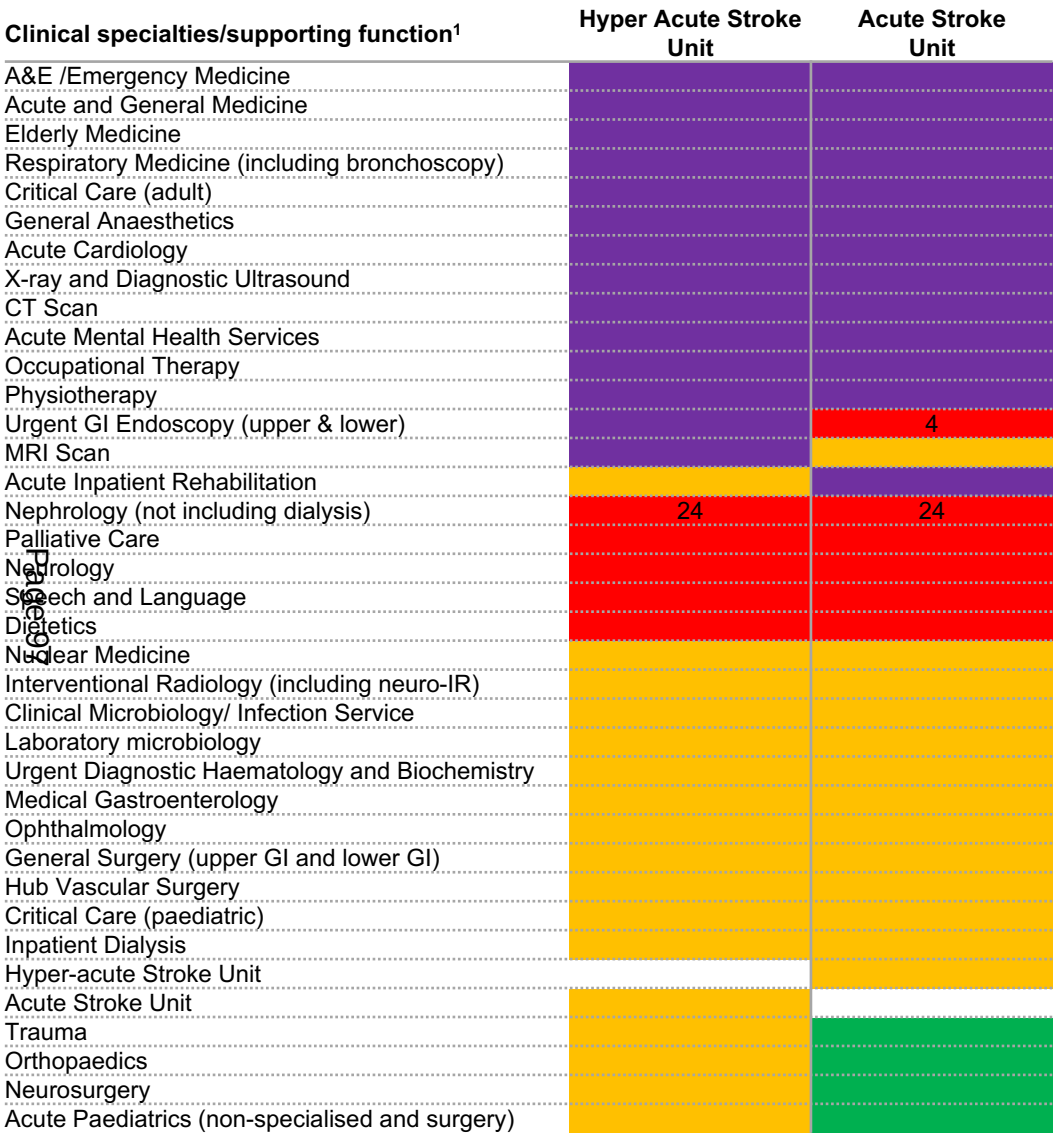
- Elderly Medicine
- Respiratory Medicine
- Critical Care (adult)
- General Anaesthetics
- Acute Cardiology
- X-ray and Diagnostic Ultrasound
- CT Scan
- Acute Mental Health Services
- Therapy; SLT/OT and Physiotherapy
- Physiotherapy
- Urgent GI Endoscopy[1]
- MRI Scan[1]
- Acute Inpatient Rehabilitation[2]

What are the critical interdependencies?



Notes: [1] Services marked as 'does not need to be on the same site' for both HASU and ASU have been excluded from this table

Source: The Clinical Co-Dependencies of Acute Hospital Services: Clinical co-dependecy grid, South East Coast

What are the other critical interdependencies and enablers?

Other dependencies

- Rehabilitation services including community beds, residential/nursing care homes.
- Early supported Discharge services
- Ambulance services
- Patient transport services
- Social Services

Enablers

- IT
- Communication
- Workforce
- Public transport

Local questions for consideration

Question	Comment
Speech and language	• View at STP workstream that this requires co-location – inreach is not adequate(this differs form the senate recommendations)
Does a HASU need to be co-located with a Trauma unit	• Suggestion from CEOs and AOs re co-location with existing trauma unit; STP workstream questioned this but did agree to being on a 24hr ED with full diagnostics and medical cover • Impact on trauma unit EDs is a concern • Clinical advice is that there is clear evidence of benefit and potential of harm • Pts, re delays in diagnosis/staff, need to move, communicate across sites/financial due to transfers of trauma pts/education/ambulance risk re choice of conveyance destination
Ability of a hospital to take on a HASU?ASU	• To be worked through in the detailed site options including application of bed numbers and staffing availability

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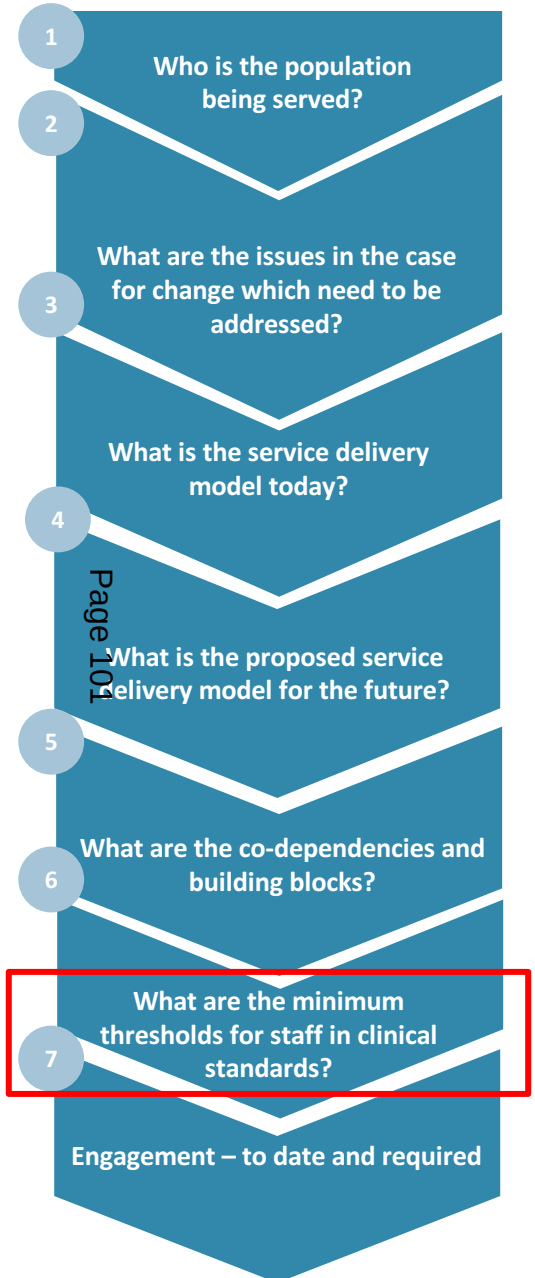
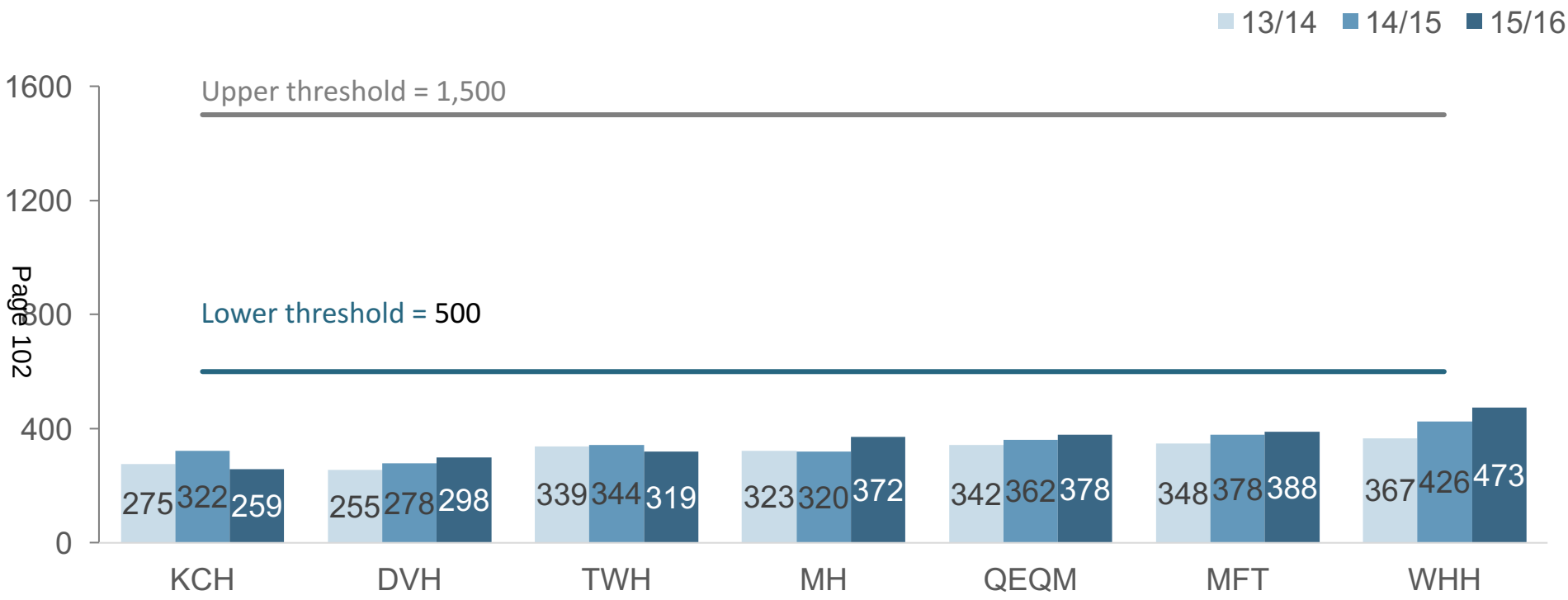


- HASU requirements; 24/7 consultant availability with minimum 6 trained thrombolysis physicians on rota and consultant led ward round 7 days a week, 2.9 WTE Nurse (80:20 registered unregistered per bed ,Per 5 beds; 1 Physiotherapist, 0.68 Occupational Therapist, 0.34 S&L therapist, 0.20 Clinical Psychologist, 0.15 Dietician [3]
- HASU Volume requirements; >500 and < 1500 confirmed stroke patients

What are the minimum thresholds for volume in clinical standards?



- At present, stroke is delivered at 7 acute sites.
- Volume thresholds suggest a requirement for 2-4 sites.
- Further work done suggests a need for 3 sites to meet all critical criteria.

Notes a65 patients per year form East Sussex
b70 patients per year from South London (into DVH)
72 hour cohort refers to the processes of care in the first 72 hours of stroke, beyond which patients enter into post-acute stroke care processes

Source: SSNAP clinical audit Apr 15– Mar 16, K&M Case for Change – Stroke, QOF 2014

What are the minimum thresholds for staff in clinical standards?

	Threshold/ Requirement	DVH 23	MH 26	TW 10	Medway 25	QEQM 24	K&C 24	WHH 24	Total gap Jun 2016*
1	Min 6 stroke consultant rota* May require more to manage a units volume of activty	x	x	x	x	x	x	x	29.5
2	2.9 nurses per bed (80/20)	x	x	x	x	x	x	x	65.18/24.37*
3	1.0 wte physio per 5 beds	x	x	x	x	x	x	x	8.75
4	0.68 per 5 beds Occupational therapist	x	x	x	x	x	x	x	11.49
5	0.34 per 5 beds SLT	x	x	x	x	x	x	x	9.89
6	0.15 Dietician								n/k
7	0.20 Clinical Psychologist								n/k

Notes: We don't have a complete data set for therapies or untrained nurses
Detail on dietician and clinical psychologist not collected
** just noted the total gap, this is iterative and staff move and are appointed, so would need to be looked at again in detail when geographic options are worked up in detail

Source: 'As Is/Future State' workforce assessment; updated June 2016

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1. Who is the population being served?
2. What are the issues in the case for change which need to be addressed?
3. What is the service delivery model today?
4. What is the proposed service delivery model for the future?
5. What are the co-dependencies and building blocks?
6. What are the minimum thresholds for staff in clinical standards?
7. Engagement – to date and required

- Over the last 2 years EKHUFT has engaged with key stakeholders internally and externally through a series of EKHUFT and East Kent Strategy Board events.
- Extensive engagement events carried out in North Kent, West Kent and Medway over the last 6 months

Engagement

Over the last 2 years there has been a Kent & Medway review of stroke.

- There was a governance structure created with a Programme Board and Clinical Reference Group (CRG)
- Public and clinical engagement events took place throughout the process, with key engagement events have been tabled on the next slide.

Engagement events to date (January 2017) (Page 1 of 2)

DATE	EVENT	ATTENDEES	PURPOSE
June to Sept 2015	10 Listening Events across K&M Focus groups with the stroke asscition and Hard to Reach groups		To develop the Case for Change and inform decision making criteria
Nov and Dec 2015	3 Deliberative Events: "People's Panels" - 2 in Maidstone and 1 in Ashford	Members of the public	Pre-consultation engagement to work through review process, discuss priority indicators and test the emerging options
Nov 2015	K&M Review 1st Clinical Engagement Event: Presentation by Professor Tony Rudd, National Clinical Lead for Stroke	All staff connected with all 7 stroke units (Therapists, Consultants, Nursing staff, SALT etc)	Progress of the K&M Stroke Review, clinical models and service delivery options. To inform the options appriasal process
Sept to Oct 2016	4 Public Deliberative Listening Events held in conjunction with Health Watch and the Stroek Assocaiation – coordinated by the K&M Stroke Review Process - Sandwich; Ashford; Maidstone; Gillingham	People who have had a stroke, their carers and members of the public	To share the case for change, discuss the on-going review proces, the emerging findings and invite feedback and challenge
Feb to April 2016	3 Direct Engagement Events: 1 x Minority Ethnic Forum in Medway 2 x Asian population in Gravesham	Members of the public, targeted non English speaking communities	To share the case for change, discuss the on-going review process and invite feedback and challenge
April 15 to Sept 2015 March to Sept 16	Presented to CCG Clinical Forums	GPs CCG representatives	To bring together the attendees to discuss the way forward in achieving a stroke service that is clinically and financially sustainable
11.2.16	EK Strategy Board	EK Clinical Chairs, AO's, Provider CEOs, Healthwatch	To update and align to the EK strategy

Engagement events to date (January 2017) (Page 2 of 2)

DATE	EVENT	ATTENDEES	PURPOSE
July, Sept 15, Jan and March 2016	- K&M Commissioning Assembly	K&M CCG Clinical Chairs and AOs, KCC, Specialist Commissioning	To review the Case for Change and inform options appraisal and advise on modelling
April 2015 to Nov 2016	K&M Stroke Review Programme Board - Quarterly meeting - - Also presented 7 times to K&M Joint Health Overview & Scrutiny Committee (JHOSC) Sept 15 to Nov 2016 - Presented to individual HOSC/HASC April and July/Aug 15	Clinical and patient representatives including: Stroke Clinical Lead for Kent, Surrey & Sussex, NHS England, Clinical Experts, CCG representatives, Stroke Association, Health watch ,South East Coast Ambulance Service and Engagement Leads	Agree what actions need to be taken for the review to be successful
Oct 2015 to Nov 2016	K&M Review Clinical Reference Group (CRG) - Monthly meeting	Clinical and operational representatives from all acute hospitals and providers; links to Programme Board	Provides clinical scrutiny to the review process and actions undertaken
March 2016	K&M Programme Board Challenge Session	Clinical and patient representatives including: Stroke Clinical Lead for Kent, Surrey & Sussex, NHS England, Clinical Experts, CCG representatives, Stroke Association, South East Coast Ambulance Service and Engagement Leads JHOSC members	To review progress of the options appriasal and confirm areas of challenge, further detailed modelling and agree non viable options in relation to the criteria
Oct 2014 to June 2016 May 2015, Nov 15 and January 16 Early 2015 ?Jan to April	EKHUFT Organisation of Stroke Services Meetings - Quarterly development and strategy meetings - MTW Stroke Improvement Board - MTW public engagement events	Staff from all 3 stroke units in East Kent; South East Coast Ambulance; Kent Community Health Foundation Trust MTW Stroke leads and executive team Patients and members of the public	Develop the stroke service in east Kent and align to service reviews To advise and align the K&M Review with the MTW Stroke improvement programme To discuss and develop solutions to stroke performance across MTW
Oct 2016 Feb 2017	East Kent Clinical Engagement Stroke Service Away Day Events	Staff from the 3 Stroke Units in east Kent; along with K&M guests and speakers	To continue with strong staff engagement and involvement in the review process and outcomes

External stroke flows into Kent and Medway

6 October 2017

Strokes from neighbouring CCGs treated in Kent and Medway

The table below shows the actual incidence of stroke in neighboring CCGs that have been treated in Kent and Medway over the last 3 years

	2014/15					2015/16					2016/17				
	DVH	TWH	WHH	Other K&M	Total	DVH	TWH	WHH	Other K&M	Total	DVH	TWH	WHH	Other K&M	Total
NHS Bexley CCG	32	0	0	4	**36**	49	0	1	1	**51**	44	0	2	0	**46**
NHS Hastings and Rother CCG	0	4	12	1	**17**	0	12	13	1	**26**	0	4	14	1	**19**
NHS High Weald Lewes Havens CCG	0	53	1	0	**54**	0	61	0	7	**68**	0	66	0	3	**69**
NHS Greenwich CCG	3	0	0	0	**3**	2	0	0	2	**4**	1	2	0	3	**6**
NHS Bromley CCG	0	0	1	1	**2**	1	1	0	1	**3**	3	1	0	3	**7**
NHS Horsham and Mid Sussex CCG	0	1	0	0	**1**	0	4	0	0	**4**	0	1	0	0	**1**
NHS East Surrey CCG	0	0	0	0	**0**	0	1	0	0	**1**	0	1	0	1	**2**
NHS Eastbourne, Hailsham and Seaford CCG	0	0	1	0	**1**	0	1	0	0	**1**	0	1	0	1	**2**

SOURCE: Kent and Medway provider data returns (2015/16), Carnall Farrar analysis

Modelled flows from Bexley, Greenwich and Bromley

When considering the travel time to the nearest stroke unit, assuming that all 7 sites in Kent and Medway operate as stroke units, the following populations would fall within the catchment for Kent and Medway hospitals

All ages	DVH	TWH	WHH
NHS Bexley CCG	227,626	0	0
NHS Greenwich CCG	115,939	0	0
NHS Bromley CCG	0	0	0

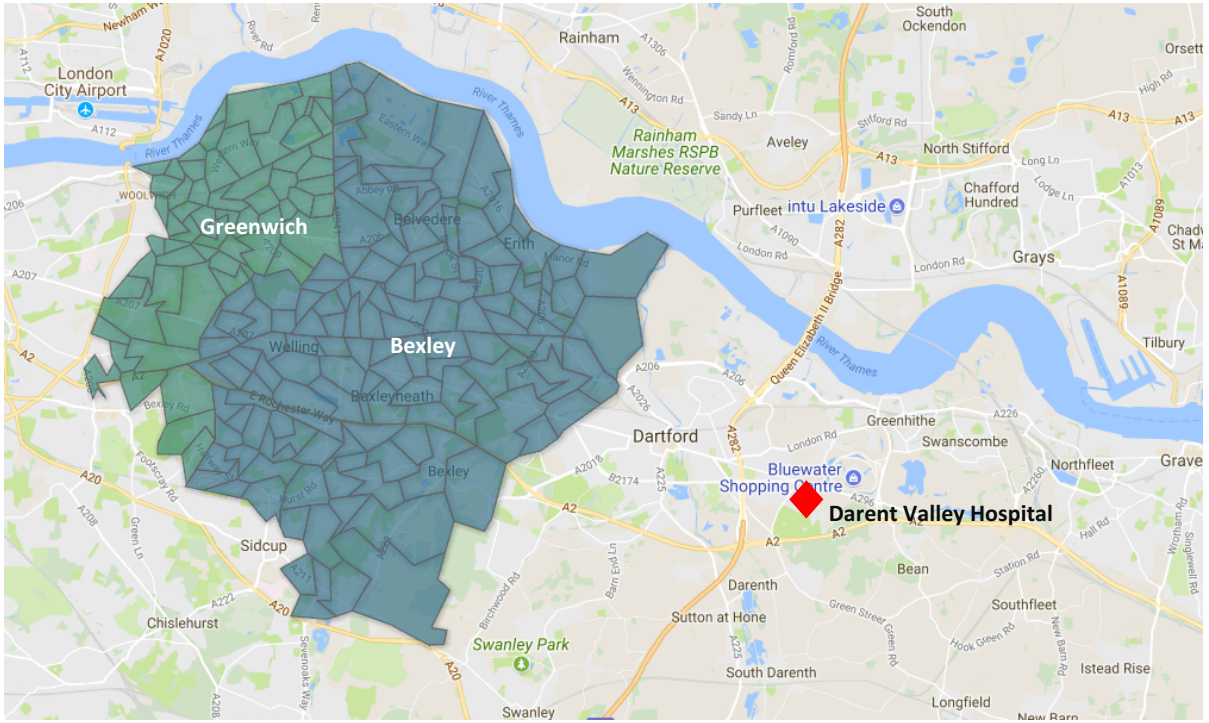
70+ population	DVH	TWH	WHH
NHS Bexley CCG	26,054	0	0
NHS Greenwich CCG	6,949	0	0
NHS Bromley CCG	0	0	0

Highlighted right are LSOAs of the labelled CCGs representing the populations above. These, by the travel time model, flow to:

Darent Valley Hospital:

- Bexley
- Greenwich

All LSOAs in Bromley CCG flow to PRUH



SOURCE: Provider data returns (2016/17), Basemap travel times (car, off-peak), ONS population data (2015), Carnall Farrar analysis

Modelled flows from East Sussex

When considering the travel time to the nearest stroke unit, assuming that all 7 sites in Kent and Medway operate as stroke units, the following populations would fall within the catchment for Kent and Medway hospitals

All ages	DVH	TWH	WHH
NHS Hastings and Rother CCG	0	25,307	15,136
NHS High Weald Lewes Havens CCG	0	49,619	0
NHS Horsham and Mid Sussex CCG	0	0	0
NHS East Surrey CCG	0	0	0

70+ population	DVH	TWH	WHH
NHS Hastings and Rother CCG	0	4,549	3,194
NHS High Weald Lewes Havens CCG	0	8,203	0
NHS Horsham and Mid Sussex CCG	0	0	0
NHS East Surrey CCG	0	0	0

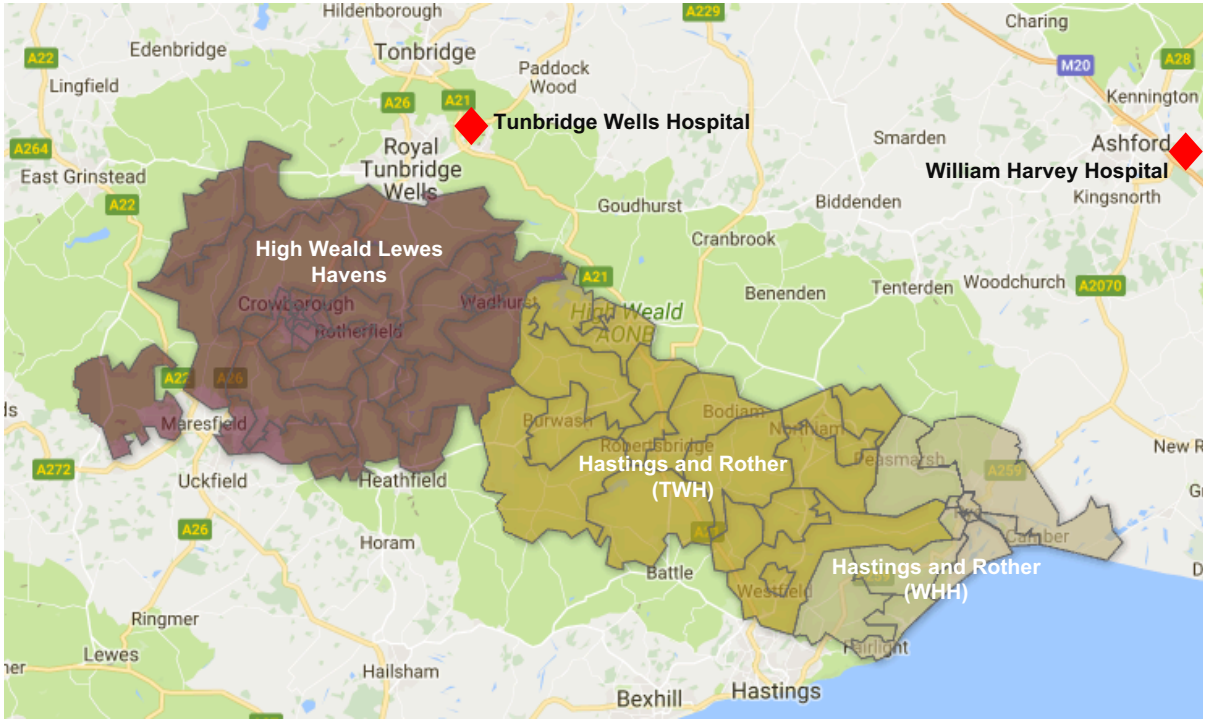
Highlighted right are LSOAs of the labelled CCGs representing the populations above. These, by the travel time model, flow to:

Tunbridge Wells Hospital:

- High Weald Lewes Havens
- Hastings and Rother

William Harvey Hospital:

- Hastings and Rother



SOURCE: Provider data returns (2016/17), Basemap travel times (car, off-peak), ONS population data (2015), Carnall Farrar analysis

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

Date of meeting: **30 November 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 sub-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.

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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 sub-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) inspections and the Trust's wider recovery plan. Meets approximately 4 times per year. Membership: Cllr Belsey and Cllr O'Keeffe. The most recent minutes are attached at **appendix 2**.
- Following the publication of SECAmb's performance figures in October, the Chair of the HOSC SECAmb sub-group wrote to the Chief Executive of SECAmb to express his significant concern about the performance levels reported, particularly in relation to response times and call handling which were very significantly below target. The full letter is attached at **appendix 3.**

Brighton & Sussex University Hospitals NHS Trust (BSUH)

- A joint sub-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). The most recent minutes attached are at **appendix 4**.

Mental health services

- A Joint Sussex HOSCs 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. The minutes of the most recent meeting were noted at the 21 September HOSC.

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

Contact Officer: Harvey Winder, Democratic Services Officer
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Email: Harvey.winder@eastsussex.gov.uk

Work Programme for Health Overview and Scrutiny Committee

Future work at a glance

Updated: November 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.

Issue	*Objectives and summary*	*Organisation giving evidence*
29 March 2018		
Sussex and East Surrey Sustainability and Transformation Partnership (STP)	To consider an update on the NHS Sussex and East Surrey Sustainability and Transformation Plan (STP) and its implications for healthcare in East Sussex. Note: Timing is provisional depending on the progress of the STP.	Wendy Carberry, Chief Officer, HWLH CCG; Dena Marshall, STP Programme Director
Clinically Effective Commissioning	To consider an update on Clinically Effective Commissioning programme which is aiming to review and standardise clinical thresholds and policies across 8 CCGs in the Sussex and East Surrey Sustainability and Transformation Partnership (STP) area.	Wendy Carberry, Chief Officer, HWLH CCG
Connecting 4 You Update	A further update on the progress of Connecting 4 You programme.	Wendy Carberry, Chief Officer, HWLH CCG
GP Access	A report on the state of access to GP practices in East Sussex, to include discussion of challenges around vacancies, registration and electronic access.	Ashley Scarff, Director of Strategy, HWLH CCG; Jessica Britton, Chief Operating Officer EHS/HR CCG

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
28 June 2018		
Urgent Care	To consider a report on the progress of the East Sussex Better Together (ESBT) urgent care strategy, including an update on future plans for NHS 111.	Mark Angus, Urgent Care System Improvement Director
2 October 2018		
NHS 111	A report on the progress of the NHS 111 re-procurement.	Colin Simmons, 111 Programme Director (Sussex)

Other HOSC work

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

Issue	***Objectives / Evidence***	***People / HOSC timescale***
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 to be circulated in November 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: 17 October 2017 Next meeting: TBC late-Jan/Early Feb 2018
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: 4 October 2017 Next meeting: Early Feb 2018
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: 24 January 2017
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: 9 February 2018
NHS 111	An update on the progress of the NHS 111 procurement to be circulated to the Committee by email.	December 2017/January 2018
Health and Social Care Connect (HSCC)	A visit to the HSCC in St Mary's House, Eastbourne. To also include a presentation on the Service.	24 November 2017

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

A meeting of the South East Coast Ambulance Service (SECAmb) NHS Foundation Trust – Regional HOSCs Sub-Group held at SECAmb Headquarters, Crawley on Tuesday 17 October 2017

Present: Mr Bryan Turner (Chairman, West Sussex HASC); Cllr Ken Norman (Chairman, Brighton & Hove HOSC); Cllr Ann Norman (Member, Brighton & Hove HOSC); Cllr Mike Angell (Vice-Chair, Kent HOSC); Cllr David Mansfield (Member, Surrey Wellbeing and Health Scrutiny Board)

In Attendance: Daren Mochrie (Chief Executive, SECAmb); Jon Amos (Acting Executive Director of Strategy and Business Development, SECAmb); Mark Whitbread (Consultant Paramedic, SECAmb); Claire Lee (Officer, East Sussex HOSC); Andrew Baird (Officer, Surrey WHSB); Nuala Friedman (Officer, Brighton & Hove); Lizzy Adam (Officer, Kent HOSC) and Helena Cox (Officer, West Sussex HASC)

Apologies: Cllr Colin Belsey (Chair, East Sussex HOSC); Cllr Ruth O'Keefe (Vice-Chair, East Sussex HOSC); Cllr Sue Chandler (Chair, Kent HOSC); Cllr Wendy Purdy (Chair, Medway HOSC); Cllr David Royle (Chair, Medway Children's OSC); Dr James Walsh (Vice-Chairman, West Sussex HASC); Giles Rossington (Officer, Brighton & Hove HOSC) and Jon Pitt (Officer, Medway HOSC)

CQC re-inspection report key findings and Trust response

1. Daren Mochrie, highlighted to members the key themes from the recent Care Quality Commission (CQC) re-inspection report and feedback from the Quality Summit, which was held on 5 October. The Trust was disappointed with the overall rating but was pleased with the pockets of good and outstanding practise, particularly in relation to 111.

2. Two 'Notice of Proposal' had been issued to the Trust in relation to Medicines Management and 999 call recording, which had since been withdrawn due to significant improvements since the notice had been issued. In relation to 999 recording, there were issues with the telephony platform and this was on the Trusts risk register. Improvements had been made and the issues were now a small number. A paper would be presented to the Trust Board to seek approval to replace the telephony platform to resolve issues of technically finding calls and the static on the line. The Trust had brought in a member of staff to help with the issues and Mr Mochrie was confident that the Trust would have a grip on this. The replacement platform would be funded from money received as the Trust was in special measures. BT was also recording the line to trace any fall out calls. It was asked what the target would be in relation to numbers of calls recorded/completed. This would be between 95-100%.

3. The Trust had 17 'must-do's' set by the CQC. Eleven task and finish group (these built on the success of the medicines management task and finish group chaired by Mr Mochrie) had been set up and were chaired by a member of the executive leadership team, to monitor a comprehensive action plan and ensure rigour and grip in terms of improvement. Mr Mochrie's presentation focused on an example of some of the 'must-do's', which included:

- **Incident Reporting** – There was a need to improve incident reporting and reduce the current backlog. It was asked how many serious incidents the Trust reported each month, to which members were told that there was

about 400 incidents a month which were reported but around one a week was then considered to be a serious incident, so approximately 50 per year. Members were told of the good relationship which the Trust had with other blue light colleagues, although a vitally important relationship for the Trust was with other health colleagues in relation to serious incidents. Mr Mochrie expressed his wish to make the organisation more of a 'learning organisation', minimising mistakes and learning from those that did occur.

- **Safeguarding** – Members were informed that the Trust had not necessarily had the right resource in the key areas but there were some improvements and plans in place for all staff to complete level 3 safeguarding training.
- **Staffing in EOC** – Staffing in the control centre on 999 call handling was a challenge since we had moved to the new EOC. There is a robust plan in place to recruit new staff and plans to recruit a more multidisciplinary clinical workforce. Since the move to the new EOC we have implemented seamlessly a new command and control system. On 22 November, the national Emergency Response Programme (ERP) would be implemented at the Trust.
- **Improved ACQI – Heart Attack** – A strategy would be implemented across the Trust in relation to improving clinical outcomes for, in this example, heart attack patients. A new health informatics system would be in place by March 2018 which would provide more meaningful data and audit. Members were informed that the Trust had 70 Critical Care Consultant Paramedics who were targeted to patients who were really sick, with a critical care hub within the control centre. Members were informed that Mark Whitbread, a consultant paramedic, had been employed by the Trust to drive the strategy, embed it within the organisation and engage with staff.
- **Staff Engagement** – The Trust planned to design solutions from the bottom up and had held a number of local staff engagement sessions across the Trust. It was early days but there were signs of improvement, with a 200% increase in the response rate for the staff Friends and Family test. Feedback from the unions was also improving. Work would continue and the importance of the leadership team leading by example was emphasised.

4. Mr Mochrie emphasised that much more pace was needed on what was required to be done and the year would focus efforts on areas within the overall Trust strategy and the various different work streams to take the organisation forward. The Trust's project management office was wrapping around the task and finish groups to ensure evidence of improvement .

5. In terms of the Quality Summit and discussions with partners, Mr Mochrie highlighted the importance of handover delays at emergency departments across the Trust area and that this was something that needed to be addressed as a whole system and would have a significant impact on the performance of the Trust and patients. Members agreed that they would like to receive monthly performance/handover delay statistics to identify hotspot areas, which would allow HOSCs to ask the question of local health partners if required. Regarding the cleaning of vehicles once a patient had been handed to an acute trust, members were informed that it would be for the paramedics to decide whether they would need to visit a make ready system or not to be prepared for the next job.

6. SECAmb had not previously had a surge management plan, unlike the acute trusts and other ambulance trusts such as London, so was working with partners to put a surge plan in place before the winter. To address demand and handover delays system solutions were required in the community as well as emergency

departments as it was not a good use of paramedic time to be spending hours on scene trying to secure additional pathways or looking after patients in emergency departments awaiting handover. In terms of handover delays, it was asked where the area sat nationally. Members were informed that there were hospitals in the patch which were in the top 10 hospitals nationally for delays. Mr Mochrie explained that there was work underway with commissioners in regard to demand and capacity modelling to ascertain whether it had the right baseline funding to meet demand or whether additional investment in SECAmb was required. Mr Mochrie's view is that by investing in the right ambulance model it could take pressure off other parts of the system. For example if SECAmb transported 10% less patients to attending emergency departments this would have a significant benefit to the whole system but this model needed funded. Between now and January, the Trust would work with commissioners and an external company – Operational Research in Health (ORH) to undertake a demand and capacity review and there needed to be a conservation with all stakeholders on any potential models which would be planned for January 2018 onwards.

7. An enquiry was made as to what staff turnover levels were at the Trust. Members were informed that the turnover of advanced paramedics was high as they could receive higher paid rates working at acute trusts or in Primary care. This is why this needs included in the demand capacity modelling. It was also asked what impact there had been on the ambulance service in regard to Friday/Saturday call outs for issues related to the use of alcohol. Members were informed that with better data collection the Trust would be able to understand this more but like most ambulance Trusts alcohol related calls were significant during these times. There were additional issues regarding fallers, in that there were not 24/7 fall prevention team support so an ambulance was called to lift patients, so more work was needed with local authorities and Careline and nursing homes to try and address the problem. Members agreed that receipt of SECAmb on data regarding call outs to care homes/falls/alcohol/mental health would be incredibly useful and give councillors the opportunity to take issues forward. Mr Amos highlighted that the data was available at a high level and could be shared in order for the importance to be highlighted.

Professor Lewis report - key findings and Trust response

8. Mr Mochrie informed members that the Professor Lewis had identified issues of a culture of bullying and harassment at the Trust, which was disappointing but the Trust was taking appropriate action including individual investigations to address this. The Trust Board had agreed that the report should be made publically available as they did not wish to hide the findings contained in the report and want to encourage and open and honest culture. The Board would receive a further report at the end of the month regarding the strategy moving forward and continued efforts to strengthen staff engagement. An additional member of staff with an OD/cultural background had been employed to drive this work forward.

Quality Improvement Plan (QIP)

9. Mr Amos informed members that a revised QIP was to be presented to the Trust Board next week, with measures which could be tracked on a weekly/monthly basis and was much more focused on key performance indicators. There were challenges of balancing finances, quality and performance and the focus on a

demand and capacity review would assist this. It was agreed that the revised QIP would be presented to members at the next meeting of the sub group.

10. Members were informed that the Trust had not formally been notified whether NHSI would keep the Trust in special measures but believed this would not be reviewed until the Trusts re-inspection next year.

Performance and Clinical Outcomes

11. Members noted that a paper regarding performance and clinical outcomes was not attached so would be circulated separately. Challenges of staff turnover in the control room were discussed, these was due to multifactorial factors and were typical of overall system pressures regarding workforce. The impact of control room relocation to Crawley was starting be seen regarding control room turnover although all call centres tended to have a high turnover of staff. A lot was being done regarding recruitment processes. All control centre staff were being trained on the national ambulance response programme. The impact of the temporary relocation of services from Kent & Canterbury Hospital was raised. Mr Amos informed Members that the Trust was working with East Kent CCGs who had agreed short-term funding to resource additional journeys; as a result, there had been no real impact on the Trust's performance. Focused work with NHS Improvement was being undertaken to reduce handover delays particularly at the Ashford site.

12. In terms of headlines, the capacity to answer calls in the control room was a core focus and the impact on Red 1/Red 2 response times, as was patient safety and wait times. The Trust was looking at those patients in the 'tail end' who wait longer than 8 or 9 minutes. From 22 November the national ambulance response programme would be adopted by the Trust and Red 1 and Red 2 calls would disappear and be replaced by new clinically led targets.

13. There was a new online system for appraisals and e-learning for staff across the Trust which allowed staff to access these when they are out and about. It was early days but there had been uplift in the numbers of staff completing training and feedback had been positive. Regarding quality, historical backlogs were being cleared with extra staff being brought in to help. Financially the Trust was to achieve £15m of efficiencies this year which was on track but there were pressures in other areas.

Ambulance Response Programme (ARP)

14. Mr Amos presented members with details of the new national Ambulance Response Programme (ARP). Currently the Trust had 60 seconds to answer a call and deploy a resource at which time the clock starts for an 8 minute response. There are a large number of patients within that cohort and doesn't differentiate well, with multiple resources being sent to one patient in order to hit targets. There approximately 750,000 duplicate calls a year. The ARP wad developed working with patients groups and changes the order in which questions are asked, using technology to identify the location of the caller. The time allowed prior to resource despatch has been extended to 4 minutes for calls other than cardiac arrest to ensure the right resource goes to the right patient. The national review saw no patient harm as a result of the changes and positive feedback had been received from staff, patients and stakeholders.

15. The four new categories were detailed as follows, with a response by an ambulance in the first instance, expected for the first two:

Category	Target Time	Example	Target
Category 1	7 minutes	Cardiac, life threatening	50% within target time
Category 2	18 minutes	Stroke, critical burns	50% within target time
Category 3	120 minutes	Late stages of labour, non-severe burns, diabetes	90% within target time
Category 4	180 minutes	D&V, infections	90% within target time

16. The longer terms challenges emerging from the ARP were that there would need to be a change to the mix of vehicles needed, as SECAmb had a large number of cars at the moment. Ambulance Trusts would be monitored and the first set of data which would show the impact on SECAmb would be available in January. Local issues in East Sussex regarding maternity provision were raised due to the target time of 120 minutes to reach women in the later stages of labour and that work would be needed to communicate rationale to the public. Uninjured falls were cited as a hidden group as patients could wait 3-5 hours for assistance. Staff in the control room will continually monitor and re-prioritise if necessary. It was asked how categories related to the out of hours service, the benefit of a new platform would make it easier to refer category 4 calls to the out of hours service with an automated referral system. It was agreed that the presentation slides would be shared with members after the meeting.

Surge Management Plan

17. Mr Amos informed members that discussions were currently ongoing with partners regarding a surge management plan for the Trust to ensure that there could be prioritisation and balance of risk. It was planned to share details with the sub group at the next meeting.

Cardiac survival to discharge data

18. Mark Whitbread, Consultant Paramedic, informed members that he had been employed by the Trust to ascertain how outcomes for those patients treated for cardiac arrest can be improved and shared data regarding analysis of cardiac arrest data over April – June 2017. Mr Whitbread explained the use of 'utstein' figures when considering cardiac arrest data so that figures across the country could be compared like for like. The higher survival rate figures relating to the Isle of Wight needed the caveat of the small numbers the data was based on. Data was being reviewed by the Trust Board on a monthly basis. However, the Trust was struggling to receive outcome data from some acute trusts across SECAmb's area, especially St Peters, Chertsey, although there was no mandate for trusts to share this data. Six to twelve months of data was needed to breakdown to understand the geography and be under constant review.

19. The current cardiac arrest data for SECAmb in 2016/17 was 22.2%, the Trust wished to raise this to between 30-40%, going above 40% would be extremely challenging. A rise of 1 or 2% was also quite hard.

20. Mr Whitbread had presented the Trust Board with a number of recommendations based on his work so far. One of these was related to public education and promote resuscitation and access to defibrillators. Calls are to be triaged correctly so that a response is despatched quickly and can reach a specialist centre when required. Members noted that there was only one specialist centre in Kent, with other options based at Brighton and St Georges, London. The recommendations were short, medium and long term. Members were informed that the Fire Brigade Union had called on their members to reject a proposal to be able to co-respond with the ambulance service.

21. Members discussed the location of defibrillators and agreed to speak to their local communities to ensure that defibrillator cabinets are not locked and available to be used quickly when needed.

Date of Next Meeting

22. It was agreed that the next meeting of the sub group would be held in late January/early February 2018. Claire Lee would liaise with the Trust on possible dates.

Members of the sub group were given a tour of the control room followed the conclusion of the meeting.

Mr Bryan Turner
Chairman
Health and Adult Social Care Select Committee

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County Hall
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PO19 1RQ

15 November 2017

SENT BY EMAIL

Daren Mochrie
Chief Executive
South East Coast Ambulance Service
NHS Foundation Trust
Nexus House
4 Gatwick Road
Crawley
West Sussex
RH10 9BG

Dear Daren,

SECAMB Performance and HOSC support

I am writing on behalf of all the HOSC Chairs in the SECAMB area in light of the performance figures reported to the October Trust Board meeting. I am sure you will understand that we feel the need to place on record our significant concern about the performance levels reported, particularly in relation to response times and call handling which were very significantly below target. This level of performance was notable enough to be reported in the media and to generate questions and concerns locally.

As you know, we had some discussion on performance challenges at our recent regional HOSCs Sub-Group meeting, although the performance report itself had inadvertently been omitted from the papers. We noted the contributory factors you mentioned, particularly abstraction of EOC staff for training on the new CAD and Ambulance Response Programme (ARP), recruitment issues linked to the move of EOCs to Crawley and a focus on addressing the lengthier waits for red category calls, perhaps at some detriment to the 8 minute standard performance. We also noted the range of action the Trust is taking to improve and the planned transition to ARP standards from 22 November.

The HOSCs appreciate the extent of challenges facing SECAMB and welcome the new leadership you are bringing to addressing these. Committees wish to be constructive in our role as a 'critical friend' to the Trust and to support the achievement of the Trust's improvement plan. In order to undertake this role to best effect we would emphasise the importance of sharing performance data with us on a regular and timely basis which will enable HOSC Chairs and Members to provide a rounded and accurate picture in response to queries, as well as to raise questions with our local commissioners and providers where appropriate.

We discussed sharing data on handover delays with the HOSCs on a monthly basis, given the impact of these delays on overall Trust performance. The HOSCs would also like to request an interim update on overall performance in early December to tie in with the Trust's Board at the end of November.

We look forward to a more detailed discussion and a further performance report, to include early data based on ARP standards, at our next meeting to be arranged for early February.

Yours sincerely

Cllr Bryan Turner
Chair, West Sussex HASC
Chair, Regional SECAMB HOSCs' Sub-Group

Cc: Cllr Ken Norman, Chair, Brighton and Hove HOSC
Cc: Cllr Colin Belsey, Chair, East Sussex HOSC
Cc: Cllr Sue Chandler, Chair, Kent HOSC
Cc: Cllr Wendy Purdy, Chair, Medway HOSC
Cc: Cllr Ken Gulati, Chair, Surrey HOSC
Cc: Jon Amos, SECAMB Acting Director of Strategy and Business Development

Joint Sussex HOSC Working Group: BSUH Quality Improvement

Wednesday 04 October 2017 Meeting Note

HOSC attendees:
Cllr Ken Norman, Chair (BH HOSC); Cllr Colin Belsey (ES HOSC), Cllr Ruth O'Keeffe (ES HOSC); Mrs Anne Jones (WS HASC), Dr James Walsh (WS HASC), Mr Bryan Turner (WS HASC)

BSUH attendees:
Nicola Ranger, Chief Nurse; Pete Landstrom, Chief Delivery & Strategy Officer

1. Apologies

1.1 Apologies were received from Cllrs Kevin Allen, Louisa Greenbaum and Johanna Howell.

2. Notes of the last meeting

2.1 A meeting note from the 30.03.17 meeting was agreed.

Ms Ranger and Mr Landstrom gave three presentations: on the recent CQC inspection (3); on trust quality improvement plans (4); and on specific plans to make improvements in A&E (5).

3. Recent CQC inspection report results and next steps

3.1 Nicola Ranger told the group that the recent CQC inspection report had seen an improved rating for the trust: from *Inadequate* to *Requires Improvement*. The CQC made some positive comments on improvements within the Trust.

3.2 The CQC believes that BSUH is beginning to address its corporate culture issues. It is important to note that the CQC did not inspect against the *Well-led* domain in 2017, as the trust leadership team had only recently been appointed at the time of the inspection. Because of this the BSUH *Well-led* domain still shows as *Inadequate* (the 2016 inspection rating) and the trust remains in *Special Measures*.

3.3 The 2017 inspection has seen significant improvement in the *Caring* domain, with all BSUH services now either good or outstanding in terms of *Caring*.

3.4 Some key services have also seen performance improve substantially – e.g. maternity, urgent care and diagnostic imaging.

3.5 Current areas of concern include the *Safety* domain and the Critical Care service where the CQC picked up on significant culture issues caused by

the move of neurological services from Hurstwood Park to the RSCH site. However, whilst the cultural problems highlighted by the CQC are serious, it is important to recognise that the inadequate score for *Safety* against this service does not mean that Critical Care services at BSUH are unsafe: clinical outcomes (e.g. mortality and morbidity rates) are in fact very good when bench-marked against comparators.

3.6 In answer to a question from Cllr O'Keeffe about the degree of improvement, Mr Landstrom told members that turning around BSUH is a long-term task. Whilst the direction of travel is positive, people need to concentrate as much on the plans for improvement as on what has happened to date.

3.7 In response to a question from Dr Walsh on the Critical Care department, Mr Landstrom told the group that the CQC had identified issues with a very long back-log of incidents and a lack of evidence to demonstrate that the service had learnt from previous incidents. Culture problems connected with the single-siting of trauma were also evident. Ms Ranger added that the CQC had also focused on trust failures in identifying when patients required Critical Care services.

3.8 In answer to a question from Mrs Jones on ambulance performance, Mr Landstrom explained that some aspects of this were covered in the CQC inspection report: for example ambulance to hospital handover times. However, the bulk of ambulance services are inspected separately (i.e. as part of SECAmb's CQC regime).

3.9 In terms of financial pressures, BSUH is currently on track to deliver on its planned year-end financial position (a deficit of £60M). This is good news as it means that the trust does not have to borrow at very high interest rates, as it would be forced to do if it was significantly off-track. It is however recognised that this is a very large deficit.

3.10 The trust has also recently agreed cost improvement plans; established a leadership development programme; had significant Emergency Department (ED) investment approved.

3.11 BSUH has recently introduced a Single Oversight Committee where the trust engages with all its regulators. The aim of this is to reduce the amount of duplication and for the Trust to work to one improvement plan.

4. BSUH Quality Improvement

4.1 Improving staff culture is a key priority for the trust, and the corporate centre can assist by establishing some guiding principles. Cultural change will take time and it is important to maintain focus: having an action plan in place does not mean that culture will improve without consistent reinforcement of messages over time. It also needs to be recognised that this is a long-standing problem and several past attempts to improve organisational culture have failed.

4.2 The trust recognises that patient views are an important driver of improvement and will make efforts to reach out to a wide range of patients. Western has done some excellent work around using some very challenging patient views to improve services, and this will inform the work at BSUH.

4.3 The trust has adopted a new approach to quality improvement planning. Some of its planning will be focused on the CQC's demands for improvement. These can be generally very transactional in nature. Separately, BSUH has identified five 'breakthrough objectives' for change and has developed these into a set of clear and measurable priorities.

4.4 Firstly, there will be more focus on the care of deteriorating patients. The trust does well in terms of most measures of clinical safety: mortality and morbidity rates are relatively low as are statistical measures of avoidable harm suffered by patients whilst in hospital (e.g. pressure sores and falls). However, the trust has studied all Serious Incidents that have taken place over the past 18 months, and has found evidence that BSUH is sometimes challenged in terms of quickly identifying and responding to deterioration. This may partly because staff have become habituated to dealing with increased acuity of patients in recent years and have consequently become slower than they should be in reacting to worsening conditions. The trust also needs to look at the current administrative demands placed on front-line staff. For example, nurses need to fill in more than 40 assessments for every admission. If this can be managed-down into something more reasonable then staff should have more time to interact with patients and be better placed to spot deterioration.

4.5 The second breakthrough objective is to improve staff attitudes to patients. Whilst it is doubtless the case that the great majority of staff consistently display an excellent attitude, some staff attitude is not where we would want it to be. The aim is therefore to reduce complaints about staff.

4.6 The third priority is to improve staff perceptions of the trust. Staff survey results also show that staff are sceptical that patient care is the top priority for BSUH (52% believe it is, compared to a national average of 74% and a score for Western of 86%).

4.7 The fourth priority will be to ensure that there are no Referral To Treatment (RTT) waits over more than 52 weeks. The national RTT target is 18 weeks, but BSUH has no chance of hitting this target in the short term.

4.9 The final priority is to decrease the number of non-admitted A&E patients who are not treated within 4 hours (i.e. patients who will not ultimately require admission as in-patients). The aim is to decrease the number of 4 hour breaches by 75%.

4.10 There are deliberately few breakthrough objectives. This is to allow proper focus on the five targets that have been identified and to ensure that there are in fact delivered.

4.11 As well as the five targets detailed above and the CQC must and should-dos, the trust has a number of strategic priorities. These include continuing to improve quality (with a particular focus on the Emergency Department and on the Intensive Care Unit); refreshing the clinical strategy (lots of successful work has already taken place in terms of developing the Major Trauma Unit); transforming organisational culture; and enhancing leadership (including additional investment in HR capacity and in clinical leadership just below board level).

4.12 The trust will also undertake 'deep-dives' to better understand some key areas of work. These are: fire regulation compliance, patient flow, people & culture, new governance structure, critical care – culture and deteriorating patient, and infection control.

4.13 Workforce remains a major challenge for the trust, as it is for the NHS across the South East of England. BSUH is keen to look at developing nursing apprenticeships so as to provide a route into nursing for people who might otherwise have been discouraged by the abolition of bursaries.

5. A&E Improvement Plan

5.1 BSUH has four distinct A&E access Points: at the RSCH, at Princess Royal (PRH), at the children's hospital (RACH), and at the Sussex Eye Hospital. Performance across all sites varies, but RSCH typically experiences the greatest pressures.

5.2 A&E attendances are actually fairly static, bucking the national trend where they have been rising. This suggests that local diversion measures have been relatively effective.

5.3 While the national target for A&E is that 95% of patients should be seen within four hours, the trust is setting itself an initial target of 90%. This is realistically achievable. Moreover, evidence suggests that an A&E department operating at 90% will generally be functioning well. The target is already being applied.

5.4 In seeking to understand A&E performance, the trust has split attendees into two categories: admitted and non-admitted (i.e. will the patient eventually be admitted to the hospital for treatment or not).

5.5 In terms of non-admitted patients, key to improving performance will be to ensure that the RSCH Urgent Care Centre (UCC) is working effectively, that those patients who will be treated directly by A&E staff are managed efficiently, and that the PRH A&E is re-developed to provide a dedicated area for 'minors' (currently minor and major patients are seen in the same area).

5.6 In terms of admitted patients, the key issue is Delayed Transfers of Care (DTOCs). This has been a long-term problem, particularly at RSCH and is the challenge of the health and care system rather than any single organisation. There are some internal improvements that should help things: for example, improving the number of a.m. discharges. Currently very few patients are

discharged in the morning, even though a.m. discharges have a much more positive impact for flow through the hospital than p.m. ones. This is partly about getting patients and their families used to the idea that they should expect and arrange for a morning discharge. It is partly about the hospital getting its procedures right too: e.g. ensuring that medications are available on discharge and not several hours later.

5.7 Although the 90% target is challenging it is achievable: it amounts to around 10 fewer breaches per day at RSCH.

5.8 Key actions for A&E include:

- Re-design of the UCC and changes to how triage is delivered.
- The RSCH PAT area is very effective, but there is a need to protect staffing as the PAT area is currently suspended when the ED is very busy, which is counterproductive.
- Changes to diagnostics: e.g. blood tests tend currently to be bundled together which means that the results of relatively quick-to-process tests are delayed while other tests are completed. Splitting the tests will mean that some results are available more swiftly.
- Up to 20% of blood tests are cannot be used as the blood has haemolysed by the time the test is taken. This can be avoided by using different procedures.
- The creation of a dedicated treatment area at PRH for minors.
- A dedicated A&E consultant will now be employed at PRH until 10pm.

5.9 There was discussion of what can be done about people presenting inappropriately at A&E. Ms Ranger told members that it was important to address the issue of people who made frequent unnecessary presentations. Mr Landstrom added that RSCH already has excellent links with mental health, rough sleeper and drugs & alcohol services which helps to manage this cohort of attendees. However, the high prevalence of mental health problems in Brighton & Hove means that the issue is persistent.

5.10 In response to a question from Mrs Jones about links with Out Of Hours (OOH) services, Mr Landstrom told the group that GPs are already embedded in RSCH A&E and there are plans to do the same at PRH.

5.11 In answer to a query from Cllr Belsey about the possible introduction of a ‘breakfast room’ for patients being discharged, members were told that this has just been agreed and will be introduced soon along with a revamp of the RSCH discharge lounge.

5.12 There are also significant physical improvements planned to the ED at RSCH. These include adding 30+ new beds, building two new short-term stay wards and reconfiguration of A&E once the extra beds are available.

5.13 The Chair thanked Ms Ranger and Mr Landstrom for their time. Members agreed that they were considerably assured by what they had heard. They particularly welcomed the decision to focus on a few key targets.

7. Date and focus of next meeting

7.1 It was agreed that another meeting should be booked for early 2018. Support officers will liaise with BSUH to identify a date that makes sense in terms of the trust's reporting commitments. The next meeting will provide an update on progress against the targets detailed above as well as information about the deep-dives that will have taken place.