HEALTH OVERVIEW AND SCRUTINY COMMITTEE

THURSDAY, 27 SEPTEMBER 2018

10.00 AM COUNCIL CHAMBER, COUNTY HALL, LEWES

MEMBERSHIP -

East Sussex County Council Members
Councillors Colin Belsey (Chair), Phil Boorman, Bob Bowdler (Vice Chair), Angharad Davies, Stuart Earl, Sarah Osborne and Alan Shuttleworth

District and Borough Council Members
Councillors 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 28 June 2018** *(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. **NHS Sustainability** *(Pages 17 - 50)*

6. **Urgent Care** *(Pages 51 - 64)*

7. **Work programme** *(Pages 65 - 78)*

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

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

19 September 2018

Contact Claire Lee, 01273 335517,
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Email: claire.lee@eastsussex.gov.uk

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

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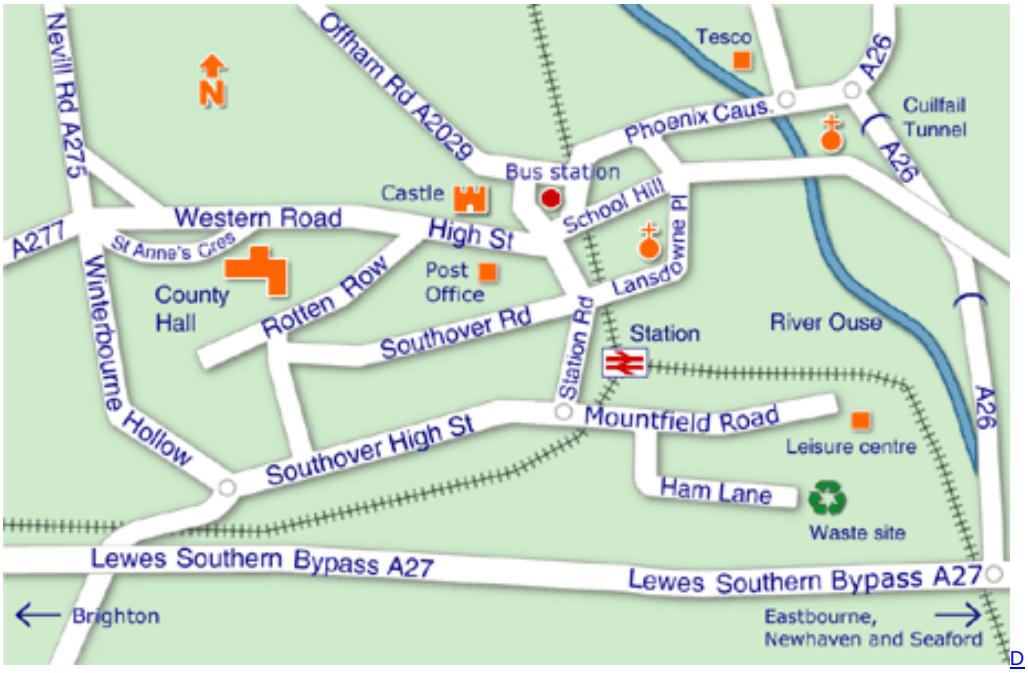

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HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Lewes on 28 June 2018

PRESENT:

Councillors Colin Belsey (Chair), Councillors Phil Boorman, Bob Bowdler, Angharad Davies, Stuart Earl, Sarah Osborne and Alan Shuttleworth (all East Sussex County Council); Councillors Barnes (Rother District Council), Councillor Mike Turner (Hastings Borough Council), Councillor Susan Murray (Lewes District Council), Councillor Johanna Howell (Wealden District Council), Geraldine Des Moulins (SpeakUp) and Jennifer Twist (SpeakUp)

WITNESSES:

Eastbourne, Hailsham and Seaford Clinical Commissioning Group (CCG) / Hastings and Rother CCG
Jessica Britton, Chief Operating Officer
Mark Angus, Urgent Care System Improvement Director

High Weald Lewes Havens CCG
Ashley Scarff, Director of Commissioning and Deputy Chief Officer
Hugo Luck, Deputy Director of Primary and Community Care

East Sussex Healthcare NHS Trust
Dr Adrian Bull, Chief Executive
Vikki Carruth, Director of Nursing

LEAD OFFICER:

Claire Lee, Senior Democratic Services Adviser

1. MINUTES OF THE MEETING HELD ON 29 MARCH 2018

1.1 The minutes of the meeting held on 29 March 2018 were agreed as a correct record.

2. APOLOGIES FOR ABSENCE

2.1 Apologies for absence were received from Cllr Janet Coles.

3. DISCLOSURES OF INTERESTS

3.1 There were no disclosures of interest.

4. URGENT ITEMS

4.1 There were no urgent items.

5. EAST SUSSEX HEALTHCARE NHS TRUST: CARE QUALITY COMMISSION INSPECTION REPORT

5.1. The Committee considered a report on the recent Care Quality Commission (CQC) Inspection Report on East Sussex Healthcare NHS Trust (ESHT) and an update on the Trust's work to improve End of Life Care (EOLC).

5.2. Dr Adrian Bull, Chief Executive, ESHT, and Vikki Carruth, Director of Nursing, ESHT, introduced the report and answered the following questions from the Committee.

Making financial savings without compromising quality and safety performance

5.3. Dr Bull said that the trust has had troubled finances for a number of years and had a deficit of £48m prior to his arrival in mid-2016. The underlying financial position was worse than that at the time, however, and was being enhanced by one or two one-off in-year contributions. A report by Dame Ruth Carnall in 2016 said that the finances were on a rapidly deteriorating trajectory and were heading towards a deficit of more than £60m. The Trust has arrested this deterioration and the deficit for 2017/18 was £54m, with plans for a deficit of £45m for 2018/19.

5.4. Dr Adrian Bull said that the Trust's aim is to maintain quality and safety improvements made over the last two years whilst reducing its financial deficit. He was clear that whilst ESHT would work to tackle financial issues, the trust would not do so by making short-term cost saving measures that would imperil quality and safety. He clarified that it was not the case that financial improvements were being ignored in order to improve quality and safety.

5.5. Dr Bull explained that a range of initiatives have been undertaken to achieve this financial position, for example, significantly improving financial reporting, and allowing devolved responsibility for budgets to the service level, rather than top down corporate budget planning. Dr Bull explained that every financial initiative the trust develops goes through a formal quality improvement assessment process to ensure that the initiative will not have an adverse effect on clinical performance. Large areas of financial inefficiency that still need to be addressed include agency staff, drug costs and length of stay of patients.

5.6. Dr Bull said that many of the trust's initiatives to improve quality will also deliver financial savings because poor quality care costs money, for example, unnecessary lengths of stay, avoidable readmissions, and extra treatments for preventable infections. He explained how two years ago the length of stay for emergency care was over 6 days but is now 4.6 days. This meant that despite the significant increase in admissions over the past two years, the total number of bed days has fallen and the trust has been able to reduce the number of beds it is running, thus saving money.

Exiting Financial Special Measures

5.7. Dr Bull said that it is less clear how the trust can emerge from financial special measures compared to quality special measures. This is in part because the latter happens as the result of a CQC recommendation whereas there is no equivalent for financial special measures. He believed that the NHS Improvement (NHSI) team will take a subjective view that the trust can come out of special measures once it has fulfilled a number of criteria, for example, having a satisfactory plan to get to a financial break-even position; demonstrating an ability to deliver this plan; and instilling confidence that the plan will be achieved without NHSI oversight. He said that

he felt NHSI is now more sensitive to the risk of driving trusts into a difficult quality position through focussing entirely on financial improvement.

5.8. Dr Bull explained how a five-year plan is being developed with the Clinical Commissioning Groups (CCGs) and NHSI that will enable the trust to break even in three years' time. If this plan is adopted then the earliest that the Trust can come out of special measures is 12 months' time. He cautioned that the scale of the task should not be underestimated and is something the system has tried to address for more than 10 years.

Sustainability and Transformation Fund

5.9. Dr Bull explained that the Sustainability and Transformation Fund (SFT) was additional government funding of £2.5bn introduced into the system a few years ago that NHSI opted to hold back from trusts to incentivise them to achieve their control total. ESHT has been in negotiations with NHSI over its target control total, for example, the control total for 2017/18 was a £35m deficit. If the Trust had hit that deficit – which it did not – it would have triggered £13m of SFT funding that would have reduced the net deficit to £22m. Furthermore, ESHT ended up last year with a significant cash flow problem in attempting to achieve this accelerated deficit reduction plan. The control total for 2018/19 is a £21m deficit and will trigger £15m of STF funding if reached. NHSI now accept that this is an unrealistic trajectory for the Trust but argue that it is beyond their powers to adjust it. Dr Bull said therefore that for now STF is out of reach for the trust. The five-year plan would bring back the possibility of receiving it in future years, however, and is based on a more achievable trajectory that will avoid the cashflow problem of last year. He clarified that the trust is funded in cash up to the control total deficit and beyond that point the trust must use its reserves. ESHT's reserves are now negative and a low interest rate reserve loan is used instead, which does not harm the trust's year to year operational performance.

Collaborative financial planning

5.10. Dr Adrian Bull said that all of the ESBT Alliance organisations have their own financial pressures and are separately regulated, meaning that sometimes organisations can be tempted to look inwards to solve their own problems. He said that ESHT was consciously working to maintain its focus on the wider system and will continue to attend joint financial meetings, such as the Financial Recovery Board, to discuss financial pressures on each organisation in the ESBT system and the impact changes one makes will have on the others, for example, work is being commissioned to look at the impact on the savings East Sussex County Council is making to its preventative Adult Social Care services. The trust is also working with partner organisations to plan for winter pressures and ensure the system has the necessary resource to meet the extra demand.

Date of publication of CQC action plan

5.11. Dr Adrian Bull said that an action plan developed in response to the CQC's 'must do' and 'should do' recommendations has to be submitted to the CQC. This is a public document and will be completed shortly and then published. In addition, the Trust's Quality Account will be published imminently and will include quality priorities along with the plans of how to achieve them. There is also a 2020 strategy document that is publically available and will be made published at the same time as the Quality Account.

A&E performance at Eastbourne DGH and Conquest Hospital

5.12. Dr Bull explained that the A&E services at Conquest Hospital and Eastbourne District General Hospital (EDGH) had both significantly improved over the past 18 months, for example, performance against the A&E 4 hour wait time averaged around 70% across both sites 18 months ago and the trust was in the bottom 20 trusts in England, whereas over the past 6 months the performance has risen to 90% and is in the top 20 trusts in the country. The increase in waiting time performance has been similar at both sites, with both A&E Departments at various times performing slightly better than the other.

5.13. Dr Bull clarified that the specific reason why EDGH A&E Department remained as requires improvement and the Conquest Hospital was rated good was due to an issue with the reception and admin team at EDGH being short staffed, under pressure and getting too few breaks. This had been identified by the CQC as the only 'must do' action and the Trust was working now to rectify it. He said he was disappointed that this had happened as it was an issue that the trust had previously recognised at both sites and action had been taken to address it, however, it appeared that only Conquest Hospital had implemented the actions. In addition to this 'must do' action, the CQC had also identified that mental health care in A&E was worse at the EDGH, but Dr Bull was confident that this was due to a one-off incident during the inspection and standards were common across both sites. Dr Bull added that there is a change in leadership happening at EDGH (unrelated to the inspection findings) and this is being taken as an opportunity to unify leadership of emergency care across the two sites and focus on improving standards. He said that staff at the EDGH had been disappointed that they had not received a good rating.

Triaging at A&E

5.14. Vikki Carruth explained that the system in place at A&E aims to triage a patient once immediately upon their arrival. This is to ensure that if they need immediate treatment they are directed to 'majors' and otherwise are asked to take a seat in the waiting area. Dr Bull said that in the last 12 months nurse rounds have been introduced at the A&E waiting areas to ensure that all patients who are waiting are not forgotten or left in discomfort. Ms Carruth said that she believed the system was efficient but that some patients may be confused by the triage process, so the trust plans to put up signage to explain visually the journey through A&E.

Effect of CQC rating on recruitment

5.15. Dr Adrian Bull said that there is no doubt that two years ago ESHT was finding it difficult to recruit because it was rated inadequate, was in special measures for quality, and had a poor reputation. However, he believed that the current CQC rating of requires improvement would not affect recruitment as around two thirds of trusts have the same rating. In addition, recent improvements to the trust's reputation have helped with recruitment in a number of areas, for example, every trainee midwife who recently graduated has been recruited to the trust; and a recent consultant advertisement received three high quality applications whereas before they often received none. However there is still a national shortage of certain roles, for example, consultants in haematology, that makes recruitment an ongoing challenge.

Bullying and harassment

5.16. Dr Bull assured the Committee that the trust has taken explicit measures on bullying and harassment. As a result of these measures some very senior people have changed their behaviour noticeably, which staff have commented is evidence that the trust is taking the issue seriously. He said that specific interventions were made in two speciality departments that had difficult reputations and unhappy staff. The interventions included replacing some of the leadership, and taking actions to address interpersonal issues. Both departments have now achieved cultural improvements that have been remarkable, leading to them receiving national accreditation this year. In addition, the NHS Staff Survey last year showed that the Trust was one of the most improved for engagement with its staff.

Expanding new roles

5.17. Dr Bull said that both the matron's assistant and junior doctor's assistant roles have been successful and valuable to the trust and the trust is seeking to expand these roles. Dr Bull and Vikki Carruth outlined some additional roles and training opportunities that have been introduced, or are in the process of being introduced:

- Physician's associates, which is a role that assists medical staff and is widely used in the United States;
- Surgical care practitioners;
- A new training role for healthcare assistants to allow them to become associate practitioners, just beneath the level of registered nurse; and
- clinical orderlies to support clinical staff on wards and departments.

5.18. Vikki Carruth added that much work had been done to improve retention of existing staff, for example, a range of initiatives were in place around improving staff wellbeing and resilience, including the use of Schwartz rounds. Flexible working is also being introduced for a number of staff who are older and in physical roles, providing them with shorter or different shifts.

Reconfiguration of stroke services at EDGH

5.19. Dr Adrian Bull said that the two wards currently designated as stroke units at the EDGH are not all taken up by stroke patients. The proposed reconfiguration of beds will enable the more effective concentration of stroke patients on a single ward with all staff on the ward trained to care for stroke patients. He said he did not see it as a downscaling of the stroke service.

5.20. Dr Bull said that the changes to stroke wards are part of a wider review of the 750 beds in ESHT that will reduce the overall number across both sites of approximately 75-80 – with the option to open them again during winter – that is being driven in part due to the reduced length of stay of patients at the trust in recent years. The review also involves a rebalancing between medicine and surgery beds that will result in relatively more medical beds. This is because in previous years it has increasingly become necessary to move medical patients into surgery beds during busy periods, which is not good practice.

End of Life Care for children and young people

5.21. Vikki Carruth explained that there are several co-ordinating groups set-up to manage EOLC for children and young people of which she is a member, for example, an EOLC steering

group that includes colleagues from paediatrics and community services; and a steering group for children with complex needs that are likely to cause life limiting illnesses. These groups demonstrate the Trust's commitment to providing the best possible care for children and young people, particularly during the complex time of transitioning to adult care services. She said that EOLC for children and young people is more difficult and specialist, and less understood and well developed as a whole than it is for older people who are more likely to be facing the end of their life. There are also more ethical discussions for EOLC in younger people than older people, particularly around issues such as resuscitation.

Response to Gosport Hospital report

5.22. Vikki Carruth confirmed that Graseby pumps were not used in ESHT and had not been for eight years. Ms Carruth said that whilst she did not believe that ESHT had any of the problems Gosport Hospital had around syringe driver usage, prescription dosages, or whistleblowing policies, as highlighted in the recent report, she nevertheless thought that the Trust should review that this was the case. An assurance report will be provided to the ESHT Board for consideration in the near future.

EOLC rating

5.23. Vikki Carruth said she was confident that the EOLC service will receive a rating of good from the CQC on re-inspection with some areas highlighted as outstanding. She was disappointed that the service was not re-inspected but that did not detract from the improvements that had been made. Whilst acknowledging it was not perfect, the concerns around the EOLC service were not about the level of care the service provides but around the fact that there is not a systemic practice of documenting discussions with patients and relatives about EOLC arrangements, which the service is working to rectify. In addition, the National EOLC Collaborative Team visited ESHT in May 2018 and has said it wishes to share some examples of EOLC care at the Trust as best practice around the country.

Seven Day Specialist Palliative Care Team (SPCT)

5.24. Jessica Britton said that she would inform the Committee by email about the progress of the SPCT business case.

5.25. The Committee RESOLVED to:

1) note the report;

2) request a copy of ESHT Action Plan;

3) request an email about the progress of the SPCT business case.

6. URGENT CARE

6.1. The Committee considered a report providing an update on the redesign of the urgent care system as part of both the Connecting 4 You and East Sussex Better Together programmes, and the pause of the NHS 111 procurement process.

6.2. Ashley Scarff, Director of Commissioning Operations, HWLH CCG; Hugo Luck, Deputy Director of Primary and Community Care, HWLH CCG; Jessica Britton Chief Operating Officer, EHS/HR CCG; and Mark Angus, Urgent Care System Improvement Director, EHS/HR CCG; introduced the report and answered the following questions from the Committee.

Continuation of existing NHS 111 contract

6.3. Mark Angus said that the CCGs are about to enter discussions with current NHS 111 providers to ensure continuity of service beyond the end of the current contract in April 2019. He is confident that continuity of service can be achieved.

NHS 111 procurement process

6.4. Mark Angus said that the CCGs are intending to do further engagement with the market and see whether there are any learning opportunities from other NHS 111 system plans being developed elsewhere in the country. This will help to ensure there is a positive response from providers to the procurement process when it is reinitiated. He said it was important to reflect that the decision to pause the procurement process was not an indication of a flawed procurement process and this view is supported by NHS England.

6.5. Jessica Britton said that the redesign of Urgent Treatment Centres (UTCs) in the East Sussex Better Together (ESBT) area of East Sussex is on pause until the impact of the pause in NHS 111 procurement can be determined. She did not anticipate that it would impact the plans significantly but it was necessary to ensure that the new specification UTCs will be deliverable within the revised timescales. Ms Britton said that further update on the effect on UTCs would be presented at the next HOSC meeting.

Lewes Victoria Hospital

6.6. Hugo Luck confirmed that the Lewes Health Hub and Lewes Victoria Hospital (LVH) UTC would not be duplicating services as the two services will be integrated together into a single urgent care system. He explained that the three GP practices that have combined to create the Lewes Health Hub will treat patients with long term conditions at the Health Hub (or in the individual practices prior to the completion of the Hub) and patients requesting urgent care will be asked to go to the UTC at the LVH where some of the Lewes GPs will be present, along with emergency nurse practitioners (ENPs). Mr Luck illustrated this separation by explaining that a patient may ring their GP practice with an urgent care need and be directed to go to the LVH instead, or they may book an appointment at the UTC online, or via NHS 111. The triaging of patients at the UTC will be undertaken by a doctor and around 50 patients a day who would otherwise have seen their GP at a practice will see an ENP instead, which will be more suitable for their needs, and conversely 20% of current minor injury unit (MIU) patients at the LVH will see a GP instead due to their medical need. The model also makes use of the extended access to primary care currently being procured as the UTC will offer evening and weekend GP cover.

6.7. Hugo Luck explained that the current Minor Injuries Unit (MIU) at Lewes Victoria Hospital already had a diagnostic and X ray capability and that the main difference between it and the planned UTC would be the medical oversight provided by GPs, which will enable the treatment of a much wider range of illnesses.

6.8. Hugo Luck said that the model will require additional staffing but the current MIU that is run by Sussex Community NHS Foundation Trust (SCFT) has a low vacancy rate. Existing staff have been trained up over the past two years as part of an earlier re-procurement of community services that involved training up MIUs, which now aligns with NHS England's urgent care requirements.

6.9. Hugo Luck said that the LVH building has an underutilised ward that, subject to the confirmation of the business case, will be converted into three consultation wings. The building tender will go out in July and building work will begin in September. As the care model, staff and funding are in place, subject to this building work being delayed, the UTC will be in operation by December 2018. A full communications plan with patients will also be undertaken at a suitable time.

Other UTCs

6.10. Hugo Luck said that there is a Sussex and East Surrey Sustainability and Transformation Partnership (STP) review of UTC locations that is determining where other UTCs may be required. There is a clear need for a UTC at Brighton, Eastbourne and Hastings but it is more difficult to determine in other areas, for example, a UTC at Uckfield would be only 8-9 miles from the A&E at Princess Royal in Haywards Heath and so could be duplicating the service. He said that HWLH CCG was committed to maintaining the MIU presence where possible at the sites in Crowborough and Uckfield.

6.11. Jessica Britton confirmed that there were no plans in the ESBT area to have UTCs outside of Hastings and Eastbourne but other urgent care improvements would be put in place such as primary care extended access.

Reduction in preventative ASC services

6.12. Ashley Scarff said that ongoing savings to Adult Social Care preventative services require more than ever closer working with the voluntary sector organisations that play a part in the urgent care system, which starts at the preventative stage. HLWH CCG will look to maximise opportunities as much as it can within the resources available to make sure that initiatives that are the bedrock of the urgent care strategy are not disrupted.

6.13. Jessica Britton agreed and said that ESBT is predicated on how to best treat people outside of a hospital setting through investing in primary and community services and working with the voluntary and community sector. ESBT has a community resilience programme that is shared with HWLH CCG and both CCG areas are currently procuring extended primary care access, which is a preventative service in so far as it can help ensure people are treated early in a primary care setting, reducing the need for hospital admissions.

Effect of CCG savings

6.14. Jessica Britton said that the CCGs are looking at financial recovery programmes to stabilise in-year finances and become solvent over the next three to five years. The plans – some of which have been discussed by the CCGs at Governing boards – will comprise a number of things. The ESBT CCGs are looking at a £18m saving for 2018/19 – 3% of the total allocation, which is totally achievable and the CCGs are confident that they can deliver it. Ms Britton said that there are currently no proposals for savings across services commissioned by

the CCGs and that any savings that would result in service changes would be the subject of public consultation.

6.15. The strategy for improving the primary care estate includes a number of projects and proposals from individual practices that are considered by the CCGs as part of a planning cycle. The necessity of each project will continue to be reviewed and assessed as normal. Currently there are no proposals to stop any building works, but future works will need to take account of the need for achieving sustainable financial recovery within the CCGs.

6.16. The Committee RESOLVED to:

1) note the report;

2) agree to suspend the work of the HOSC sub-group considering Urgent Treatment Centre proposals in the East Sussex Better Together area, pending re-submission of the proposals in the autumn; and

3) request a further report on the progress of urgent care redesign in September 2018.

7. HOSC FUTURE WORK PROGRAMME

7.1 The Committee considered its work programme.

7.2 The Committee RESOLVED to:

1) agree the work programme;

2) agree that the Chair writes a letter to the relevant CCGs requesting more detailed information about the reasons for the NHS 111 procurement delay;

3) request a report to be circulated by email on the progress of improving cancer care services in East Sussex;

4) agree to nominate Cllr Bowdler as a member of the HOSC working group for Sussex Partnership NHS Foundation Trust (SPFT);

5) request a briefing on post-natal mental health care in East Sussex; and

6) raise the issue of mental health waiting times at the next HOSC working group for SPFT.

The meeting ended at 12.10pm

Councillor Colin Belsey
Chair

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

Date of meeting: **27 September 2018**

By: **Assistant Chief Executive**

Title: **NHS Sustainability**

Purpose: **To provide HOSC with an update on the Clinical Commissioning Groups' (CCGs) financial plans for 2018/19; the Clinically Effective Commissioning programme; and the Sussex and East Surrey Sustainability and Transformation Partnership (STP).**

RECOMMENDATIONS

The Committee is recommended to:

1) consider and comment on the report; and

2) identify any proposals that require further scrutiny.

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1. Background

1.1. The Health Overview and Scrutiny Committee (HOSC) is scrutinising a number of issues that relate to work by the NHS commissioners and providers to deliver financial and clinical sustainability to the East Sussex health economy.

1.2. The specific issues are:

- The financial savings proposals of the three Clinical Commissioning Groups (CCGs) in East Sussex for 2018/19
- The latest progress with the Sussex and East Surrey Sustainability and Transformation Partnership (STP)
- The progress of the Clinically Effective Commissioning (CEC) programme.

1.3. This report combines these different issues into a single report for consideration by the Committee.

2. Supporting Information

Financial Savings proposals

2.1. The three CCGs in East Sussex – High Weald Lewes Havens CCG (HWLH CCG); Eastbourne, Hailsham and Seaford CCG (EHS CCG), and Hastings and Rother CCG (HR CCG) – ended the 2017/18 financial year in deficit.

2.2. EHS and HR CCGs ended the year with a combined financial deficit of £37m, which was the first time they had been in deficit in four years. The underlying financial position has deteriorated in part due to increases in unit activity and costs of local services, in particular an increase in acute services of £22m.

2.3. The two CCGs agreed with NHS England a Financial Recovery Plan (FRP) that, if achieved, will see the CCGs end the 2019/19 financial year reaching a 'control total' of a £32m combined deficit. If the CCGs achieve this control total they will receive a payment of £32m from the Commissioner Sustainability Fund that will reduce their deficit for the year to zero.

2.4. In order to reach the control total the CCGs will need to deliver Quality, Innovation, Productivity and Prevention (QIPP) savings of £18m, amounting to around 3% of their total expenditure. The QIPP savings include both schemes that deliver improved quality and efficiency and drive transformation; and a 5% reduction in non-acute budgets (excluding Primary Care and

Mental Health). They fall across five key categories, Medicines Management, Planned Care, Urgent Care, Community, and Running Costs.

2.5. NHS England subsequently placed EHS and HR CCG into legal directions in July 2018. As part of these legal directions, the two CCGs are required to develop a joint 'system-wide' FRP together with East Sussex Healthcare NHS Trust (ESHT), which is also in financial special measures, and a 3-5 year plan setting out how the system will return to financial balance and sustainability by 2022/23.

2.6. A summary of these two plans is included as **appendix 1** to this report. The report in appendix 1 outlines that the system-wide control total for 2018/19 is £77m (£45m from ESHT and £32m from the CCGs) and that it will be achieved through the delivery of £19.2m Cost Improvement Programme (CIP) savings at ESHT and £18m QIPP savings at the CCGs. **Appendix 2** sets out the individual QIPP savings planned for 2018/19.

2.7. HLWH CCG ended 2017/18 with a deficit of £9m. The CCG has agreed its FRP in conjunction with other CCGs in the Central Sussex and East Surrey Area (CSESA) South area. The CCG will aim to deliver £9.2m QIPP savings to reach a control total deficit of £10.7m.

2.8. HWLH CCG has produced a report (attached at **appendix 3**) that updates the committee on the proposed savings including that the CCG is on track to deliver its agreed deficit of £10.7m as at the end of Quarter 1 and that £2.3m of unmitigated risks remain, i.e., savings that have not yet been identified or that have a significant risk to delivery.

Sussex and East Surrey Sustainability and Transformation Partnership (STP)

2.9. The NHS England Five Year Forward View vision of better health, better patient care and improved NHS efficiency required local health and care systems to came together in January 2016 to form 44 Sustainability and Transformation Plan (STP) 'footprints'. The health and care organisations within these geographic footprints are working together to develop and deliver Plans which aim to help drive sustainable transformation in patient experience and health outcomes for the longer-term. Plans are also expected to demonstrate how the health system will achieve financial balance by 2020/21.

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

2.11. The Sussex and East Surrey STP covers an area that also contains four 'place-based plan' areas – East Sussex Better Together (ESBT), Central Sussex and East Surrey Area (CSESA) South, CSESA North, and Coastal Care. The place based plans focus on integration of health and social care services in localities, developing community services, proactive management of long term conditions and increased emphasis on prevention and self-care. The STP workstreams cover strategic issues that can be more effectively delivered at scale, such as ICT, workforce and acute care.

2.12. An update on the STP is attached as **appendix 4** and includes updates on the governance arrangements of the STP, including the appointment of a single Accountable Officer, Adam Doyle, for all the CCGs in the STP, and the development of a unified case for change for the whole STP.

2.13. Most STPs cover more than one HOSC area, necessitating liaison between HOSCs on scrutiny arrangements. Informal liaison is continuing between HOSC Chairs and Officers in Sussex and Surrey in order that local HOSCs are in a good position to undertake any more formal scrutiny should this be required.

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

Clinically Effective Commissioning (CEC)

2.15. Clinically Effective Commissioning (CEC) is a workstream of the STP being carried out across the CCGs in Sussex only. Its aim is to improve the effectiveness and value for money of healthcare services. This is to be achieved through developing a single set of Sussex-wide clinical policies for procedures that are of low clinical value, which are separated into three separate 'tranches'; and ensuring National Institute of Health and Care Excellence (NICE) guidelines are applied to these policies in a uniform way.

2.16. HOSC considered an initial presentation on CEC back in September 2017. The report attached as **appendix 5** updates the Committee on the progress of implementing CEC. **Appendix 6** provides a list of the individual tranches.

2.17. CEC covers more than one HOSC area, which would necessitate the creation of a Joint HOSC if any CEC proposals are considered to be a 'substantial development or variation' to health services by more than one of the affected HOSCs. Discussions with the Chairs of HOSC are underway about the potential need to establish a JHOSC in advance of the need of the NHS to consult with any HOSCs, although there are no known potential substantial variations at this stage.

3. Conclusion and reasons for recommendations

3.1 HOSC is recommended to consider and comment on the report.

PHILIP BAKER
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An overview of ESBT Alliance Financial Recovery Plans 2018/19 and beyond, including a summary of delivery projects for Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG

1. Background

1.1 The East Sussex Better Together[1] (ESBT) system reported a combined deficit of £92m at the end of March 2018, with both the Clinical Commissioning Groups (CCGs) and East Sussex Healthcare NHS Trust (ESHT) reporting significant variances against their plans. In addition East Sussex County Council (ESCC) ended its year at break-even, but was required to support the Adult Social Care position through central reserves and has a further £8.4m cost reduction plan agreed for this year[2].

1.2 In June 2018, the ESBT Strategic Commissioning Board received a report outlining the ESBT financial position. This provided an overview of the ESBT system including a range of areas where ESCC savings proposals (that were under consultation at the time) and a range of CCGs' Quality Innovation Productivity and Prevention (QIPP) plans.

1.3 ESBT Alliance is widely recognised for the significant improvements it has made including:

- Putting even more local people in touch with the right services at the right time, Health and Social Care Connect now receives over 11,000 contacts/referrals per month
- Reductions in delayed transfers of care – down from 8% to 1.4%
- Reductions in the length of time patients stay in hospital[3] – down by 1 day on average which means 1,000 fewer bed days each month, every month
- Significant improvements against the 4 hour A&E waiting time target, with ESHT now being one of the top quartile performing A&Es nationally
- Reductions in unnecessary hospital admissions - to date 72% of people seen by our Crisis Response team had not been readmitted to hospital within a month
- Reductions in those patients staying more than six nights in an acute hospital setting by almost 20% over the last year

[1] The ESBT Alliance is a health and care partnership of Eastbourne, Hailsham and Seaford CCG; Hastings and Rother CCG, East Sussex County Council, East Sussex Healthcare NHS Trust and an associate partner of Sussex Partnership NHS Foundation Trust

[2] It is important to note that the local authority is not required to be part of the system-wide financial recovery that the CCGs and ESHT have been required to develop. This information is included here for completeness as ESCC are a key partner in the ESBT Alliance.

[3] The length of time patients stay in hospital is often referred to as Length of Stay (LOS)

- Over 17,000 people have been helped by our benefits and debt advice service which we set up to reduce money-related health problems

1.4 However, despite these improvements, we have not yet reduced the level of activity and the costs of that activity as much as is needed, and both the CCGs and ESHT are in deficit, with the Trust being in financial special measures since October 2016; and the CCGs were issued Legal Directions in July 2018. As part of these Legal Directions the CCGs have been required to develop an in-year financial recovery plan (FRP) and a 3-5 year plan that is integrated across our system, together with East Sussex Healthcare Trust (ESHT).

2. Purpose of this report

2.1 This report outlines the key elements of our system-wide FRP including:

- An outline of the work the CCGs and ESHT are prioritising to ensure financial balance is achieved this financial year, 2018/19
- An outline of the work the CCGs and ESHT are further developing to ensure a financially sustainable health and care system in the longer term (over the next 5 years, 2019/20-2022/23)
- A summary of the CCGs QIPP programme as requested by HOSC.

2.2 It is important to note that the ESBT Alliance is our place-based system that aims to improve health and wellbeing; enhance care, quality and experience for local people; and make the best use of our combined resources to ensure sustainable services as part of the wider Sussex and East Surrey Sustainability Transformation Partnership (STP). Our local system financial challenges are reflected across the STP and indeed much of the NHS nationally.

3. Our current financial position – the challenge in 2018/19

3.1 The CCGs and ESHT have agreed with the NHS nationally that they will deliver an agreed deficit (control total) across the system of £77m in 2018/19; a £45m deficit for ESHT and a £32m deficit for the CCGs. If the CCGs reach their £32m target deficit, then NHS England will make a Commissioner Sustainability Fund available of £32m, which means the CCGs would break-even in 2018/19, however a system deficit of £45m would remain.

3.2 Sections 4 and 5 of this report below outline the steps that ESHT and the CCGs are taking to deliver their target deficits in 2018/19. This is delivered through a Cost Improvement Programme (CIP) at ESHT and a Quality Innovation, Productivity and Prevention (QIPP)[4] Programme at the CCGs.

4. East Sussex Healthcare NHS Trust in 2018/19 CIP

4.1 East Sussex Healthcare NHS Trust has initially planned for receipt of £397m in income in 2018/19 (£270.4m of which is paid from the CCGs allocation for local services). This income is largely distributed in line with activity levels at the Trust, on the basis of a pricing system called 'payment by results.' Actual activity levels,

[4] QIPP is a NHS programme that has been in place since 2009 providing a framework for enabling the NHS to use evidence-based techniques to improve quality whilst making efficiency savings.

particularly for urgent and non-elective care, have been significantly above planned levels in the first half of the financial year, creating operational and financial pressures for the Trust, and a further financial challenge for the system and commissioners.

4.2 The Trust is seeking to deliver cost improvement plans of £19.2m in 2018/19, in order to secure a planned deficit of £44.9m. The Trust has set a target above this level - for £23.5m - for savings across the organisation, recognising that cost improvements can sometimes take time to do properly, and to avoid impacting on the quality of services for patients, and allowing for in-year delays in delivery.

4.3 The Trust has robust systems in place to ensure that cost improvement savings are developed and delivered in a way which has not adverse impact on quality and safety – with an established Quality Impact Assessment process, personally led by the Chief Nurse and the Medical Director. The Trust's Quality and Safety Committee is focused on continuing to press for improvements in quality and safety across the organisation, and maintains a rigorous review process for potential adverse consequences of cost improvements.

4.4 The Trust's Cost Improvement Programme is driven by evidence and analytical information (from national tools such as the Model Hospital, as well as detailed benchmarking of services) and is aimed at reducing the underlying financial deficit in a sustainable way over time. Delivery is supported by a Recovery Director, and through a Programme Support Office, and the programme is aligned with the CCG QIPP programme through the System Financial Recovery Board.

4.5 Working with clinicians and key stakeholders across the organisation, and the wider health economy, the Trust has started development of a detailed clinical and financial sustainability strategy, to help deliver the objectives of East Sussex Better Together and ESHT 2020. We are committed to extending engagement with a broader range of stakeholders across the system. However, the initial work on the clinical and financial sustainability plan provides a robust platform to support the development of the whole system sustainability plan, under development with the CCGs and with East Sussex County Council, described below.

5. The CCGs QIPP programme

5.1 If we didn't implement any plans to transform the way services are delivered to local people to make better use of our resources, we would have a gap of £50m. Therefore, the QIPP programme that we have put in place aims to reduce our predicted spending in 2018/19 by £18m to achieve the agreed deficit of £32m.

5.2 Our QIPP programme includes 18 schemes which are actively delivering a planned total of £18m, with further schemes in the pipeline to be further developed to support sustainable recovery over the next 5 years. Our schemes aim to improve the way services are delivered to local people and improve the efficiency of these services as a result. All schemes are subject to quality and equality impact assessments. Some examples of the service transformation that we are working with partners to deliver include:

- Within the CCGs **Medicines Management** domain**,** we are continuing our **Medicines Optimisation in Care Homes Service** to provide an annual medication review for all care home patients (residential and nursing care homes). In addition, we are also supporting pharmacists working in GP practices and community health

services to reduce inappropriate polypharmacy (ensuring people get the right choice of medicines, at the right time, and are engaged in the process by their clinical team).

- Within the **Planned Care** domain, we are implementing a **Re-designed Diabetes Pathway.** The re-designed pathway will deliver two key services to support diabetics: an Integrated Diabetes Service including diabetes self-management education (DSME), and an Urgent Access Diabetic Foot Clinic. It is anticipated that this project (when fully delivered) will reduce impact of diabetic complications by 29% and amputation rates by 38% within 3 years, whilst reducing system-wide costs which are considerable both for initial treatment and on-going social care costs (for example housing adaptations estimated to be in the region of £15k per patient per year). Currently, there is wide variation in the prevalence of diabetes and the care offered locally, which is provided using a traditional medical model with less strong integration between primary and secondary care. We have conducted a whole system pathway review and are putting in place an integrated service to better manage people's needs.

- Within the **Urgent Care** domain, we are implementing a **High Intensity User (HIU) Service.** This project is one of our projects to address the emerging upward trends in Urgent and Emergency Care. The ESBT system has seen an overall 6.1% increase in A&E attendances (6.2% for at ESHT) in 2017/18 compared to the national increase of 2%. In addition ESBT has seen an increase in unplanned emergency admissions of 13.4% (14.7% at ESHT) compared to the national increase of 4%. Following a system wide urgent and emergency (UEC) demand diagnostic to better understand what is driving the increases in demand across the system, we are adopting best practice from Blackpool and implementing a High Intensity User (HIU) service. This will offer a robust way of reducing frequent user activity to 999, NHS 111, A&E, GP contacts and hospital admissions, freeing up front line resources to focus on more clients whilst reducing costs. The HIU service uses a health coaching approach, working with high users of services and supporting the most vulnerable clients within the community to flourish, whilst making the best use of available resources.

5.3 Further details for all the live QIPP schemes are provided at Appendix 2.

6. CCGs' progress in meeting its financial challenge in 2018/19

6.1 At the end of July 2018, the CCGs are forecasting that we will meet our £32m deficit control total. We are currently forecasting to deliver QIPP schemes savings of £14.7 (at 2018/19 year end) against our target of £18m, and have further plans in place to increase delivery to achieve the full target.

6.2 We are also working very closely with ESHT to make sure we can better manage increasing activity within our current resources.

7. Developing a system that is financially sustainable over the next 3-5 years

7.1 Our system continues to face a number of challenges and changes:

- We have a growing and ageing population, one of the most elderly in the country with an increasing number of people living with long term and multiple conditions.
- Demand is growing, last year our growth in demand was significantly higher than the national average for unplanned admissions and A&E attendances.

- We have some significant health inequalities, particularly in coastal towns, where pockets of deprivation lead to poorer health outcomes
- We have significant workforce challenges both in our ageing workforce profile (this is especially notable in some areas of general practice), recruitment and retention and the need to transform our workforce
- There are challenges regarding timely access to services, and the appropriateness of premises and infrastructure needed for service delivery.

7.2 Whilst our work together as ESBT Alliance partners has brought significant improvements in service quality and performance (outlined in 1.3 above), our challenges clearly remain. We are committed to building on our ESBT progress so far, and are ensuring a shared focus on becoming a financially sustainable health and care system.

7.3 Our ESBT ambition for achieving this still holds true; and is now further strengthened with system-wide plans for financial sustainability supported by national experts in key areas.

7.4 The CCGs and ESHT continue to work together to develop an integrated longer term plan and will report to HOSC on this at their next meeting.

Appendix 1

Description of QIPP Schemes

Our Action Plan: FRP Domain - Medicines Management

Lead Senior Manager: Head of Medicines Management **Timescale for delivery: 2018/19**

Building on previously successful medicines optimisation programmes, the CCGs **Medicines Optimisation work plan for 2018/19** is planned to deliver a further **£3.8m savings** across both CCGs in 2018/19. The following is a summary of the main FRP Medicines Optimisation (MO) projects for 2018/19.

Polypharmacy reviews - £1.24m

We will continue with our Medicines Optimisation in Care Homes service to provide an annual medication review for all care home patients (residential and nursing care homes). We will also be supporting pharmacists working in GP practices and community Health services to reduce inappropriate polypharmacy.

Diabetes - £0.508m

We will continue to focus on reduction of inappropriate polypharmacy in diabetes and cost effective choices for Insulin needles and Blood Glucose Testing Strips.

Pain Management - £0.384m

We will continue our award winning work on individual reviews to reduce inappropriate use of opiates and other strong pain killers in Primary care.

Respiratory prescribing - £0.235m

We will continue to focus on increasing cost-effective formulary choices, stepping down therapy as appropriate and improving patient compliance with inhaled therapy. We will be realising efficiencies in prescribed oxygen costs through more regular reviews.

Nutrition - £0.129m

Prescribing support dietitian resource has been successful in improving prescribing over the last 2 years and will continue to support management of malnutrition in Primary care.

. Our Action Plan: FRP Domain - Medicines Management

Lead Senior Manager: Head of Medicines Management **Timescale for delivery: 2018/19**

Cost effective drug choices - £0.108m

We will implement formulary changes to cost-effective drug choices within a therapeutic area.

Low Value Medicines - £0.413m

We will be supporting our GPs and patients with the de-prescribing of the 18 medicines identified nationally as **Low Value Medicines** for the NHS.

Self-care - £0.3m

We will implement the national **Self-care programme** to reduce GP prescribing of items that could be purchased over the counter. We will run public campaigns and supporting GPs and community pharmacists to work together on patient pathways for minor ailments.

Prescribing Support scheme - £0.483m

We will continue to be implement a local scheme to improve quality and reduce variability in prescribing practice. This along with other business as usual medicines management support e.g. Optimise Rx, electronic decision support tool delivers the remaining QIPP. Currently we have 100% engagement in these schemes.

Alongside these targets optimisation schemes we have a range of further system-wide priorities that support the ongoing optimisation of medicines use. We will be implementing the following:

- Following on from previous successes in **Antimicrobial stewardship,** we will be implementing further audits and peer review in Primary care to support implementation of the national Quality Premium indicators in this area.
- Building on the four local practices participation in the national pilot for **Clinical pharmacists in GP practices**, we will be working with local federations to recruit a further 8 pharmacists and 2 pharmacy technicians to the programme.
- We will be rolling out a **new web-based platform for the joint formulary** which will be accessible to clinicians across the health economy.
- We are supporting the **integration of local community pharmacy services,** such as, urgent supply of repeat medicines, treatment for minor ailments. This year we will be rolling out **Refer to Pharmacy** software where electronic discharge information from the hospital can be sent to Community pharmacists for patients who would like support with their medicines when they are discharged from hospitals.

Our Action Plan: FRP Domain - Planned Care

Lead Executive: Acting Director Performance and Delivery **Timescale for delivery: 2018/19**

The CCGs **Planned Care work plan for 2018/19** is planned to deliver **£7.437m savings** across both CCGs in 2018/19. The following is a summary of the main FRP Planned Care projects for 2018/19.

MSK Diagnostic Re-design - £0.6m

ESHT waiting times for diagnostics and the capacity within the service are currently under unsustainable pressure as a result of the number of requests received both internally and externally from primary care. In addition, the new MSK service contracts include all diagnostic testing and any requests for diagnostic testing outside of this programme are paid for by CCGs on an ad hoc basis. This project will reduce demand for diagnostic testing, supporting overall reduction of waiting times at ESHT and improve value for money. We have good system-wide management and clinical engagement and leadership for this project, giving us confidence in its reliability.

Clinically Effective Commissioning - £0.3m

In 2017/18 the CCGs participated in the Clinical Effective Commissioning (CEC) programme as part of the STP to reduce variation in Low Priority Procedures (LPPs), ensuring that NICE Guidance is applied in a uniform way and identifying further LPPs that may need to be included in the programme in the future. This project will ensure that we as a place-based system, as part of the CEC programme, are robustly applying existing policies and only approving procedures that meet agreed criteria. In doing so we plan to deliver £0.3m of savings this year, with further opportunities in years 2 and 3 of our plans. Effectively implementing our policies in this area will mean that we:

- Make the best use of finite resources for our population by allowing funding to be concentrated on treatments which result in the most health gain.
- Offer better treatment access to patients with a high clinical priority by reducing inappropriate referrals / admissions to the waiting lists.
- Ensure that procedures of limited effectiveness are not commissioned, thereby preventing potential harm without benefit for our population.

Our Action Plan: FRP Domain - Planned Care

Lead Executive: Acting Director Performance and Delivery **Timescale for delivery: 2018/19**

Diabetes Pathway Re-design - £0.054m – 2018/19

Locally, there is wide variation in the prevalence of diabetes and the care offered, which is provided using a traditional medical model with little integration between primary and secondary care. We have conducted a whole system pathway review and identified the following issues: local people have poor outcomes, with higher than expected complications and rates of amputation; there is a wide variation in the quality of diabetes care offered within primary care; coordination between primary and secondary care is inconsistent yet essential for complex patients; non-elective spend and primary care prescribing is high and many patients don't receive an annual foot check or retinal screening; limited access to rapid foot assessment; lack of support for patients to enable them to self-manage. The re-design will deliver two key services to support diabetics: an Integrated Diabetes Service including diabetes self-management education (DSME), and an Urgent Access Diabetic Foot Clinic. It is anticipated that this project (when fully delivered) will reduce impact of complications by 29% and amputation rates by 38% within 3 years, whilst reducing system-wide costs which are considerable both for initial treatment and on-going social care costs (for example housing adaptations estimated to be in the region of £15k per patient per year). The benefits of this programme will continue on years 2 and 3 of our plans.

Reduced Referral Variation - £0.283m

Our review of benchmarked referral data shows that there is a range of unwarranted GP referral variation across different GP practices within the same geographical locality for the same CCG. We have begun appreciative enquiry engagement sessions and shared learning exercise with our GPs aimed at bringing referral rates in line with the weighted CCG average. This is planned to deliver: a reduction in unwarranted variation in GP referrals measured by first attendance outpatient data where there is no subsequent follow up or procedures. Through education and training and improved availability of consultant advice and guidance, this project will also increase skills within primary care and foster closer working between primary and secondary care, improving the quality of care and experience for the patient. Targeted work will continue as part pf our plans on years 2 and 3 with further benefits to be realised.

iMSK Prime Provider - £0.5m

The iMSK triage service for Hastings and Rother is showing a reduction in Secondary care costs of £500k per annum based on activity last year and this year. This will be tracked for the remainder of the year

Changes to MSK contract - £1.2m

The value of our contract with Sussex Musculoskeletal (MSK) Partnership in Eastbourne Hailsham and Seaford CCG area is being implemented in line with the reduction in costs in MSK service provision already planned as part of existing transformation of MSK services.

Changes to out of area acute and independent sector contracts - £4.2m

We are reviewing our London and Independent Sector contracts, with the intention of repatriating activity locally where possible. In addition, we are reviewing all non-contractual activity to ensure that this is appropriate and meets the needs of our population and have identified opportunities to release funding.

Our Action Plan: FRP Domain - Urgent Care

Lead Executive: Urgent Care System Improvement Director **Timescale for delivery: 2018/19**

Our Urgent Care FRP programme builds on transformation work already underway aimed at making best use of our resources whilst improving performance against NHS constitutional standards and the experience for local people. For our 2018/19 FRP, this transformation activity is planned to deliver **£3.3m of savings** focussed on three key areas:

- Reduction Excess Bed days at ESHT
- Targeted spend to support winter at ESHT
- Primary Care Streaming at ESHT

Reduce Excess Beddays – *Improving Patient Flow project: £1m – 2018/19*

During 2017/18 we implemented a Patient Flow Improvement project that yielded the a wide range of benefits including, a reduction of Delayed Transfers of Care (DTOCs) from between 7.3% to 7.6% in Q4 of 2016/17 to between 1.1% and 1.7% in Q4 of 2017/18; a reduction in acute Non Elective length of stay by over 1 day per episode; a reduction in patients in acute beds waiting longer than we would like to be appropriately discharged. The implementation of this project has delivered a wide range of system improvements and improvements to hospital flow, and of course, benefits to patients. The project interventions include the introduction of the following:

- Ambulatory and acute assessments at Eastbourne District General Hospital from December 2017
- Multi Agency Discharge Events (MADE) and enhanced discharge control
- Discharge to assess
- System-wide work to improve patient flow

Delivery began in October 2017, with a impact on spend falling into the last four months of 2017/18. The £1m FRP for 2018/19 is the full year effect of this project delivery, moving into business as usual, giving us significant confidence in our ability to deliver this sum.

Our Action Plan: FRP Domain - Urgent Care

Lead Executive: Urgent Care System Improvement Director **Timescale for delivery: 2018/19**

Targeted spend to support winter at ESHT - *£1.5m 2018/19*

In line with system-wide guidance from NHSE and NHSI, we are working with ESHT to agree our winter 2018/19 proposals that will include action to ensure that we have robust arrangements in place to ensure well managed system service capacity (including beds) supported by action to ensure 7 day flow enabled by workforce redesign.

Primary Care Streaming - *£0.8m 2018/19*

In 2017/18 we allocated a budget of £1.6m to the introduction of Primary Care Streaming of patients who attend A&E to support service provision in meeting the need of individual patients. Analysis modelled 21.9% of A&E attendances to be streamed to the service, however the actual monthly usage in Q4 of 2017/18 was 2.76%. Reflecting this experience, we are reviewing our Primary Care Streaming and funding options to understand the true cost of the service; the best way to structure funding for this; and the contract model to incentivise the primary care streaming model and optimise its use. Our review will focus on outcomes that will support genuine provider costs; agreement of a contract that enables the model to succeed; and re-designs the access criteria to broaden the group of patients who will be eligible for the service.

High Intensity User Service - £492k 2018/19

There is currently no focused management of High Intensity Users using a key worker approach. This project is one of two projects to address the emerging upward trends in Urgent and Emergency Care. The ESBT system has seen an overall 6.1% increase in A&E attendances (6.2% for ESHT attendances) in 2017/18 compared to the national increase of 2%. In addition ESBT has seen an increase in non-elective emergency admissions of 13.4% (14.7% for ESHT admissions) compared to the national increase of 4%. The ESBT CCGs Urgent Care team commenced a system wide urgent and emergency (UEC) demand driver diagnostic, which commenced in May 2018 to better understand what is driving the increases in demand across the system.

Cont'd..

Our Action Plan: FRP Domain - Urgent Care

Lead Executive: Urgent Care System Improvement Director **Timescale for delivery: 2018/19**

High Intensity User Service - £492k 2018/19 – cont'd

A High Intensity User (HIU) service (developed by NHS Blackpool CCG) offers a robust way of reducing frequent user activity to 999, NHS 111, A&E, GP contacts and hospital admissions, freeing up front line resources to focus on more clients and reduce costs. It uses a health coaching approach, targeting high users of services and supports the most vulnerable clients within the community to flourish, whilst making the best use of available resources. The results for the patient cohort included were as follows:

- 999 calls were down by 89%
- A&E attendances down by 93%
- Admissions were down by 82%
- 98% reduction in self-harm incidences
- 44% reduction in police calls for the client cohort.

- This approach has been replicated across the country and is now live in 41CCGs with another 15 CCGs going live in the next quarter to support winter pressures (as well as Spring, Summer and Autumn).

Our Action Plan: FRP Domain - Community

Timescale for delivery: 2018/19

The CCGs **Community work plan for 2018/19** is planned to deliver **£2.76m savings** across both CCGs in 2018/19. The following is a summary of the community projects contributing to the 2018/19 FRP:

Continuing Healthcare/Funded Nursing Care - £1m in 2018/19: Lead Executive – Acting Director of Performance and Delivery

Our review of the benchmarking data indicated that we are an outlier for Funded Nursing Care and under some of the benchmarking, also for Continuing Health Care. This project focusses on avoiding growth by maintaining a good grip on our budgets in this area (CHC contracts have been maintained at the same value of £25M over the past 3 years). This includes continuation and further tightening of our: regular case review programme; invoice validation and check-against-care process; robust, consistent and transparent application of the national CHC framework and adherence to the CCG CHC policy; ensuring fair and equitable process supported by good governance and continual review for service efficiencies; continued working with the source and purchasing team; patients and carers satisfaction survey and feedback mechanisms; and a case management review programme which can result in an increase or a decrease in care package in response to changing individual needs including factoring in sustainability

Continuing Healthcare High Cost Package Review - £800k 2018/19 - Acting Director of Performance and Delivery

To ensure equitable application of the CHC Provision Policy, CHC undertake to ensure patients not only continue to meeting eligibility requirements but receive packages of care in line with said Policy. As a result of capacity within the existing team, whilst reviews have been undertaken, capacity issues have prevented meaningful reviews to be completed and followed through where historic and complex issues have prevented changes in care delivery. Working across the three East Sussex CCGs CHC have identified in between 70 -90 patients on high cost packages that require application and consideration of the CHC Provision of Care Policy. The needs of the patient and their current packages are reassessed to determine appropriate provisions and funding of care.

Our Action Plan: FRP Domain - Community

Timescale for delivery: 2018/19

The CCGs **Community work plan for 2018/19** is planned to deliver **£2.76m savings** across both CCGs in 2018/19. The following is a summary of the community projects contributing to the 2018/19 FRP:

Extended Primary Care Access - £0.1m: Lead Executive – Urgent Care System Improvement Director

We are currently out to procurement for this service. Working with the 111 programme team (Sussex-wide), we have identified opportunities for patients who will use the new service to be redirected to away from A&E to the extended access service via direct booking. We have modelled the service impact of this urgent care re-design to amount to a reduction two patients per day from A&E beginning in November 2018.

Cost reduction in non-acute budgets (excluding Mental Health and Primary Care) - £1.5m: Lead Executive – Chief Finance Officer

Better Care Fund Budget realignment and tighter controls, CCG corporate budget capping and decommissioning of proven ineffective community contracts

NHS
Commissioning Alliance
Brighton and Hove CCG
Crawley CCG
East Surrey CCG
High Weald Lewes Havens CCG
Horsham and Mid Sussex CCG

An overview of the financial position and recovery plans for 2018/19 for NHS High Weald Lewes Havens CCG

Summary

1.1 This report provides a summary of the financial position for HWLH CCG at the end of Month 4 (30 July 2018). The draft month 5 position is due to go to the CCG Governing Body on 25th September 2018.

1.2 The CCG is currently reporting that it is on track to deliver its agreed planned deficit £10.7m control total before Commissioner Sustainability Funding (CSF).

1.3 If the plan is achieved the CCG will receive a total of £10.7m of Commissioner Sustainability Funding (CSF) enabling the CCG to break even. At the end of Q1 the CCG received 10% (£1.1m) of the CSF as it was able to report on plan and the forecast deficit is now £9.6m after CSF.

1.4 To achieve this it needs to secure £9.2m (3.8%) of savings in year.

1.5 The reported position currently highlights unmitigated risks of £2.3m which represents the risk of delivering the required level of savings.

2 Budget Plans

2.1 Information in relation to budget plans and associated Commissioner Sustainability Funding (CSF) for 2018/19 were presented to the Governing Body in July 2018.

2.2 Following achievement of the financial plan for the first quarter, the CCG received its first quarter Commissioning Sustainability Funding (CSF) in month 4. As a result of this funding, the CCG's Plan was adjusted to a revised control total deficit of £9.6m (£2.5m at month 4).

3 Financial Position

3.1 At month 4, the CCG is showing a year-to-date deficit position of £2.5m and a forecast outturn of £9.6m deficit. This is in line with the revised plan detailed in section 2. The potential risks to achieving the forecast position are set out later in this report.

4 Savings Plans

4.1 A summary of the individual saving plans to achieve the required level of savings of £9.2m is included in the Financial Recovery Plan. The Alliance has established a Turnaround Board and place-based Delivery Boards to provide oversight and scrutiny of the savings programme. This is supported by a Programme management Office Function (PMO).

4.2 Currently, the plan includes £0.7m that is unidentified (reduced from £2.5m in month 3) and further work is being progressed to identify mitigating actions. The process of identifying further savings will continue through the South Place Delivery Board and Management Team.

4.3 The status of saving plans has been assessed in terms of confidence in the level of savings attributed and the delivery of each scheme. This indicates that current plans contain a small number of schemes with significant risk to delivery and the majority of schemes assessed as amber. Based on the level of unidentified savings and the risk assessment of recommended schemes there is a significant risk to delivery of the full level of savings. The reported position to NHSE includes a total of £2.3m as an unmitigated risk in relation to achievement of savings plans for 2018/19 which remains unchanged from month 3.

5 Risks and Mitigations

5.1 As set out above the most significant identified risk is in relation to delivery of the savings plan.

5.2 The CCG is recognising a risk of £0.6m in relation to acute services. The ESHT contact offer is £0.6m above plan subject to further discussions. The CCG is also recognising risks in Mental Health services. These risks relate to the CCG's core contract with Sussex Partnership NHS Trust (£0.240m), non- contract activity (£0.720m), specialist placements (£0.044m) and Improved Access to Psychological Services (IAPTs)

(£0.201)m. These are all shown as fully mitigated at month 4 through Trust and CCG actions.

6 Financial Recovery Plan

6.1 The Financial Recovery Plan (FRP) has been updated to reflect further information requests from NHSE and re-submitted on 20 July. The revised FRP includes further information on the delivery plan for savings including a risk assessment, phasing of savings, reporting and key milestones.

6.2 **The FRP and further action proposed to mitigate the risk will be presented to the Governing Body on 25th September.**

7 Conclusion

7.1 The reported position at Month 4 is in line with the CCGs financial plan, approved by NHSE. The position includes a reported £2.3m unmitigated risk and a number of other risks which are being actively managed. There is still a significant level of risk to achieving the CCG plans which will be reported in detail to the Finance and Performance Committee and managed through the Alliance Turnaround Board.

8 Recommendation

8.1 To note the CCG's financial position at Month 4.

Date: 15 September 2018

Lead Director: Mark Baker, Strategic Finance Director

Appendix 1: Summary Operating Cost Statement

High Weald Lewes Havens CCG Operating Cost Statement (Summarised)	Year to Date £000's			Annual £000's		
	Plan	Actual	Variance	Plan	Forecast	Variance
Acute Services	41,416	41,553	(137)	126,987	127,223	(236)
Mental Health Services	6,055	6,094	(40)	18,164	18,124	40
Community Health Services	7,202	7,051	150	21,605	21,277	328
Continuing Health Care Services	4,225	4,010	215	12,474	12,249	225
Primary Care Prescribing Services	8,766	8,743	23	26,037	26,037	0
Primary Care Services	2,122	2,120	2	6,367	6,367	0
Other Programme Services	2,217	2,296	(78)	7,002	7,359	(357)
Commissioning Services Total	**72,002**	**71,867**	**135**	**218,636**	**218,636**	**0**
Delegated Co-Commissioning Services	7,229	7,230	(0)	21,689	21,689	0
Delegated Co-Commissioning Services Total	**7,229**	**7,230**	**(0)**	**21,689**	**21,689**	**0**
Corporate Costs (Running Costs)	1,236	1,235	1	3,708	3,708	0
Corporate Costs (Non Running Costs)	1,019	1,155	(136)	3,056	3,056	0
Corporate Costs Total	**2,255**	**2,390**	**(136)**	**6,764**	**6,764**	**0**
Contingency	0	0	0	1,198	1,198	0
Unidentified Savings	0	0	0	(699)	(699)	0
Reserves Total	**0**	**0**	**0**	**499**	**499**	**0**
Net Operating Cost Statement Total	**81,486**	**81,487**	**(1)**	**247,588**	**247,588**	**0**
Revenue Resource Limit	**78,995**	**78,995**	**0**	**237,982**	**237,982**	**0**
Surplus/(Deficit)	**(2,491)**	**(2,491)**	**1**	**(9,606)**	**(9,606)**	**(0)**

Sussex & East Surrey
Sustainability & Transformation Partnership

STP programme update

1. Summary

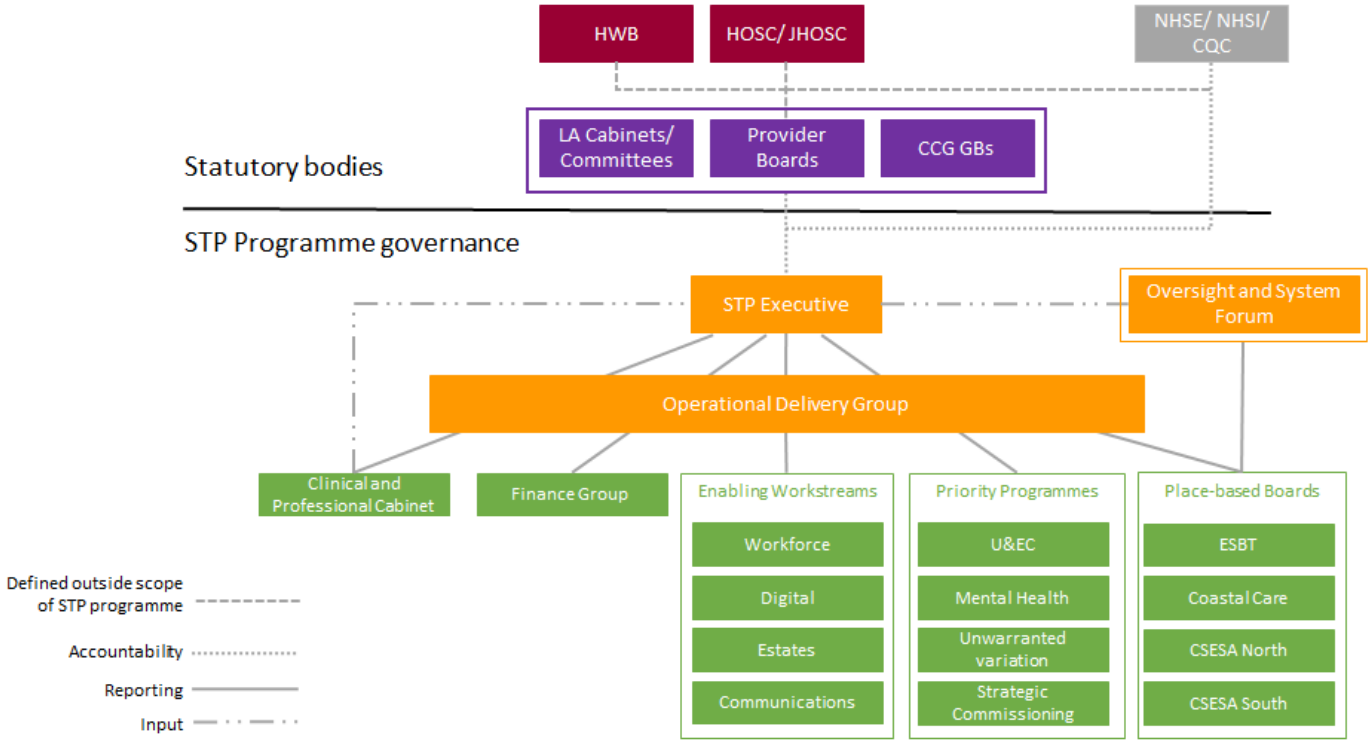
- The STP is a Partnership of 24 organisations across Sussex and East Surrey, including four upper tier local authorities.
- The STP Executive Chair is Bob Alexander and, working alongside him and the Chief Executives of the NHS organisations, is a programme director, supported by a small programme team.
- There are a number of workstreams focused on immediate priorities and there are four 'place-based plans', based around the emergency care systems within the STP.
- Recent governance review has taken place to refine, clarify and improve the governance arrangements. These are inclusive, initially focused on the NHS organisations within the partnership.
- Discussions are underway around the future of commissioning across the STP. This follows the creation of the Central Sussex Commissioning Alliance and a shared Accountable Officer across CCGs.

2. Governance

2.1 A review of the STP governance has taken place and refined arrangements have been designed, developed and accepted by the STP Executive, Programme Board and Oversight Group.

2.2 The arrangements aim to define and embed roles and responsibilities of the STP leadership, give greater clarity around accountability and provide assurances around progress and delivery of STP programmes and local plans. The arrangements are intended to compliment the accountability of individual partner organisations. The new arrangements include the formation of an Operational Delivery Group, which is the "engine room" of the STP where the work of the workstreams is co-ordinated and discussed.

2.3 Due to the changing nature and dynamics of STP development, the new arrangements will be regularly reviewed to ensure they are working effectively and remain fit for purpose.



3 Workstreams

3.1 The current workstreams for the STP are as follows and are aligned to the agreed immediate priorities of the STP.

- Mental Health
- Urgent and emergency care
- Medicines Management
- Clinically Effective Commissioning
- Continuing Healthcare
- Back office functions
- Estates
- Digital
- Workforce
- Communications and Engagement
- Finance

3.2 A 'baseline review' recently took place to look at the progress to date of the workstreams and to see what additional support was required to help them progress. Some workstreams are more advanced than others – particularly Mental Health and the Clinically Effective Commissioning Programme. The mental health workstream has formed an STP Programme Board and a case for change. The Clinically Effective Commissioning Programme is a Sussex-only piece of work. However, it is working very closely with the Surrey Collaborative to ensure there is consistency across the boundaries.

4 Recent developments

4.1 The STP Executive are currently discussing the strategic and longer-term priorities of the STP for the year ahead. These are aligned, and in addition to, the work taking place within the workstreams.

4.2 Discussions are taking place around the future of commissioning across the STP. Recent consolidation of CCGs through the Central Sussex and East Surrey Commissioning Alliance has realised a number of benefits, including streamlined processes and sharing of best practice and expertise. Adam Doyle took over as Accountable Officer for Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG on 17 September and is now the single Accountable Officer for all the CCGs across the STP. There will now be discussions around how the CCGs can work closer and more effectively together.

4.3 Work is currently underway to develop a case for change for the STP, which identifies the key challenges and areas that need improvement across our local health and care system. A lot of work has taken place around case for change within local transformation plans and specific areas, such as mental health, but this is the first time a unified case for change has been developed across the STP. This is being led by the STP Clinical Cabinet and will be an important reference point for all the partnership organisations and will be a focus for engagement with the public and stakeholders. The final draft of the case for change is currently being reviewed by the STP Clinical and Professional Cabinet and the STP Executive with a view to final sign off soon.

4.4 An outline business case is now being written for the building of a new pathology unit at Princess Royal Hospital in Haywards Heath. This comes following an announcement in April by the Secretary of State around an allocation of money to the STP for the unit, subject to business case approval. The proposed new unit will improve and speed up how pathology services are carried out and make them more sustainable for the future. The proposal makes it possible to centralise microbiology and other specialties from Brighton and Sussex University Hospitals NHS Trust and Surrey and Sussex Healthcare NHS Trust, who have been working together to provide pathology services on different sites.

4.5 The STP has received funding from Health Education England to create a small team to progress the workstream around workforce across Sussex and East Surrey. The programme work includes looking at STP-level workforce planning and information projects, talent management, leadership development and ways in which employment checks and training can be streamlined.

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UPDATE ON SUSSEX CLINICALLY EFFECTIVE COMMISSIONING PROGRAMME

1. What is the Clinically Effective Commissioning Programme?

Clinically Effective Commissioning (CEC) is a Sussex and East Surrey STP initiative established in 2017, which aims to improve the effectiveness and value for money of healthcare services by ensuring that commissioning decisions across the STP are consistent, reflect best practice, are in line with the latest clinical evidence and represent the most sensible use of limited resources.

The aim of the programme is to bring a uniform systematic approach to policy review and implementation across all the CCGs in the STP to remove unwarranted variation and apply sound clinical decision making within agreed policies. This ensures equity of access, improved clinical outcomes, better patient experience and efficient demand and capacity management across the system.

To enable this to happen, all Sussex CCGs have come together as part of the CEC Programme and agreed to take a single approach to identifying, developing and agreeing areas of focus.

It should be noted that currently, although East Surrey CCG is part of the Sussex and East Surrey STP, it operates as part of the Surrey Priorities Group which is the Surrey Equivalent of the Sussex CEC programme. Commissioners are currently considering the opportunity of realigning East Surrey CCG to the Sussex CEC Programme.

2. The Sussex CEC programme of work

The programme is divided into three work streams:

1. Developing a single set of Sussex wide clinical policies for procedures that have low clinical value or where evidence demonstrates the value of having treatment thresholds
2. Introducing IT solutions to support clinical decision making
3. Improving communications and engagement around clinical policies with GPs, the acute trusts and the wider public

So far, the work of the Sussex CEC Programme has been grouped into three tranches of policies:

- **Tranche 0** - covering 79 procedures, predominantly only commissioned by exception.

- **Tranche 1** covering 12 procedures where the policies already existed across the CCG's but had different threshold criteria and so the aim was to align the policies across the STP

- **Tranche 2** covering a further 19 procedures, for which there is considerable variation in existing policies or lack of policies.

Tranches 0-2 have been ratified by all Sussex CCGs and are being implemented with acute trusts in the STP.

3. Policy Pipeline for 2018/19

For 2018/19, there is an emerging pipeline of potential new policies which is currently being scoped out. These projects are likely to be more impactful and therefore likely to require wider public and patient consultation before being considered.

4. CEC Delivery Plan

A CEC Delivery Plan for 2018/19 has been developed and approved by the CEC Programme Board in June 2018. This has been shared with the 7 CCG Governing Bodies and endosed in their June/July meetings.

The Delivery Plan has two components:

a. A mobilisation Plan

This plan is designed to ensure that the technological and process infrastructure is in place to support effective implementation of existing and new CEC policies. This refers to rolling out clinical decision support tools in primary care and other IT-enabled system that allow commissioners and providers to ensure that the agreed policies are being adhered to.

In addition, two implementation groups (MSK and General Surgery) will focus on ensuring that the whole patient care pathway follows the evidence base supported by the Clinical Policies and treatment thresholds across Sussex.

b. The Process Review

This review has been set in motion to help ensure that the whole policy development process (from idea to full implementation) is robust, has got adequate engagement

with clinicians, STP partner organisations, patients and the wider public, and the right level of challenge is in place at all stages of the policy development and implementation.

Furthermore, an **Ethical Framework** has been developed to support decision making.

5. Changes to Governance and Patient/Public Engagement

In parallel to the Delivery Plan, work is underway to strengthen the governance and formal decision-making arrangements governing the CEC programme with a view to streamlining these and strengthening oversight and transparency of the CEC programme as a whole.

As part of this the following developments are currently underway:

- The establishment of a **Joint Committee of the CCGs** to streamline the policy approval process. A consultation with CCG Governing Bodies is currently underway around the Terms of such a committee and a decision on establishing this is underway with a decision expected by October 2018.

- The establishment of a **Joint Health Overview and Scrutiny Committee** of the Local Authorities within the STP. This has been discussed with the Chairs of the HOSC and HASC during June with a view to considering the implications of proposed policies which may require formal consultation. The Chairs have committed to exploring how such a Joint committee could be established to ensure a single consistent formal consultation process, where this is necessary.

- A **Communications and Engagement Group** has been established, comprising Communications and Engagement leads from across the STP area; this group will support the use of an Engagement Framework which was co-produced with patients, Voluntary and Community Sector (VCS) and Healthwatch from across the STP area. In addition, patient/carer leaders, Healthwatch and VCS representatives will be involved appropriately in the development of discrete communications and engagement plans for individual areas within Tranche 3.

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Tranche 0: Covers 79 procedures, predominantly only commissioned by exception.

- Alternative therapies
- Cosmetic or plastic surgery procedures
- Breast surgery procedures
- Facial procedures
- Skin and subcutaneous procedures
- Ear, nose, throat procedures
- Gynaecology procedures
- Neurology/neurosurgery procedures
- Ophthalmology procedures
- Other surgery procedures
- Urology procedures
- IPG exclusions & clinical trials
- Cosmetic or plastic surgery procedures
- Musculoskeletal procedures
- NHS England commissioned services
- Foetal alcohol spectrum disorder

Tranche 1: Covers 12 procedures where the policies already existed across the CCGs but had different threshold criteria and so the aim was to align the policies across the STP.

1. Asymptomatic Gallstones surgery
2. Blepharoplasty
3. Chalazion surgery
4. Circumcision
5. Dilation and Curettage
6. Female Sterilisation surgery
7. Hallux Valgus Surgery
8. Reduction Mammoplasty
9. Revision / Augmentation Mammoplasty
10. Rhino/ Septoplasty
11. Tonsillectomy
12. Trigger Finger surgery

Tranche 2: Covers a further 19 procedures, for which there is considerable variation in existing policies or lack of policies.

1. Arthroscopy/ Knee washout (in patients with knee osteoarthritis)
2. Brow Ptosis surgery
3. Carpal tunnel syndrome (surgical treatment of)
4. Excision of Haemmorhoid surgery
5. Female genital prolapse/stress incontinence (assessment of)
6. Ganglia (Excision of ganglia)
7. Grommets in children under 12 (ventilation tubes) (Insertion of)
8. Grommets in older children (12 and above) and adults (ventilation tubes) (insertion)
9. Hernia Treatments
10. Hysterectomy for heavy menstrual bleeding
11. Minor Skin Lesions (treatment of)
12. Obstructive sleep apnoea surgery in adults
13. Penile Implants
14. Uterine fibroids (minimally invasive surgery for)
15. Varicose veins surgery
16. Knee replacement surgery (primary)
17. Hip replacement surgery (primary)

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

Date of meeting: **27 September 2018**

By: **Assistant Chief Executive**

Title: **Urgent Care Redesign in East Sussex**

Purpose: **To update HOSC on the redesign of the urgent care system as part of both the Connecting 4 You and East Sussex Better Together programmes; and to provide an update on the NHS 111 procurement process**

RECOMMENDATIONS

The Committee is recommended to:

1) **Consider and comment on the progress of the NHS 111 procurement process**
2) **consider and comment on the progress of urgent care redesign in the Connecting 4 You and East Sussex Better Together areas.**
3) **Agree to resume the work of the HOSC sub-group considering Urgent Treatment Centre proposals in the East Sussex Better Together area.**

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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 by December 2019;
- the commissioning of the nationally mandated increase in Extended Primary Care Access (access to GP appointments outside core hours and at weekends) by October 2018.
- the re-procurement of NHS 111 to include the ability to book patients into UTCs and to have a Clinical Assessment Service (CAS) that can hear and treat patients over the phone.

1.3 UTCs and extended access to GP services are being developed separately in the Connecting 4 You (C4Y) and East Sussex Better Together (ESBT) areas of East Sussex. NHS 111 is being re-procured across the whole of Sussex, led by Coastal West Sussex Clinical Commissioning Group (CCG) on behalf of all the Sussex CCGs.

2. Supporting information

NHS 111

2.1. The Chair of HOSC was contacted by the 111 Programme Director (Sussex) on 14 June with notification that a decision had been taken to stop the current NHS 111 procurement for

Sussex, which was due to appoint a provider to deliver a redesigned 111 service to the nationally mandated specification from 1 April 2019.

2.2. The Committee considered a verbal update at its 29 June meeting. It was assured by officers that the pause was not due to a flawed procurement process and that NHS England shared this view; officers were undertaking further engagement with the market and researching what NHS 111 models were being developed elsewhere in the country. Discussions with the current NHS 111 provider – South East Coast Ambulance Service NHS Foundation Trust (SECAmb) – were about to begin to ensure continuity of service beyond the end of the current contract in April 2019.

2.3. Coastal West Sussex CCG has provided an update (attached as **appendix 1**) on the progress of the NHS 111 procurement and its impact on the urgent care redesign programmes in the ESBT and C4Y areas of East Sussex.

2.4. The update report outlines how the revised procurement process will be taken to the seven Sussex CCG Governing Bodies in September for agreement. Discussions with the current providers are also underway to ensure continuity of service for patients after 1 April 2019 for up to a year until the new service is in place, which is anticipated to be 1 April 2020.

East Sussex Better Together

2.5. HOSC considered reports on urgent care redesign in the ESBT area in December 2016, September 2017, March 2018 and June 2018.

2.6. At the March meeting HOSC considered proposals from Eastbourne, Hailsham and Seaford Clinical Commissioning Group (EHS CCG) and Hastings and Rother CCG (HR CCG) to establish two UTCs co-located with the A&E departments at Eastbourne District General Hospital (EDGH) 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.

2.7. The Committee agreed that the proposed relocation of walk-in services constituted a 'substantial development or variation to services' requiring consultation by the CCGs with the Committee in accordance with health scrutiny legislation.

2.8. At its June meeting the Committee learned that the pause in the NHS 111 procurement process meant it was necessary for CCGs to review the UTC proposals over the summer and update HOSC in September. The Committee was informed that the CCGs did not believe the impact of the NHS 111 procurement would be significant on UTC plans.

2.9. HOSC had formed a sub-group to take responsibility for considering the UTC proposals in detail and preparing a response for consideration by the Committee**.** Given the review being undertaken by the CCGs, HOSC agreed to suspend the sub-group's work pending re-submission of proposals to the Committee.

2.10. A further update on ESBT urgent care redesign provided by EHS and HR CCGs is attached as part of **appendix 2**. The report outlines that a revised delivery timeline for the UTC plans has been set with an operational date of 1 October 2019. The CCGs have also conducted a further options appraisal and have identified four options for UTC reconfiguration, as well as a 'do nothing' option; these options will be considered by the CCG Governing Boards on 26 September. The outline business case will be published in October 2018; public engagement will take place during November and December 2018; and a final business case will be agreed by the CCGs' Governing Boards in February 2019.

2.11. The timeline for implementing the proposals means that HOSC may wish to recommence the HOSC sub-group considering Urgent Treatment Centre proposals in the East Sussex Better Together area to ensure that it can consider the revised options in a timely manner.

2.12. Alongside the proposal to establish co-located UTCs with the local A&E departments, the ESBT CCGs are required to commission the nationally mandated increase in Primary Care Extended Access (PCEA) (access to primary care appointments outside core hours and at weekends) by 1 October 2018.

2.13. **Appendix 2** provides an update on progress to date setting out how:

- South Downs Health Care Limited in partnership with HERE will provide PCEA in Bexhill, Eastbourne, Hailsham and Seaford – initially in two hubs (Eastbourne and Bexhill) from 1 October and five by January 2019. This will provide 100% extended access coverage for EHS CCG and 30% coverage for HR CCG.
- The provider of the remaining 70% coverage in the HR CCG area will be determined on 19 September following the outcome of a second procurement process.

Connecting 4 You

2.14. The Committee considered an update on the progress of the urgent care redesign as part of the C4Y programme at its June 2018 meeting. The Committee was informed about, amongst other things, the progress with implementing changes to the Minor Injuries Unit at Lewes Victoria Hospital to establish it as a UTC and the plans to roll out extended access to primary care across the High Weald Lewes Havens (HWLH) area by October.

2.15. HWLH CCG has provided a further update (attached as **appendix 3**) on the progress of plans to roll out extended access to primary care in the C4Y area of East Sussex.

2.16. The update outlines how Care Unbound, a subsidiary of HERE, has been appointed to deliver the PCEA service across the HWLH area from 1 October through a minimum of 4 hubs in line with national requirements at a cost of £6m over 5 years. The CCG explains that the timetable for delivering Improved Access has been ambitious and risks to delivery remain, although mitigating actions are in place.

3. Conclusion and reasons for recommendations

3.1 This report provides HOSC with an update on developments in relation to urgent care as part of the C4Y and ESBT programmes, including specific proposals in relation to UTCs. HOSC is recommended to consider and comment on the updates.

PHILIP BAKER
Assistant Chief Executive

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East Sussex HOSC update for September 2018.

NHS 111 Procurement update for Sussex

The decision was made on 13 June 2018, by the seven, Sussex CCGs' Accountable Officers and their Governing Body Chairs to halt the current procurement process for the new NHS 111, Clinical Assessment Service (CAS) and Visiting Service for Sussex.

We knew that by stopping the procurement it would delay the go-live date for the new service and have some impact on other elements within Integrated Urgent Care, such as Urgent Treatment Centres (UTCs), these are being commissioned locally and are still aiming to meet an October 2019 – December 2019 go live.

Two options were submitted to Governing Bodies in July to either direct award the contract for three years or re-procure the service. All seven CCGs' Governing Bodies agreed the proposed option to restart the procurement, but wanted to see some changes to the procurement process, as it did not deliver what was required the first time round.

The NHS 111 Transformation Programme Board has reviewed the procurement approach, service specification and procurement timetable in August, with the agreement to take the proposed changes to the seven Sussex CCG Governing Bodies in September.

As part of the procurement approach, we will be running an additional market engagement event to explain to potential bidders the changes we have made. The event is to be organised in line with when the procurement goes live. All the Sussex HOSC and HASC Chair of HOSC are invited.

We want to give assurance that our commissioners across Sussex are in the process of confirming with our current NHS 111 provider SECAmb and our GP Out of Hours (OOH) provider IC24 to ensure we have continuity of service for our patients after 1 April 2019 for up to a year until the new service is in place. The conversations have been positive and all seven of the Sussex CCGs' are still on track to meet NHS England's national nine key outcomes of integrated urgent care, listed below:

1. A single call to get an appointment during the out-of-hours period.
2. Data and Information can be shared between providers.
3. The capacity for NHS 111 and urgent multidisciplinary clinical services need to be jointly planned.
4. The Summary Care Record (SCR) is available in the CAS and elsewhere.
5. Care plans and special patient notes are visible to the Clinicians in the IUC and in any downstream location of care.
6. Appointments can be made to in-hours and extend access to primary care services - offering services in the evening and at weekends.
7. There is joint governance across Urgent and Emergency Care.
8. Suitable calls are transferred to a CAS containing GPs and other health care and social care professionals.

9. The Workforce Blueprint products and guidance are implemented across all providers.

As a programme, we are committed and to delivering integrated urgent and emergency care across Sussex, to ensure it benefits the clinical workforce, benefit patients and local populations; and, provide better value for our taxpayers' money.

Recommendations

The committee are recommended to:

Note the update on the 111 procurement for the Sussex CCGS

East Sussex Better Together (ESBT) – Urgent Care Redesign Programme Update

Mark Angus, Urgent Care System Improvement Director for East Sussex Better Together

This paper provides a summary update on the progress being made on the ESBT Urgent Care Re-Design Programme in respect of Urgent Treatment Centres (UTCs) and Primary Care Extended Access (PCEA).

1. Urgent Treatment Centres

1.1. Background

UTCs are nationally required to be in place by no later than **01 December 2019** and beyond this date services should no longer be referred to as walk in centres (WICs), minor injury units (MIUs) or urgent care centres (UCCs).

On 28 March 2018 the ESBT CCGs' Governing Bodies approved an outline business case that proposed to develop UTCs that will be co-located to our two local hospital A&E departments at Eastbourne District General Hospital (EDGH) and Conquest Hospital by **01 April 2019.**

The CCGs plans and proposals to develop UTCs were also submitted to the East Sussex Health Overview and Scrutiny Committee (HOSC) on 29 March 2018**.**

In June 2018 the Sussex CCGs took the decision to stop the 111 procurement process. Whilst there has been agreement to start a new procurement process it is anticipated that full implementation of the new NHS 111/Clinical Assessment Service (CAS) contract will not be in place until **01 April 2020**.

The CCGs' Governing Bodies were informed in June 2018 that, as a consequence of the decision to stop the 111 procurement process, there was a need to assess the impact of this decision on our local plans to develop UTCs. This also provided an opportunity to consider the pre-consultation engagement feedback we have received since we submitted our detailed UTC proposals to HOSC in March 2018**.**

1.2. Impact of NHS 111 Procurement Decision on UTC Plans

The ESBT plans to develop UTCs were designed to align with an integrated approach to urgent care that would bring together a number of services such as GP out of hours (OOH), primary care streaming and walk in urgent care access, and would be supported in part by the implementation of the national Integrated Urgent Care (IUC) specification and the operational delivery of the new NHS 111/CAS by **01 April 2019.**

Therefore the impact that the decision to stop the 111 procurement has on our local UTC plans relates principally to the timing of the IUC re-design elements and related contract negotiations and extensions, which are currently taking place with existing service providers.

The ESBT CCGs have reviewed the timelines of our UTC plans and have aligned them to deliver our UTCs by **01 October 2019.**

1.3. Progress to date

Since the initial iteration of the Outline Business Case was presented to the CCGs' Governing Bodies on 28 March 2018, further communication and engagement with the public and key stakeholders has taken place:

- UTC Proposals to HOSC (March 2018);
- Provider Market Engagement activities (May 2018);
- Consultation feedback from HOSC Subgroup (April and May 2018);
- 'Shaping Health & Social Care' events (May 2018);
- Patient Participation Group (PPG) Forums (in both CCGs); and
- East Sussex Seniors' Meeting.

There have also been developments of a number of external factors which influence the development of our local UTCs:

- Understanding of the national and local integrated urgent care model has matured;
- Greater understanding of local patient demand for primary urgent care services (PUCS), i.e. NHS 111, Walk In Centres and GP out of hours services ;and
- NHS 111 Procurement Stop Decision.

In response to the understanding afforded from the above, the ESBT Urgent Care Planning and Design Group (UCPD) decided to revisit the proposed UTC options by way of a further options appraisal to test their robustness against this new intelligence.

A Commissioners' Workshop was held on 02 August 2018 to review the new intelligence available and consider its impact upon UTCs. As an outcome of this meeting (in addition to the option of 'do nothing') four options were identified for each CCG.

It was agreed to hold a second workshop to score these options against a set of criteria to ascertain which would be the preferred option for each CCG.

The second workshop took place on 05 September 2018. In addition to CCG staff, invitations were made to representatives from HOSC, PPGs, Hastings and Eastbourne Borough Councils, Healthwatch and Lay-Members of the CCGs' Governing Bodies. Representatives from Healthwatch, PPGs and a CCG Governing Body Lay-Member attended.

1.4. Next Steps

The outcome of the options appraisal and related recommendations will be submitted to the CCGs' Governing Bodies on **26 September 2018**. However until the outcome of the options appraisal and related recommendations are formally considered by the CCGs governing bodies it is not possible to include these in this paper.

The table below sets out the key governance milestones to ensure that the national requirement for CCGs to establish designated UTCs by no later than **1 December 2019** is achieved.

Table 1: ESBT UTC Timelines

Key Milestone	**Delivery Date**
Options Appraisal Paper to CCGs' Governing Bodies	September 2018
Updated Outline Business Case and plans for further public engagement and communications	October 2018
Further public engagement	November - December 2018
Final Business Case to CCGs' Governing Bodies	February 2019
Procurement of UTCs	February - May 2019
Mobilisation	May - October 2019
UTCs Operational	October 2019

Whilst we progress our UTC plans and proposals all patients registered at Hastings Medical Practice / Eastbourne Station Health Centre will continue to have on-going access to GP services with no break in provision of services.

Local people will still be able to access walk-in services, seven days a week, from 8am-8pm. For patients already registered with a GP at our current walk-in centres, appointments continue as normal.

1.5. Public Engagement and Communication Plans

The CCGs plan to undertake further public engagement activities following the CCGs' Governing Bodies' consideration of the options appraisal review and submission of an updated outline business case to its meeting on **31 October 2018**.

The revised UTC timelines allow for a two month period of further engagement during November and December 2018.

2. Primary Care Extended Access

2.1. Background

In the GP Forward View (GPFV) published in 2016, NHS England (NHSE) stated that CCGs would be expected to work at scale to provide improved access collectively, in primary care access hubs. An initial deadline of 01 April 2019 for 100% mobilisation was issued, with 50% mobilisation by 01 October 2018. In February 2018, this timescale was amended to 100% population coverage, 7 days a week, 365 days a week by **01 October 2018.**

NHS Operational Planning and Contracting Guidance 2017-2019 provides detail of what CCGs need to provide. Specific requirements include the following:

- Weekday provision of access to pre-bookable and same day appointments to general practice services in evenings (after 6.30pm) to provide an additional 1.5 hours a day;

- Weekend provision of access to pre-bookable and same day appointments on both Saturdays and Sundays to meet local population needs;
- Provide robust evidence, based on utilisation rates for the proposed disposition of services throughout the week;
- Appointments can be provided on a hub basis with practices working at scale; and
- A minimum additional 30 minutes consultation capacity per 1000 population, rising to 45 minutes per 1000 population. The guidance also states that CCGs will be required to secure services following appropriate procurement processes.

2.2. Progress to date

Following a process a provider (South Downs Health and Care Limited in partnership with HERE trading as Care Unbound Limited) were awarded a contract to provide PCEA services for the populations of Bexhill, Eastbourne, Hailsham and Seaford and the CCG is currently in contract negotiations with the provider to deliver the service from **01 October 2018**. This will provide 100% extended access coverage for Eastbourne, Hailsham and Seaford (EHS) CCG and 30% coverage for Hastings and Rother (H&R) CCG.

In relation to the remaining 70% coverage for H&R CCG the CCGs were unable to award a contract following the outcome of the initial procurement process. In response, the CCGs offered a further opportunity to bidders for the Hastings and Rother lots, via a second stage procurement process and whilst it is recognised that the delivery timescales for 100% extended access coverage by **01 October 2018** has been challenging, the CCGs are working closely with providers and local GPs so that services will be in place by the **01 October 2018** deadline.

A communications plan to ensure that local people are aware of the new service provision from 1 October is being finalised and will be rapidly implemented.

3. Temporary closure of Eastbourne Station Health Centre

On 26 August 2018 a major flood at the Eastbourne Station Health Centre, run by IC24, caused significant damage to the facility and both the walk in centre and registered practice services have been affected.

Commissioners and providers worked collaboratively and quickly to put in place contingency measures to ensure service provision as follows:

- Registered practice services – Temporarily re-located to the Grove Road Practice; and
- WIC services – Temporarily re-located to EDGH with IC24 and East Sussex Healthcare NHS Trust (ESHT) working together to provide an urgent primary care service for walk in primary care patients.

It is anticipated that that work to repair the ground floor of the Eastbourne Station Health Centre will be completed by the end of September 2018, which will enable the registered practice service to be moved back to the health centre.

The timescales for the repair of the remainder of the building are still to be confirmed but are anticipated to require a period of at least two months to be completed.

The contingency plans were mobilised quickly and effectively and all providers are working positively together to ensure that any negative impact on patient access and experience is minimised.

The commissioners continue to work with IC24 and ESHT and are closely monitoring the impact of the temporary re-location of these services on patients.

4. Recommendations

The committee are recommended to:

- **Note** the update on the ESBT CCG's plans to develop UTCS, the next steps and related timescales;
- **Note** the update on the ESBT CCGs' plans to establish 100% coverage of Primary Care Extended Access by **01 October 2018**,
- **Note** the temporary re-location of Eastbourne Health Centre services.

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Commissioning Alliance
Brighton and Hove CCG
Crawley CCG
High Weald Lewes Havens CCG
Horsham and Mid Sussex CCG

NHS High Weald Lewes Havens CCG

Improved Access in Primary Care

Summary

This paper sets out the progress towards delivering Improved Access to Primary Care in HWLH CCG area

Introduction

NHS England set out in the GP Forward View that CCGs would be expected to work at scale to provide improved access collectively, in primary care access hubs. An initial deadline of 1 April 2019 for 100% mobilisation was issued, with 50% mobilisation by 1 October 2018. In February 2018, this timescale was amended to 100% mobilisation by 1 October 2018.

NHS Operational Planning and Contracting Guidance 2017-2019 provides detail of what CCGs need to provide. Specific requirements include the following

- Weekday provision of access to pre-bookable and same day appointments to general practice services in evenings (after 6.30pm) to provide an additional 1.5 hours a day.
- Weekend provision of access to pre-bookable and same day appointments on both Saturdays and Sundays to meet local population needs.
- Provide robust evidence, based on utilisation rates for the proposed disposition of services throughout the week.
- Appointments can be provided on a hub basis with practices working at scale.
- A minimum additional 30 minutes consultation capacity per 1000 population, rising to 45 minutes per 1000 population. The guidance also states that CCGs will be required to secure services following appropriate procurement processes.

Progress to date

A Patient Survey, with input from two Patient Participation Groups, was sent to all householders in HWLH in October 2017, which informed a project plan and service specification was developed and agreed in January 2018. Following a procurement process, a provider (Care Unbound, a subsidiary of HERE) was appointed and the CCG in currently in contract negotiations with them to deliver the service across the CCG area from 1 October 2018. This will be delivered from a minimum of 4 hubs in line with the national requirements. A full communications plan is being prepared to inform patients of the new service; and how it can be accessed.

Potential risks

The committee should be aware that delivery of the service has featured on the CCG risk register for some time, due to a number of reasons as follows

- Length of procurement. Given the size of the contract (c.£6m over 5 years), NHSE advised the CCG to go to procurement. This process was pressurised when the initial call for bids resulted in only one bidder passing through the initial procurement stage. Reflecting on the lessons learned from the Patient Transport Service procurement, the decision was taken to go out to tender again. This has resulted in a contracted mobilisation phase that presents challenges to the provider.
- Data Sharing. The national requirements include a need for the Improved Access service to access and add to the patient record. This means the successful bidder needs to agree separate data sharing agreements with each practice in HWLH.
- Workforce. HOSC will be aware of the current workforce problems throughout the NHS, which includes General Practice. Practices across HWLH have reported difficulties for some time in recruiting medical and nursing staff.

Mitigations

The CCG is taking a number of actions to mitigate against the risks, including the following.

- A day by day mobilisation plan has been agreed and is being reviewed weekly by the CCG and provider
- An agreed Data sharing protocol, based on good practice in Brighton and utilised by the same provider with practices there, has been circulated with all HWLH practices. Additional support has been agreed with the STP digital lead to ensure GPs and patients can feel confident that their data is secure.
- The provider is in negotiations with GP practices; Sussex Community NHS Foundation Trust; and South East Coast Ambulance Service NHS Foundation Trust to ensure enough GPs and support staff are in place to deliver the service.

Conclusion

The timetable for delivering Improved Access has been ambitious, and risks to delivery remain. Mitigating actions are in place, and the CCG is working with the provider to ensure every effort is made to deliver the service by the 1 October deadline. However clinical safety and data protection remain paramount, and the CCG will not compromise these for this to be achieved.

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

Date of meeting: **28 June 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

The Committee is recommended to agree the work programme.

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

2.2 Both active Joint HOSC sub-groups have three representatives from East Sussex HOSC. The two joint HOSC sub-groups have been set up to scrutinise the following Trusts:

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, Howell and Murray. The next meeting is planned for October.

Sussex Partnership NHS Foundation Trust (SPFT)

- A Joint Sussex HOSCs sub-group to scrutinise SPFT's 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, Bowdler and Osborne. The last meeting was on 11 September and minutes will be circulated to the Committee when available.

Joint HOSC Kent and Medway Stroke Review

2.3 A Joint HOSC was established earlier in the year – comprising members of East Sussex, Kent, Medway and London Borough of Bexley – to formally consider the proposals of Kent and Medway Clinical Commissioning Groups (CCGs) to reconfigure stroke services in Kent and Medway from seven acute stroke units to three Hyper Acute Stroke Services (HASU). Cllr Belsey and Howell are the East Sussex representatives.

2.4 Over the summer, the CCGs consulted on five potential options for where the three HASUs would be located. The CCGs have now published a press release and FAQ setting out the 'preferred option' reached by the CCG Joint Committee meeting on 13 September (FAQ attached as **appendix 2**).

2.5 The preferred option is to reconfigure stroke services in Kent and Medway onto three HASUs at Darent Valley Hospital in Dartford, Maidstone Hospital and William Harvey Hospital in Ashford.

2.6 The next stage in the CCGs' review process is to develop a decision-making business case that will be submitted to the CCG Joint Committee for a final decision in January 2019. The JHOSC will submit its formal recommendations to this Joint CCG Committee ahead of its decision.

2.7 The CCGs' final decision will then be reported back to the individual HOSC meetings in early 2019 for consideration.

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 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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Health Overview and Scrutiny Committee – Work Programme

Current Scrutiny Reviews		
Title of Review	**Detail**	**Proposed Completion Date**
Kent and Medway Stroke Review Joint Health Overview and Scrutiny Committee	A Joint Health Overview and Scrutiny Committee (JHOSC) was established in March 2018 comprising two members of East Sussex HOSC, plus representatives from Kent County Council, Medway Council and the London Borough of Bexley to consider the NHS proposals to reconfigure stroke services in Kent and Medway. The proposals involve reconfiguring seven existing Acute Stroke Units (ASU) in Kent and Medway to three Hyper Acute Stroke Units (HASUs). The NHS consulted on five options for configuration over the summer and is due to make a decision on a preferred option by December 2018. HOSC is expected to consider the JHOSC's report and recommendations along with the CCGs' final decision at its 28 March 2019 meeting and will take a decision on whether the proposals are in the best interests of the health service for East Sussex residents. Membership: Cllr Belsey and Howell (Sub: Cllr Davies)	28 March 2019

Urgent Treatment Centres (UTC) in Eastbourne and Hastings	The Committee agreed in March 2018 that proposals to establish UTCs by relocating the walk-in centres from Eastbourne Station and Station Plaza in Hastings to the Eastbourne District General Hospital (EDGH) and Conquest Hospital, respectively, constituted a 'substantial variation of health services' requiring the Clinical Commissioning Groups (CCGs) to formally consult with the Committee. The Committee established a review board to consider the UTC proposals in more detail and consider the outcomes of the proposed public consultation. The review board has met twice so far. Following the pause in the NHS 111 procurement process, the CCGs agreed to review the UTC plans. HOSC agreed to pause its review until such time as the UTC plans are re-developed. Membership: Cllrs Belsey (Chair), Turner, Barnes and Coles and Jennifer Twist.	TBC 2019
Initial Scoping Reviews		
Subject area for initial scoping	**Detail**	**Proposed Dates**
Sussex Joint Health Overview and Scrutiny Committee	A Joint Health Overview and Scrutiny Committee may need to be established during the autumn to consider any Sussex-wide proposals from the Sustainability and Transformation Partnership (STP) and Clinically Effective Commissioning programme that are deemed to be a 'substantial variation' to existing health services'. To date there has been no indication of specific substantial variations but it is a statutory requirement to consider any such proposals that affect more than one local authority area via a JHOSC.	29 November 2018
List of Suggested Potential Future Scrutiny Review Topics		

Suggested Topic	Detail	
Ear, Nose and Throat (ENT) services	The Committee may need to consider proposals for the future provision of ENT services at East Sussex Healthcare NHS Trust (ESHT).	
Preventative aspects of East Sussex Better Together and Connecting 4 You	Possible item for future scrutiny identified at HOSC away day – February 2018.	
Scrutiny Reference Groups		
Reference Group Title	**Subject Area**	**Meetings Dates**
Brighton & Sussex University Hospital (BSUH) NHS Trust HOSC working group	A joint Sussex HOSCs working group to scrutinise the BSUH response to the findings of recent Care Quality Commission (CQC) inspections and the Trust's wider improvement plan. CQC re-inspection report anticipated. Membership: Cllrs Belsey, Murray and Howell	Last meeting: 4 April 2018 Next meeting: TBC Oct 2018
Sussex Partnership NHS Foundation Trust (SPFT) HOSC working group	Regular meetings with 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. Membership: Cllr Belsey, Bowdler and Osborne	Last meeting: 11 September 2018 Next meeting: TBC 2019
The Sussex and East Surrey Sustainability and Transformation Partnership (STP) HOSC working group	Regular liaison meetings of HOSC Chairs in the STP footprint with STP Executive Chair and Communications and Engagement lead to update on STP progress. Membership: HOSC Chair (Cllr Belsey) and officer	Last meeting: 29 June 2018 Next meeting: 26 September 2018
Regional NHS liaison	Regular (approx. 4 monthly) liaison meetings of South East Coast area HOSC Chairs with NHS England Area Team and other regional/national organisations as required e.g. NHS Improvement, NHS Property, CQC	Last meeting: 10 May 2018 Next meeting:

	Membership: HOSC Chair (Cllr Belsey) and officer	TBC Nov 2018
Reports for Information		
Subject Area	**Detail**	**Proposed Date**
Patient Transport Service (PTS)	The Committee received email updates on the first year's performance of the PTS following a contract transfer to South Central Ambulance Service in April 2017. The final performance update was circulated in July 2018 along with a report by Healthwatch on PTS. Overall improvement is shown but with some continued areas for improvement. The Committee will consider any future reports by Healthwatch before determining if further scrutiny is required.	TBC
Quality of Maternity Services	Following the report considered by the committee in March 2018, further briefings on postnatal care and the development of ante-natal care (in terms of preventing stillbirths) were requested.	Circulated June and September 2018
Cancer Care Performance	HOSC requested a future report on cancer care performance figures at local NHS trusts to be circulated initially by email.	Autumn 2018
Training and Development		
Title of Training/Briefing	**Detail**	**Proposed Date**
Centre for Public Scrutiny (CfPS) National health scrutiny and assurance conference	A conference organised by CfPS to explore current and future health policy and issues and identify the role of health scrutiny committees. To be attended by the Chair and Vice Chair	14 September 2018
Committee away day	The Committee requested a follow-up to the away day held in February 2018 to focus on questioning skills and possible future areas of scrutiny.	TBC 2019

Future Committee Agenda Items		Author
All meetings		
Committee Work Programme	To manage the committee's programme of work including matters relating to ongoing reviews, initial scoping reviews, future scrutiny topics, reference groups, training and development matters and reports for information.	Senior Democratic Services Adviser
29 November 2018		
Mental Health Services in East Sussex	To consider Sussex Partnership NHS Foundation Trust's plans to develop inpatient mental health services in East Sussex.	Representative of Sussex Partnership NHS Foundation Trust (SPFT)
Winter Planning	To consider the robustness of local plans for managing winter pressures. To include the local health system approach to minimising delayed transfers of care due to NHS reasons.	Representatives of CCGs & ESHT
28 March 2019		
Kent and Medway Stroke Review	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.*	Kent and Medway Sustainability and Transformation Partnership, HWLH CCG
South East Coast Ambulance Service Performance and Improvement	To consider an update on the Ambulance Trust's performance and improvement. *Timing provisional dependent on an anticipated Care Quality Commission inspection.*	Representative of South East Coast Ambulance Service NHS Foundation Trust (SECAmb)

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Transforming health and social care in Kent and Medway

NHS

Review of urgent stroke care services: Frequently asked questions following announcement of the preferred option

17th September 2018

Frequently asked questions

Question: what were the five options that were being considered for urgent stroke services in Kent and Medway?

Answer: The proposals that we consulted on were to establish hyper acute stroke units in Kent and Medway, and the proposals recommend establishing three units. The proposals set out five options for where these three units could be located across Kent and Medway.

These five proposed options were:

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

Question: Which of the five options has been identified as the preferred option?

Answer: The NHS in Kent and Medway has today published details of the preferred option for the configuration of stroke services that care for people in the immediate period following a stroke.

The preferred option was identified at an evaluation workshop that involved representatives from all CCGs across Kent, Medway East Sussex and south east London, including GPs, commissioners and patient representatives. Councillors from Kent, Medway, East Sussex and Bexley were also in attendance. The evaluation workshop identified **Option B** as the preferred option with the proposal to establish three hyper acute stroke units (HASUs), alongside acute stroke units at the following hospital sites: **Darent Valley Hospital in Dartford, Maidstone Hospital, and the William Harvey Hospital in Ashford.**

It is important to stress that, while this combination been identified as the preferred option, at this stage no formal decisions have been taken about the future of urgent stroke care in Kent and Medway and more work will now be undertaken to look at the potential implementation of this option in the future. This work will be set out in a 'decision-making business case' for the Joint Committee of ten clinical commissioning groups from Kent and Medway, Bexley and East Sussex to consider before they make a final decision in December 2018 or January 2019.

Question: Why was this option chosen to be the preferred option?

Answer: While it was clear that all of the options could provide improved urgent stroke services, after careful and detailed consideration and thorough evaluation of the five options using agreed criteria and detailed evidence and data, the we believe that Option B best

meets the evaluation criteria that have been used to determine the best possible configuration of urgent stroke services in Kent and Medway. These criteria are:

- **Quality** – ensuring the quality of urgent stroke care will be improved if the preferred option is implemented
- **Access** – patients across Kent and Medway, or for whom a Kent and Medway hospital is their nearest, can reach a HASU within a reasonable time frame, supporting the Kent and Medway ambition to offer those stroke patients who need them (only 15-20% of stroke patients do) clot-busting drugs within 120 minutes of calling 999 with stroke symptoms.
- **Workforce** – there are enough staff or robust plans to recruit and retain them, to ensure that the option can be implemented.
- **Ability to deliver** – ensuring that the preferred option can be successfully implemented if given the go-ahead
- **Finance** – ensuring that the preferred option can be implemented within the parameters of the capital investment available

Going from five possible options to one preferred option was always going to be a challenging step in the process. All the options had the very real potential to improve stroke care, and there was little to differentiate between them. The purpose of the post-consultation evaluation was to look closely at the fine differences between the options and identify which option was the 'best of the best'.

Question: How did you arrive at this preferred option?

Answer:

The preferred option was identified following careful consideration of the responses to a public consultation, all the evidence and data gathered during the four-year review, and further detailed evaluation of five shortlisted options.

The Joint Committee of CCGs* was satisfied that the consultation did not identify any new evidence or viable new options that required a change to the consultation proposals. However, the responses to consultation emphasised important issues for consideration during the implementation of the final option. For example, people were concerned about travel times, relatives and carers visiting loved ones, effective rehabilitation close to home and the ability to staff the new units. These and other issues will all be considered in the detailed implementation plans for the final option.

Following extensive and detailed evaluation of all the options, the preferred option was selected because it offers the best mix of clinical quality, access, ability to deliver, and value for money.

Sessions have been held with senior clinicians, decision-makers and patient representatives over the last few weeks to look at all of the data, evidence and analysis on urgent stroke care for patients across Kent and Medway and surrounding areas.

* The Joint Committee of Clinical Commissioning Groups for the Kent and Medway Stroke Review is made up of GP representatives from the ten consulting CCGs – all eight from Kent and Medway, and High Weald Lewes Havens CCG in East Sussex and Bexley CCG in south east London. The CCGs from East Sussex and south east London are included because some of their population are impacted by the proposed changes to services in Kent and Medway.

In a meeting on Thursday 13th September, representatives from all CCGs across Kent, Medway East Sussex and south east London, including GPs, commissioners and patient representatives held a workshop to identify the preferred option. Councillors from Kent, Medway, East Sussex and Bexley were also in attendance. During this meeting they considered each option against sub-criteria and detailed data and evidence for each of the evaluation criteria listed above. They looked at information from each hospital trust as well as data and analysis relating to access and travel times, deliverability, staffing and capital funding. The evaluation workshop attendees agreed that while all of the options were deliverable and could bring about the improvements to urgent stroke services that the Kent and Medway Stroke Review has identified as key objectives, Option B was preferred as it evaluated most highly and offered the best mix against the criteria.

Because the next stage of the review process – the drafting of the decision-making business case and subsequent assurance process and then final decision-making - will take some months, we wanted to let people know what the preferred option is. This is especially important for staff at local hospital trusts who may be affected by the final decision. It's important though to remember that a final decision hasn't yet been made. Option B is the preferred option being put forward for the Joint Committee of CCGs to consider in their decision-making.

Question: How did the views and feedback you heard during the public consultation influence the preferred option?

Answer:

The Joint Committee of CCGs was satisfied that the consultation did not identify any new evidence or viable new options that required a change to the consultation proposals. However, the responses to consultation emphasised important issues for consideration during the implementation of the final option. For example, people were concerned about travel times, relatives and carers visiting loved ones, effective rehabilitation close to home and the ability to staff the new units. These and other issues will all be considered in the detailed implementation plans for the final option.

On June 29th, we published a report of the consultation activity that showed in excess of 2 million people were reached during the consultation and over 5,000 responses were generated. The responses to the consultation were independently analysed to identify a number of key themes which have been carefully considered in the process of identifying a preferred option, and will remain a focus as the detailed implementation . You can see both of these reports here.

The consultation told us that people in Kent and Medway, and boarder areas, want to have hyper acute and acute stroke units, and understand the rationale for consolidating services onto fewer hospital sites in order to make the most of the resources we have. On that basis we were confident that we should progress with our plans to establish hyper acute and acute stroke units.

The consultation told us that the public understood the rationale for the proposed three HASUs, but would like to have seen four HASUs as there is concern about the increase in travel times for some people that will result from consolidating services. Following the consultation, the clinical reference group and JC CCG discussed these issues at length. They carefully considered what the latest evidence tells us regarding the benefits of care in hyper acute stroke units, the travel time data – which has been refreshed and reviewed again in detail, the information we have on our current and likely future workforce, and the

latest evidence on the minimum number of patients a HASU should see in order to be safe and effective. Having considered all these factors, the stroke clinical reference group and the JC CCG were satisfied that the number and potential location of hyper acute units should not change from the proposals consulted on.

Question: What are the next steps? How will a final decision be made?

Answer: There is more work to do before a final decision is made. The next steps are:

- Develop a decision-making business case (DMBC) – a detailed document that will describe how the preferred option was selected and set out an implementation plan that will cover areas such as workforce, estates and capital requirement.
- The decision-making business case will be reviewed by the South East Clinical Senate (senior doctors and other clinicians from across the south east region) and assured by NHS England and NHS Improvement. The Joint Health Overview and Scrutiny Committee will also continue to be engaged.
- Once the assurance process is completed, the DMBC will be presented to the JC CCG at a meeting for a final decision. We anticipate this meeting will take place in December 2018 or January 2019.

It is important to stress that, even once the preferred option has been identified, a formal decision about the future of urgent stroke care in Kent and Medway will not be made until the assurance process has been completed and the JC CCG have met and made a formal decision.

Question: What will happen to staff at existing stroke units that aren't part of the preferred option?

Answer: We know that this may be an anxious or worrying time for some staff. We have plans in place to support staff, answer their questions and help them to understand what any changes might mean for them.

We also know from staff feedback that specialist stroke staff support the development of hyper acute stroke units to improve the quality of care for patients and the identification of a preferred option brings us closer to being able to deliver the first class care our stroke teams strive for.

We believe there is an exciting future for staff working in stroke services across Kent and Medway. However, if changes were unsuitable for individuals, we expect that organisations would work to offer staff alternative roles allowing them to stay on their current site.

At the moment we face staffing challenges with significant vacancies in the stroke services at all six current sites. We believe that setting up three hyper acute stroke units would improve recruitment and retention in the medium to long term.

Question: What about rehabilitation?

Answer: The Kent and Medway Stroke Clinical Reference Group, made up of doctors, nurses, paramedics and therapists, is currently looking in detail at the rehabilitation pathway for stroke patients. We want to ensure stroke patients have access to effective local rehabilitation services delivered close to or in their own homes after their acute phase of care is completed. This was a clear point of view that came through the consultation responses. People rightly put emphasis on making sure that all aspects of care along the stroke pathway were effective and that rehabilitation services would be delivered locally and close to home.

Over the next few months the NHS will be gathering views and feedback on the proposed approach to rehabilitation from stroke survivors, their families and carers, front-line staff, local councillors and the public to help inform detailed implementation plans.

Question: How does the work looking at the configuration of hospitals in east Kent link in with the preferred option for urgent stroke services?

Answer: In December 2017, we published the 'medium list' of options for how hospital services in east Kent might be organised in the future. One of these options included the possible creation of a new hospital site in Canterbury. This is being looked at along with other ways of providing emergency and urgent hospital care across east Kent. Any decision to build a new hospital would be subject to planning permission and part of a much longer process. We need to act now to create a new and better system for urgent stroke services across the whole of Kent and Medway based on the facilities that we currently have. If a new hospital is built and the William Harvey Hospital was no longer a long-term option for emergency and specialist services – then we would anticipate any hyper acute stroke service would also move with them, subject to a formal public consultation.

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