HEALTH OVERVIEW AND SCRUTINY COMMITTEE

THURSDAY, 29 MARCH 2018

10.00 AM COUNCIL CHAMBER, COUNTY HALL, LEWES

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

District and Borough Council Members
Councillor Mary Barnes, Rother District Council
Councillor Janet Coles, Eastbourne Borough Council
Councillor Mike Turner, Hastings Borough Council
Councillor Susan Murray, Lewes 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 30 November 2017** *(Pages 7 - 16)*

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. **GP Access** *(Pages 17 - 50)*

6. **East Sussex Better Together Urgent Care Redesign** *(Pages 51 - 80)*

7. **Maternity Services in East Sussex** *(Pages 81 - 112)*

8. **Kent and Medway review of stroke services** *(Pages 113 - 118)*

9. **HOSC future work programme** *(Pages 119 - 130)*

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

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

21 March 2018

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Next HOSC meeting: 10am, Thursday, 28 June 2018, County Hall, Lewes

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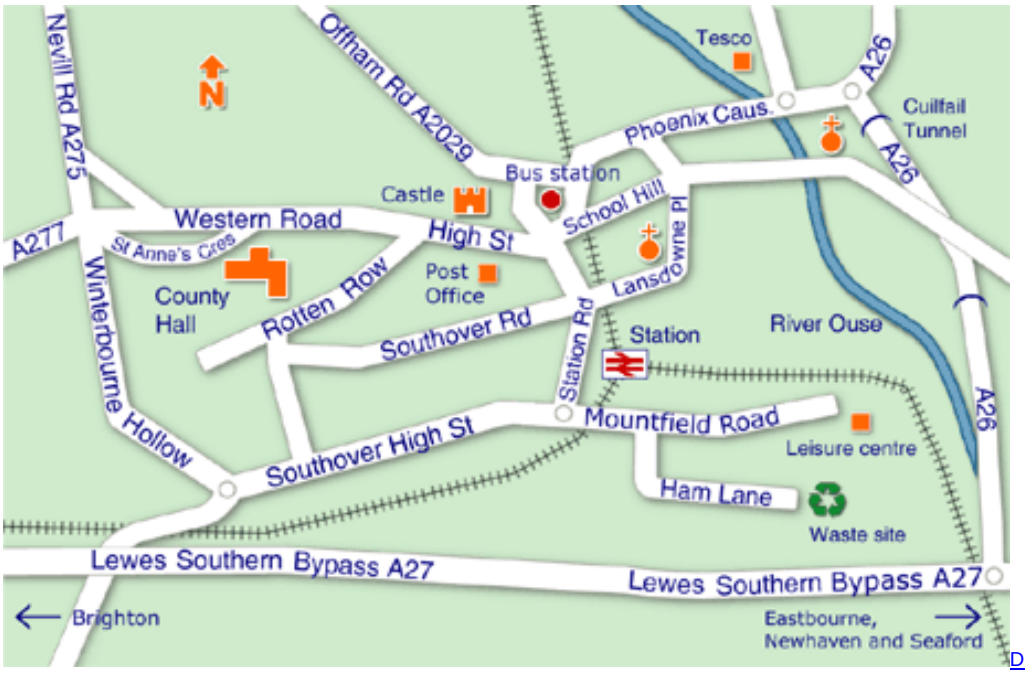

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HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Lewes on 30 November 2017

PRESENT:

Councillor Colin Belsey (Chair); Councillors Phil Boorman, Bob Bowdler, Angharad Davies, Ruth O'Keeffe, Sarah Osborne and Andy Smith (all East Sussex County Council); Councillor Janet Coles (Eastbourne Borough Council), Councillor Mike Turner (Hastings Borough Council), Councillor Susan Murray (Lewes District Council), Councillor Johanna Howell (Wealden District Council) and Jennifer Twist (SpeakUp)

WITNESSES:

Eastbourne, Hailsham and Seaford Clinical Commissioning Group (CCG) / Hastings and Rother CCG

Jessica Britton, Chief Operating Officer

Garry East, Director of Performance and Delivery

Lisa Elliott, Senior Performance and Delivery Manager

High Weald Lewes Havens CCG

Ashley Scarff, Director of Commissioning and Deputy Chief Officer

Sam Tearle, Senior Strategic Planning & Investment Manager

Kim Grosvenor, Dementia Programme Lead

Hugo Luck, Associate Director of Operations

Dr Phil Wallek, GP, School Hill Medical Practice, Lewes

East Sussex Healthcare NHS Trust

Joanne Chadwick-Bell, Chief Operating Officer

Kent and Medway Sustainability and Transformation Plan

Michael Ridgwell, Programme Director,

LEAD OFFICER:

Claire Lee, Senior Democratic Services Officer

16. MINUTES OF THE MEETING HELD ON 21 SEPTEMBER 2017

16.1 The Committee agreed the minutes as a correct record of the meeting held on 21 September.

17. APOLOGIES FOR ABSENCE

17.1 Apologies for absence were received from Cllr Bridget Hollingsworth and Geraldine Des Moulins.

18. DISCLOSURES OF INTERESTS

18.1 There were no disclosures of interest.

19. URGENT ITEMS

19.1 There were no urgent items.

20. CONNECTING 4 YOU UPDATE

20.1. The Committee considered a report providing an update on the Connecting 4 You (C4Y) health and social care transformation programme.

20.2. Ashley Scarff, Director of Commissioning and Deputy Chief Officer, High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG); Dr Phil Wallek, GP, School Hill Medical Practice in Lewes; Hugo Luck, Associate Director of Operations, HWLH CCG; Kim Grosvenor - Senior Programme Manager – Mental Health and Dementia Transformation, HWLH CCG; and Sam Tearle - Senior Strategic Planning & Investment Manager, HWLH CCG, provided a presentation and answered questions from HOSC members.

20.3. Jennifer Twist explained that she represented Speak Up on the C4Y Programme Board and welcomed the involvement of the voluntary sector at all levels of the transformation programme.

Role of Central Sussex and East Surrey Area South

20.4. Ashley Scarff explained that Central Sussex and East Surrey Area (CSESA) South's main purpose is to integrate the constituent CCGs' leadership and governance arrangements in order to increase their capacity and ability to work collectively. He confirmed that it would not replace C4Y as the place-based plan for transforming health and social care in the HWLH area of East Sussex. This is because transformation workstreams will be undertaken at the most appropriate level, and for community and primary care services this will be at C4Y level.

Communities of Practice

20.5. Ashley Scarff elaborated that the four Communities of Practice in HWLH area are broadly analogous to the Integrated Locality Teams that have been developed in the East Sussex Better Together (ESBT) area. Communities of Practice is the name given to integrated services that are provided by East Sussex County Council, Sussex Community NHS Foundation Trust (SCFT) Sussex Partnership NHS Foundation Trust (SPFT), GP practices and the voluntary sector across 4 geographical locations that cover populations of 30-50,000. At this size services can be delivered at a responsive local level whilst still being financially sustainable and the scale is based on national guidelines. He said that within the Communities of Practice

'outer shell' are other services such as the Lewes Health Hub, which is the name given to combined GP-led services within the Lewes Communities of Practice area.

Future priorities of C4Y

20.6. Ashley Scarff said that frailty has been chosen as the main priority of C4Y for 2017/18 as it encompasses a number of elements of out of hospital care, such as falls prevention, proactive care and urgent care. Developing services around how best to support people living with frailty will also help to determine the optimum configuration for the Multispeciality Community Provider (MCP) accountable care system, i.e., how community, primary and social care services ultimately be integrated into a single system in the C4Y area.

GP Streaming service

20.7. Hugo Luck explained the GP Streaming Services at Royal Sussex County Hospital (RSCH), Princess Royal Hospital (PRH) and Tunbridge Wells Hospital (TWH) and provided assurance that it will not take GP capacity from other areas of the healthcare system because:

- IC24 already employed salaried GPs at the RSCH A&E Department as additional clinicians to the Emergency Department. The GP Streaming Service will separate these patients from the rest of the A&E department so patients can be triaged directly to a GP.

- The Streaming Service at PRH has employed GPs who may not want to work in general practice but want to use their GP skills in a different setting. These can be GPs who are semi-retired or have taken a break from working in a GP practice.

Winter Resilience Planning

20.8. Hugo Luck said that in order to help achieve the 85% bed occupancy target over the Christmas period a concerted effort will be undertaken in the week leading up to Christmas to reduce bed occupancy at acute hospitals. The main challenge, however, is the second week of January as admissions begin to rise. Plans are therefore also being developed for this spike in activity, for example, using the additional winter planning money announced in the budget to increase bed capacity by opening additional interim community beds.

Reduction in non-elective admissions

20.9. Hugo Luck explained that most Delayed Transfers of Care (DTOC) are caused by non-elective admissions often via the Emergency Department. He said that the development of the frailty pathway should have a positive effect on the number of non-elective admissions, however, the non-elective admissions data may not prove this causation because a number of other factors can affect admission rates.

Discharge to assess

20.10. Hugo Luck clarified that the new Discharge to Assess process involves discharging patients from hospital with an initial package of care to meet their immediate healthcare needs before the long-term assessment can be carried out in their home. The package of care varies depending on need and is provided for as long as the patient needs it, whether it is a discharge to assess package or a longer term package. The package of care will be regularly assessed depending on the patient's improving or worsening condition. He said that Discharge to Assess is already carried out in Brighton & Hove and has been found to be effective.

20.11. Hugo Luck said that the Continuing Healthcare Team in the HWLH area can provide long-term assessments in a more timely manner in a patient's home than at hospital. This is because all of the hospitals used by HWLH patients are outside of the HWLH area, meaning that it can be quicker for the Team to reach them at their home address than at hospital.

20.12. Joe Chadwick-Bell added that the standard national way of working for hospital trusts always includes an initial assessment of the patient before they leave the hospital whether they are in a ward, A&E Department or acute assessment unit. The patient is assessed by a team comprising a therapist, social worker and nurse, who will assess whether they are safe to leave and what package of care they require. She agreed that long term assessments are better conducted at home as a patient's care need can be determined more accurately when assessed in their home.

Role of family and carer in patient's care

20.13. Hugo Luck said he was confident that, wherever possible, a patient's package of care is discussed with their family as quite often they will have a role in the ongoing care, for example, around medicine management.

20.14. Hugo Luck agreed that a patient's stated needs may be different to their actual needs. He said that the *Let's Get You Home* programme includes a pilot that is working to feed in concerns of the families and views of clinicians, alongside the patient's own stated needs, when carrying out an assessment of a patient.

Dementia Golden Ticket roll-out

20.15. Kim Grosvenor explained that an increasing number of GP practices are improving early diagnosis of dementia in part because the Golden Ticket model provides a more comprehensive and less time consuming dementia service post diagnosis than was previously available. There is still some variability in the pace of roll out of the new model for the service amongst GP practices, although HWLH CCG is not aware of any GP practices that will not consider using the service, and this has been reflected in the phased plan to cover the whole CCG area.

20.16. Kim Grosvenor explained that there is a Golden Ticket training programme for GP practices (next Waves in January and March 2018) and is fully booked. The training will not encompass all GP practices, so alternative methods of ensuring full Golden Ticket coverage may be considered after the training schedule is complete, for example a peripatetic team that rotates around GP practices in the HWLH area. She clarified, however, that since October 2017 everyone in the HWLH area has been getting a comprehensive diagnosis at home and improved diagnostic support regardless whether or not their practice is signed up to the Golden Ticket.

HSCC role in referral Golden Ticket

20.17. Kim Grosvenor confirmed that Health and Social Care Connect (HSCC) is the refer pathway to the Golden Ticket Dementia Guide Service..

Rural access to Golden Ticket

20.18. Kim Grosvenor said that there was good evidence of the Golden Ticket working well in rural areas as the pilot was carried out in Buxted. The Golden Ticket includes free transport for any dementia patient that needs help to access community-based interventions.

Assistance to patients

20.19. Kim Grosvenor explained the Golden Ticket's Guide Service offers emotional advice and support to patients and carers where necessary, for example, where they require assistance with assessments over the phone, or to fill out a lasting power of attorney form.

Number of Dementia patients in HWLH area

20.20. Kim Grosvenor said that the expected number of people identified as having dementia in the HWLH area by the time of the end of the Golden Ticket roll-out in 2019 will be just over 2,000.

Assessments following initial diagnosis

20.21. Dr Phil Wallek explained that patients placed on the Golden Ticket pathway are entitled to a 40 minute review meeting in their GP practice with a dementia specialist within 10 days of diagnosis. This is a holistic conversation that includes discussion of medical needs, quality of life, relationships with family, and support needs.

Blip clinic

20.22. Dr Wallek explained that the 'blip clinic' is available to families or carers of dementia patients on the Golden Ticket pathway. A blip clinic is a 40 minute appointment with a primary care practitioner and secondary care nurse adviser where necessary changes can be made to a patient's care arrangements as soon as issues arise. This is in order to avoid a crisis at a later date necessitating an admission to a more specialised and costly service.

Advertising the Golden Ticket

20.23. Kim Grosvenor said that there is a national campaign based around the strap line "*Worried about your memory? Go to a GP"* that encourages people to seek early diagnosis. There is also information in relation to the Golden Ticket in affiliated GP practices and online.

Proactive diagnosis

20.24. Dr Phil Wallek said that GPs who are part of the Golden Ticket pathway take the opportunity to proactively screen at risk patients for dementia when they attend the GP practice as part of their routine six-monthly or annual appointment, and refer them to the Memory Assessment Service if necessary. This is done using a standardised, nationally validated tool for identifying dementia. He said that referrals to the Memory Assessment Service can still be made where there are concerns by the patient or family but not the GP.

Harder to engage patients

20.25. Kim Grosvenor said that the Golden Ticket includes access to the Respite Service hosted by ESCC that specialises in working with families of patients who are in denial about their symptoms. GP Practices that are part of the Golden Ticket may offer to combine dementia conversations as part of other GP visits, such as for flu jabs, if the families express concern about a patient.

Lewes Health Hub

20.26. Dr Wallek explained that the successful bid for the new Lewes Health Hub included additional funding that has allowed the three GP practices that comprise the Lewes Health Hub partnership to take staff out of frontline work to run six-week projects around service transformation, such as information governance, and prescriptions and chronic disease. This allows new services commissioned by HWLH CCG, such as the Prescription Ordering Service (POS), to be integrated easily into the Lewes Health Hub. Ultimately this means that it will be clear what services will need to be provided in the new Lewes Health Hub building once it has been built. He added that in the meantime staff are utilising the existing space within the three practices, and are planning to utilise space in the Lewes Victoria Hospital as an urgent treatment centre.

Patient Confidentiality

20.27. Dr Wallek said that all patients in Lewes have been notified that all three GP practices will share patient records, but only clinicians and staff directly involved in care of the patient can access them. He added that receptionists will be upskilled over the next year to be *Patient Navigator*s who can direct patients to the most suitable place for them to receive care, which will not necessarily be a GP. This will potentially involve directing the patient to a third sector organisation, so patients will need to be happy to have their medical information shared.

20.28. The Committee RESOLVED to:

1) note the report;

2) request a future update in June 2018 with a focus on the progress of urgent care redesign; and

3) request that recent non-elective admission figures in the HWLH CCG area are provided by email, and request an interpretation of the data is provided.

21. CANCER PERFORMANCE IN EAST SUSSEX

21.1. The Committee considered a report providing an overview of cancer performance in East Sussex.

21.2. Jessica Britton, Chief Operating Officer, EHS/HR CCG; Joe Chadwick-Bell, Chief Operating Officer, East Sussex Healthcare NHS Trust (ESHT); Lisa Elliott, Senior Performance and Delivery Manager, EHS/HR CCG; Garry East, Director of Performance and Delivery, EHS/HR CCG and Ashley Scarff, Director of Commissioning and Deputy Chief Officer, responded to questions from HOSC members.

2 week initial referral meeting

21.3. Joe Chadwick-Bell explained that, where appropriate, patients will generally receive a diagnostic test before their initial referral meeting with a consultant, rather than this referral meeting being their first point of contact with secondary care. Lisa Elliott said that in the case of suspected lung cancer, for example, a patient would, where possible, not see a consultant until they had been for a CT Scan as it is more useful for the consultant to see the scan to determine next steps. She added that a suspected cancer patient will be fast tracked through diagnostics, indicating they are treated with some urgency.

21.4. Joe Chadwick-Bell said that the aim is for patients to have the first consultant referral meeting within 7 to 8 days rather than the national target of 2 weeks. Lisa Elliott said that if a patient has not heard back from a hospital they can ask their GP to chase the referral status for them, or the patient can do this directly.

Patient Choice

21.5. Joe Chadwick-Bell said that a significant number of the breaches of the 62-day time to treatment target are due to patient choice, i.e., patients choosing not to attend their appointments – sometimes because they forget and sometimes because they choose not to go. There is a specialist nurse whose role is to contact patients to explain the importance of attending the initial referral appointment and this helps to ensure that ESHT meets its 2 week referral time. Some of the very long wait time breaches are due to patients who are very anxious and for them attempts are made at alternative diagnostic methods. Lisa Elliott added that a root-cause analysis is conducted for each 62-day breach to determine the cause of the breach, and a clinical harm review of the patient is also carried out. Joe Chadwick-Bell clarified that a target of 85% of patients being treated within 62 days of diagnosis takes into account the number of

patients who exercise patient choice. The failure to meet that target indicates that there are other reasons beyond patient choice that account for the target not being met.

One-stop consultancy visit

21.6. Joe Chadwick-Bell explained that each cancer pathway has been reviewed in order to determine whether a 'one-stop' diagnostic clinic could be established for patients attending the initial consultancy meeting, enabling them to see all of the necessary specialists in one go, which is established practice in some hospitals. The feasibility of establishing these clinics is determined by clinical best practice and whether it is possible to concentrate specialist clinicians and nurses in one place. The breast cancer pathway is one that is considered suitable for a one-stop diagnostic.

21.7. Garry East added that some 62-Day breaches occur due to people being on the waiting list for hospital services in London, however, when the patients are seen they may then be able to receive a one-stop diagnostic. There is a balance to be struck between seeing patients promptly and being able to provide a full diagnostic when they attend.

Recording stage at time of diagnosis

21.8. Lisa Elliott said that although the staging is generally recorded by the consultant as 1, 2, 3 or 4, it is not always recorded in the right way (correct coding) so that this cannot be easily taken from the electronic system, which explains the low percentage of instances where the cancer stage has been recorded on diagnosis. A considerable piece of work is being undertaken as part of ESHT's Cancer Improvement Plan to ensure that the right code is used to improve the data collection. Jessica Britton added that this was a problem nationally.

Quality of scanners

21.9. Joe Chadwick-Bell said that CT scanners and MRI scanners at EDGH and Conquest Hospital are going to be replaced. The CT scanner in Conquest Hospital is expected to be replaced early in 2018.

Cancer Quality Improvement Programme

21.10. Lisa Elliot explained that the Cancer Quality Improvement Programme is carrying out a number of projects to raise awareness in Hastings and Rother. Jessica Britton added that a large number of community volunteers have been trained to raise awareness about cancer, which is an effective way of raising awareness in some communities that may be less aware of cancer symptoms.

21.11. The Committee RESOLVED to:

1) Note the report;

2) Request a future report on cancer care performance figures either as a committee report or by email;

3) Provide additional detail on the timescales for the programme to standardise the recording of cancer staging at the time of diagnosis; and

4) Request confirmation of whether mobile scanning facilities are able to undertake all types of scan, including those where enhanced detail is required.

22. KENT AND MEDWAY REVIEW OF STROKE SERVICES

22.1. The Committee considered a report providing an overview of the review of stroke services underway in Kent and Medway and to consider the potential implications for East Sussex residents.

22.2. Ashley Scarff, Director of Commissioning and Deputy Chief Officer; and Michael Ridgwell, Programme Director, Kent and Medway Sussex and East Surrey Sustainability and Transformation Plan, responded to questions from HOSC members.

22.3. Michael Ridgwell said that the consultation is likely to include four reconfiguration options, although the details of the options have not yet been finalised. Meeting certain travel times is a requirement for all of the shortlisted options, specifically that a patient – including those outside Kent and Medway – is able to reach the stroke unit within one hour. This travel time analysis is being developed in close collaboration with South East Coast Ambulance NHS Foundation Trust (SECAmb). Access considerations are also being considered by an independent company, particularly for disenfranchised or isolated populations.

Capital investment

22.4. Michael Ridgwell confirmed that all hospitals in the Kent and Medway area will require capital investment in order to make the necessary changes to create 24/7 Hyper Acute Stroke Unit (HASU) with a co-located Acute Stroke Unit (ASU).

Attracting consultants

22.5. Michael Ridgwell said that there are significant issues with attracting stroke consultants to all of the hospital in Kent and Medway, so it is difficult to say which would be the most difficult to attract consultants to. He explained, however, that being able to say that a HASU reconfiguration is underway has resulted in some increase in the ability to recruit staff, including the recruitment of one consultant; this appears to be the case in other areas that have gone through this process. Ashley Scarff added that there is tangible evidence that following the consolidation of stroke services the Royal Sussex County Hospital (RSCH) is now more attractive to medical staff, and it would be reasonable to expect the same across Kent.

Thrombectomy

22.6. Michael Ridgwell said that thrombectomy – the surgical removal of a clot – is a new service commissioned by NHS England that is not yet widely provided by hospitals outside of London. NHS England is, however, recommending that CCGs and trusts begin developing their own thrombectomy centres. He confirmed that each of the four reconfiguration options will include the opportunity for one of the sites to develop as a thrombectomy centre in the future. He added that developing a thrombectomy centre will require a complex process of developing other services that sit alongside a HASU, but it is being given consideration.

RECOMMENDATIONS

The Committee RESOLVED to:

1) note the report;

2) 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) 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.

23. HOSC FUTURE WORK PROGRAMME

23.1 The Committee agreed the work programme subject to the following amendments:

1) defer the Connecting 4 You report from the 29 March to 28 June 2018 meeting;

2) accept the update on the BSUH Stroke Services Review by email in March 2018, and include the update as an appendix to the 29 March 2018 Work Programme item;

3) defer the update on End of Life Care to the 28 June 2018 meeting; and

4) add an item on the quality of maternity services, to include consideration the findings of an Eastbourne Borough Council survey, to the 29 March 2018 meeting.

The meeting ended at 12.35 pm.

Councillor Colin Belsey
Chair

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

Date: **29 March 2018**

By: **Assistant Chief Executive**

Title: **GP Access**

Purpose: **To provide an overview of East Sussex Clinical Commissioning Group (CCG) strategies for ensuring accessible and sustainable GP services for the county.**

RECOMMENDATIONS

HOSC is recommended:

1) **To consider and comment on the East Sussex CCG reports.**

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

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1. Background

1.1 The Health & Social Care Act (2012) changed commissioning arrangements for GP practices. Formerly the responsibility of local Primary Care Trusts (PCTs), primary care commissioning was transferred to NHS England (NHSE) Area Teams from April 2013.

1.2 In November 2014, the Department of Health introduced a co-commissioning initiative. This offered CCGs the opportunity to work with NHSE Area Teams to 'co-commission' GP services.

1.3 In East Sussex, Eastbourne, Hailsham & Seaford CCG and High Weald Lewes Havens CCG both opted to be early adopters of co-commissioning. Hastings & Rother CCG began co-commissioning from April 2016. Co-commissioning arrangements subsequently developed into full delegation of primary care commissioning in many areas, including East Sussex. Local CCGs therefore now have responsibility for planning, commissioning and monitoring local GP services for their populations.

1.4 Most GP practices are independent businesses which are contracted to provide NHS services by commissioners. All GP practices providing NHS services are required to be a member of a CCG. Both nationally and locally GP practices are increasingly working together in various forms of partnership or federation to share resources and provide a wider range of services locally.

2. Supporting information

2.1 HOSC Members have raised a number of issues in relation to GP services which this report aims to address, falling into three main areas:

- **The sustainability of GP services** – particularly in relation to workforce challenges, population growth and rising demand.

- **Practice closures** – the reasons why closures occur, the process for managing these and the impact on patients and other local practices.

- **Accessibility of GP services** – including availability of appointments, use of digital technology to improve access and the physical accessibility of premises.

2.2 Local CCGs have provided reports outlining their approach to ensuring accessible and sustainable GP services for their populations. Appendix 1 is a report from Eastbourne, Hailsham and Seaford and Hastings and Rother CCGs on the approach being taken through the East Sussex Better Together programme. Appendix 2 is a report from High Weald Lewes Havens CCG on the approach being taken through the Connecting 4 You programme. Representatives of the CCGs will be in attendance to discuss the reports with HOSC.

3. Conclusions and reasons for recommendations

3.1 HOSC Members have raised a number of issues in relation to the sustainability and accessibility of GP services which this report aims to address. The committee is invited to consider the reports from local CCGs and whether further scrutiny of this issue, or specific aspects of it, is required.

PHILIP BAKER
Assistant Chief Executive

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

Report: To provide an overview of East Sussex Better Together CCGs strategies for ensuring accessible and sustainable GP services for our local populations

To: East Sussex Health Overview and Scrutiny Committee

From: Fiona Kellett, Head of Finance
Paula Gorvett, Director of Localities and Primary Care

Date: 19 March 2018

1. Introduction

East Sussex Better Together (ESBT) is our whole system transformation programme to tackle the challenges of improving quality and experience and delivering a sustainable health and care system locally.

Our shared vision is the establishment of a fully integrated health and social care economy in East Sussex that makes sure people receive proactive, joined up care, supporting them to live as independently as possible. The delivery of strong and resilient primary care services is central to the delivery of our vision. It is evident that workforce and workload pressures continue to pose a significant challenge to our primary care services both locally and nationally.

The purpose of this report is therefore to provide an update on:

- **The sustainability of GP services** across the ESBT footprint, particularly in relation to workforce and workload challenges as a consequence of recruitment and retention difficulties and population growth resulting in rising demand.
- **Practice closures:** The reasons why closures occur, the process for managing these and the impact on patients and other local practices.
- **Accessibility of GP services** including availability of appointments, use of digital technology to improve access and the physical accessibility of premises.

2. Background

Primary Care covers healthcare provided in the community by General Practitioners (GPs), Community Pharmacists, Dental Practitioners and Optometrists. In total these services account for around 90% of all patient interaction with health services.

This paper focuses on services provided by GP practices within Eastbourne, Hailsham and Seaford (EHS) and Hastings and Rother (H&R) for which the CCGs have delegated responsibility for commissioning from NHS England (NHSE) as of 01.04.2015 and 01.04.2016 respectively. The responsibility for commissioning Pharmacists, Dental Services and Optometry remains with NHSE.

Within EHS CCG there are currently 20 practices serving a total CCG population of 196,135. Practice list sizes range from 3,600 patients to a large multi-partner practice with a list size of 17,800.

Within H&R CCG there are currently 25 practices serving a total CCG population of 188,457. Practices range from a single handed practice with a list size of 2,650 to a larger multi-partner practice with a list size of 16,000.

3. Strategy Development

As CCGs, we are embarking on a refresh of our primary care strategy. This outlines our strategic intentions around the future of primary care and its transformation in relation to our overarching ESBT vision and national General Practice Forward View (GPFV) requirements and priorities.

This is based around the development of a primary care system that revolves around the needs of the individual, supporting people to get the care they need, as directly as possible, delivered by the right person. Set in the context of managing increasing demand and reducing resources, this focuses on resilience and sustainability, addressing workforce and workload issues, delivering high quality services to improve outcomes and experience, and introducing systems and processes to support working at scale. A copy of a presentation outlining our high level strategy is provided in **annex 1**.

To support this, the ESBT CCGs have committed to investing in primary and community based services as part of our strategic investment plan to reduce reliance, where appropriate, on higher cost settings of care.

4. Primary Care Sustainability

4.1. Workforce

4.1.1. Workforce objectives

Workforce is recognised as a significant challenge and risk to delivering a sustainable primary care service and therefore features as one of the four key priority areas underpinning our emerging strategy. The overarching aim is to increase capacity in order to meet growing demand through the introduction of new roles and innovative ways of working whereby Primary Care becomes truly multi-disciplinary, and patients are supported and navigated towards the person best placed to deal with their condition, at the right time, in the right place.

In order to support delivery of this, we have developed a focused primary care workforce plan with the following aims:

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

Our workforce plan will aim to ensure that EHS and H&R are in the best position to recruit and retain our staff, ensure they are well placed and have the right skills to deliver the care needed by our local populations.

4.1.2. Current position / Vacancies

A number of workforce pressures are evident across both CCGs, in particular GP and practice nurse vacancies:

- In H&R there are approximately 16 WTE GP vacancies based on the UK average number of 0.58 WTE GPs per 1,000 patients.
- In H&R, practices themselves have reported 12.05 WTE GP vacancies and 4.8 WTE practice nurses vacancies;
- In EHS there are approximately 11 WTE GP vacancies based on the UK average number of 0.58 WTE GPs per 1,000 patients.
- In EHS, practices themselves have reported 10.03 WTE GPs absent and 1 WTE practice nurse absent.

It should be noted that self-reporting on vacancies is voluntary and may not capture the full position.

As identified in **annex 2**, there is an additional risk that this position will be exacerbated by the number of GPs and practice nurses reaching retirement age in the near future. This is considered particularly acute in Hastings and St Leonards for both professional groups, with the added challenge for nursing in the Hailsham and Bexhill localities.

This position is potentially further challenged due to:

- difficulties filling GP training places both nationally and locally plus the implications of Brexit and tougher immigration rules for overseas recruits;
- the younger and newly qualified workforce seeking more flexible work options and being less keen to take on the responsibility of a partnership;

Practices manage any vacancies in the way that best works for them including the use of locums and implementing new ways of working across their practice teams.

As part of the work to support delivery of our strategic direction of travel and GPFV priorities, we have developed or are in the process of implementing a number of initiatives to attract, train, support and retain colleagues as outlined below.

4.1.3. Recruitment and retention

The CCGs have established and supported a number of initiatives to support recruitment of GPs and practice nurses. Examples include:

- **International Recruitment:** ESBT fully participated in the successful STP wide bid led by High Weald Lewes Havens (HWLH) CCG for inclusion in the 2018 NHSE International Recruitment of GPs initiative for which 12 practices have expressed an interest, representing a spread across both CCGs;

- **Nurse Apprentices:** The CCGs are actively supporting the development of apprentices at levels 2, 3 and 4;
- **Locum Medical Bank:** The CCGs are subsidising the cost of locums managed through a federated approach to enable practices to focus on long term workforce planning.

In addition, GPFV monies have been made available to ensure ESBT can participate in key career fairs and maximise opportunities for attracting the future primary care workforce.

However, recognising the severe national workforce supply issues, much time has been spent in conjunction with our Community Education Provider Network (CEPN) to develop and implement initiatives to invest in the development and retention of primary care staff in East Sussex. Initiatives include:

Medical Staff:

- **GP Portfolio Fellowship scheme:** This has provided an opportunity for joint working across our ESBT Alliance with our GP fellows working on an integrated project in partner organisations (one each in Sussex Partnership Foundation Trust (SPFT), East Sussex Healthcare NHS Trust (ESHT) and East Sussex County Council (ESCC)) whilst also being placed in primary care two days per week;
- **GP Bursary scheme:** This scheme makes £5,000 available to newly qualified and those within the first years post-qualification to support them to continue with their career development whilst also encouraging them to remain working within East Sussex.
- **GP Career Plus scheme:** This scheme is targeted at GPs wishing to leave the profession by offering sessions in GP mentoring and clinical leadership alongside clinical sessions to support a more challenged GP practice. An e-platform is in place, allowing practices to advertise their vacancies to the growing pool;
- **Developing Physician Associates (PAs) in East Sussex:** General practice trainers have been supported to host a number of PAs whilst they undertake training. The CEPN is now working to develop a PA portfolio role to include a community rotation as well as primary care, aiming to make this an attractive career opportunity for qualified PAs and help retain them within primary care.

Nursing staff:

- **Leadership development:** This has entailed working with the Leadership Academy to develop leadership competencies within our nursing workforce, and in particular, increasing the numbers of mentors and educators to support the new nurse associate roles. This has also involved the development of Advanced Clinical Practitioner roles using the credentialing framework for existing nurse practitioners and supporting new trainees;
- **General Practice Nursing:** The development and the delivery of a nationally developed General Practice Nursing ten point action plan across the ESBT footprint;
- **Bursaries:** Continuation of investment in nursing bursaries to support academic development and in turn assist with staff retention;

- **Continuing Professional Development**: ESBT has been instrumental in supporting the development of a clinical skill bundle across our STP area with a view to ensure standardisation of a mobile workforce. We are also recruiting a development nurse to work across the CCG areas and support new staff.

In addition to the above, we are reviewing **ways** to retain experienced doctors and nurses reaching the end of their career; examples include offering more part time options, mentoring and speciality work.

4.1.4. Service redesign and Primary Care Workforce development

Whilst the CCGs have clearly developed plans to both recruit and retain our primary care workforce, it is recognised that this, in isolation, will not address the workforce and workload issues facing general practice in particular.

Therefore, as part of our GPFV plans, we have established a Primary Care Service Redesign Fund which encourages federations or groups of practices to work together to introduce new models of care and broader workforce opportunities. 25 practices have signed up to the scheme during 2017/18 with multiple bids approved. The return on investment will see several examples of extending the primary care team with new roles, creating greater capacity and an improved service for patients. Examples include:

- On the day primary care mental health therapist appointments, including substance misuse service;
- First contact advanced physiotherapy offering on the day appointments for patients with common MSK complaints;
- GP led health coaching service offering one to one and group activities for service users with long-term conditions;
- Paramedic Practitioner home visiting service and in-practice urgent clinics;
- Care navigation to seamlessly enable patients to access the wider range of primary care appointments.

These will be subject to a robust evaluation to assess the level of benefits realisation and scalability during the course of 2018/19.

4.1.5. Sustainability - Primary Care at Scale

There is an increasing recognition that the traditional practice led / small GP partnership model of delivery of primary care is often too small to respond to the demographic and financial challenges facing the NHS. Central to our emerging strategy is to support GP practices and other professionals, such as clinical pharmacists, to work together in a more integrated, collaborative partnership approach (or networks) to deliver more sustainable services. This should result in a number of benefits including access to a wider range of local services for patients within the local community, increased staff resilience, improved staff satisfaction, work life balance and learning opportunities, and improved financial sustainability. The CCGs are therefore working with the four GP Federations within our ESBT footprint to encourage and facilitate collaboration and joint working between groups

and clusters of practices where this will support primary care and deliver improvements to our local populations.

5. Practice Closures

Across the ESBT footprint, there has been one practice closure due to partner resignation which took place in October 2017. This was the Cornwallis Plaza practice in Hastings.

The CCG supported the managed closure of Cornwallis Plaza surgery following the resignation of the contract holder and the managed list dispersal of c17,000 patients to three local practices. All affected patients were written to in advance of the changes to advise them of their new surgeries or, in the case of a small cohort living out of area, with advice on how to find a new GP surgery.

A number of face to face registration sessions were held by the CCG primary care team to assist patients in registering with alternative surgeries. All vulnerable patients were flagged prior to transfer and the team regularly monitored this list to ensure all vulnerable patients were re-registered.

We are currently finalising a lessons learned report from the Cornwallis Plaza dispersal and will be sharing the lessons from this widely with practices and other colleagues. This information will be used to inform our action plan and how we work collaboratively with our practices to identify any where there may be challenges. In addition, the CCGs are introducing a more targeted, risk-based approach to practice support visits.

6. Accessibility

6.1. Overview

The CCGs are committed to providing patients with improved access to primary care across the ESBT footprint that is joined up, easy to navigate and provided locally. Our approach is being informed by the views of local people as we work with practices, patients and providers to design our long-term models of care including the implementation and roll out of care navigation and our approach to Social Prescribing (social prescribing, sometimes referred to as community referral, is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services). These initiatives are aimed at helping practices to manage demand and support people accessing the right services at the right time including, non-medical services to improve their well-being and access sources of community and social support.

6.2. Access and availability of appointments, including extended access

All GP practices across EHS and H&R CCGs deliver core general medical services between 08.00 – 18.30 hours. In addition, 13 out of 20 and 17 out of 25 practices provide the extended hours Directly Enhanced Service in EHS and H&R CCGs respectively. This is a national, optional service that practices can choose to

deliver, commissioned by NHS England whereby practices extend their opening hours according the needs and wishes expressed by patients,

In addition, there is now a national requirement for CCGs to commission extended access to primary care, which can be provided by practices, localities or from central locations. The requirements include providing access to pre-bookable and on the day appointments for primary care including additional weekday hours from 6.30pm – 8pm, and on Saturdays and Sundays according to local need.

CCGs are required to provide an extra 30 minutes per 1000 population from October 2018. For H&R CCG, with a population of 188,457 patients, this is equal to 95 extra hours per week. For EHS CCG, with a population of 196,135 patients this is equal to 97.75 extra hours per week. If there is patient demand NHSE have indicated an aspiration of 45 minutes per 1000 population.

Soft market testing has been undertaken via a request for information and the options for the procurement approach to be followed are due to be considered by the ESBT CCGs in March 2018 with a procurement process to follow ready for implementation in October.

In order to inform our approach, a public engagement activity via an online and paper based survey to seek the views of local people on the their preferences on the time of day they would wish to be able to access extended primary care services has recently been undertaken. A total of 1,271 people responded. These results are currently being analysed and will inform discussions with potential providers going forward and shape the service we commission locally.The results of this survey will inform the final design and service specification.

It should be noted that, as well as delivering additional appointments, CCGs are required to ensure that this extended access service is procured and delivered alongside the redesign and integration of urgent primary care. Urgent care redesign forms part of a separate report to this committee. As part of this, the CCGs must ensure these services are also delivering or working towards the direct booking of routine appointments (pre-bookable and same day) into extended access evening and weekend GP services.

6.3. The use of Digital technology to improve access and support

As part of our digital strategy, a number of significant initiatives have been agreed and have or are in the process of being implemented across the ESBT footprint with the aim of supporting sustainability and / or improving access to services. In particular, all practices are now on the same clinical system and we have a programme that encourages practices to trial new technologies with a view to rolling out those that are most successful. Examples of initiatives being trialled include:

- **Intelligent messaging / enhanced SMS:** this provides patient messaging services and has been rolled out to all practices. Early indications are that this has been very successful.
- **Online consultations:** A selection of practices will be piloting two alternative suppliers of on-line consultation software. The expectation is that following evaluation a preferred supplier will be selected and the software rolled out across all practices by March 2019.
- **Skype Consultations:** Skype consultations have been piloted in one Hastings practice and have been popular with patients. Depending on the results of the evaluation the CCGs will consider the appropriate approach for further roll out.
- **Roll out of NHS e-referrals:** The CCGs are working very closely with our local provider and supporting practices to ensure early adoption of NHS electronic referrals system which includes prompt access to advice and guidance.
- **Mobile Working:** The CCGs have supported general practice staff to adopt mobile working by introducing a variety of approaches to enable remote access and working off site.
- **Telephony:** The CCGs are working with practices to consider options for a major telephone upgrade across all practices that will be able to offer fully integrated communications systems including flexible models of call handling.

6.4. Investment in premises and estates to ensure modern facilitates that are fit for purpose

The CCGs are working with ESBT alliance partners on an ESBT wide estates strategy recognising the importance of the estate as a key enabler to support clinical services. This builds on the ESBT Strategic Estates Plan, produced in 2016/17 by NHS Property Services (NHS PS) in conjunction with ESBT which focused on the NHS PS property portfolio the CCGs operate from and GP primary care estate.

The strategy will promote the flexible use of space and the co-location of primary, community, voluntary and secondary care services where appropriate to meet the needs of the local population.

In the meantime, the CCGs are making significant investment to support the development of an improved estate that is fit for purpose and will assist the recruitment and retention of primary care workforce. Across both CCGs, there are 16 premises proposals at various stages of development.

7. Conclusion

The committee is asked to note the plans and progress made in supporting the delivery of a sustainability of primary care in Eastbourne, Hailsham and Seaford (EHS) CCG and Hastings and Rother (H&R) CCGs.

The Future of Primary Care Across ESBT

Building and developing our strategy

What is Primary Care?

- Primary Care (PC) is first-contact, accessible, continued, comprehensive and coordinated care.
  - First-contact care is *accessible* at the time of need;
  - *Continued* care focuses on the long-term health and well-being of a person;
  - *Comprehensive* care is a range of services appropriate to peoples' problems in the community;
  - *Coordination* is the role by which primary care acts to coordinate other specialists that the patient may need.

Primary care is provided by a number of different services including General Practice, Dentistry (which is currently commissioned by NHSE), Pharmacies, Community Services, Charitable and Voluntary Organisations, Physiotherapists, Mental Healthcare Workers and Opticians.

The National Context

- Economic and workforce constraints, coupled with an ageing population are putting Primary Care in England under significant strain.
- Nationally, Primary Care organisations are responding to pressures by forming new structures to allow care provision at greater scale e.g. federations, networks, super partnerships.
- General Practice Five Forward View – a national 5 year programme which aims to boost Primary Care by encouraging a step change in the level of investment and support into General Practice. It includes help for struggling practices, plans to reduce workload, expansion of a wider workforce, investment in technology and estates and a national development programme to accelerate transformation of services.
- GP Forward View link: https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

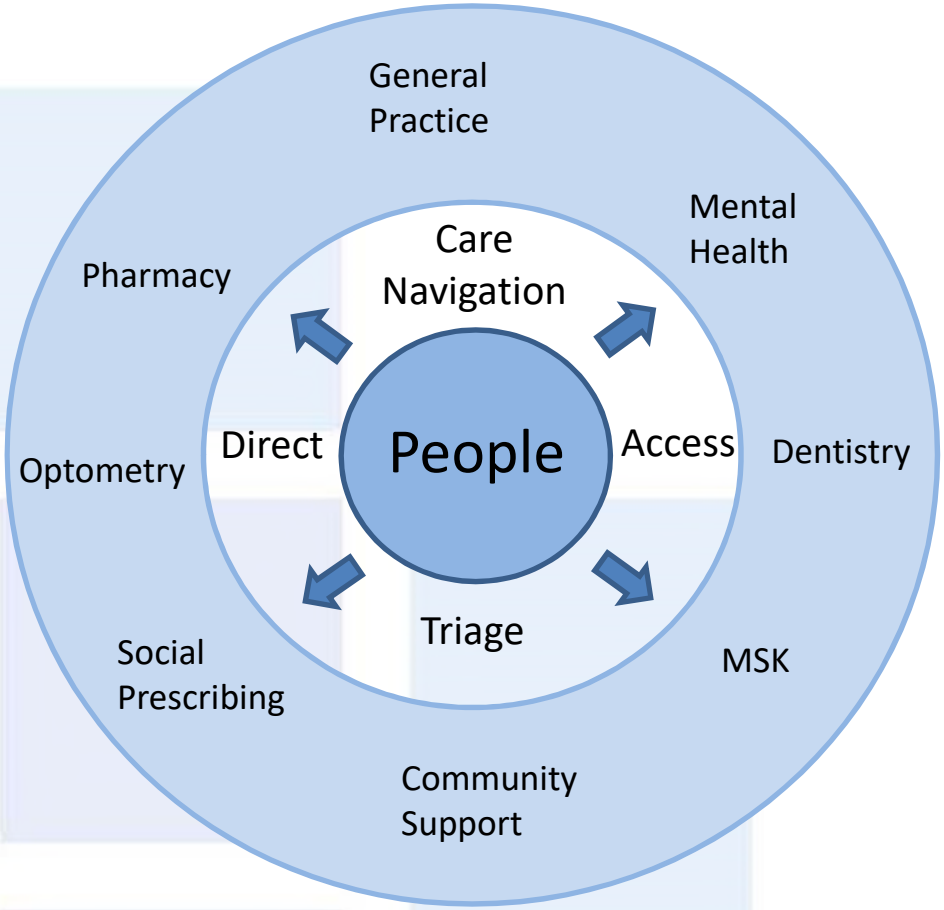
The Local Context

- Our population is growing and people are living longer, so demand for health and social care is growing faster than our budget.
- ESBT is our whole system transformation programme to tackle the challenges of quality and funding.
- Our shared vision is that by 2020/21, there will be an integrated, sustainable health and care economy in East Sussex that ensures people receive proactive, joined up care, supporting them to live as well and as independently as possible which:
  - ✓ Focuses on prevention and early intervention;
  - ✓ Provides high quality seamless care as close to home as possible;
  - ✓ Reduces inequality and improves outcomes across the population.
- In order to support this vision, there is a firm commitment to continue investing in Primary Care.
- ESBT recognises the value of a strong general practice base which can be a network of partnership-led, GMS/PMS practices alongside other models where needed.

The Development of a Primary Care Strategy

- Members of the local Primary Care team, the CCGs, LMC, GP Federations and representatives of GP practices have met to create this version of the strategy.
- Concepts have been drawn from Vanguard sites and other examples of good practice locally and around the country.
- Comments have been invited from across the local health community and the strategy adapted.
- A public and stakeholder engagement process is on-going.
- The aim is to have a clear strategy underpinned by a detailed roadmap arrived at by widespread consensus.

ESBT - A New Model for Primary Care



We intend to foster a Primary Care system that revolves around the needs of the individual and can get them the care they need, as directly as possible, delivered by the most appropriate person.

Our Strategic Intent

Current State

- Practice led primary care
- Unstable Workforce
- Multiple processes and approaches
- Allocated / awarded contracts
- Data used to evidence and trigger payment by results
- Isolated, practice varying/patient varying access into care
- Care can be predominately reactive and there is system-wide inequality

Future State

- Integrated, collaborative working
- Adequately resourced with succession plans
- Standardised systems, processes and approaches with locality focus
- Co-designing pathways and delivering local services at scale
- Data used to develop understanding of patients and localities and manage business
- Integrated, seamless care based around the practice list and at scale, patient accessible primary care
- MDT Primary Care teams resulting in reduction in health inequalities via prevention and self-management.

Detailing our Strategic Intent

In order to implement our strategy, we will invest and transform in several areas:

- Workforce - retain, attract and diversify the workforce;
- Resilience - creating sustainable, responsive, shared resources;
- Quality - having the highest clinical and quality outcomes;
- Processes - centralised work flow and interface.

Through centralising some activities, individual General Practices can focus on how to best respond to the particular needs of their population. Harmonising some functions can support appropriate diversity and is not a threat to practices continuing as individual entities.

Primary Care Workforce

Our Challenge: Too few key people to comprehensively staff a traditional primary care service.

Our Vision: Primary Care becomes truly multi-disciplinary. Patients are navigated towards the person best placed to deal with their condition, at the right time, in the right place.

Our Roadmap:

- We will support the training and development of the Primary Care Multi-Disciplinary Team (MDT).
- We will help to embed new ways of working in Primary Care.
- We will encourage centralised employment of key staff who can be seconded to or shared by practices.
- We will attract and retain colleagues.

Resilience in Primary Care

Our Challenge: We have a system of individual practices that rely on key individuals, both clinical and administrative. It only takes small changes for systems to struggle.

Our Vision: Greater centralisation of administrative and clinical functions enabling work and clinical resources to flow from areas that are overwhelmed to areas that have capacity through an embedded and sustainable network.

Our Roadmap:

- We will encourage the standardisation of procedures to allow the centralisation of high quality administrative functions, policies and procedures.
- We will create a system that allows a practices' patients to receive help when the practice itself is no longer able to manage their demand.
- We will promote self-care and encourage people to find their own solutions to their problems.
- We will support the development of premises and facilities that support the Primary Care strategy and are fit for purpose.

Quality of Primary Care

Our Challenge: There are too many inconsistencies in the quality, accessibility and type of care provided with no minimum standard, no consistent, governance and clinical support mechanism.

Our Vision: People can expect to get a good consistent standard of care no matter where it is accessed.

Our Roadmap:

- We will develop communication networks for clinical expertise to rapidly flow where it is needed.
- We will blur traditional primary and secondary boundaries through the sharing of knowledge and skills.
- We will support the development of standardised and centralised systems, tools, protocols, resources and processes.
- We will foster an effective shared governance and safeguarding framework.
- We will invest in clinical leadership and development.
- We will support change that ensures people get good care wherever they access it.

Systems and Processes

Our Challenge: Work is often not done by the most appropriate part of the system and frequently duplicated or delivered in silo.

Our Vision: The Primary Care work force will work in a truly integrated way and take responsibility for their part of the system, manage it and deliver it well.

Our Roadmap:

- We will foster a first-point-of-contact triage service that directs people appropriately so that GPs do not always need to be the centre of a person's care.
- We will encourage the fluidity of resources and new models of employment designed to work across Primary Care.
- We will develop systems (including IT and comms), procurement and other systems-related resources to enable Primary Care to evolve.
- We will move from payment based purely on activity to payment based on measurable outcomes where possible.
- We will continue to implement and develop ESBT pathways supporting care closer to home.

Primary Care Interfaces

- Primary Care can only be effective in the context of effective Secondary Care, Mental Health Care, Social Care and the Voluntary and Community sector.
- The interfaces between these different segments of the overall Alliance structure are crucial.
- Work is underway to create protocols for how work (and the resulting funding) is passed between different organisations within the Alliance.
- We will engage with the public to help them get the best from Primary Care. We will have fair, honest and open discussions about the strategy and the challenges. We will aim to make it easiest to get help from the best place to get that help.

Next Steps

The aim is to have a clear strategy underpinned by a detailed roadmap arrived at by widespread consensus. This will be achieved through:

- Extensive engagement across General Practice – presentation outlining high level strategy to be shared at both Membership and Learning Events (MELEs) in March 2018.
- The development of a detailed roadmap underpinned by clear milestones and an associated investment plan by 31st March
- Sign off via CCG GPFV Steering Group – April 2018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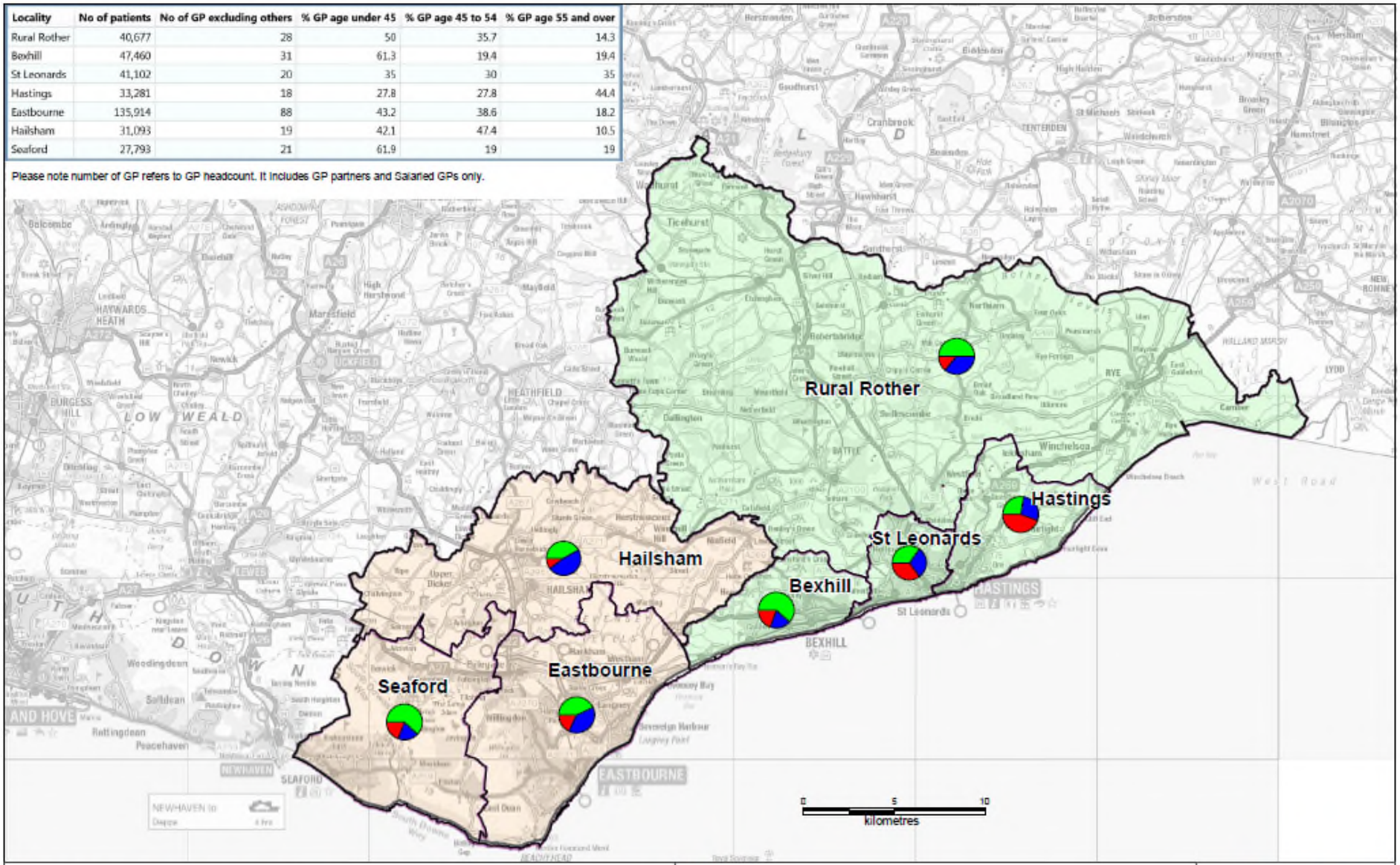
Appendix 1

GP age by locality

Annex 2

Locality	No of patients	No of GP excluding others	% GP age under 45	% GP age 45 to 54	% GP age 55 and over
Rural Rother	40,677	28	50	35.7	14.3
Bexhill	47,460	31	61.3	19.4	19.4
St Leonards	41,102	20	35	30	35
Hastings	33,281	18	27.8	27.8	44.4
Eastbourne	135,914	88	43.2	38.6	18.2
Hailsham	31,093	19	42.1	47.4	10.5
Seaford	27,793	21	61.9	19	19

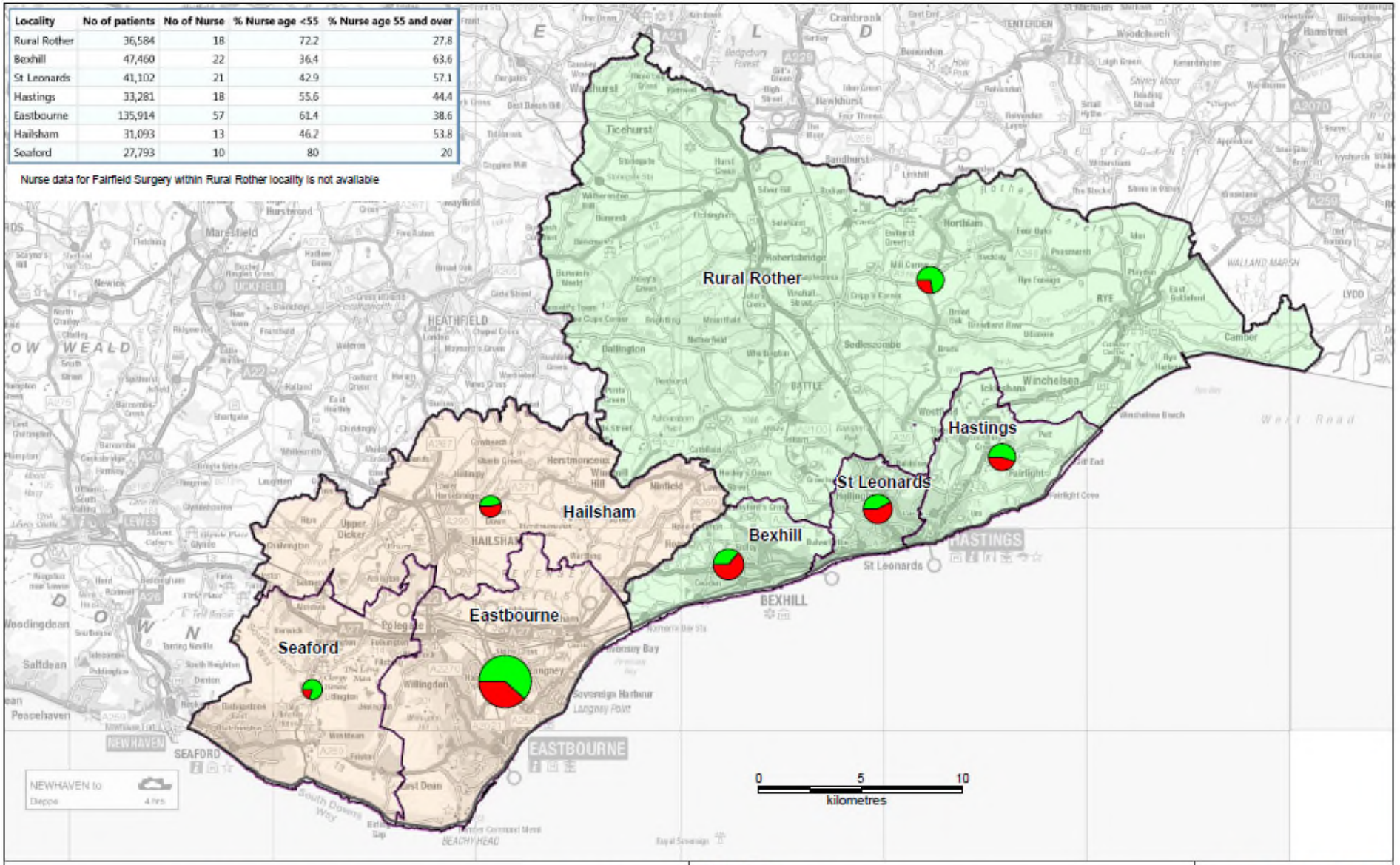
Please note number of GP refers to GP headcount. It includes GP partners and Salaried GPs only.



Nurse age by locality

Locality	No of patients	No of Nurse	% Nurse age <55	% Nurse age 55 and over
Rural Rother	36,584	18	72.2	27.8
Bexhill	47,460	22	36.4	63.6
St Leonards	41,102	21	42.9	57.1
Hastings	33,281	18	55.6	44.4
Eastbourne	135,914	57	61.4	38.6
Hailsham	31,093	13	46.2	53.8
Seaford	27,793	10	80	20

Nurse data for Fairfield Surgery within Rural Rother locality is not available



NHS Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG

Nurse Workforce: Age Profile by Commissioning Locality
(Based on NHS Digital: wMDS, March 2017 dataset)

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Report: To provide an overview of the current position of GP services in the NHS High Weald Lewes Havens (HWLH) Clinical Commissioning Group (CCG) area of East Sussex; and support for these services provided by the CCG

To: East Sussex Health Overview and Scrutiny Committee

From: Sally Smith, Director of Primary Care and Integration

Dr Peter Birtles, Primary Care Clinical Lead and Governing Body member

Date: 20 March 2018

Background

Health and social care services are facing unprecedented pressures with demand rising against a relatively static funding environment. Demand on primary care services and general practice in particular is growing at a record rate at a time when workforce challenges are also increasing.

General Practitioners (GPs) play a pivotal role in providing preventative and primary general medical care to their local population, advising on health promotion, coordinating and providing chronic disease management, diagnostics and early intervention, to support patients to manage their own care wherever possible in their homes. It is estimated that over 80% of urgent care is managed in primary care settings.

Specific pressures and challenges facing primary care and general practice include:

- A growing and ageing population
- Increasing complexity of patients both physical and mental health needs
- Increasing patient expectations
- Rising demand and workload pressures
- Emerging financial pressures and the requirement to deliver efficiency savings
- Threats to the sustainability of general practice in its current form
- Workforce challenges including:
    - Reduced number of entrants choosing General Practice as a specialty
    - National recruitment difficulties, multiple vacancies
    - Ageing workforce profile
    - Retention issues
    - Morale issues
    - Impact of Brexit and resulting tighter immigration controls that may apply

The geographic profile of HWLH CCG area is varied, from coastal towns in the Havens in the South, through the larger towns in Lewes and Uckfield, to the rural areas of the High Weald. The demographic profile is also varied, with a higher than

national average older population and pockets of less affluent patients residing across all areas, but primarily in the south of the CCG area.

As there are no acute providers within the CCG boundary approximately 85% of referrals from primary to secondary care are to out of county providers

ONS Predicted Population Growth ('000s) shown by Community Education Provider Network (CEPN) grouping

CCG (CEPN)	Age group	2017	2027	2037	Growth +/-	%age growth
Learning Together (B&H CCG and HWLH CCG)	**<19**	117	125	128	11	9.1%
	20 – 64	329	342	349	20	2.6%
	>65	106	129	162	57	**50.0%**

Although HWLH CCG patients primarily report healthier outcomes, in the area of the Havens, incorporating Newhaven and Peacehaven, statistics are significantly worse than East Sussex for the following; 21% GP reported prevalence of smoking in people aged 15+ (21%), GP reported asthma (7%), with 2.4% GP reported Chronic Obstructive Pulmonary Disease (COPD), 7.4% GP reported diabetes in people aged 17+, and 5.9% GP reported chronic kidney disease in people aged 18+. HWLH also has one of the oldest populations in the country with more than 25% over 65, and with age comes frailty and illness.

Practice profiles	HWLH
Single-handed practices	0
Partnerships	20
Lowest list size	3251
Highest list size	12652
Practice closures	2
Practice mergers	0

The CCG is a membership organisation, comprised of 20 practices of variable size and was in the first wave of CCGs to assume delegated responsibility for commissioning primary care. However, the committee should be reminded that GPs remain small independent businesses who hold contracts in perpetuity with NHS England and therefore can at any stage submit 6 months' notice of termination of their contract. In addition, the contractual levers which can be utilised by the CCG are different from those with acute and community NHS Trusts.

A breakdown of the GP demographics, providing age profiles of GPs in the CCG is provided below.

Workforce profile

CCG	% GPs under 35 years	% GPs 35 – 54 years	% GPs aged 55 years and over	% Unknown
NHS High Weald Lewes Havens	16.2	67.8	16.0	2.7

As of 1st March 2018, the population of 170,000 patients is served by 20 surgeries, 4 practices having branch surgeries and consequently providing Primary Care to patients from 27 surgery sites. GPs are required to provide essential and urgent medical services to their patients between 08.00 to 18.30 hours weekdays, and this is provided by a workforce comprising of GPs, Paramedics, Physicians Associates, Practice Nurses, and Health Care Assistants. Each surgery employs a different combination of clinical staff which is determined by a number of factors including the needs of the patients. Practices also have the option to provide Extended Hours under a Directed Enhanced Service (DES) outside these times, of which 17 out of 20 Practices do.

Despite increases in population size, the CCG has seen a decrease in the available General Practice workforce of 5% in Whole Time Equivalents (WTE) and 6% decrease in overall headcount.

Current Position

Since the formation of the CCG in 2013, there have been two surgery closures, both single handed GP surgeries; Central Surgery in June 2014 and Foxhill Medical Practice in December 2016. In each case the patients (2,500 and 2,800 respectively) were dispersed to neighbouring practices in Peacehaven. As a result, Rowe Avenue Surgery and Meridian Surgery practice lists grew from 6,179 to 6,782 and 10,489 to 12,438 respectively over that time.

The national challenges to GP recruitment have been evident, and until recently the practices in our area have managed the pressures. However, the inability to recruit partners and salaried GPs has affected some of the rural areas where surgeries have historically been managed with a main surgery site and a branch surgery (or surgeries) which open for a limited number of sessions. The difficulty to recruit has manifested in rural practices having to consolidate the clinical workforce and this has resulted in the closure of one branch surgery and the proposed closure of another.

Wadhurst Medical Group, a partnership of five GPs, was unable to recruit to replace a partner of 28 years, despite advertising for 2 years. With the planned increase in housing and thus patients, the partners reviewed their ability to maintain safe services across three sites (Wadhurst, and two branch surgeries; Frant and Ticehurst) and applied to vary their GMS contract and close the site at Frant. This village surgery provided care for a population of 700 local patients, and also provided

this population with a dispensary. All patients retained registration with Wadhurst surgery, and consequently did not have to re-register with another practice, however they do have to travel 7 miles to the main surgery in Wadhurst.

The partners at Rotherfield Surgery have similarly been unsuccessful in recruiting another partner over the past two years. In order to continue to provide safe services the partners proposed to close the Rotherfield surgery site, increasing the clinical capacity at The Brook Surgery site, one mile away, where all 7.000 patients from both the Rotherfield and The Brook sites could be seen. Following the public meeting, the Practice Partners and Parish Council are exploring options to maintain service provision from both sites with the plan for the Parish Council to buy the premises and retain a presence of the GPs in the village.

There are considerable housing developments proposed in Uckfield, Wadhurst, Heathfield and the Havens, each with several hundred homes proposed. In addition smaller level infill continues and there is a smaller but still considerable proposal for additional homes in Crowborough. Recently, purpose-built large nursing homes have been constructed, with a further 60 bedded unit opening in Ringmer. This adds to the increased pressure on primary care workforce.

All these developments pose significant challenges to the provision of existing primary care services, both in terms of infrastructure and workforce.

CCG Support for General Practice

Support for General Practice from the CCG can be categorised in a number of ways as follows

- Promotion of, and support for new Models of Care
- Initiatives to reduce increasing pressure on primary care
- Investment in extended access to primary care for patients

New Models of Care

To assist with easing pressures, the practices in the Havens are currently considering options of working more closely together in both Peacehaven and Newhaven, which will increase resilience. Currently one practice in Newhaven is 2 WTE GP partners short of optimum headcount; and the two Peacehaven practices are anticipating losing more of the GP workforce over the next 6 months.

In Lewes, the three practices, River Lodge, School Hill and St Andrews surgeries, have been successful in gaining a small amount of funding from the NHS England Estates and Technology Transformation Fund, which is assisting in their plans to build a new Lewes Health Hub (current working name) which will house all three practices and enable new and innovative ways of working with health and social care integration through a Primary Care Home model. The practices have been successful in becoming part of the second wave of the National Association of Primary Care (NAPC) and are receiving guidance and support to assist with their plans. The proposed date for completion is 2020.

Initiatives to reduce increasing pressure on primary care

High Weald Lewes Havens CCG has been successful in bidding for international GP recruits. Across the Sussex and East Surrey Sustainability and Transformation Partnership (STP) area a total of 80 recruits will be brought to work with practices in all CCGs, with seven practices in HWLH expressing interest in accepting one of the new GPs who will be integrated into the practices from the end of 2018.

Increasing population and demands on Primary Care continue to cause pressures which require a variety of new ways of working and additional funding to improve as follows.

1) **The introduction of 10 high impact changes identified by NHS England in HWLH**

   7 practices have gained benefit from this and we are in process of getting feedback to try and encourage other practices to take up the scheme.

   These are all aimed at reducing GP workload, freeing up GP time to concentrate on clinical work, and improving the quality of the working day.

2) **Medicines Management**

   Clinical pharmacists and technicians sit within individual practices reviewing medicines currently prescribed, evaluating polypharmacy (the concurrent use of multiple medications by a patient), carrying out home visits, and answering medicine queries for the GPs

   The POD is a CCG based telephone service managing routine repeat prescription requests. Such requests place a considerable burden on GP time in and out of hours.

3) **Enhanced Healthcare in Care Homes (EHCH)**

   EHCH is a CCG commissioned service to improve the level of care to nursing homes by incentivising GPs to undertake weekly proactive rounds and develop detailed care plans. As well as improving patient care, this increases professional satisfaction for GPs through the provision of protected time to carry out this work. They are supported by the CCG medicines management team who carry out detailed medicines reviews on all residents which can also take a lot of GP time. In addition, GPs have access to consultant geriatrician support for more complex patients.

3) **Community geriatrician service**

   Started as a pilot in the Havens and has now been rolled out to the whole CCG. GPs now have the facility to refer complex patients directly to a consultant working in the community for face to face consultations either in surgery or in the patient's home. This is reducing the number of multiple home visits the GPs have to do as well as reducing admissions to hospital

The geriatricians are also supporting the community hospital multi-disciplinary team (MDT) rounds helping to treatment plan patients, a role which previously feel to GPs, often for patients not registered to them. This frees up time for GPs to concentrate more on core services for their registered lists.

The Geriatricians also support the GPs in their enhanced nursing home work

4) Lewes Health Hub

The Lewes Health Hub, plans for which were presented to a previous committee meeting by Dr Phil Wallek, is a project whereby the three practices in Lewes are joining forces to provide a Primary Care Home method of care incorporating the transformation of Lewes Victoria Hospital Minor Injuries Unit into an Urgent Treatment Centre (UTC) with GP cover, able to see and treat both minor injuries and minor illnesses. This will significantly improve ease of access for patients. CCG plans for a UTC were previously presented to the committee as part of the new Community Services contract with Sussex Community NHS Foundation Trust, previously labelled as Minor Injuries and Minor Ailments and Illnesses (MIAMI) units.

The CCG has encouraged and facilitated the discussions from the beginning and continues to do so as well as offering management support and signposting to additional funding streams. It has also brokered the discussions between the practices and the community provider.

Investment in extended access to primary care for patients

As mentioned earlier, 17 out of the 20 practices provide the NHS England extended access Directed Enhanced Services (DES) for pre-booked appointments. These appointments are offered to patients outside regular surgery hours, including evenings and at weekends, according to local demand. The CCG is also currently involved in a procurement process to commission the NHSE General Practice Forward View Improved Access initiative to provide additional access for one and a half hours from 18.30 to 20.00 Monday to Friday and weekend cover to meet local population needs. HWLH has a procurement plan to enable this mandated service to be commissioned and in place by October 2018.

Conclusion

The provision of primary care services in High Weald, Lewes and the Havens is not exempt from the challenges faced nationally in terms of demand; and availability of the workforce. The committee is asked to note the current position of member GP practices and the initiatives being undertaken to address the issues faced.

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

Date of meeting: **29 March 2018**

By: **Assistant Chief Executive**

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

Purpose: **To update HOSC on the redesign of the urgent care system as part of the East Sussex Better Together programme, with a focus on the development of Urgent Treatment Centres in Eastbourne and Hastings.**

RECOMMENDATIONS

1) To agree that the proposed relocation of the walk-in primary care service as part of the development of Urgent Treatment Centres in Eastbourne and Hastings constitutes a 'substantial development or variation' to services requiring consultation with the committee under health scrutiny legislation.

2) To establish a Task Group to consider the proposals in more detail and prepare a HOSC response for consideration by the committee in June.

3) To agree any key questions or lines of enquiry for the Task Group to investigate.

4) To comment on the Clinical Commissioning Groups' proposed approach to public engagement.

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1 Background

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

1.2 Following a national review in 2014, NHS England set out clear commissioning standards to ensure future urgent and emergency care services are integrated and offer a consistent service. In March 2017, NHS England and NHS Improvement published the *Next Steps on the NHS Five Year Forward View* which highlighted the importance of delivering integrated urgent care services to help address the fragmented nature of out-of-hospital services. There are 10 nationally set key deliverables in relation to urgent and emergency care including the roll out of standardised new 'Urgent Treatment Centres' (UTCs) which will be open 12 hours a day (minimum), seven days a week, integrated with local urgent care services.

2 Supporting information

2.1 HOSC last received a progress report on East Sussex Better Together (ESBT) urgent care redesign in September 2017. This included updates on the three main components of the local system redesign:

- the development of A&E departments into Integrated Urgent and Emergency Care Departments
- the re-design and re-procurement of NHS 111 (Sussex-wide)
- the provision of 24/7 access to same day general practice (GPs), including the future provision of Primary Care Out of Hours services and a review of the Eastbourne and Hastings Walk-in Centres.

2.2 At the time of the last report the ESBT urgent care programme was considering where the development of UTCs would sit within the locally agreed service model with various options under consideration.

2.3 A further update on ESBT urgent care redesign provided by Eastbourne, Hailsham and Seaford and Hastings and Rother Clinical Commissioning Groups (CCGs) is attached at **appendix 1**. The report focuses on the proposed local approach to commissioning UTCs which has now been developed, in line with national requirements, and sets this within the context of the wider urgent care system redesign which continues to progress.

2.4 The proposed approach to establishing UTCs is for these to be co-located with the A&E departments at Eastbourne District General Hospital and the Conquest Hospital in Hastings. This would involve the relocation of the walk-in primary care services currently located at Eastbourne and Hastings stations since UTCs will provide a walk-in service as well as bookable appointment slots. The intention is for the UTCs to be operational by April 2019. The existing Walk-In Centres also have a registered patient list and consideration is being given to future general practice provision for these patients.

2.5 Alongside the plan to establish co-located UTCs with the local A&E departments, the ESBT CCGs are required to commission the nationally mandated increase in Extended Primary Care Access (access to primary care appointments outside core hours and at weekends) by October 2018. The preferred model of provision for Extended Primary Care Access will be through the establishment of a number of primary care access hubs across ESBT CCGs, including town centre provision in both Hastings and Eastbourne.

3. HOSC role

3.1 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.

3.2 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.

3.3 In this case, the walk-in service is available to the whole population and it has particular relevance to some specific vulnerable groups such as homeless people, people with mental health and substance misuse needs. Although a walk-in service will continue to be available, it will be relocated from town centre locations to the acute hospital sites in Eastbourne and Hastings. All the current users of the existing service would be affected in some way. For these reasons HOSC is recommended to agree that the proposals constitute a 'substantial development or variation' requiring consultation with the Committee.

3.4 In order to undertake a more detailed review of the proposals in a timely way it is recommended that HOSC establish a Task Group to review evidence, meet with key witnesses and formulate a report and recommendations for consideration by the committee in June.

3.5 HOSC is also invited to propose any key questions or lines of enquiry for the Task Group to investigate in the course of its work.

3.6 Alongside the duty to consult with HOSC on substantial service changes, NHS organisations have a separate duty to engage patients and the public in an appropriate and proportionate way in the design of services. Part of HOSC's role is to scrutinise the way engagement is undertaken with affected groups, particularly in relation to service change.

3.7 As outlined in previous reports to HOSC, there has been considerable public and stakeholder engagement in developing the ESBT urgent care model and it is proposed this will continue. In relation to the specific plans for the establishment of UTCs and relocation of the walk-in service as part of this, the CCGs propose to undertake a targeted consultation focusing on the most affected groups as identified through an equalities screening process, as well as being open to the general public. A summary of the proposed approach is included **at annex 2 of appendix 1**

and HOSC is invited to comment. Feedback from consultation will be made available to the HOSC Task Group to inform the HOSC response.

4. Conclusion and reasons for recommendations

4.1 This report provides HOSC with an update on developments in relation to urgent care as part of the ESBT programme, including specific proposals in relation to UTCs. HOSC is recommended to agree the recommendations as set out which will enable the committee to respond appropriately to the CCGs.

PHILIP BAKER
Assistant Chief Executive

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Report: **East Sussex Better Together (ESBT) – Urgent Care Redesign Programme Update: Urgent Treatment Centres**

To: East Sussex Health Overview and Scrutiny Committee

From: Mark Angus, ESBT Urgent Care System Improvement Director

Date: 19 March 2018

Overview:

The Health and Overview Scrutiny Committee members are asked to note progress with the development and implementation of our integrated urgent care service model specifically relating to:

- Our plans to establish Urgent Treatment Centres
- Our plans to engage and consult with local people on our proposed plans.

This paper provides a summary update on the progress being made on the Primary Urgent Care Services workstream of the East Sussex Better Together (ESBT) Urgent Care Transformation Programme with specific reference to our plans to establish nationally mandated Urgent Treatment Centres.

1. Context

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

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

Following a national review, NHS England (NHSE) set out very clear commissioning standards in September 2014 to ensure future urgent and emergency care services are integrated and offer a consistent service.

In March 2017, NHSE and NHS Improvement (NHSI) published the Next Steps on the NHS Five Year Forward View (FYFV)[1], which highlighted the importance of delivering functionally integrated urgent care services to help address the fragmented nature of out-of-hospital services. A key aim of the FYFV is to provide care closer to peoples' homes and help tackle the rising pressure on all urgent care services (primary and hospital) and emergency admissions.

The nationally set commissioning standards and key deliverables are informing and shaping how we – through ESBT – best organise and provide local urgent care services.

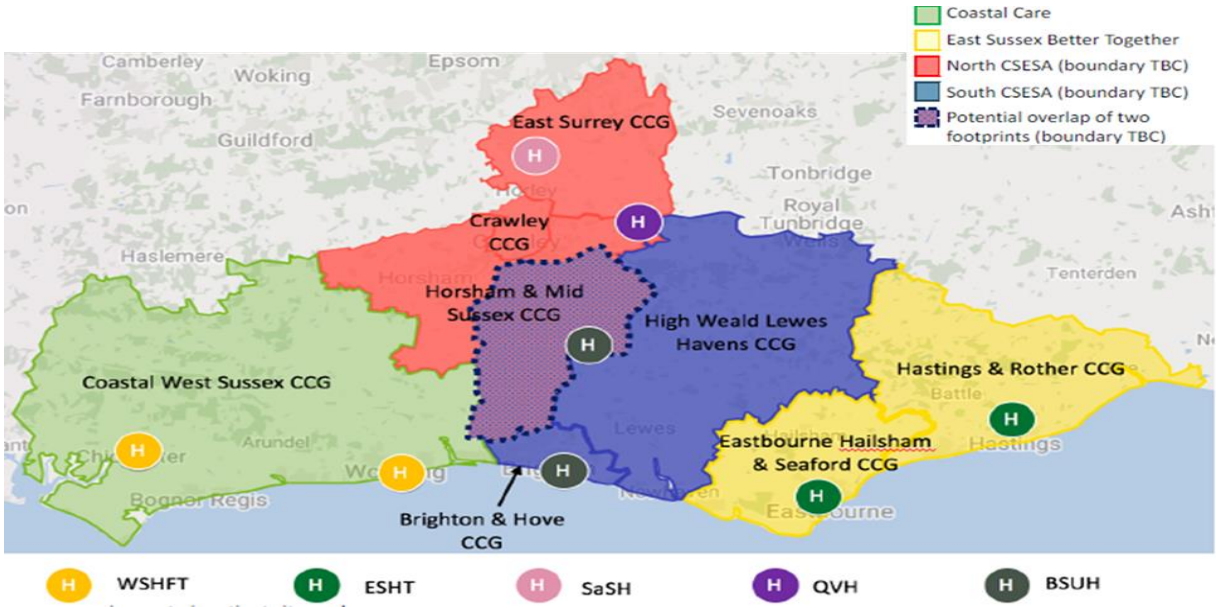
[1] Next Steps on the Five Year Forward View (March 2017)

2. Introduction

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

The ESBT[2] urgent care re-design and transformation programme is framed within the wider place based Sussex and East Surrey Sustainability and Transformation Plan (STP). The STP place based footprint for Sussex and East Surrey is set out in the Figure 1 below.

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



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

Following on from the previous paper submitted to the Health Overview and Scrutiny Committee (HOSC) in September 2017, this paper provides an update on the workstreams relating to Primary Urgent Care Services, as set out below, underpinning the ESBT urgent care transformation programme. It specifically sets out our plans to deliver nationally mandated Urgent Treatment Centres and our plans to engage and consult with local people on these plans.

[2] ESBT includes the areas covered by Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG

3. Scope

The following services are included in scope in our description of Primary Urgent Care Services:

- NHS 111;
- GP Out of Hours (OOH) Home Visiting Service;
- GP (In Hours and Out of Hours);
- Urgent Primary Care Walk-in Services.

4. Service Model

The ESBT Integrated Urgent Care (IUC) model, which has continued to be developed by the ESBT Urgent Care Planning and Design (UCP&D) Group, is attached as **Annex 1**. It reflects the commissioning standards for IUC[3] published in September 2015 by NHSE and it is congruent with the national IUC Service Specification, which was published in August 2017.

The model meets national deliverables as set out in the Next Steps: FYFV (March 2017) and the national planning guidance Refreshing NHS Plans for 2018/19[4] (February 2018) and the Sussex and East Surrey STP Urgent and Emergency Care delivery plan.

Key updated principles of the model design are as follows:

- The intention is to offer an integrated 24/7 urgent care service.
- There will be a single-entry point via the new Sussex NHS 111 and the Clinical Assessment Service (CAS) from 1st April 2019 to fully integrated urgent care services, recognising that access to urgent GP appointments remains unchanged.
- The new Sussex NHS 111 and CAS (staffed centrally, virtually or a mixture of both) to support people accessing the right service for them, will offer access to a wide range of clinicians such as GPs, pharmacists, dental and mental health services and specialists, and will offer advice to patients and healthcare professionals.
- The aim is for the new NHS 111 service to ensure that if a patient needs to speak to a clinician via 111 they are able to and that a range of clinicians are available to help them there and then.
- Clinicians will have a robust accurate directory of services which will enable them to refer patients to the appropriate local service.
- Patients requiring access to face to face Primary Care Urgent Services will be directly booked into appointments by the CAS.
- Face to Face same-day Primary Care Urgent Services will be provided by nationally standardised Urgent Treatment Centres (UTCs) and locality based out of hours and weekend Primary Care Extended Access services, including town centre provision in Eastbourne and Hastings.

[3] NHS England Integrated Urgent Care Service Specification (25th August 2017)
[4] NHS England Refreshing NHS Plans for 2018/19 (2nd February 2018)

- UTCs will be established as co-located services with our local A&Es and services provided at our acute hospitals in Eastbourne and Hastings, which our local stakeholders identified as the optimum location for integrated urgent care hubs.

5. NHS 111/Clinical Assessment Service/Out of hours GP Home Visiting

The procurement of a Sussex-wide NHS 111 service and CAS is underway. The service specification includes provision of a GP OOH home visiting service for all Sussex CCGs, with the exception of Coastal West Sussex CCG.

The vision for an Integrated Urgent Care Clinical Assessment Service (IUC CAS) offers a transformational opportunity to deliver a model of urgent care access that will streamline and improve patient care across the urgent care community. Patients will be able to call a single number and speak to a clinician who will advise them. They will receive immediate clinical advice or be booked into the right service to assess or treat them on the same day.

This will significantly improve the way patients access local urgent health services as patients will receive a complete episode of care concluding with either: advice, a prescription, or an appointment for further assessment or treatment. The expectation is that the new Sussex 111 will reduce the requirement for referral to same day face to face primary care urgent care services.

For those patients, who following assessment by the 111 CAS, require access to an urgent care face to face base service, the 111 CAS will be digitally enabled to directly book patients into these services.

The new Sussex 111/CAS service is due to be operational by 1st April 2019. This timeline requires CCGs to ensure that the development and commissioning of urgent care face to face services, i.e. UTCs and Primary Care Extended Access hubs, are aligned to this timescale and are able to accept direct bookings by 01 April 2019.

6. Primary Urgent Care Service

There are two key elements to the ESBT plans to develop and improve Primary Urgent Care Services as follows:

- The national requirement to commission additional Primary Care Extended Access services by October 2018.
- The national requirement to establish designated UTCs by no later than March 2019,

6.1. Primary Care Extended Access

As set out in the Next Steps: FYFV (March 2017) and the national 2018/19 planning document, Refreshing NHS Plans for 2018/19 (February 2018), the ESBT CCGs are required to commission 30 minutes additional primary care extended access per 1,000 head of population by October 2018. This is to provide access to GP appointments outside core general practice hours and at weekends.

ESBT CCGs are required to commission an additional 95 hours per week for H&R CCG and 97.75 hours per week for EHS CCG, equating to over 40,000 additional appointments per annum across our area. A minimum of 20% of this capacity will be allocated for the new 111/CAS service to directly book into.

Soft market testing has been undertaken via a request for information process and the options for the procurement approach to be followed are due to be considered by the ESBT CCGs in March 2018.

Following soft market testing feedback from potential providers the ESBT CCGs preferred model of provision of Extended Primary Care Access will be through the establishment of a number of primary care access hubs serving a locality and a group of local GP practices, including town centre provision in both Hastings and Eastbourne.

A public engagement activity via online and paper based survey to seek the views of local people on their preferences on the time of day they would wish to be able to access extended primary care services has recently been undertaken. The ESBT CCGs received 1,271 responses to the survey and the results of this survey will inform the final design and service specification.

The ESBT Extended Primary Care Access planning timelines are aligned to the national October 2018 deadline.

6.2. Urgent Care Treatment Centres

6.2.1. The national and local Case for Change

The development of designated UTCs is a nationally mandated service change.

The national planning guidance for 2018/19: Refreshing NHS Plans 2018/19, published in February 2017, makes clear that all designated UTCs should be in place by the end of 2018/19.

From the outset of the national review of urgent treatment services in the NHS, patients and the public said there was a confusing mix of walk-in centres, minor injuries units and urgent care centres; so many people just chose A&E even if less convenient and often with long waits.

In response, the national plan is to standardise as many services as possible so they offer better and consistent opening times every day, and more tests and treatments – and all under the single banner of ‘Urgent Treatment Centre’ which NHS 111 can book patients into.

The local and national urgent care system is experiencing significant demands on patient flow across services. In particular, A&E departments have been under increased pressure. In addition, the current urgent care system is fragmented and challenging for patients and the public to navigate effectively.

It is therefore crucial to offer a viable alternative to A&E departments for patients to be able to access. There is a national drive towards an IUC system that aligns community services, emergency departments and ambulance services and connects all urgent and emergency care services together so the overall physical and mental health and social care system becomes more than just the sum of its parts.

Key drivers for the change are:

- **Driver 1**: Increase the efficiency and effectiveness of urgent care to manage increased demand due to demographic pressures;
- **Driver 2**: To reduce demand on A&E departments;
- **Driver 3**: Improve information and advice, to enable people to plan for the future and to self-care;
- **Driver 4**: Improve the patient journey by improving consistency and access;
- **Driver 5**: Develop urgent care provision that is fit and sustainable for the future.

Our urgent care transformation programme and the development of UTCs and Extended Primary Care Access hubs will deliver the following benefits to the ESBT population:

- A more integrated approach to urgent care;
- Improved patient navigation of urgent care pathways (e.g. one phone call to NHS 111);
- Provision of 24/7 access for patients to urgent treatment services
- Reduction in patient and public confusion over the mixture of urgent care; services providing a clearer route to access services and standardising the services offered;
- By co-locating services be able to offer patients a broader range of services, clinical skills and access;
- Improved patient experience (e.g. more services);
- Improved access for patients to services (e.g. diagnostics / treatment of minor illnesses).
- Providing patients with faster assessment and treatment (e.g. shorter wait times than the emergency department (ED) and improved access for those who need to be seen in ED).
- Provide patients with greater certainty by enabling patients to be pre-booked into urgent care services via NHS 111, their GP or by Ambulance services.
- Improved A&E Department performance through a reduction in waiting times for treatment;
- An alternative to conveyance to A&E for ambulance services;
- Urgent Primary Care needs being managed by Primary Care Clinicians;
- Increased Primary Care resilience by freeing up General Practitioners;
- Increased use and more flexible use of local resources (e.g. community service use instead of acute services);

6.2.2 The development of the ESBT UTC service model

The ESBT A&E Delivery Board (AEDB) and the ESBT Urgent Care Transformation Programme, supported by the East Surrey and Sussex Urgent and Emergency Care Network (UECN) held a professional stakeholder meeting on 15 September 2017 to consider where the nationally mandated development of UTCs should sit within the overall ESBT urgent care service re-design model.

The UTC stakeholder workshop also took into account the outcome of our significant engagement so far with local people. Through our bespoke stakeholder events, widespread survey and extensive and focussed engagement with diverse public groups and individuals, and our ESBT Shaping Health and Care Events in 2015, 2016 and 2017, we have discussed urgent care and what is important to local people.

We have undertaken specific engagement work in local GP practices to understand how people access services and what is important to them in doing so. East Sussex Healthwatch has also undertaken engagement on reasons for people accessing urgent care and we collect ongoing feedback through our ESBT Public Reference Forum. Outcomes of all of this work have directly shaped and informed the urgent care model design principles.

People have told us that what is important to them in accessing urgent care is as follows:

- It is important to be able to access urgent care over the phone;
- Access to services in the evening or at the weekends is important and the ability to find advice when you need it;
- It is particularly important to be able to access a same-day appointment or an appointment within 48 hours;
- People are clear about the importance of having the right information about urgent services and to have confidence these services offer quality advice;
- The role of digital technology was highlighted and improving the availability of this information and advice is important;
- There are mixed views about the importance of seeing your usual GP, or a GP in your practice, or the option to use a video call; and
- The importance of GP appointments generally was prominent but people also discussed the value of other professionals in providing support as part of an urgent care network of support and services.

The following were the key planning principles agreed at the workshop:

- In principle agreement that there was at present a requirement for one UTC per CCG area based upon how patients currently access urgent care, an assessment of future need and the need to develop a sustainable urgent care model;
- In principle agreement that where possible urgent primary care services should be co-located and on as few a number of locations as possible to concentrate resource and mitigate the identified workforce risks.

In considering the options for the development of UTCs consideration was given to developing the existing Walk in Centres in Hastings and Eastbourne to meet UTC standards or to develop UTCs as part of the ESBT urgent care vision to establish urgent care integrated hubs at our acute hospitals.

The ESBT Alliance Executive and East Sussex Local A&E Delivery Board have agreed, subject to business case approval, to the option to develop UTCs at our acute hospitals on the basis of the following key points:

- Enables the provision of 24/7 access to urgent care treatment services
- Enables the integration of existing GP out of hours base visit services and primary care A&E streaming services (diverting existing primary care activity away from A&E) with the provision of UTCs.
- Provides access to a broader range of diagnostic services e.g. access to x-ray.
- Enables immediate transfer of sick patients from the UTC to A&E and other acute assessment services, e.g. ambulatory care, surgical and medical assessment units.
- Mitigates the workforce risk of having multiple providers and centres providing urgent care services across ESBT CCGs
- Provides a model that enables flexible use of multi-disciplinary teams across urgent and emergency care services.
- Provides a more sustainable model of urgent treatment services and significantly improved access that fits within the available financial envelope.
- Is strategically aligned with the mandated requirements of the broader national and STP IUC transformation programme.
- Provides a model of care that is consistent with what local people have told us is important.

All CCGs are mandated to establish designated UTCs and High Weald Lewes and Havens CCG are planning to designate the Lewes Minor Injury Unit (MIU) as an UTC by 1st April 2018. It is anticipated that ESBT CCG patients who currently access the Lewes MIU will also access the Lewes UTC from the 1st April 2018 if this is the most appropriate and convenient service for them.

6.2.3 The ESBT UTC service specification

The ESBT model and service specification that has been developed for ESBT UTCs will bring together the following services as an integrated urgent primary care face to face service as part of the front door model at both EDGH and Conquest Hospital:

- A&E Primary Care Streaming (diverting existing primary care activity away from A&E);
- GP Out of Hours Base Visits;
- Urgent Care Walk in and Bookable Face to Face (F2F) Services.

A summary of the key elements of the proposed ESBT UTC service are as follows:

- The UTC will be open 24 hours a day 365 days a year.

- The UTC will be either a GP-led service, under the clinical leadership of a GP, or a service that is jointly led with ED Consultants.
- There will be an option for bookable appointments with a GP or other members of the multi-disciplinary team.
- The UTCs in ESBT will provide both pre-booked same day and “walk-in” appointments, however patients and the public will be actively encouraged to use the telephone or internet to contact NHS 111 first whenever an urgent care need arises, with access via NHS 111 becoming the default option over time, as walk-in attendances diminish.
- There will be an effective and consistent approach to primary prioritisation of “walk-in” and pre-booked appointments, and same day appointment slots.
- Where appropriate, patients attending the UTCs will be provided with health and wellbeing advice and sign-posting to local community and social care services where they can self-refer (for example, smoking cessation services and sexual health, alcohol and drug services).
- The UTCs will provide the necessary range of services to enable people with communication needs to access British Sign Language, interpretation and translation services.

6.2.3.1. Access to the UTCs – ‘Walk in’ patients

- A nurse-led streaming service at first point of contact will be in place at both acute hospital sites integrated into the formal registration of a patient to achieve a clinical, visual and verbal assessment of the patient as quickly as possible, allowing for immediate prioritisation of a patient based on clinical need.
- The patient will be assessed by the nurse, who will be qualified to assess and assign patients to the correct stream, e.g. A&E majors, specialist ambulatory care units or UTCs.
- The screening protocol used will be a visual check, speech test, chest pain, highlighting any unscheduled revisits within 72 hours with the same condition and injury or illness, to ensure safety and consistency.
- ‘Walk in’ patients will be clinically assessed within 15 minutes of arrival, but will only be prioritised for treatment over pre-booked appointments, where it is clinically necessary.
- Following clinical assessment, patients will be directed to the reception point that will be a single point of registration for all ambulatory attendances.
- At the reception point patients will be given an appointment slot within the appropriate stream and with the appropriate healthcare professional, which will not be more than two hours after the time of arrival.

6.2.3.2. Access to the UTCs – Bookable appointments

- Patients who require an appointment in the UTC will be able to book by a single phone call to NHS 111, with NHS 111 using the Directory of Services (DoS) to locate the most relevant service where an urgent care requirement is identified and the need cannot be met within the GP setting or extended access services local hub.

- Any non-urgent calls to NHS 111 CAS in hours (08:30-18:30) will be signposted to their GP first, with the ability to book into the UTC if needed. Working alongside the NHS 111 call handling service, the Sussex CAS will contain a multidisciplinary clinical team who may, following a clinical assessment and where an urgent face to face consultation is deemed necessary, refer patients to the closest UTC or OOH GP service. Wherever possible, this referral will be supported by a booked appointment.
- Where the UTC service has blocked out appointments for use by the Sussex NHS 111 service and CAS, a protocol and time frame must be agreed to free these appointments back for use by that service should they not be required.
- Operating as a 24/7 service, Health Care professionals will have direct access to the CAS for clinical advice.
- Where the requirement to be seen by primary care is identified and there is not an absolute need for the patient to be seen by their own GP, the option of being seen by other primary care provision such as at the UTC will be available. Bookings to this service will be made by NHS 111 only if the patient has been assessed and referred by a GP working within the IUC/CAS or other clinical staff where locally agreed.
- A patient's GP will also be able to book a patient directly into the UTC where a same day urgent care requirement is identified and the need cannot be met with the GP setting or Extended Access services. Where a GP Practice has the ability/capacity to triage the patient, the GP will be able to directly book into the UTC. Where this ability is not in place, the patient will be asked to book in via NHS 111.
- Local patients will be encouraged to use NHS 111 as the primary route to access an appointment at the UTCs. Patients who have a pre-booked appointment made by NHS 111 or their GP Practice will be seen and treated within 30 minutes of their appointment time at the UTC.

6.2.4 Implementing our ESBT UTC model

The ESBT CCGs Governing Bodies are due to consider the full UTC business case at their meeting on the 28th March 2018. Following agreement of the business case we plan to consult with local people so we can raise awareness of the proposed improvements and further understand the differential impacts this might have on how people access services.

The development of UTCs at our acute hospitals together with the development of the new NHS 111/CAS service and the commissioning of additional Primary Care Extended Access will mean that there will no longer be a need for walk in services to be provided by our current town centre walk in centres in Eastbourne and Hastings. This is because improved services with the option to book into Primary Care Extended Access or UTC and to walk in to UTCs will be available.

Therefore, as part of our business case development we have undertaken a detailed analysis of the current users of our urgent care services and have undertaken an equality impact assessment to ascertain the differential impact our plans may have on different communities who use urgent care services.

The improvements to the IUC model across ESBT over the next year represent a level of change that means there is a level of complexity to our plans due to the interdependent nature of the various design changes being implemented. We will provide updates to the HOSC as required.

The equality impact assessment that has been undertaken indicates a particular need to consider the impact of these changes on vulnerable patients, children and young people and this is an area of focus for our planned engagement and consultation activity.

The timescales for the establishment of ESBT UTCs, allowing for public consultation and engagement, procurement and mobilisation should ensure that the ESBT UTCs are operational by 01 April 2019.

7. Our plans for further engagement

We want to continue to engage and consult with people in a meaningful and proportionate way on our proposed service changes regarding the development of urgent treatment centres and the changes to how patients will access the walk in element of urgent care services

We plan to:

- set out our proposals for improving access to and the quality of our urgent care services,
- test out the impact of re-locating the walk in aspect of urgent care services,
- test out our proposals for mitigating any differential impact on any patient groups,
- give the opportunity to people to provide feedback so that can we deliver the best model for local people with the resources that are available.

A paper setting out our summary plans to engage and consult local people is attached as **Annex 2.**

8. Timescales and next steps

As highlighted above, we have made good progress on further developing our local plans with the expectation that this will result in further improvement for local people,

The redesign of NHS 111, including a new CAS, in line with national requirements, our planned re-design of our primary care urgent services, including our proposed plans to establish a new UTC standardised service and Extended Primary Care Access, are subject to procurement or re-procurement procedures being followed.

This has previously been reported to HOSC and the summary of updated milestones and timelines are set out below in Table 1:

Table 1: Summary of milestones and timelines:

Key Milestones	**NHS 111 Procurement Timetable**	**Primary Care Extended Access**	**Urgent Treatment Centres Timetable**
Current contract end dates	March 2019	N/A	(Walk in Centres – March 2018 extending to 31 March 2019)
Public Engagement/Consultation	Completed	Completed	By June 18
Procurement process	March 2018 - March 2019	April 2018 – September 2018	July 2018- October 2018
Implementation of new service	April 2019	October 2018	April 2019

Following the outcome of the planned engagement work it is proposed that we provide a report back to the HOSC, providing information on the feedback received and describing how the outcome will inform the final design of our proposed urgent care service.

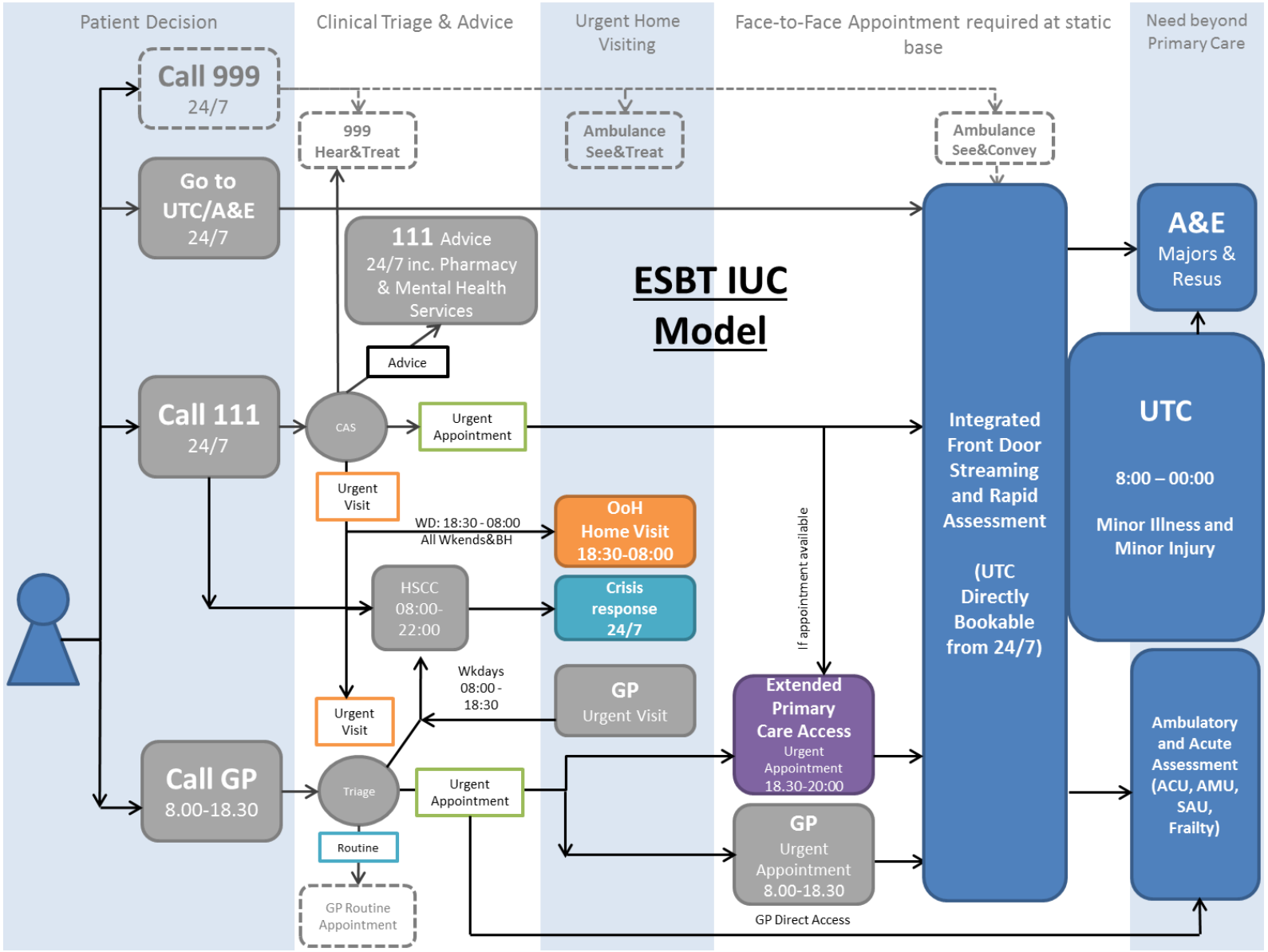
Conclusion

The Health and Overview Scrutiny Committee members are asked to note progress with the development and implementation of our integrated urgent care service model specifically relating to:

- Our plans to establish Urgent Treatment Centres
- Our plans to engage and consult with people on our proposed plans.

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

Annex 1 – East Sussex Better Together Integrated Urgent Care (IUC) Service Model



Annex 2

Summary consultation plan regarding the implementation of UTCs in the East Sussex Better Together CCGs' area.

Introduction

Our ESBT Alliance Communications and Engagement Strategy sets out a commitment to clear communications and the active involvement of local people in the design of services.

We also have a communications and engagement plan as part of our wider urgent care system transformation. We have undertaken much work on this that has informed our journey so far and we will continue to engage local people as these wider plans develop and roll out.

This summary plan gives some information for context about our wider urgent care engagement work and explains our specific proposals for consultation with regard to the establishment of Urgent Treatment Centres (UTCs).

Our Communications and Engagement Aims as part of the wider Urgent Care Transformation Programme

- We will ensure that local people are aware of the variety of local health and care services available to them when they become unwell outside of 'normal' hours of operation.
- We will make it easier for people to make appropriate choices about their urgent health and care needs.
- We will involve local people in shaping those services where it is possible within the limitations of national requirements.
- We will ensure the service proposals consider our duties in relation to health inequality and equality impacts.
- We will communicate and involve our staff in this process to enable them to support and signpost patients appropriately.
- We will ensure that there is good understanding and engagement with our proposals across all stakeholders in our health and care system.

Our Model – Current and Future

To support our transformation of urgent care services, we want to describe our services in clear and accessible language and formats so that patients can easily navigate the system.

To inform this we have undertaken a series of communications and engagement workshops with the Urgent Care Planning and Design Group, Urgent Care Steering Group, staff engagement leads from relevant organisations and Communications and Engagement Leads to understand our current and future models and what this means in terms of the key areas of change for local people and staff.

We will create a number of 'products' giving information about our plans, including a simple visual outlining our urgent care services.

We have shaded below the aspects that directly relate to UTCs as well as Extended Primary Care Access as the development of the Extended Primary Care Access is very closely aligned with the establishment of UTCs in order to provide good access to local people.

Table A – Our current and future urgent care model and what this means for local people

Our Current Model	Our Future Model	Key Changes for Patients
NHS 111 and Clinical Assessment Service NHS 111 and Clinical Assessment Service Telephone service Limited access to multi-professional clinical teams Signposting service to other services such as GP out of hours, Walk in Centres and A&E. Unable to directly book patients into services.	NHS 111 able to ensure patients who need to be able to talk to a clinician will be put through to an appropriate clinician. Patients will be able to access NHS 111 online using web access and mobile applications. The clinical assessment service will have access to a broad range of clinicians (GPs, Paramedics, Nurses, Pharmacists, Dentists, etc) to better meet patient need. Following clinical assessment if a patient requires an urgent face to face same day appointment the 111 CAS will be to directly booked a patient into Primary Care Extended Access service, or if not appropriate, into Urgent Treatment Centre The NHS 11/CAS will also contact GP practices to arrange routine GP appointments for patients. Pre-booked patients will be required to be seen within 30 minutes of their appointment time at UTCs.	- Streamlined, faster service with more access to clinicians with the aim of 'consulting and completing' the episode of care on the phone. - Reduction in number of cases with onward referral to services - Increased number of patients with self – care advice. - Streamlined access to repeat prescriptions - Access to bookable appointments where appropriate. - Access to wrap around support through referral to Health and Social Care Connect

<u>GP Out of Hours (OOH) – Base Visits.</u> 8pm to 8am and 24/7 at weekends and on bank holidays Bases co-located with A&E at Conquest Hospital and Eastbourne District General Hospital (Hastings service currently temporarily re-located to the Hastings Walk in Centre) Full GP OOH rota cover has been challenging.	<u>Urgent Treatment Centres</u> - 24/7 Clinical Triage through the NHS 111 Clinical Assessment service - Face to Face Base Visiting: evenings after 6.30pm and weekends will be delivered as part of the locally commissioned integrated UTC service - The GP out of hours home visiting services is being procured as part of the NHS 111/CAS service	- Access to GP Out of Hours appointments is streamlined through NHS 111 and is directly bookable if there is a patient need - These appointments will be delivered either through Home Visits or as face to face appointments in UTCs or Primary Care Extended Access. - Clinical triage will be conducted through a phone call to NHS 111.
<u>Health and Social Care Connect.</u> 8am to 10pm 7 days a week services providing co-ordination and access to community health and social care services for health care professionals and patients.	<u>Health and Social Care Connect</u> - 'Wrap around' community services via telephone - Complex health and social care queries - Will provide a local based 111 CAS extension to the NHS supporting pathways and access to community services for vulnerable patients and specific pathways, e.g. Urinary Tract Infections, Non-Injury Falls, Blocked Catheters, other infections. - 'Wrap around' community services via telephone line 8am to 10pm - Consideration is being given to developing the HSCC model further to provide 24/7 cover as part of the CCGs plans.	- Extended hours access - Potential access to children's services - Single telephone number to reach clinical advice - Access to Crisis Response 24/7 - Developing 24/7 service provision - Specialist mental health clinical advice
<u>Walk in Centres (WIC)</u> 8am to 8pm 7 days a week – provision of primary care and urgent primary care walk in services. Town centre locations in	<u>Urgent Treatment Centres(UTCs)</u> - 7 days a week, 24 hours a day - Urgent Treatment Services will be co-located with our Acute Hospitals EDGH and Conquest	- Relocation of walk in facilities to hospital sites. - Access to wider range of clinicians, tests and treatments through co-location at hospital sites.

Hastings and Eastbourne. GP led minor illness and minor injury service for adults and children of any age. Access to diagnostics services with the exception of x-ray. Services not directly bookable by NHS 111 Provision of GP registered practice services	- Patients will have access to a broader range on diagnostic services, including X-ray. - NHS 111/CAS, GPs and Ambulance services will be able to directly book patients into UTCs. - Patients who walk in will be triaged within 30 minutes and seen with 2 hours. - Patients who are pre-booked via 111, the GP or Ambulance services will be seen within 30 minutes of their pre-booked appointment time. - Walk in access through UTC - Simplified access to urgent care services - Broader clinical skill mix to better manage people's wide ranging needs. This includes GPs, Physiotherapists, Nurse Practitioners (including Paediatric Nurses), Health Care Assistants, Mental Health Workers and Social Workers. - Patients who attend UTCs who require other services will be able to be directed quickly into A&E or other acute services such as specialist Ambulatory Care and assessment units based at the hospital. - Important and relevant patient level clinical information will be accessible by the UTCs clinical staff. - UTC service offer will be consistent across counties.	- These staff will work alongside our A&E consultants and emergency care staff at both hospital sites to ensure patients' needs are met as quickly as possible. Patients can seamlessly be referred on to appropriate community services to better support them on discharge. This will include having immediate access to emergency care if issues are serious. - Simplification and integration of 'confusing' existing urgent care service model. - Directly bookable appointments through 111 and GP extended access appointments. - Currently there can be long waits for patients accessing A&E (A&E has a four hour national target) or WIC; this will be significantly improved at UTCs (15 minutes triage and seen within 2 hours). - To include primary care streaming activity.

Extended Access Primary Care Some limited practice based provision across ESBT.	Extended Access Primary Care - An additional 30 minutes per 1,000 population equating 192.75 hours additional hours across the ESBT CCGs per week (over 40,000 appointment slots per annum). - GP Extended hours (18:30-20:00 minimum) - Weekend and bank. Holiday service provision - Preferred model to be a number of locality based Primary Care Hubs serving a number of GP practices; including provision for town centre access in Eastbourne and Hastings - A minimum of 20% of this additional capacity will be reserved for use by NHS 111/CAS to be able to directly book into this capacity. - Important and relevant patient level clinical information will be accessible by the extended access services clinical staff.	- Extended opening hours at some existing practices available to wider locality - Appointments bookable through NHS 111 and GP practices - Potential service to support patients with chaotic lifestyles - Improved access to primary care
A&E	A&E	- Improved access and waiting times in A&E. - Used for the right purposes leading to reduced waiting times. - Immediate referral to A&E for emergency from the UTC.
In hours GP services Access to GP appointments in hours.	In hours GP services Access to GP appointments in hours.	No change

<u>A&E Primary Care Streaming</u> 6 month Pilot at Eastbourne District General Hospital and Conquest Hospital has beee running since 31st October 2017 GP led service running from 10am to 10pm 7 days a week. Patients are triaged by an A&E nurse and if their needs can be met by a primary care delivered service they are directed into the GP led Primary Care Streaming service	<u>Urgent Treatment Centre (UTCs)</u> - Patients who currently present to A&E who do not require an A&E level assessment and treatment and whose needs can be met by primary care will be triaged and streamed into the co-located Urgent Treatment Centre.	- Improved access and waiting times in A&E. - A&E used for the right purposes.
<u>Underpinned by</u> NHS 111 and Clinical Assessment triage Improved patient record sharing. NHS 111 Directory of Services		

Our Key Messages about UTCs

We will ensure our communications address the following questions:

- What is an Urgent Treatment Centre?
- Who is leading on the development?
- Why are we making these changes?
- When will the changes happen?
- How will it change access to urgent care services?

We will explain to people that:

- We asked local people about their priorities for urgent care in 2016 and much of that feedback informs our approach; (you said/we did).
- Our walk-in services are moving location to ensure improved access to clinicians, diagnostics and treatments and a fully integrated urgent and emergency care service.
- There will be a walk in facility at our planned urgent treatment centres.
- There will be more access to GPs out of usual business hours.
- There will be telephone and online services as well as face to face appointments.
- We are redesigning our services in line with the national requirements for Urgent Care.

- Our model is part of the approach across the Sussex and East Surrey Sustainability and Transformation Partnership (STP).
- Our new model will enable patients to experience one integrated, seamless service.
- We need to ensure our services are affordable in the context of financial and system pressures.

Who do we need to engage with?

Our detailed work in relation to the development of UTCs includes stakeholder mapping and equality analysis.

This has told us that we need to consider the following……

- We need to engage staff in supporting local people in making changes to the way services will be accessed, with the aim of ensuring staff continue to move away from historic patterns of advice that may mean patients are encouraged to use A&E when other more appropriate alternatives are available.;
- We need to have clear messages about access to GPs in hours because we receive regular feedback about difficulties getting appointments;
- We need to consider the existing patient lists at the walk in centres and how best to communicate and engage with them;
- We need to consider public transport in relation to the change in location of our walk in facilities;
- We need to consider the key protected characteristic groups who may be affected by our proposal, including: disabled people, insecurely housed and/or homeless people, younger people, those not registered with a GP, those with English as an additional language, those with substance misuse issues and people with learning disabilities.
- We will also consider working age people who use the walk in centres outside of normal GP hours.[5]

Our engagement so far

We have carried out significant engagement about what matters to people when they need out of hours appointments, same-day health or social care advice, care and treatment. As part of creating this plan we have mapped this feedback to ensure we are responding to the priorities of local people.

Table B – Our previous and planned engagement

Engagement so far	Priority future engagement
• ESBT Alliance Urgent care consultation August – November 2016 • Healthwatch East Sussex Hastings Listening Tour	• People with no fixed abode/homeless people • Working age populations and commuters

[5] We identified the groups with protected characteristics who are most likely to be affected, through our Equalities Screening that we have conducted as part of the Urgent Care Transformation Programme

• Shaping Health and Care conversations about our NHS 111 re-procurement • GP Extended Access Survey January 2018 • Public Reference Forum reports 2017/2018 • Long term conditions survey • Healthwatch East Sussex Survey – The Pathway to Urgent Care – Turning Up Where The Light Is On • The Pathway to Urgent Care https://www.healthwatcheastsussex.co.uk/wp-content/uploads/2015/01/AE-Path-to-Urgent-Care-Report.pdf	• People with severe mental health problems and/or those with alcohol and/or drug misuse problems • People for whom English is not their first language • Disabled people • Young people • Parents of younger children, as well as disabled children and/or those with long term health conditions • Carers • Rural communities • People and families living in lower socio-economic areas • People who are Deaf, Blind or who have other sensory impairment

Table C – How we have responded to the views of local people so far

We have shaded the aspects that are particularly relevant to the development of UTCs in the table below.

Feedback	**How we have used this feedback to shape the new model of urgent care services**
It is important to be able to access urgent care over the phone	Our model includes 24/7 access to NHS 111 and Clinical Assessment Service. Single telephone number to access Health and Social Care Connect within East Sussex Access to clinical advice through a single point of access Secamb admission avoidance pathway integrated with HSCC during opening hours and diverted to Onecall overnight.
Access to services in the evening or at the weekends is important	Our model includes an increase in the amount of GP appointments and the new service will give patients the ability to pre-book appointments after 6.30pm and on Saturdays and Sundays where appropriate. Crisis response team to provide up to 72 hours emergency support as an alternative to A&E and emergency admission. We have consulted local people about their preferences for evening and weekend access and they have told us that their preference is for Saturday afternoon appointments so this will be used to build our extended services.

The ability to find advice when you need it	Our model offers telephone and online advice 24/7. Access to self- care advice. Clinicians will have a robust accurate directory of services which will enable them to refer patients to the appropriate local service. Developing additional service profiling for community services.
It is particularly important to be able to access a same-day appointment or an appointment within 48 hours	Our model enables local people to access same day appointments where this is appropriate. This will include the ability to access pre-bookable appointments at our new Urgent Treatment Centres and access to triage within 15 minutes of accessing the service and an appointment within two hours.
It is important to have the right information about urgent services and to have confidence these services offer quality advice. People need to understand the difference between urgent and emergency care.	We will produce clear information about our services which will include simple visuals and leaflets. We will ensure our websites also provide clear information with 'click through' links to signpost people to the right service for their needs. We will use social media to share important information and utilise local media where helpful. We will ensure our communications meet the requirements of the Accessible Information Standard.
The role of digital technology is important	NHS 111 is developing access to NHS Online as an alternative access channel to urgent care triage and advice NHS 111 and Clinical Assessment service will support the developing ESBT Integrated Digital Care Record to enable efficient patient record sharing. ESBT are currently supporting practices to utilise alternative methods of consultation where appropriate e.g. remote consultations, on-line advice and guidance, skype.
Mixed views on the importance of seeing your usual GP, or a GP in your practice, or the option to use a video call	Access to a clinician and appointment on the same day was important to ESBT patients and we have designed a system that will support that. We will provide a variety of ways to access GP appointments both inside and outside of normal hours through primary care extended hours access. This will provide an additional 95 hours of appointments across both CCGs through GP practices and primary care access hubs. There will be 40,000 extra appointments, 20% of which will be bookable via NHS 111.
The importance of GP appointments generally was prominent but people also discussed the value of other professionals in providing support as part of urgent care network of support services (e.g. pharmacists)	Our ESBT Alliance has been developing local GP services by enabling access to other healthcare professionals in practice settings; for example Advanced Nurse Practitioners, prescribing Pharmacists and Paramedics. Our Urgent Care model will include an improved urgent care offer in our local pharmacies directing patients from NHS 111 to community pharmacies for their advance medication supplies.

There should be better access to patient records both for patients and professionals and these should be shared between services	ESBT Urgent Care and Digital teams are developing shared patient records through the Integrated Digital Care Record. Digital solutions will be aligned – I.e. booking appointments, patient information, Directory of Services (DoS) profiles and Post Event Messages (PEMs)
The importance of self-care and proactive prevention was highlighted (for example access to non-medical support from community or voluntary organisations and) and education so local people understood the services available that can best support them.	Our ESBT Alliance has been investing in social prescribing as a way of supporting local people to access non-medical services in the community. ESBT has commissioned social prescribing services across both CCGs which GPs can refer to directly and signpost to community / voluntary services. Enhanced support for people with long term conditions through increased GP training.
There needs to be services for urgent mental health needs	ESBT system is working closely with colleagues across the Sussex and East Surrey STP to develop a bid to secure national transformation funding to develop 24/7 acute mental health liaison cover in our A&E departments, as set out in the national Mental Health Five Year Forward View. ESBT are working with SPFT on developing MH professional skills within HSCC – this is commissioned by West Sussex and Brighton and Hove
69% of people rated it 'important' or 'very important' to be able to walk in somewhere for an assessment without the need to book first	Our Urgent Treatment Centres will include the option for 'walk in' access.

How are we consulting on our plans for UTCs?

If the business case for UTCs is agreed by the CCG Governing Bodies at their meeting on 28th March 2018 we will undertake appropriate public consultation and welcome an opportunity to discuss the best approach to this with the Health and Overview Scrutiny Committee.

We will make general information on our plans available throughout the consultation period using available communication routes and channels including the CCGs websites, partner websites, our local community networks, GP practices etc. We will also use social media to provide information and link people with opportunities to feedback.

Specifically, we will:

- set out our proposals for improving access to and the quality of our urgent care services;
- further test out the impact of re-locating the walk in aspect of our urgent care services;
- test out our proposals for mitigating any differential impact on any patient groups;
- give the opportunity to people to provide feedback so that can we deliver the best model for local people within the resources that are available.

In addition we plan to engage specifically with communities identified through the Equality Impact Assessment as shown in the table below.

Finally, we will ensure our staff across the ESBT Alliance providing these services are involved and are able to have their say.

Table E – Our Consultation Plans

Date	Stakeholders	Activity
29th March 2018	Local people from the Black and Minority Ethnic Community	Information sharing about our plans for urgent care transformation with the Hastings Older Peoples Ethnic Group (HOPE-G)
29th March 2018	Health and Overview Scrutiny Committee – Local Councillors	Presentation of Urgent Care Business Case and our plans to communicate and engage across the Urgent Care Transformation Programme
14th April 2018	Local people and stakeholders	Rye Seniors Fair
April 2018	Patient Participation Group Area Forums for Eastbourne and Hastings	Information sharing and consultation with PPG members.
1st/8th May 2018	Key stakeholders including local people, community and voluntary sector groups and staff from across the ESBT Alliance	ESBT Alliance Shaping Health and Care Events in Eastbourne Hailsham and Seaford CCG area (taking place in Seaford) and Hastings and Rother CCG area (taking place in Battle)
May-June 2018	Local people, particularly those using the Walk In Centres and those aged 20-30.	Public Reference Forum engagement with local people in Eastbourne and Hastings Town Centres.

To be confirmed	Older people; including carers and those with long term health conditions.	Consultation via East Sussex Seniors Association, Health and Care Group
To be confirmed	Younger People	Consultation via Eastbourne and Hastings Youth Councils
To be confirmed	Homeless People	Consultation via Seaview Health Centre
To be confirmed	Parents of children aged under 5 (particularly younger parents)	Consultation via Children's Centres
To be confirmed	Parents of children with special education needs, disabilities and long term health conditions	Consultation via East Sussex Parent Carer Network
To be confirmed	Carers	Consultation via East Sussex Carers Association

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

Date of meeting: **29 March 2018**

By: **Assistant Chief Executive**

Title: **Maternity Services in East Sussex**

Purpose: **To consider the quality and performance of maternity services for East Sussex residents, including feedback from local women obtained from a survey undertaken by Eastbourne Borough Council.**

RECOMMENDATIONS

1) To consider and comment on the attached report of survey findings from Eastbourne Borough Council (appendix 1)

2) To consider and comment on the attached report on the quality of maternity services for East Sussex residents from East Sussex CCGs (appendix 2)

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1. Background

1.1. Maternity services for East Sussex residents are commissioned by the three local NHS Clinical Commissioning Groups (CCGs) and mainly provided by three NHS Trusts:

- East Sussex Healthcare NHS Trust (ESHT) – a consultant-led service at the Conquest Hospital in Hastings and a midwife-led unit (MLU) at Eastbourne District General Hospital
- Brighton and Sussex University Hospitals NHS Trust (BSUH) – consultant-led services in Brighton and Haywards Heath
- Maidstone and Tunbridge Wells NHS Trust (MTW) – consultant-led service at the Tunbridge Wells Hospital (Pembury) and MLU service in Crowborough.

1.2. All three Trusts also provide ante and post-natal care and support home births.

1.3. HOSC last formally considered maternity services in September 2016 when the committee reviewed the work undertaken by ESHT as part of the Trust's Quality Improvement Plan in response to an inspection by the Care Quality Commission. In September 2017, HOSC Members visited the Eastbourne MLU and met with ESHT's Head of Midwifery and the consultant Chair of the ESHT Maternity Board to receive an update on the ongoing development of the Trust's maternity service.

2. Supporting information

2.1. During 2017 Eastbourne Borough Council undertook a survey of women who had registered a birth in East Sussex during 2016. In its report on the survey findings the Borough Council indicated that the survey was undertaken in light of ongoing local concerns in Eastbourne following the reconfiguration of ESHT's maternity services in 2014. This reconfiguration concentrated the consultant-led service previously provided across two sites (both Eastbourne and Hastings) onto a single site (Hastings) with a MLU remaining in Eastbourne. The Borough Council indicated that it wished to undertake direct consultation with those who have experienced the changed service so as to be able to analyse the impact of the changes on service quality and patient safety.

2.2. HOSC received a request in November 2017 to consider the findings of the survey which was agreed by the committee at the last meeting on 30 November 2017. A summary report on the survey findings provided by Eastbourne Borough Council is attached at appendix 1. The full report

(including all appendices) is available on the Council's website. Representatives from the Borough Council will present the report to HOSC.

2.3. In order to gain a fuller picture of the quality and performance of maternity services for East Sussex residents HOSC also requested a report from the East Sussex CCGs which is attached at appendix 2. Representatives of the CCGs will present the report to HOSC. Representatives from ESHT will also be in attendance.

3. Conclusion and reasons for recommendations

3.1. HOSC is invited to consider and comment on both the Eastbourne Borough Council survey findings and the NHS report.

PHILIP BAKER
Assistant Chief Executive

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

Working in partnership with **Eastbourne Homes**

East Sussex Maternity Services

Research into the experience of mothers giving birth across East Sussex in 2016

Survey undertaken by Eastbourne Borough Council in partnership with and under the rules of the Office for National Statistics

Councillor Robert Smart
Lead member for conduct of survey
(and former Non-executive Director and Audit Chairman,
East Sussex Healthcare NHS Trust)

Councillor David Tutt
Leader of Eastbourne Borough Council

Peter Finnis
Eastbourne Borough Council Monitoring Officer
(Statutory Officer with responsibility of survey)

October 2017

CONTENTS

IMPORTANT NOTE - Structure of this Document:

This version of the Maternity Survey document includes the full text of the overarching report presenting the specific data arising from each of the questions asked covering the headline statistical information followed by the specific data arising from questions relating to before, during and after the birth, plus reference to additional feedback received.

The remaining elements contained in appendices to the full report are available online at the following link:

www.lewes-eastbourne.gov.uk/eastbourne-borough-council-news/review-of-east-sussex-maternity-services/

These include:

- The base information in respect of the survey covering ONS statistics,
- The questionnaire and correspondence used
- A map of the County showing the CCG areas, hospital locations and response levels from each of the CCG areas
- Full details of the raw data received from across the County and also the same data proportioned to responses from each of the CCG areas. These also contain the additional feedback comments received from respondents, again, specific to each CCG area

Background and Introduction

In 2014, the three principal East Sussex Clinical Commissioning Groups issued a consultation document entitled ‘Better Beginnings’ which, among other things, proposed options for the future of maternity services across East Sussex.

All the options presented would result in either the Eastbourne District General Hospital (“EDGH”) or Hastings Conquest Hospital (“Conquest”) losing full consultant led maternity services. This was despite the rulings in 2008 by the Secretary of State and the Independent Review Panel that EDGH should maintain full consultant led maternity services.

On behalf of the local community, Eastbourne Borough Council (“EBC”) submitted a highly detailed and evidence based response arguing the case that both hospital sites should retain these services and expressing strong concerns about patient safety.

This response was co-signed by the Leaders of both political groups on the Council, the MP, the Council’s Hospitals Champion, the President of Eastbourne Chamber of Commerce, the Chair of the Eastbourne Hospitality Association, the Chair of the 1066 Country Federation of Small Businesses, the Editor-in-Chief of the Eastbourne Herald, and the Chair of Churches Together.

Subsequently, one of the options offered for consultation that resulted in the loss of consultant led maternity services at the EDGH was chosen and implemented as the permanent configuration. This confirmed the “temporary” centralisation of consultancy led maternity services and in-patient paediatric services at Hastings which had been implemented in May 2013.

EDGH and Conquest are the two acute hospitals managed by East Sussex Healthcare NHS Trust (“ESHT”) to serve the estimated population of 525,000 in East Sussex. ESHT aspires “to provide safe, compassionate and high quality care to improve the health and well-being of the people of East Sussex.”

In conducting this survey, it is therefore necessary to look at the whole of East Sussex and to make relevant comparisons between the three principal CCG's of the levels of service provision within it.

In this context it is useful to note that over the last 7 years ESHT has reduced the number of babies it has delivered by about 1,000 whilst the number of births in East Sussex have remained about the same but with over 2,000 babies (40%) delivered outside ESHT. Within these totals, through the period of reconfiguration, the number of births per annum at EDGH has reduced dramatically (from over 2,000 to less than 300.)

Since the decision made in 2014, local concerns have remained strong. As a result, with the service arrangements having now been in place for some time

and having regard to ongoing concerns, it is prudent to undertake direct consultation with those that have experienced the changed service. This is so as to be able to analyse the impact of the changes on service quality and, above all, patient safety.

Eastbourne Borough Council has taken on this responsibility as a natural follow-up to previous input, and as the leader of the Eastbourne community, being the area most affected by changes. In undertaking this work, it is the sincere hope that relevant agencies take on board its findings in a positive way, especially where the feedback received can help guide future service provision and address any current issues that may be putting patient safety at undue risk.

Methodology

In order to ensure that this survey would carry due independent legitimacy EBC approached the Office for National Statistics ("ONS") to propose conducting it under their auspices. This was a very thorough process as the governance requirements are rigorous. The ONS were satisfied as to the reasons for the survey and the governance being proposed and agreed to provide the support necessary to enable EBC to carry out the survey.

The innovative approach has been to use the latest information available for the registration of births in East Sussex. The ONS has privileged access to these records and released the following summary information in July 2017 for the calendar year 2016. This is apparently the first time that a local government authority has used such registration records.

Extract from ONS "Live births and stillbirths by area of usual residence of mother, 2016":

	Live Births	**Stillbirths**
East Sussex	5,219	19
• Eastbourne	1,048	8
• Hastings	1,115	6
• Lewes	898	3
• Rother	751	1
• Wealden	1,407	1
England, Wales and elsewhere	696,271	3,112

The ONS agreed to identify all mothers registering a live birth in East Sussex in 2016 and to distribute EBC's questionnaire to them. The ONS distributed the questionnaires to remove the need for EBC to receive contact details for the women identified and protect their confidentiality. The ONS eliminated a small

number (largely those duplicated through multiple births) and the first mailing was made to 5,131 mothers registering a usual address in East Sussex.

A second mailing to 3,944 mothers who had not replied was made some 4 weeks later.

The questionnaire was reviewed and approved by the ONS and each questionnaire contains a unique reference number ("URN") which protects the anonymity of the respondent but allows the reply to be attributed to a specific postcode district.

EBC produced all the paperwork, having allocated URN's to postcode districts, for the ONS to mail out. Mailings included a pre-addressed Freepost envelope within which the completed questionnaires were returned to EBC and held securely under the supervision of the Monitoring Officer. The ONS had no involvement in that stage and subsequent stages of the project. The data from the questionnaires was then transcribed onto a bespoke computer application from which it can be interrogated in a variety of ways to present the survey outcomes set out in this report. Indeed further interrogation of the information would be possible by relevant parties.

Since data received from each respondent is stored by postcode district, it is possible to analyse the data by CCG areas, whose boundaries are not coterminous with local authority boundaries used by the ONS, hence the very small number of East Sussex residents in the BH and HMS CCG's with responses.

Although stillbirths were not covered by this survey it should be recognised that the 2016 statistics above (8/1048) show Eastbourne as an outlier with a significantly higher incidence than within East Sussex or nationally. The trend since 2013 has been upward. 15 of the 19 stillbirths for 2016 in East Sussex were registered at the Conquest. This deserves investigation by relevant agencies.

Headline Information

- There have been 1,652 replies and an additional 355 (approximately 7%) were returned undelivered presumably because the mother has since moved.

- This represents a response rate of approximately 35% if we eliminate those returned undelivered.

- 1,550 replies received before the cut-off date have been analysed as part of the survey

- The vast majority of responses were very complete with few questions skipped and a huge 69% (1069) provided additional comments which provide a rich seam of feedback.

- We have analysed the dates of birth provided by respondents and found no strong variances amongst the days of the week (although weekend births are slightly lower) or through the months of the year, which now range from 10 to 21 months ago**.**

- The gender of children born to our respondents were 51% male/ 49% female and the 32 multiple births reported (over 2%) is a rather higher percentage than the1.5% in East Sussex overall for 2016**.**

- Our respondents reported that the birth was their first/second/third/other in proportions 44%/38%/13%/5%**.**

- Based on postcode districts the replies have been analysed between the 3 major CCG areas and 2 smaller ones (A map showing the CCG areas with hospitals/birthing centres is attached to the full document as an appendix). This will allow the CCG's to review information directly relevant to them and allows the reader to make comparisons between them.

- The response rate has been excellent from all CCG areas within East Sussex with similarly high response rates from the EHS CCG and HWLH areas, and slightly lower for the others, particularly HR.

- Before reporting separately on specific questions within the pre-natal, birth and post-natal sections, it is instructive to group together the overall satisfaction levels for these three distinct phases with the number of responses:

	Excellent	**Good**	**Poor**	**Very Poor**	**No. of Responses**
Pre-natal	40%	54%	5%	1%	1,530
Birth	62%	32%	4%	2%	1,509
Post-natal	36%	47%	12%	5%	1,485

- Without making any judgement on these absolute satisfaction levels it is very clear that there is considerably more dis-satisfaction with postnatal care. This is strongly supported by the large number of additional comments which generally appear to provide more adverse feedback than these percentages suggest.

- Similarly it is instructive to group together the two questions asked about mothers' wishes to give birth at a location with doctors on site. The first asked “Did you wish (before the birth)...”, the second “Would you wish (if having another child).. to give birth at a location with doctors on site”

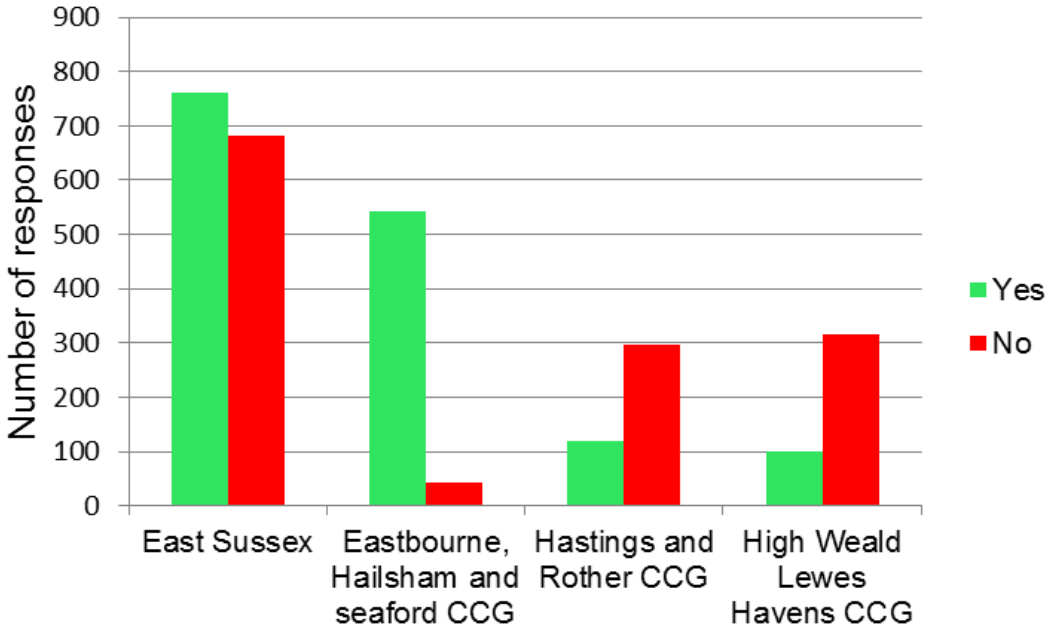
	Yes	**No**	**No. of Responses**
Before the birth	73%	27%	1,527
For another birth	78%	22%	1,522

- This is a very strong response and it is of note that the wish to give birth with doctors on-site actually increases after the birth experience. This percentage is close to that contained in the national survey conducted by the Women’s Institute in conjunction with the National Childbirth Trust which reported that 82% of women wished to give birth with doctors on-site, including both alongside Midwife Led Units and Consultant Led Units (“support overdue WI/NCT May 2013”).

- Finally we come to the only question that specifically refers to EDGH:

“If you were to have another child, would you choose to give birth at Eastbourne District General Hospital if a full obstetric service were available.”

A total of 1445 responses were received to this question



- The large number (542) of respondents from Eastbourne, Hailsham and Seaford CCG area who answered yes to this question is overwhelming. It is notable that a high number (220) of respondents from other CCG areas who expressed the same preference.

- The wishes of mothers served by the Eastbourne, Hailsham and Seaford CCG appear to be abundantly clear but there is also considerable potential for demand from the other 2 CCG's.

- 93% of them would choose to give birth at Eastbourne DGH if a full obstetric service were available.

- A simple extrapolation of the 762 on the total annual births for East Sussex (5,219) gives a potential demand of 2752 births annually at EDGH. Weighting it for the response rate by CCG gives a total demand of over 2,500.

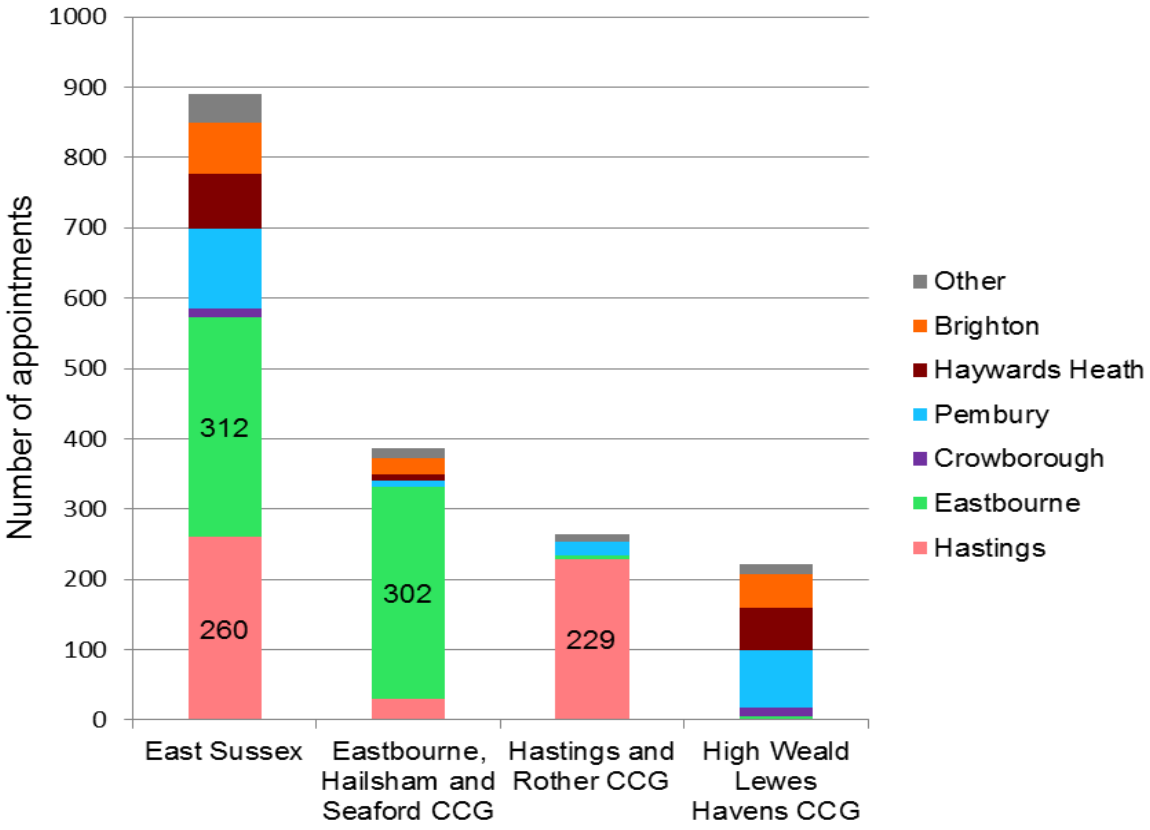
During Pregnancy

Question:

“Did you have an appointment with a consultant before birth? If yes, where was it?”

- 954 out of 1537 respondents answered yes to this question (62%), 890 of these went on to indicate where:

Response:



Comments:

- This is very significant with a higher number of such appointments in Eastbourne compared to Hastings where consultants are based. It further demonstrates the strong demand for services in Eastbourne.

- Of the 312 mothers having an appointment with a consultant before birth in Eastbourne only 47 (15%) then went on to give birth in Eastbourne.

During birth

Question:

“Where was the child born?”

- 1545 respondents answered this question.

Response:

Comments:

- Almost all of our respondents answered this question. The great change from the previous graph is the dramatic shift of location from Eastbourne to Hastings.

- The small number of respondents giving birth at Eastbourne (just 115) is remarkably low and is consistent with the trend as shown in **Appendix A**.

- These numbers include both those respondents who did and those who did not see a consultant during pregnancy, and therefore would be expected to be lower risk and more likely to give birth at Eastbourne with no consultant presence on delivery.

- For HWLH there is a large discrepancy between the very low 2% of actual births through ESHT in total (only 6 at the Conquest and 2 at the EDGH) and the 24% (100 respondents) who "would wish to give birth at EDGH if a full obstetric service was available (see page 9).

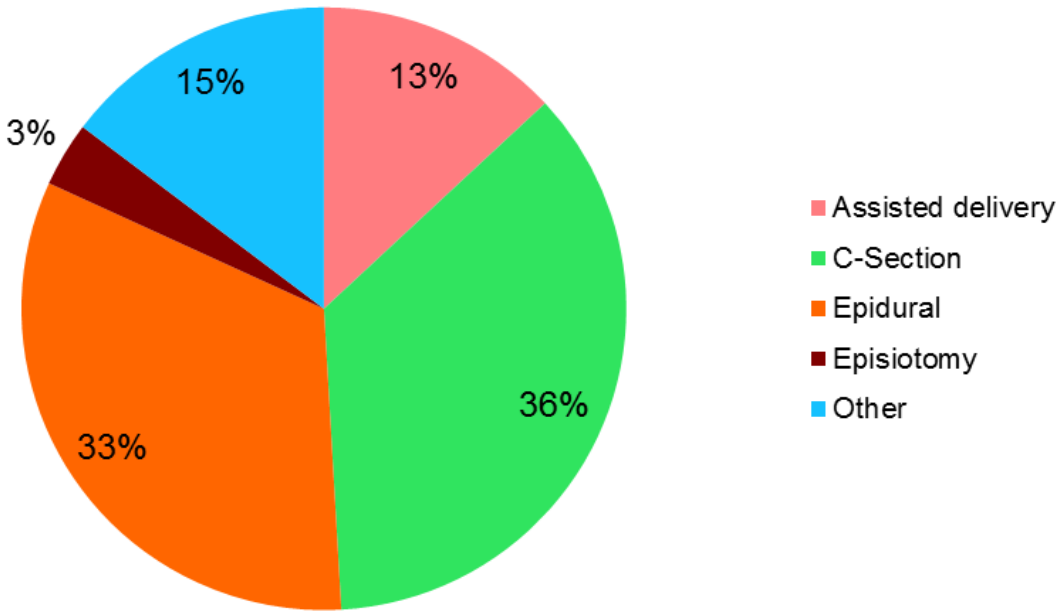
- It should be noted that "other" locations for birth includes 2 respondents who gave birth in a vehicle (and a 3rd in the questionnaires not analysed.)

Question:

"Did you require a doctor's intervention during labour?"

Of the 1523 respondents who answered this question, 51% said "yes" and 49% "no". Of those that answered "yes" the various interventions are described by the following pie-chart:

Response:



NOTE: There is a full analysis of responses included in the "assisted delivery" and "other" categories in the above chart on pages 37 to 41.

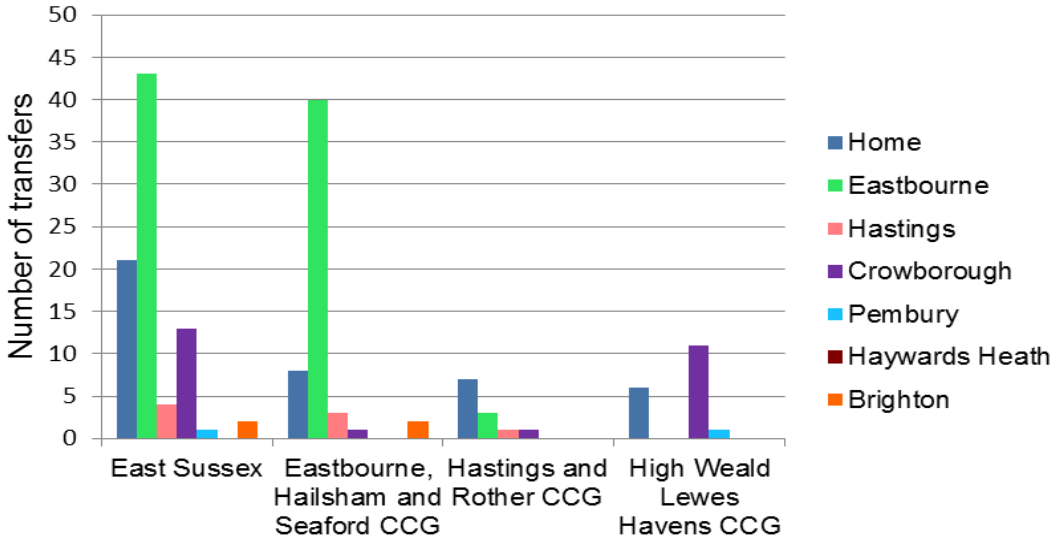
Question:

"If you were transferred during labour from where to where?"

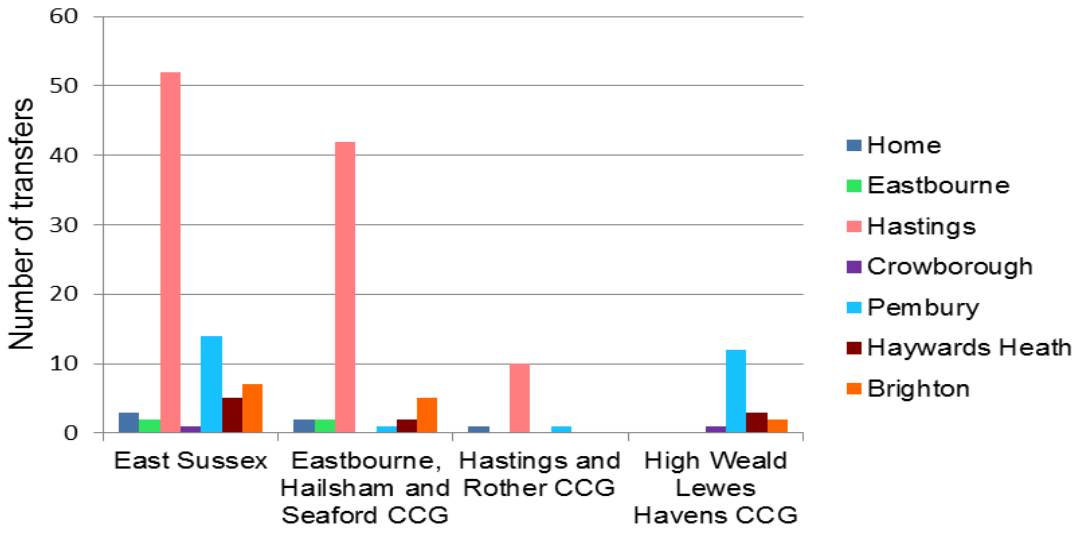
- 90 respondents reported that they were transferred during labour.

Response:

Transfers during labour from:



Transfers during labour to:



Comments:

- Compared to the other CCG's, EHS has a very significantly greater number of transfers during labour. By far the largest number of such transfers was from Eastbourne (43) and adding to the number of respondents who gave birth at EDGH (115) it means that of those mothers who started labour at EDGH, 27% were transferred during labour.

- The comparable percentage for home births is 23% and for Crowborough, 18%.

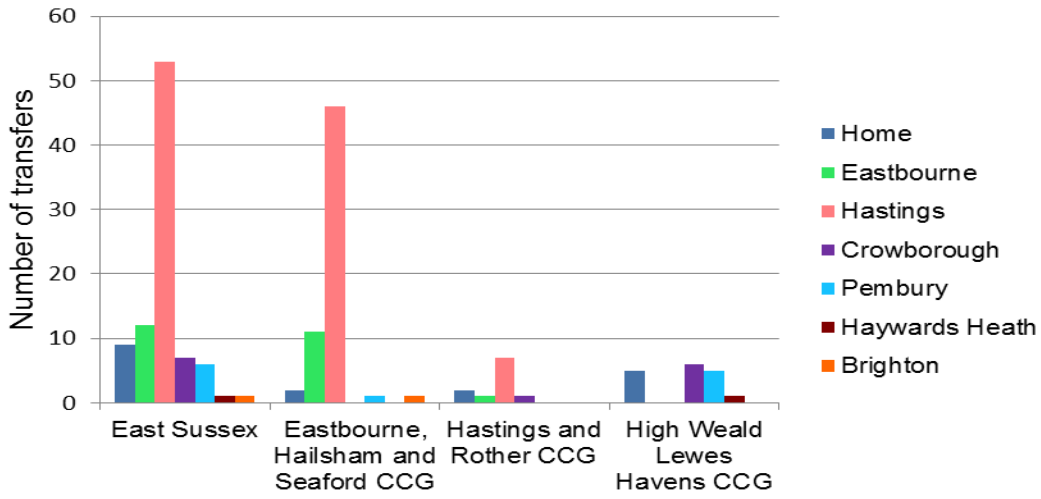
After the birth

Question:

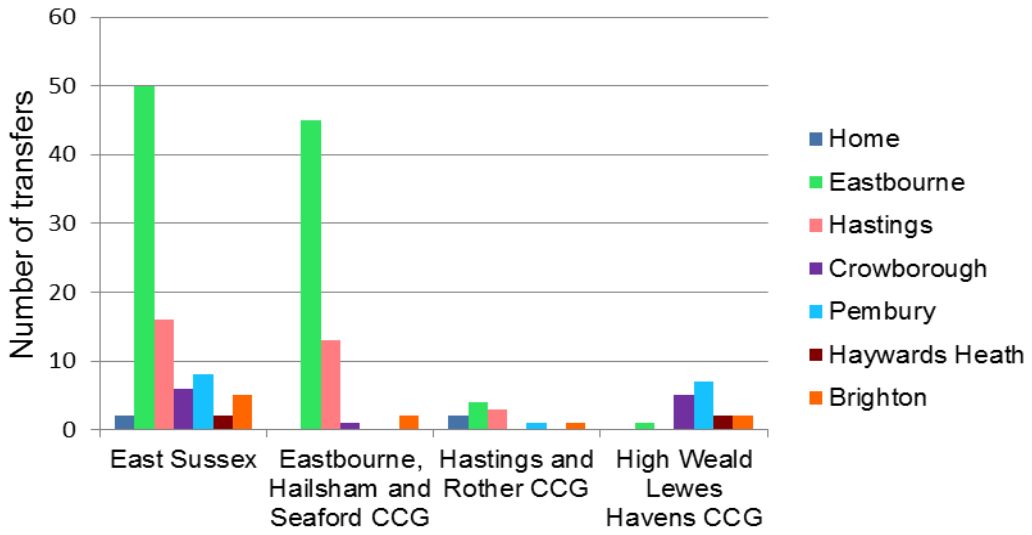
“If you were transferred after the birth to another location please indicate from where to where : “

Response:

Transfers after the birth from:



Transfers after the birth to:



Comments:

- These movements after the birth are remarkably similar to the movements during labour in that the largest movement by far is from Hastings to Eastbourne. However there are also movements to a more acute setting following birth with total transfers between Hastings and Eastbourne and the reverse adding up to 60 transfers out of the total of 89.

- In this respect it can clearly be seen that mothers served by EHS are very significantly more likely to be transferred after birth than mothers served by the other CCGs.

Additional feedback received

Question:

“Are there any comments you would like to make about the maternity services offered to you?”

- Comments have been received from 1,069 respondents out of the 1,550 analysed (69%) Many of the comments are both positive and negative and so are difficult to categorize.

Response:

All of the free flow feedback comments received as part of this survey have been set out in full and organised into the CCG areas from where they originated in appendices to the full report.

In the spirit of making the fullest possible customer feedback information available to interested parties, we would invite and encourage the CCG’s and others to analyse these comments as much valuable first-hand user experience is contained here.

Report: Quality of maternity services for East Sussex residents

To: East Sussex Health Overview and Scrutiny Committee

From: Allison Cannon, Chief Nurse, Sussex CCGs

Date: 19 March 2018

1. Executive Summary

1.1 The purpose of this briefing is to provide information to the East Sussex Health and Overview Scrutiny Committee (HOSC) about the quality and safety of the maternity services commissioned on behalf of East Sussex residents.

1.2 The predominant focus of this report is East Sussex Healthcare NHS Trust (ESHT) due to the number of residents within the county who give birth there, and the interest in these services expressed by HOSC members.

1.3 Where the available data allows this paper will draw upon comparable information from Brighton and Sussex University Hospitals NHS Trust (BSUH) and Maidstone and Tunbridge Wells NHS Trust (MTW) where a proportion of East Sussex residents choose to receive their maternity care.

1.4 This report provides key data relating to the quality and safety of services based upon a range of supporting themes:

- Summary of ESHT maternity service sustained improvement since the temporary reconfiguration in May 2013, that was subsequently made substantive following public consultation;
- Key Quality and Safety indicators; and,
- Women's experience of maternity services.

1.5 Analysis of the information in this report indicates that the quality and safety of ESHT's maternity services have improved following the "Better Beginnings" service reconfiguration of 2013/14. An ESHT maternity action plan remains in place which is monitored on a regular basis by both the Trust and the CCGs to continue to review and improve services in line with best practice.

1.6 The configuration of provider maternity services which East Sussex residents are most likely to access is as follows:

- ESHT hosts a single sited consultant led maternity service at the Conquest Hospital at Hastings with a Midwifery Led Unit (MLU) hosted at the Eastbourne District General Hospital (EDGH);
- Brighton and Sussex University Hospitals NHS Trust (BSUH) provides a Consultant led service at both the Royal Sussex County Hospital (RSCH) in Brighton and the Princess Royal Hospital (PRH) in Hayward's Heath. BSUH does not have a Midwifery Led Unit (MLU); ,
- BSUH is a tertiary centre for neo-natal and paediatric care within East and West Sussex; and,

- MTW hosts a Consultant led service at both Tunbridge Wells Hospital in Pembury and two MLUs at the Maidstone Birthing Centre (MBC) and the Crowborough Birthing Centre (CBC). [1]

1.7 A glossary of terms used in this report can be found under Annex one.

2. Sustained improvements in ESHT maternity service since the reconfiguration to a single obstetric-led service and MLU

2.1 Based upon the 2017/18 year to date information available for review, the following areas have been identified as improvements:

- Sustained reduction of overall number of serious incidents reported
- Sustained reduction in the number of serious incidents where workforce is a contributing factor;
- Overall reduction in reported trust level Babies Born before Arrival (BBA) events over consecutive years;
- Improved Consultant presence (72 hour standard) on obstetric wards maintained;
- A position for a visiting Oncologist has been met;
- Improved levels of workforce regarding substantive middle grade clinical and midwifery staff, with no over reliance upon locum midwives;
- Midwifery mandatory training compliance at 90%+;
- Midwife to birth ratio 1:28 (compared with our locally agreed indicator of 1:30, and a ratio of 1:29 or lower that Birthrate plus recommends);
- Favourable patient feedback in relation to the CQC (Care Quality Commission) maternity survey (2017);
- Improved performance within the following areas:
    - Reduction in % of reported 3rd and 4th degree tears;
    - Reduction in reported occurrences of shoulder dystocia;
    - Increased in % of Initiation of Breast feeding;
    - Continued standard of no reported cases of eclampsia;
    - Reduction in occurrences of post-partum hysterectomies;
    - Reduction in % of numbers of women who were declared to be smokers at the time of booking; and,
    - Reduction in % of the numbers women who were declared to be smokers at the time of delivery.

2.2 Areas of ongoing review for the trust include:

- Ensuring that midwifery levels are maintained;
- Ensuring that the improvements in the spontaneous vaginal delivery rate is improved via the “Normalising Birth” programme;
- Continuing with the overall improvement regarding planned Lower Segment C-Section (LSCS) and Emergency LSCS;
- Improving Cardiotachographic (CTG) interpretation; and,
- Avoidable unexpected admissions of term babies to the Special Care Baby Unit (SCBU) at the Conquest Hospital.

[1] **Please note:** The CBC was transferred to MTW from ESHT in 2016.

3. Key maternity Quality and Safety indicators

3.1 This section provides performance across a range of quality and safety indicators and is included for all three providers where this information is available. It should be noted that not all data periods are the same as data and have been used to provide a helpful overview of the indicator.

3.2 Number of Births by site (April 2015 – January 2018)

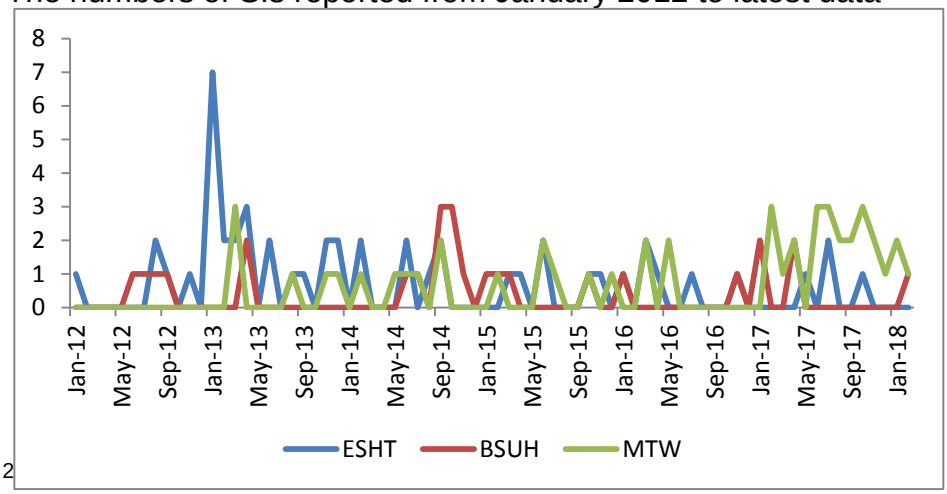
The birth rates by financial year for ESHT, BSUH and MTW are indicated below (the dates have been chosen to take into account two clear years of data and give an overview of numbers across the sites):

Trust	2015/16	2016/17	2017/18 (YTD)
Conquest Hospital	2894	2874	2619
Eastbourne Midwifery Unit	287	302	285
Royal Sussex County Hospital	3300	3235	2649
Princess Royal Hospital	2482	2350	1855
Tunbridge Wells Hospital	5742	5977	5036
Crowborough Birthing Centre	175	160	132
Maidstone Birthing Centre	429	492	404

3.2 Serious Incidents

3.2.1 The graph below indicates the number of serious incidents (SIs) reported by ESHT, BSUH and MTW from January 2012 to latest data available at the time

of writing. The numbers of SIs reported from January 2012 to latest data equate to:[2]



The key trends that have been identified by trust include:

3.2.2 ESHT

The HOSC has previously been updated around SI themes up until May 2013 which included:

- a lack of consultant presence across two obstetric led maternity sites prior to reconfiguration,
- poor middle grade doctor clinical decision making
- overreliance upon locum midwifery and middle grade clinical staff which on occasion saw shifts not filled due to same day cancellation;
- long term obstetric consultant vacancies; and,
- poor interpretation of Cardiotachographic (CTG) results.

The themes relating to ESHT maternity related serious incidents since the reorganisation of ESHT services now relate mainly to CTG issues and failure to follow trust policies and protocols. The following improvements should be noted:

- Following reconfiguration there has been no key trends identified relating to medical and midwifery staffing levels;
- The few serious incidents that are reported relate predominately to the interpretation of CTGs and a programme of training and education is underway.
- The Trust has not reported any “Never Events” in relation to maternity services during the period under review;
- No Serious Incidents have been declared as a result of a transfer from the EDGH MLU to the Conquest Hospital; and,
- There have been no maternal deaths reported by the Trust since the reconfiguration of 07 May 2013.

[2] This data is based upon national Strategic Executive Information System (STIES) data downloaded on 06 March 2018 and does not reflect any previously reported serious incident that has subsequently been downgraded. The MTW data has been taken from their internal midwifery dashboard as well as STIES to ensure that those events that take place at Maidstone District General Hospital (MDGH) are captured. The MTW data prior to April 2017 refers to Tunbridge Wells Hospital

3.2.3 BSUH

Key themes relate to:

- poor interpretation of Cardiotachographic (CTG) results; and,
- the management of high risk pregnancies/labours, and maternal health are the most common features of these incidents;
- The trust has reported one maternity related “Never Event” since January 2012 regarding a retained swab during November 2017.

3.2.4 MTW

The trust has informed commissioners that no specific themes or trends have been identified in relation to the serious incidents reported during the timeframe under review.

The trust is reporting an increase in serious incidents and this is being reviewed by NHS West Kent CCG who is the lead commissioner for the organisation.

3.3 NHS England (South Region) Maternity Serious Incidents (2016/17)

NHS England has undertaken an analysis of all reported maternity related Serious Incidents during 2016/17. This review has concluded that ESHT, BSUH and MTW are not outliers for maternity related serious incidents when compared with peer organisations.

The supporting details can be found under Annex two however the performance of the three trusts under review can be seen in the table below against the highest and lowest performing acute organisations in our region during the 2016/17 year.

3.3.1 SI per 1,000 births 2016/17 (NHS England South East sub region)

Trust	Number of births	Number of reported SIs	SI per 1,000 births
Ashford and St Peters NHS Foundation Trust (Worst)	4, 044	18	4.45
Western Sussex Hospitals NHS Foundation Trust (Best)	5,243	3	0.57
MTW	5,742	6	1.04
ESHT	3176	3	0.85
BSUH	5,856	4	0.68

3.4 Still births[3]

3.4.1 The Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) Perinatal Mortality Surveillance Report published in June 2017 indicated that stillbirth rates within the Sussex and East Surrey footprint area are at or below UK average figures.[4]

MBRRACE – UK (Jan – Dec 2015)	Births	Stillbirth rate per 1,000 births
Total UK	782,720	3.87
England	667,398	3.93
Sussex & East Surrey STP	19,358	3.86
BSUH	5,678	4.28
MTW	5, 700	3.96
ESHT	3,180	3.45

Commissioners and trusts use MBRRACE-UK for benchmarking purpose rather than Office of National Statistics (ONS) data to ensure a standardised approach is adopted as this is the recommended data source as recommended by the NHS England Improvement and Assessment Framework.[5]

The key points to note by trust can be found below:

3.4.2 ESHT

The trust has undertaken a review of stillbirth rates between 2015 and 2017:

- The overall ESHT figure for 2016 was 3.52 per 1,000 births, and within this, for women from Eastbourne the figure was 4.08;

[3] A Stillbirth has been defined as a delivery that occurred at 24 weeks and above.
[4] https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK-PMS-Report-2015%20FINAL%20FULL%20REPORT.pdf
[5] https://www.england.nhs.uk/wp-content/uploads/2017/11/ccg-improvement-and-assessment-framework-2017-18.pdf and https://www.england.nhs.uk/wp-content/uploads/2017/11/ccg-technical-annex-2017-18-v1-1.pdf

- An overall reduction in the Eastbourne women stillbirth rates from 4.08 per 1,000 in 2016 to 2.96 per 1,000 in 2017 has been identified;

- The overall ESHT figure is now below the national average of 3.19 per 1,000 births and there is evidence to suggest that the 2016 Eastbourne figure is part of a longer term trend;

- Every stillbirth is reviewed and discussed in depth at daily risk meetings and again at a Weekly Patient Safety Summit (WPSS) if classified as an amber rated incident;[6]

- ESHT have confirmed that all serious incidents will be forwarded to the new Health and Safety Executive Health Investigation Branch (HSIB) in line with national guidance.[7] This independent body will review all still births to ensure lessons are learnt and improvement requirements embedded in practice; and,

- A list of current and planned improvement actions in relation to stillbirths can be found under Annex three.

3.4.3 BSUH

Key points to note include:

- Most recent national data from 2014 shows crude, stabilised and adjusted stillbirth, neonatal, and extended perinatal mortality rates were below the national average; and,

- The CCG undertook a deep dive following a number of intrapartum stillbirths between November 2016 and April 2017, with no further cases in 2017. There were no common themes and actions have been taken to mitigate risk following individual cases.

3.4.4 MTW

Key points to note include:

- The trust has reported that all stillbirths since April 2015 have occurred at the obstetric led maternity unit at TWH and none have been reported at either the CBC or MBC;

- The organisation has undertaken a review of the events and concluded that the majority of them do not have an identifiable root cause. Of those that do have an identified cause, foetal growth restriction, foetal anomalies, complications of multiple pregnancy are most common; and,

[6] An AMBER incident within ESHT is an enhanced level for those patient safety incidents which do not meet the Serious Incident criteria however require review to protect patients from similar occurrences.

[7] From April 2018 every stillbirth, early neonatal death and severe brain injury cases each year will be referred to the HSIB

- The trust has noted that the Stillbirth rate is reducing overall with a rate per 1,000 births of 3.86, 3.79 and 3.08 from April 2015 to January 2018.

3.5 Babies Born Before Arrival (BBA)[8]

3.5.1 There is no nationally agreed definition for a baby born before arrival. For the purpose of this report the BBA definition refers to those babies born before the arrival of a midwife; as a result, even if a paramedic is in attendance it will still be a BBA. It should be noted this can give rise to slightly different figures being reported. [9]

Following a BBA the mother and baby are reviewed by a Community Midwife. If clinically indicated both mother and baby will be transferred to the most appropriate maternity unit otherwise they remain at home.

The key headlines in relation to ESHT BBAs are:

- No adverse outcomes for mothers or babies have been reported in relation to BBAs (some babies will have been transferred into maternity units for observation checks or "warming up" in line with standard practice);

- The two key themes in relation to BBAs occurring include births taking place quicker than expected and expectant mothers not seeking advice from a midwife as early as might be recommended;

- Following review the Trust has not identified proximity to a birthing unit as a significant factor in reported BBAs taking place;

- No serious incident has been declared as a result of a BBA event following the reconfiguration of ESHT maternity services; and,

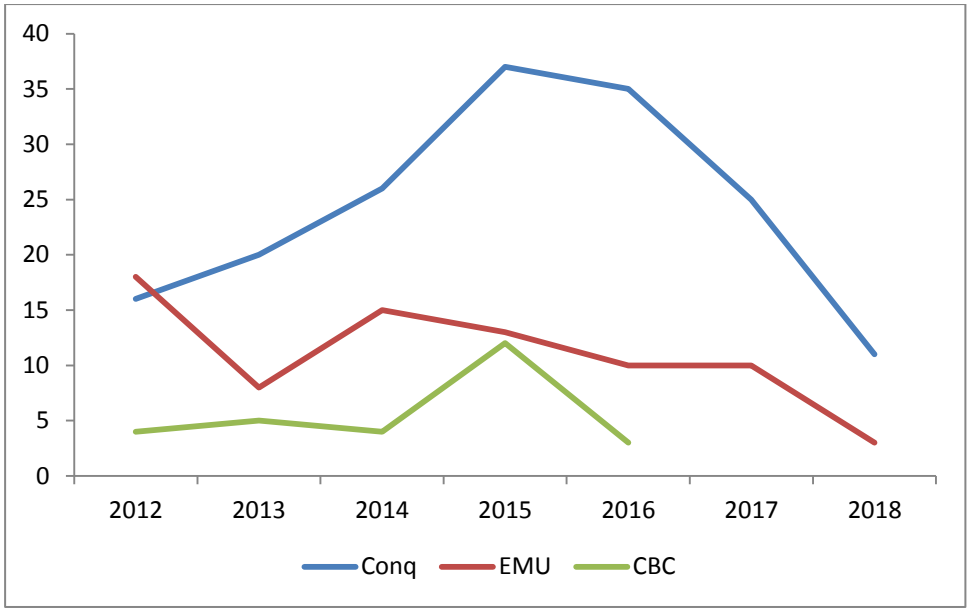
Neither BSUH nor MTW has declared a Serious Incident as a result of a BBA event occurring during the time frame reviewed:[10]

The graph below indicates the breakdown of BBAs occurring at both the EMU and Conquest sites from January 2012 to January 2018 by number, with CBC included for the period where the service there was delivered by ESHT:

[8] The agreed definition between ESHT and Commissioners of a BBA event is a birthing episode where a midwife was unable to attend. To address this the Trust has taken action to ensure that BBAs are reported in a consistent manner with sub categories of birth (for example, Born in transit in a car and Born in transit in an Ambulance), together with a conclusion as to whether the BBA was either "avoidable" or "unavoidable". This was fully implemented from 01 April 2015.

[9] The BBA figures are based upon the site where mothers were booked to give birth.

[10] Please note: MTW have reported their figures as per financial year rather than calendar months.

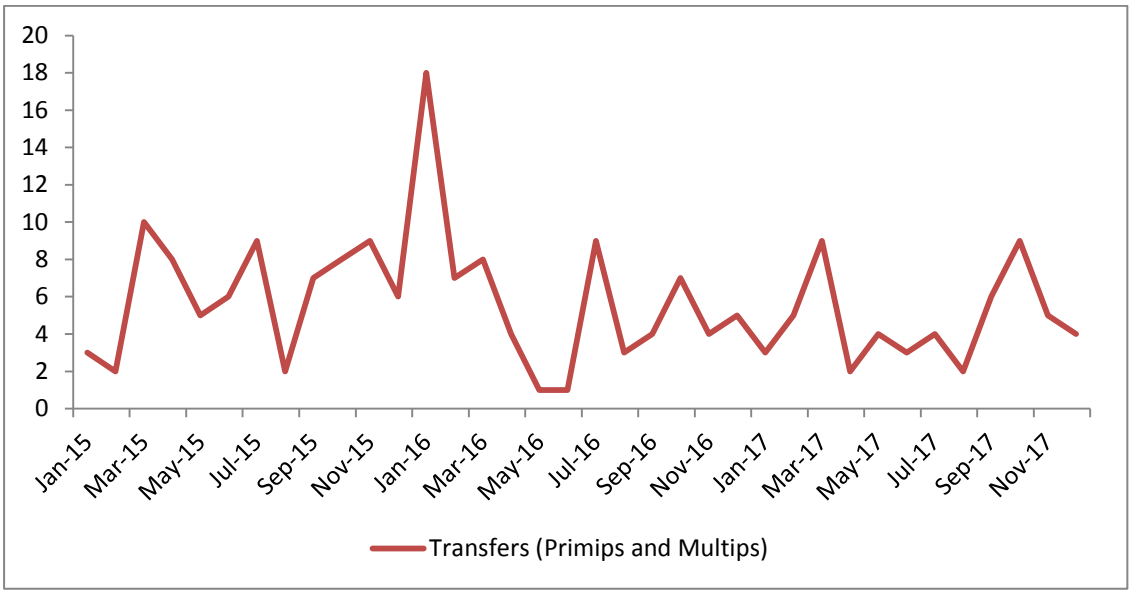


The trends in relation to ESHT remain the same as previously reported to the HOSC with the majority of BBA events taking place within the Hastings area given the data provided by ESHT.

3.6 Transfers from Midwifery Led Units (MLU)'s

3.6.1 ESHT

The graph below indicates the number of transfers from the EMU to Conquest Hospital between January 2015 to December 2017:



Primip = first time pregnancy
Multips = second or subsequent pregnancy

The top three reasons for Primip transfers during this period include:

- Delay in first stage;
- Meconium; and,
- Analgesia.

The top three reasons for Multip transfers during this period include:

- Fetal heart changes;
- Meconium; and,
- Delay in second stage.

The trust has identified improvement work regarding the provision of analgesia and action has been taken to introduce hypnobirthing from May 2018 together with the implementation of a project focusing upon sterile water injections for back pain in labour.

The trust has recorded a combined transfer rate of 20.31%, 24.25% and 25.58% for 2015, 2016 and 2017 respectively.

3.6.2 MTW

The trust has provided transfer information for the 2015/16, 2016/17 and 2017/18 (to date) years and the transfer rates for both first time mothers and subsequent births combined were 20%, 21% and 24% respectively.

The top three causes of transfer from the MLU to an obstetric unit include:

- Delays in birth stages (particularly the first);
- Analgesia; and,
- Maternal problems.

The trust has not reported a serious incident as a result of the transfers noted above.

3.6.3 BSUH

The trust maternity services comprise two obstetric consultant led units only therefore transfers from an MLU are not applicable.

3.7 Overall Lower Segment Caesarean Sections (LSCS) Rate and Emergency LSCS Rate

3.7.1 For ESHT, both these rates remain below the national standard of 11% for elected C-Sections and slightly above the 13% standard for Emergency C-Sections as of the time of writing.

They are rising at a rate of 0.33% as opposed to 0.97% pre the May 2013 - reconfiguration therefore improvement has been taking place.

The overall 2017/18 YTD (January 2018) rate for the trust for elective C-Sections stands at 10.71% and emergency C-Sections 13.89%. The combined standard stands at 24.61% against a standard of 23%.

BSUH and MTW C- Section performance (April 2017 – January 2018) can be found below:

Trust	Total C-Section Rate (%)	Elective C-Section (%)	Emergency C-Section (%)
ESHT	24.61	10.71	13.89
BSUH	28.1	15.4	12.7
MTW	27	13	14

4. Section Four: Women's experience of maternity services

4.1 Care Quality Commission (CQC) Maternity Survey (2017) review findings

During the summer of 2017 the CQC opened a national survey for all women who gave birth during February 2017. The results of this survey were published during January 2018.

Following analysis of the CQC findings the three trusts under review all fall in the "about the same as other trust" category.[11]

ESHT is taking action to ensure that women feel that they are receiving the best possible care post birth as this is an area where improvement is required.

4.2 Friends and Family Test (FFT)

4.2.1 ESHT

The trust consistently scores above the required minimum standard in relation to FFT *(this is a simple question where people are asked if they would recommend this department or ward to their friends and family)* thresholds on a monthly basis. Comments received from the FFT and other patient feedback functions are reviewed as part of quality improvement process within the trust on a regular basis.

4.2.2 BSUH

The Trust is not an outlier in terms of national patient experience measures and very much performs in line with most other Trusts. However, response rates to FFT needs further attention given the periodic dips in response rates.

[11] The other two categories being "worse than other trusts" and "better than other trusts".

More localised information tells us that continuity of midwife, consistency of information, the triage area of care and postnatal are the most challenged. But again this is in line with national trends. There is a wealth of very positive comments received about the compassion, dedication and willingness of the midwifery workforce.

4.2.3 MTW

The trust consistently scores above the required minimum standard in relation to FFT thresholds on a monthly basis. There has been a significant increase in responses in relation to the FFT rates.

4.3 East Sussex Healthwatch and maternity engagement

4.3.1 East Sussex Healthwatch has undertaken a significant amount of engagement with residents of East Sussex during 2016 to understand the experience and feedback of those who have experienced trust maternity services.

East Sussex Healthwatch engaged with the local population for the purposes of this review in the following manner:

- published a “call for evidence” during January/February 2016;
- involved women in the planning and shaping of the review;
- engaged with women and their families using enter and view activity; and
- established a working group to evaluate the feedback received and to develop an action/learning plan.

The recommendations made by HealthWatch have been incorporated into the ESHT maternity wide improvement action plan. These included actions such as a protocol for travel between units; access to units at night; labour induction review; information available to women and their families.

4.4. ESHT Maternity Review (2016/17)

4.4.1 The trust undertook a service wide midwifery review during the 2016/17 year. The findings of this review were shared previously with both Commissioners and the HOSC during September 2016.

The trust has undertaken a significant amount of improvement work in relation to maternity services during the 2016/17 year focusing upon areas such as team working, improvement and development of services, respect and compassion and engagement and involvement.

The recommendations made following this review have been incorporated into the ESHT maternity wide improvement action plan.

5. Conclusion

Following analysis of the information provided, there has been sustained improvement in the quality and safety of maternity services within ESHT following the service reconfiguration of 2013/14.

None of our local services is an outlier regarding the number of serious incidents reported per 1,000 births, BBA events or patient feedback as per the publication of the CQC maternity survey.

Ongoing improvement work continues for all providers to ensure women experience safe and high quality maternity services wherever they choose to receive their care.

Date: 20 March 2018

Author: Adrian Leah, Quality Manager, Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG, with contributions from Sarah Blanchard-Stow, Assistant Director of Midwifery and Nursing, East Sussex Healthcare NHS Trust

Annex One: Glossary of abbreviations

Abbreviation	Meaning
BBA	Babies Born before Arrival
BSUH	Brighton and Sussex University Hospitals NHS Trust
BH	NHS Brighton and Hove CCG
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CTG	Cardiotachographic
CQRG	Clinical Quality Review Group
EDGH	Eastbourne District General Hospital
EHS	NHS Eastbourne, Hailsham and Seaford
EMLU	Eastbourne Midwifery Led Unit
ESHT	East Sussex Healthcare NHS Trust
HR	NHS Hastings and Rother
HIE	Hypoxic Ischemic Encephalopathy
HOSC	Health and Overview Scrutiny Committee
HWLH	NHS High Weald Lewes Havens
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
MLU	Midwifery Led Unit
MTW	Maidstone and Tunbridge Wells NHS Trust
NHSE	NHS England
ONS	Office of National Statistics
PRH	Princess Royal Hospital
QRM	Quality Review Meeting
RSCH	Royal Sussex County Hospital
SANDS	Stillbirth and Neo-natal Death
STP	Sustainable Transformation Plan
SI	Serious Incident
UK	United Kingdom
WTE	Whole Time Equivalent
WPSS	Weekly Patient Safety Summit

Annex Two: Serious Incidents per 1,000 births (April 2016 – March 2017)

Annex Three: ESHT Improvement actions to reduce occurrences of Stillbirths

The trust has identified the following assurance actions to ensure the occurrence of a Still Birth occurring is minimised:

- Each case of stillborn is reviewed and discussed in depth at the daily risk meetings and again at the Weekly Patient Safety Summit (WPSS) if classified as an amber rated incident. All amber incidents are thoroughly scrutinised and investigated;

- All cases of still birth are discussed with the bereavement and obstetric lead to highlight any practice issues or trends in health or clinical practice. All outcomes of investigations are recorded within the DATIX system;

- As an additional level of scrutiny the Assistant Director of Nursing and Midwifery has commissioned a further audit whereby an additional review of these cases will be reviewed to be further assured with the current processes in place and outcome measures;

- Since this data was collected in 2015 the trust has recruited to a bereavement midwifery post of 0.4WTE;[12] and,

- The bereavement midwife meets with the Still Birth and Neo-natal Death (SANDS) team six weekly to review the service and feedback any concerns raised and aim to develop a service of excellence.[13]

[12] This post oversees bereavement and provides support, guidance and training to staff to empower them to support women and their families following the bereavement of their child

[13] This team has further been shortlisted for the Royal College of Midwifery (RCM) awards as a recognition for their commitment to shared learning and service provision.

Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date of meeting:	**29 March 2018**
By:	**Assistant Chief Executive**
Title:	**Kent and Medway Review of Stroke Services**
Purpose:	**To update HOSC on the Review of Stroke Services in Kent and Medway and establishment of a joint HOSC.**

RECOMMENDATIONS

1) To confirm that the proposed reconfiguration of stroke services in Kent and Medway constitutes a 'substantial development or variation' to services for East Sussex residents requiring formal consultation with HOSC;

2) To note that a Joint HOSC has been established to respond to the NHS consultation; and

3) To agree that the nominated HOSC Members undertake local evidence gathering as required to inform the East Sussex contribution to the JHOSC process.

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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 Clinical Commissioning Groups (CCGs) in Kent and Medway, through the area's Sustainability and Transformation Partnership (STP), have reviewed these services and begun a public consultation on proposals to centralise stroke services at three Hyper Acute Stroke Units (HASUs). The proposals for reconfiguration were presented to HOSC in November 2017, but the specific options for the location of HASUs were not available at that time.

1.3 The four HOSCs covering the affected areas have indicated that the proposals constitute a substantial variation to services and have established a Joint HOSC to formally respond to the NHS on the proposals.

2. Supporting information

2.1. The NHS proposal is to move away from the seven acute hospitals in Kent and Medway all providing acute stroke services to three hospitals providing hyper acute stroke units (HASUs), co-located with acute stroke units. This would mean that the other four hospitals would no longer provide acute stoke care.

2.2. The CCGs believe this proposed service model will improve quality of care and significantly improve patient outcomes based on evidence from HASUs established elsewhere in the country.

2.3. Five options have now been identified for the locations of the three HASUs as follows:

- **Option A** - Darent Valley Hospital, Medway Maritime Hospital, and William Harvey Hospital.
- **Option B** - Darent Valley Hospital, Maidstone Hospital, and William Harvey Hospital.
- **Option C** - Maidstone Hospital, Medway Maritime Hospital, and William Harvey Hospital.
- **Option D** - Tunbridge Wells Hospital, Medway Maritime Hospital, and William Harvey Hospital.
- **Option E** - Darent Valley Hospital, Tunbridge Wells Hospital and William Harvey Hospital.

The CCGs have not indicated a preferred option and will not do so until all data – including the results of the public consultation – is collated and analysed.

2.4. The CCGs began their public consultation on Friday 2 February 2018. It runs for 10 weeks until 13 April 2018 and includes a number of public listening events at locations in Kent, Medway, East Sussex and the London Borough of Bexley. Further information can be found on the consultation website.

Impact on East Sussex

2.5. 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 (HWLH) CCG area, but also part of Hastings and Rother CCG area.

2.6. 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.

2.7. The shortlisted options for the reconfiguration of services all include the retention of William Harvey Hospital, and Options D and E include Tunbridge Wells Hospital as one of the three HASUs. Of the 90 East Sussex stroke patients treated in Kent in 2016/17 14 received care at the William Harvey Hospital. The vast majority (71) received care at Tunbridge Wells Hospital and were from the HWLH area (the remaining 5 patients were treated at other Kent and Medway hospitals).

2.8. Due to the significant patient flow from its area, HWLH CCG has formally joined the joint CCG committee which will ultimately make decisions on the final configuration of services.

Establishment of a Joint HOSC

2.9. 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.

2.10. At the 30 November 2017 HOSC meeting, the Committee agreed that – 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 seemed likely that any set of options could constitute a substantial change to the services currently used by the county's residents. The Committee also agreed to authorise the Chair to make arrangements with other HOSCs to establish a Joint HOSC.

2.11. The HOSCs of Kent County Council, Medway Council and the London Borough of Bexley have all resolved that the proposals constitute substantial change for their residents, requiring that a Joint HOSC be established. The four HOSCs have collectively agreed a Terms of Reference for the JHOSC - attached at appendix 1. It should be noted that the power to refer to the Secretary of State has not been delegated to the JHOSC and remains with the four individual authorities.

2.12. The CCGs presented the options and draft consultation plan to the existing Kent and Medway JHOSC on 21 January prior to beginning the public consultation on 2 February, with the Chairs of East Sussex and Bexley HOSCs attending and invited to speak. This arrangement was agreed by the Chairs in order to allow consultation to proceed whilst arrangements for the establishment of the new JHOSC, to include East Sussex and Bexley Members, were made. Cllrs Belsey and Howell have been nominated as the East Sussex HOSC representatives, with Cllr Davies as the substitute Member.

2.13. Discussions are ongoing between the Chairs and officers of the four HOSCs to agree a process for the newly formed JHOSC to respond to the NHS. The JHOSC is expected to meet to consider the outcomes of the public consultation in June and the committee may wish to consider further evidence in relation to the proposed options at or before this time. The JHOSC is then

likely to undertake further review of evidence once the CCGs have identified a preferred option in order to provide a report to the NHS before a final decision is made. Should the agreed JHOSC process provide limited scope to consider the impact of options on East Sussex residents, it is recommended that the nominated HOSC Members gather such evidence locally in an appropriate way to inform the East Sussex contribution to the JHOSC's response.

3. Conclusion and reasons for recommendations

3.1 Now that the shortlist of five options for the location of HASUs in Kent and Medway has been published, HOSC is recommended to confirm that the proposed changes to stroke services in Kent and Medway constitute a 'substantial development or variation' to services for East Sussex residents requiring formal consultation with the committee.

3.2 HOSC is also recommended to note the establishment of a JHOSC to respond to the NHS, including the terms of reference and East Sussex membership.

3.3 Finally HOSC is recommended to agree that the nominated HOSC Members undertake local evidence gathering as required to inform the East Sussex contribution to the JHOSC process.

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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Kent and Medway Stroke Review - Joint Health Overview and Scrutiny Committee (JHOSC)

(a) Terms of Reference

(1) To consider information and make comments on proposals for a substantial variation to stroke services in Kent & Medway which affect Kent, Medway, East Sussex and Bexley and which are under consideration by a relevant NHS body.

(2) To exercise the right to make comments under regulations 23(4) and 30(5) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (the 2013 Regulations) on behalf of the relevant Overview and Scrutiny Committees of Kent County Council, Medway Council, East Sussex County Council and Bexley Council on proposals relating to stroke services in Kent and Medway under consideration by a relevant NHS body.

(3) To consider whether the proposal for a substantial variation to stroke services in Kent & Medway affecting the areas covered by Kent, Medway, East Sussex and Bexley should be referred to the Secretary of State under regulation 23(9) of the 2013 Regulations and, if deemed appropriate, to recommend this course of action to the relevant Overview and Scrutiny Committees of Kent County Council, Medway Council, East Sussex County Council and Bexley Council who may each agree to make a referral in line with their respective Constitutions. (Note: the exercise of the power to make a referral to the Secretary of State has not been delegated to the JHOSC).

(b) Rules

(1) Regulation 30 of the 2013 Regulations states that where a relevant NHS body or a relevant health service provider consults more than one local authority on any proposal which they have under consideration for a substantial development of, or variation to, the provision of a health service in the local authorities' areas, those local authorities must appoint a Joint Overview and Scrutiny Committee (JHOSC) for the purposes of the review and only that Committee may make comments.

(2) There will be a Joint Health Overview and Scrutiny Committee, for the Kent & Medway Stroke Review, comprising of:

4 Members of Kent County Council
4 Members of Medway Council
2 Members of East Sussex County Council
2 Members of Bexley Council

(3) The quorum of the Kent, Medway, East Sussex and Bexley Joint Health Overview and Scrutiny Committee is 4 Members with at least one Member from each constituent Authority present.

(4) The JHOSC will appoint a Chair and Vice-Chair at its first meeting in each municipal year. (It is expected that the Chair and Vice-Chair will be appointed from among the Kent and Medway Members on an annually rotating basis). Where a review is unfinished at the end of a municipal year, the Committee may agree that the previous year's Chair (if still a member of the committee) may continue to preside over consideration of matters relating to that review.

(5) The formal response of the JHOSC will be reached as far as is reasonably practicable by consensus and decided by a majority vote. If the JHOSC cannot agree a single response to a proposal under consideration then a minority response which is supported by the largest minority, but at least two Members, may be prepared and submitted for consideration by the NHS body or a relevant health service provider with the majority response. The names of those who dissent may, at a Member's request, be recorded on the main response.

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

Date of meeting: **29 March 2018**

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-group meeting with Sussex Partnership NHS Foundation Trust; 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.

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).

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 are attached as **appendix 2.**

2.3 The HOSC work programme will be updated and published online following this meeting. A link to the work programme is available on the HOSC webpages.

3 Conclusion and reasons for recommendations

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

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

PHILIP BAKER
Assistant Chief Executive

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Work Programme for Health Overview and Scrutiny Committee

Future work at a glance

Updated: March 2018

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*
28 June 2018		
Connecting 4 You Update	A further update on the progress of Connecting 4 You programme, with a focus on urgent care	High Weald Lewes Havens CCG
Urgent Care	To consider a report on the progress of the East Sussex Better Together (ESBT) urgent care strategy with a focus on the establishment of Urgent Treatment Centres.	Mark Angus, Urgent Care System Improvement Director, ESBT
End of Life Care	A report on the progress made by East Sussex Healthcare NHS Trust (ESHT) on its End of Life Care Project that forms part of the Trust's Quality Improvement Plan (QIP).	East Sussex Healthcare NHS Trust (ESHT)
Clinically Effective Commissioning (provisional)	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. Note: Timing is provisional depending on the progress of the programme.	East Sussex CCGs
Sussex and East Surrey Sustainability and Transformation Partnership (STP) (provisional)	To consider an update on the NHS Sussex and East Surrey Sustainability and Transformation Plan (STP) and its implications for healthcare in East Sussex. Note: Timing is provisional depending on the progress of the STP.	TBC, STP

2 October 2018		
NHS 111	A report on the progress of the NHS 111 re-procurement.	Colin Simmons, 111 Programme Director (Sussex CCGs)
Kent and Medway Stroke Review (provisional)	To consider the outcome of the Kent and Medway Stroke Review in terms of the CCGs' proposed service configuration. Note: Timing is provisional depending on the NHS decision making process.	High Weald Lewes Havens CCG
30 November 2018		
Items TBC		

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 for Quarter 1, Quarter 2 and Quarter 3. Quarter 4 performance figures requested and will be circulated alongside Healthwatch report that is due for release shortly.	Most recent email circulated to HOSC members in February 2018. Quarter 4 update expected: May/June 2018
Ambulance services	Joint South East Coast area HOSC Sub-Group to scrutinise SECAmb's response to the findings of recent CQC inspections and the Trust's wider performance and improvement plan.	HOSC Chair and Vice Chair Last meeting: 19 March 2018 Next meeting: TBC – Review of Sub-Group underway
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 recent CQC inspections and the Trust's wider improvement plan	Cllrs Belsey, O'Keeffe and Howell (Sub: Cllr Murray) Last meeting: 4 October 2017 Next meeting: 4 April 2018
BSUH Stroke Services	An update on BSUH Stroke Services since the reconfiguration of the services in 2017.	Requested from HWLH CCG. Expected: March 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: 24 January 2018 Next meeting: 1 May 2018
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: 9 February 2018 Next meeting: 10 May 2018
NHS 111	An update on the progress of the NHS 111 procurement to be circulated to the Committee by email.	January 2018
Clinically Effective Commissioning	An update circulated by email including the most recent news about the agreed standardisation by the CCGs of uncontroversial policies, the cost of the CEC to the East Sussex CCGs, and more information on the Accelerated Savings programme.	January 2018

Cancer Care Performance	HOSC requested a future report on cancer care performance figures either as a committee report or by email, dependent on performance levels.	Requested November 2017. Timing TBC
Delayed Transfers of Care for NHS Reasons	Possible item for future scrutiny	Identified at HOSC awayday – February 2018
Winter Planning/A&E resilience	Possible item for future scrutiny in Autumn 2018	Identified at HOSC awayday – February 2018
Preventative aspects of East Sussex Better Together and Connecting 4 You	Possible item for future scrutiny	Identified at HOSC awayday – February 2018

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

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

24 January 2018 12pm to 2pm

Note of the meeting

In attendance

- **Sussex Partnership NHS Foundation Trust (SPFT):** Dr. Nick Lake, Senior Clinical Director; Sam Allen, Chief Executive; Simone Button, Chief Operating Officer; Dan Charlton, Director of Communications; Dominic Ford, Director of Corporate Affairs; Dr Rick Fraser, Chief Medical Officer; Diane Hull, Chief Nurse; Beth Lawton, Chief Digital & Information Officer; Andrew Vickers, Interim HR Director
- **Brighton & Hove Health and Wellbeing Overview & Scrutiny Committee:** (Scrutiny Officer)
- **East Sussex Health Overview & Scrutiny Committee:** Cllr Colin Belsey (Chair), and Harvey Winder (Scrutiny Officer)
- **West Sussex Health & Adult Social Care Select Committee:** Dr James Walsh (Vice Chairman), Helena Cox (Scrutiny Officer), and Katherine De La Mora (Democratic Services Officer)

1. Apologies for absence

1.1 Apologies for absence were received from Cllr Ken Norman, Cllr Ruth O'Keeffe, Cllr Sarah Osborne, Mr Bryan Turner and Hilary Flynn.

2. Notes of the last meeting

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

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

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

- The mental health workstream of the Sussex and East Surrey Sustainability and Transformation Partnership (STP) is a comprehensive review of the mental health system in Sussex involving engagement with all key stakeholders. The workstream has identified 12 'opportunities' to improve mental health care.
- Implementing the 12 opportunities is a key challenge. All organisations within the STP are in agreement with 4 of the opportunities – suicide prevention; clinical care intelligence and outcomes; inpatient beds management; and reducing out of area specialist placements. The leadership in East Sussex Better Together (ESBT) and Connecting 4 You (C4Y) have expressed a desire for the development of 24/7 crisis support, which is another one of the 12 opportunities.
- The review highlighted the need for investment in crisis mental health services; illustrated by the fact that mental health services users make up about 7% of the local population yet account for about 20% of all A&E and emergency attendances.

- On the other hand, there have been challenges agreeing how other opportunities might be delivered, for example, the development of a single mental health Accountable Care System. Bob Alexander, Executive Chair of the STP, has indicated he is supportive of the 12 opportunities and will be in his role full time from 1 February.
- SPFT is working with partner organisations for a commitment to delivering the 12 opportunities. This will enable the development of a delivery plan and timescales for implementation.

3.2 Members expressed concern about the lack of timelines or a delivery plan for the Mental Health Workstream.

3.3 Members RESOLVED to contact the CCGs or STP to request information on the progress of the implementation of the mental health workstream.

4. Clinical Strategy

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

- SPFT's Clinical Strategy was published in November 2017. A previous draft from April 2017 had been seen by Members of this working group but the final version had not yet been circulated. It was clarified that the final version of the Clinical Strategy contained six priorities rather than nine priorities as set out in the previous draft.
- The Clinical Strategy has been developed from the bottom up with involvement from staff, patients, carers and other stakeholders. It articulates the type and range of services SPFT will deliver going forward to improve the quality of its services whilst operating in a financially challenging climate. Its 6 key priorities to be delivered over the next four years offers a clear road map for the trust for the first time.
- The 6 key priorities are interlinked with the 12 opportunities contained in the Mental Health Workstream. They are:
    - **24/7 mental health crisis care** – this will provide better care and release money for the rest of system by reducing A&E admissions of people having a mental health crisis.
    - **Integrated physical and mental healthcare** – because mental health secondary care service users die up to 20 years earlier on average and most die of physical issues rather than mental issues, such as suicide, diagnosing and treating physical issues alongside mental health issues will help reduce this disparity in life expectancy.
    - **Continued development of Recovery and Discovery Colleges** – there is clear evidence that educating patients so that they are empowered and able to take care of their own difficulties can drastically improve their care outcomes. Furthermore, £500 spent on education yields £1,500 in savings to the wider healthcare system. Recovery colleges involve courses co-developed and led by service users and healthcare professionals, e.g., for managing symptoms, work related stress, or getting back to employment. People graduate with an educational qualification from recovery colleges and many become course leaders themselves. Discovery Colleges are for under 18s and there are two in Sussex, with plans to develop more.

    - **Suicide prevention** – there is a higher than average rate of suicide in East Sussex, and there is a need to work more closely with other organisations to tackle it.
    - **Focus on community services** – there is a need to reorient the focus of the trust around providing community services – such as health promotion and early intervention – in order to reduce reliance on secondary care.
    - **Focus on staff and teams** – there will be a focus on improving teams and encouraging joint working between them.
- 'Provide better mental health care for 14-25 year olds' was a priority in the draft Clinical Strategy but is no longer one of the six key priorities. This is because there is already a separate detailed workstream for delivering better mental health care for 14-25 year olds.

4.2 It was RESOLVED:

1) to provide a copy of the Clinical Strategy to Members

2) to provide a briefing note that clarifies the difference between the 12 opportunities of the STP Mental Health Workstream, the six priorities of the Clinical Strategy, and any other strategies under development by SPFT.

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

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

- **West Sussex –** Members were informed that the Trust was working with commissioners to look at the provision of inpatient beds across West Sussex. A Project Manager had been appointed and the West Sussex HASC would be consulted on once timelines for the project had been drafted.
- In broad teams, SPFT wants to develop proposals for two centres of excellence: one for the care of older people, including those with dementia, and one for working age adults. This would enable the Trust to eliminate patients being treated in mixed wards (as is currently in parts of West Sussex) and provide more specialist care. There is strong clinical evidence to show that specialist centres deliver better outcomes for patients and facilitate improved multi-disciplinary and multi-agency working.
- **East Sussex –** Plans had previously been agreed with the CCGs to redevelop the St Gabriel's ward at Conquest as a dementia intensive care unit. In anticipation, St. Gabriel's ward was closed in 2015 and patients moved temporarily to Beechwood Unit in Uckfield. Subsequent feasibility testing of the architectural plans at Conquest, however, showed it was not possible to develop on that site as previously envisaged. As a result, the proposal was shelved in autumn 2017.
- The CQC has since said that the ward bays at the Department of Psychiatry in Eastbourne District General Hospital (EDGH) are not suitable as long term working age inpatient beds – as they conflict with regulations – and retaining the temporary dementia inpatient ward at Beechwoods – although it is providing a high standard of care – is not feasible long term. Plans are therefore being developed to move all

inpatient working age and older people's wards to a single site at the Conquest Hospital.

- **Brighton and Hove –** the Brunswick ward at Mill View Hospital has recently opened as a dementia intensive care unit. SPFT is the first NHS organisation to develop a family room where family members visiting inpatients can stay overnight on site.

5.2 It was RESOLVED that a briefing on the plans for East Sussex inpatient working age and dementia services be provided by email.

6. Operational Pressures

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

- The changes to s.136 of the Mental Health Act (brought about by the Policing and Crime Act 2017) requires that patients be assessed within 24 hours by a consultant and that adults should not be detained in a police cell. This has resulted in considerable pressure on the service and the highest ever number of patients in out of area private providers. There were 25 patients in such placements over the weekend of 20 January, falling to 22 by Thursday 24 January. £350k has been spent this month on private placements.
- There are currently 30 Delayed Transfer of Care (DTOC) patients in acute inpatient wards (10% of the total number of beds) and 12 in dementia wards. DTOC are being caused by people waiting for community care packages, nursing or care home placements, and, in Brighton, housing placements – due to a preponderance of patients with substance misuse issues that make it difficult to house them.
- NHS organisations and the local authorities are conducting systems calls several times a week for each DTOC case to see how the wider health and social care system can provide support.
- The proposed reduction in working age beds in West Sussex currently being developed will be in line with the number of patients requiring inpatient treatment in that county and will not affect out of area placements. Out of area private bed placements are being driven by demand for them in Brighton & Hove and East Sussex.
- Whilst DTOCs put pressure on the number of beds, they should not be considered as an inevitability, and their reduction should be seen as the way to increase bed capacity. The recent focus on DTOC in the acute sector should be mirrored in the mental health sector; despite financial pressures the acute sector – with the full support from local authorities – has reduced the number of DTOC since the summer.
- SPFT is a foundation trust and so self-funds its capital expenditure. This was previously done through producing a 1% surplus, but due to financial pressure this has not been achieved for 3 years. Therefore, capital funding is being maintained through receipts from disposals of real estate and sharing facilities with partner organisations.

6.2 It was RESOLVED to note the report.

7. Care Quality Commission (CQC) inspection

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

- SPFT was rated overall good; good in the responsive, effective, well-led and safety domains; and outstanding in the caring domain. Adult inpatient, adult community, CAMHS, and older people's community and inpatient services were all reviewed. The Trust is now the third highest rated mental health trust in England.
- The CQC highlighted as examples of positive working the leadership at Langley Hospital and the use there of data to improve patient experience; the practice of visiting families of patients due to be admitted to the Brunswick ward, resulting in a reduction in length of stay of patients; improvements made in waiting list management for CAMHS; and the iRock service in Hastings; and the new 'family liaison' staff.
- There is one 'must do' action in relation to the intercoms in the seclusion room and blind spots in the garden at Langley Hospital. The hospital is being refurbished and the garden issue is being dealt with.
- The 'should do' actions are all achievable and include single sex wards and staff appraisals.
- The CQC conducted a comprehensive inspection. The inspectors held 24 focus groups, and interviewed 192 staff, 64 carers, and 124 patients. Healthwatch also provided assistance to the CQC in West Sussex.
- ITN has been filming in Langley for the last 2 months for a documentary on life in a mental health hospital. They have spoken positively about the staff and carers, and a positive documentary like this is likely to help with recruitment and retention of staff.
- The 4 week target for patients requiring specialist CAMHS referral is being met. It is more challenging, however, for patients who do not meet the criteria for specialist care to receive a timely referral – the longest wait is for assessments of neuro-developmental issues such as ADHD and autism.
- A lot of work is being done to support less urgent referrals, for example, from April in East Sussex there will be a single point of access for young people needing emotional support that can signpost them to get the help they need, such as from the Children's Services Department, the third sector and SPFT.
- There is a national shortage of CAMHS psychiatrists so there is a need to ensure access to the right level of care, which for some people may not be a CAMHS psychiatrist. There is an active recruitment programme and strategy despite the national shortage.

7.2 The Members congratulated Trust staff on the hard work undertaken to achieve a good rating from the CQC.

8. Police and Crime Act

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

- Since the introduction of s.136 changes in 11 December a considerable amount of joint work with Sussex Police has been carried out to collectively manage the need to avoid detaining people for more than 24 hours. A joint workshop has been held and feedback from this suggests the approach is working well, with people being taken to

one of the 5 places of safety and A&E generally only if there is a corresponding physical issue, and not in police custody – which is now considered a 'never event'. The Trust is hoping to see a reduction in the use of s. 136 powers by Sussex Police.

- A robust operational plan has been in place since 11 December that includes daily calls with Sussex Police, CCGs and South East Coast Ambulance NHS Foundation Trust (SECAmb) to coordinate the conveyance of patients held under s.136 powers. This seems to be going well.

8.2 Members RESOLVED to request figures for the number of people detained under s.136 before and after 11 December.

9. Other Developments

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

- The approach to suicide is being changed across all organisations in the STP to a 'zero suicide' model. An official launch for the zero approach is set for May 2018.
- The zero approach model involves taking the approach that any suicide is unacceptable and the aim is to work towards zero suicides. This will help to change the way in which people think about suicides, and how organisations respond to suicide and manage those people in their care. It is a major piece of work but the Mersey area adopted it 4 years ago and have seen a reduction in numbers of suicides; it is being adopted increasingly across country.
- It relies on a change in culture and learning and joint up working. This involves practical things such as reviewing the amount of medication on discharge, ensuring a 7-day follow up call for all discharge, and a 3-day follow up in certain areas.
- Training involves all staff watching a short 20 minute online film to ensure that they are all have the same attitude to suicide; they are also asked to do an e-learning module.
- The introduction of a zero suicide approach is being overseen by a steering group with public health, carers, families and the voluntary sector involved.
- SPFT has met with public health leads in all three local authorities for the first time to ensure suicide strategies are all aligned.
- The trust is starting to scope whether I-Rock can be rolled out to Worthing and funding has been secured for 2 more sites in E Sussex.

9.2 It was RESOLVED to request a future update on the progress of the zero suicide approach.

10. Date of the next meeting

10.1 It was RESOLVED that:

1) a future meeting be held in May; and

2) the working group should meet three times annually.