

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

THURSDAY, 29 NOVEMBER 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, Sarah Osborne and Alan Shuttleworth

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

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

AGENDA

1. **Minutes of the meeting held on 27 September** *(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. **Winter Planning in East Sussex** *(Pages 17 - 28)*
6. **East Sussex Healthcare NHS Trust Ear, Nose and Throat (ENT) Services Reconfiguration** *(Pages 29 - 38)*
7. **Establishment of a Joint Health Overview & Scrutiny Committee (JHOSC) across Sussex and Surrey** *(Pages 39 - 50)*
8. **Work programme** *(Pages 51 - 58)*
9. **Any other items previously notified under agenda item 4**

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

21 November 2018

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Next HOSC meeting: 10am, Thursday, 28 March 2019, County Hall, Lewes

Please note that the meeting will be available to view live or retrospectively on the internet via the East Sussex County Council website:
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Map, directions and information on parking, trains, buses etc

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166 – Haywards Heath

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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 27 September 2018

PRESENT:

Councillors Colin Belsey (Chair), Councillors Bob Bowdler, Angharad Davies, Sarah Osborne and Alan Shuttleworth (all East Sussex County Council); Councillors Barnes (Rother District Council), Councillor Janet Coles (Eastbourne Borough Council), Councillor Mike Turner (Hastings Borough Council), Councillor Johanna Howell (Wealden District Council) and Geraldine Des Moulins (SpeakUp)

WITNESSES:

Samantha Williams, Assistant Director, Planning, Performance and Engagement, East Sussex County Council
Dr Adrian Bull, Chief Executive, East Sussex Healthcare NHS Trust
Jessica Britton, Managing Director, Eastbourne, Hailsham and Seaford Clinical Commissioning Group (CCG) / Hastings and Rother CCG
Mark Angus, Urgent Care System Improvement Director, Eastbourne, Hailsham and Seaford CCG / Hastings and Rother CCG
Ashley Scarff, Director of Commissioning and Deputy Chief Officer, High Weald Lewes Havens CCG
Hugo Luck, Associate Director of Operations, High Weald Lewes Havens CCG

LEAD OFFICER:

Claire Lee, Senior Democratic Services Adviser

8. MINUTES OF THE MEETING HELD ON 28 JUNE 2018

8.1 The minutes of the meeting held on 28 June 2018 were agreed as a correct record.

9. APOLOGIES FOR ABSENCE

9.1 Apologies for absence were received from Cllrs Boorman, Earl and Murray; and Jennifer Twist.

9.2 The Committee wished Cllr Earl a swift recovery from his illness.

10. DISCLOSURES OF INTERESTS

10.1 There were no disclosures of interest.

11. URGENT ITEMS

11.1 There were no urgent items.

12. NHS SUSTAINABILITY

12.1. The Committee considered a report about the financial and clinical sustainability of the NHS in East Sussex including the Financial Recovery Plans (FRP) of the three Clinical Commissioning Groups (CCGs); the progress of the Sussex and East Surrey Sustainability and Transformation Partnership (STP); and the Clinically Effective Commissioning (CEC) workstream of the STP.

12.2. Dr Adrian Bull, Chief Executive, East Sussex Healthcare NHS Trust (ESHT); Jessica Britton, Managing Director, Eastbourne, Hailsham and Seaford CCG (EHS CCG)/ Hastings and Rother CCG (HR CCG); Ashley Scarff, Director of Commissioning and Deputy Chief Officer, High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG); and Samantha Williams, Assistant Director of Planning, Performance and Engagement, East Sussex County Council (ESCC); provided answers to a number of questions from HOSC.

Financial Recovery Plans (FRP) of the CCGs

Details of savings plans

12.3. Ashley Scarff explained that the C4Y FRP involved delivering £9.2m of savings in order to reach a deficit control total of £10.7m. If this target is reached the CCG will receive £10.7m of Commissioning Sustainability Funding (CSF) that will mean it ends the year without a deficit. The FRP comprises a mixture of short and long term savings plans, for example, a major MSK redesign a number of years ago now delivers cumulative savings of £1.25m per year, which is identified in the FRP. Short term savings are to be made from discretionary spend such as overheads and corporate costs that can be stopped more swiftly and that do not have an impact on patient care, for example, vacancy freezes in CCG offices.

12.4. Jessica Britton explained that the East Sussex Better Together (ESBT) CCGs' FRP includes the delivery of £18m of Quality, Improvement, Productivity and Prevention (QIPP) schemes in order to contribute to reaching a combined deficit control total of £32m across both CCGs. As with the C4Y FRP, achieving this deficit control total will result in a CSF payment of £32m. The QIPP programme includes 18 schemes, some of which aim to improve the organisational efficiency of the CCGs; some of which involve reviewing contracts to ensure they are cost effective; and some of which involve the development of new services or pathways that are more cost effective, for example, pharmacists supporting GP practices and community health services to ensure people are given the right medications; and the High Intensity User Service that involves community-based services providing pro-active care to high users of hospital services to reduce instances of them reaching a crisis point and presenting in A&E, which is a more costly outcome to the health system. In addition the CCGs are working to ensure all other spend is contained within current budgets.

Unmitigated risk in FRP

12.5. Ashley Scarff said that HWLH CCG has identified savings schemes for all but a few hundred thousand of the target £9.2m savings in its 2018/19 FRP. These identified savings, however, are on a spectrum from assured delivery at one end to savings that are at a high risk of delivery in 2018/19, or are in an early stage of development, at the other end.

12.6. The CCG has identified £2.3m of savings categorised as at high risk of delivery and is carrying out further work to reduce these risks. This includes close management of individual saving schemes to avoid slippage, and 'over programming', i.e., identifying more savings opportunities than are required to be made in-year. This is in recognition that not all savings proposal ideas when worked up into more detailed plans will realise the same level of savings as originally estimated.

12.7. Ashley Scarff said that if the CCG does not achieve these savings it will not receive its CSF and would start the 19/20 financial year in deficit. This deficit would then continue to accumulate each year and raise the savings target required by NHS England (NHSE) to address it, resulting in a compromise to the CCG's ability to invest proactively in new community-based service redesign that are key to future financial sustainability and effective patient care.

Impact of local authority savings

12.8. Ashley Scarff confirmed that the CCGs had taken into account the impact of ongoing savings by ESCC and other local authorities to preventative social care services. The CCG is working closely with the local authority through the Connecting 4 You (C4Y) partnership board to understand the impact of the savings as much as possible and how to mitigate the impact of them. Sam Williams added that ESCC is making an 8% reduction in Adult Social Care Department (ASC) assessment capacity but is making no savings to its community care budget, therefore prioritising patient flow and ensuring that community care packages are protected.

Impact of savings on community budget

12.9. Ashley Scarff said that the CCG is going to great lengths to protect the community budget, as making savings from that budget would run the risk of significantly greater spend elsewhere in the system. He said that there is a fixed contract to provide community services with Sussex Community Foundation NHS Trust (SCFT). Therefore, any identified savings in the community budget would be coming from efficiencies to the ways in which services are provided, for example, better purchasing of supplies and consumables, reducing duplication of services, or implementing recommendations of the Government's 'Getting it Right First Time' initiative. He added that some small savings have also come from suspending community pilots such as the supplementary community transport scheme in the Havens area in order to enable the CCG to focus on protecting its core primary, acute and community services.

Impact of savings on place-based plans

12.10. Ashley Scarff said that a key goal of the C4Y and East Sussex Better Together (ESBT) place-based plans is to design and deliver innovative and transformative community services that integrate health and care locally and are delivered in the most cost effective setting. This leads to a reduction in demand in more costly parts of the health system, in particular, hospital services. Dr Adrian Bull said that the Joint Community Rehabilitation (JCR) teams are an example of successful community-based services that have been established throughout the county to reduce pressure (and therefore cost) on hospital care. The JCR provides joint health and social care assessments of patients to determine their social care reablement or medical rehabilitation needs to enable them to return quickly from hospital with appropriate care packages.

12.11. Ashley Scarff explained that these new integrated services were put in place at an additional cost with the expectation that they would deliver savings in future years by reducing demand for hospital care. However, cash restraints this year are such that return on investment from innovations needs to be achieved in-year in order for the CCGs to stabilise their systems, and the ability to implement long term investments is much more difficult.

12.12. Dr Bull explained that some of the momentum of the integration of organisations within ESBT has been lost this year due to the substantial financial pressures, although there remains a number of ongoing projects to improve integration amongst the ESBT Alliance members, for example, improving the ICT infrastructure to enable social care, primary care and ESHT employees to use common ICT systems.

Role of regulators

12.13. Ashley Scarff explained that NHS England is well aware of the financial challenges facing the East Sussex CCGs and this is reflected in the deficit control totals that recognise the CCGs will not be able to deliver a balanced budget this year. The CSF monies will also help to put the CCGs in a much better place next year. He confirmed HWLH CCG is on target to hit its deficit control total of £9.7m and Jessica Britton confirmed that both ESBT Alliance CCGs are on target to hit their combined deficit control total target of £32m.

12.14. Dr Adrian Bull said that NHSE and NHS Improvement (NHSI) have appointed a single regulator for the ESBT Alliance healthcare system that is reducing the tensions between the bodies through the development of an integrated three-year financial improvement plan.

12.15. Dr Bull explained that both NHSI and the trust agree that improving the effectiveness of care to patients will reduce the need to perform more costly medical interventions, and so help to restore the trust to financial balance. There is an ongoing debate, however, about the rate at which the trust can deliver financial improvement whilst still maintaining the significant improvements that have been made to quality and operational performance of the trust.

ESHT's financial deficit

12.16. Dr Adrian Bull said that two years ago ESHT's finances were running at a monthly deficit of £5.9m, with an independent report estimating it was on course for a £60m annual deficit. The deficit has since been reduced to £3.2m per month and the Trust is currently only slightly off track for meeting its planned deficit of £44.9m, although Dr Bull said he is confident it can be reached. NHSI has set a control total of £35m.

12.17. Dr Bull said that the Trust's planned deficit of £45m for 2018/19 is made up of four chunks that the Trust believes it can address over the next 24-36 months:

- £11-13m of Provider Sustainability Funding money. The Trust must reach its control total of £21m deficit in the current year to receive this money from NHSI, which for 18/19 will be out of reach but may not be in future years.
- £9m shortfall in income, based on PWC analysis. Receiving this money will depend on agreeing with the CCGs and regulators that the activity the Trust carries out is appropriately funded, or that the trust carries out less activity in the future, as the trust

was not previously accurately describing the work it was doing and receiving the appropriate income for it.

- £15-20m efficiency and workforce improvements. Dr Bull said this is an achievable target of 5% of turnover, e.g., it could be achieved in part by reducing the £30m annual expenditure on more costly temporary staff through recruitment of permanent staff. This has been achieved in some areas, e.g., both A&E Departments are now fully staffed whereas three years ago only 1/3 of doctors were permanent.
- Additional costs associated with running two medium sized hospitals spread across the county.

Patient and clinical engagement with proposed savings

12.18. Ashley Scarff explained that HWLH CCG would not want to undertake any savings that would have an adverse or unfavourable impact on patients. He said that all of the savings proposals go through a robust assessment process including Quality Impact Assessments and Equality Impact Assessments, so all clinical colleagues within the CCGs would be fully aware of any potential impacts on patients.

12.19. Jessica Britton explained that the ESBT CCGs have involved patients and clinicians in the development all of their plans. This includes recruiting a number of 'care pathways experts with experience', e.g., people with lived experience of diabetes are helping with the re-design of the diabetes pathway (which is planned to deliver £54k savings in 2018/19). The CCGs will also assess the impact of proposals on patients before proceeding with implementing them through Quality Impact Assessments, Equality Impact Assessments and Health Inequality Impact Assessments.

Continuing Health Care Budget and Personal health budgets

12.20. Jessica Britton explained that the CCGs are reviewing a number of individual Continuing Health Care (CHC) packages that have been in place for several years and may no longer be suitable to meet the patient's needs. The review process involves working with patients and families who have a number of services in place to streamline those services into a package of care that is most suitable to them, and meets the guidance CCGs are required to follow. Ms Britton confirmed that there had been no appeals from individuals against this process as it did not involve imposing a certain package of care, or removing care from a patient. Sam Williams added that the fact there had been no appeals is testament to the suitability of the approach taken to reviewing CHC plans. Jessica Britton confirmed that Personal Health Budgets are sometimes used to help provide community health care for some people, discussions are undertaken with the patient and family about how best to meet the person's needs.

Risk of hard Brexit on costs

12.21. Ashley Scarff explained that the effect of Brexit is currently unknown, however, there could be a potential economic impact, for example, on the cost of supplies and availability of staff. If this was to happen there would be limited ability locally to insulate against the effect as it would be a national issue affecting the whole country.

Discharge process

12.22. Dr Adrian Bull confirmed that both the medical and therapy teams must assess a patient as medically fit for discharge before they will be discharged. Readmission rates of patients are monitored closely to ensure that patients are not discharged with a medical condition and readmitted shortly afterwards. Conversely, anyone who is medically fit for discharge but remains in a hospital bed are at risk, for example, of losing muscle tone and bone density, being exposed to cross infection and losing packages of care in their home. Dr Bull said it is necessary, therefore, to strike a balance of when to discharge patients. A policy has been developed with ESCC over the last few months to ensure that patients who are refusing discharge in the hope of securing their particular preference for a residential or nursing placement are moved from a hospital bed to a more appropriate location.

Preparedness for Winter period

12.23. Dr Bull explained that the reduced lengths of stay over the last two years has enabled the Trust to set aside a number of beds during periods of normal pressure and open them in the three or four months of the winter period. There is also an enhanced winter period funding agreed with CCGs to allow the Trust to respond to the increase in demand during winter.

Sussex and East Surrey Sustainability and Transformation Partnership (STP)

Formal merging of CCGs within the STP

12.24. Ashley Scarff confirmed that there are no plans for formal CCG mergers and the current priority is to work collectively under a single Chief Accountable Officer. The CCGs' relationship, however, is continually evolving and if there is a self-evident advantage of going down the route of formally merging then it would be explored. He explained that funding for merger activities all come from the existing resource of the constituent CCGs.

Continuation of local decision making

12.25. Ashley Scarff confirmed that the increasingly close collaboration of CCGs within the STP would not result in the loss of local clinical influence or leadership, as the individual CCG Boards remain the sovereign commissioning decision making bodies within the STP.

12.26. Jessica Britton confirmed that individual place-based plans would continue, following the appointment of Adam Doyle as Chief Officer of all 8 CCGs, as they can ensure the continued integration of health and social care within local authority areas.

Advantages of commissioning at STP level

12.27. Jessica Britton explained that the STP will benefit individual CCGs by simplifying the system of commissioning some NHS trust providers, for example, mental health services across the STP area could be commissioned once from Sussex Partnership NHS Foundation Trust rather than individually by each CCG, ensuring consistency in service and the financial benefits of economies of scale.

Clinically Effective Commissioning (CEC)

Identifying further CEC proposals that may require wider consultation

12.28. Ashley Scarff explained that as part of 'tranche 3' the Clinically Effective Commissioning (CEC) programme will explore changing the CCGs' policies towards procedures if there is currently inconsistency in how treatments are offered. He said that this process will be handled very sensitively and reiterated that no decisions about the preferred way forward with services has yet been made. Identifying procedures in tranche 3 of the CEC programme has been in progress for a number of months but there is not yet a timeline for when they can be shared publicly, as there would need to be a consensus from clinicians working on the programme about what can be feasibly delivered. It may also be the case that engagement for tranche 3 could be carried out on a procedure-by-procedure basis rather than of the whole tranche 3 in one go. Jessica Britton added that there is a patient engagement group being established to ensure patients are involved in the development of these tranche 3 policies.

Implementing Tranches 0-2

12.29. Ashley Scarff explained that the CCGs are in the process of implementing tranches 0-2. This involves providing electronic versions of policy changes to clinicians who work face-to-face with patients and who would be using the amended policies for guidance on referring patients for the procedures identified in tranches 0-2. He added that some CCGs have the correct policies in place already, particularly those in Tranches 0 and 1, so the process of rolling them out will involve few changes.

12.30. Ashley Scarff said that each procedure in tranches 0-2 included a quality impact assessment that was considered by CCG governing bodies at the same time as the amended procedure policies. He said that these were considered at public governing body meetings so should be available online.

12.31. Jessica Britton clarified that tranches 0-2 are not a list of procedures that are no longer available. Instead, the tranches are a list of procedures that have had their policies for referring patients revised based on national clinical evidence and expertise, and in order to ensure consistency. This means they may not be the most appropriate course of treatment for many people. Jessica Britton agreed that the CCGs will need to consider how best to convey this message and ensure the public did not just see them as a list of cuts. She added that tranche 3 will involve a much greater conversation with local people as they are developed.

Impact on patient choice of CEC proposals

12.32. In a response to a question about a patient's right to choose where they receive care, Ashley Scarff provided assurance that patient choice is written into the NHS Constitution and that there is nothing within CEC that would affect a patient's choice to access services in London or further afield. He said there are clear rules set out in the legislation covering Payment by Results (PBR) tariffs that give patients the right to access services covered under PBR outside of their CCG area that their local CCG must pay for.

12.33. Ashley Scarff said that feedback indicates patients like to receive healthcare locally and as a result CCGs aim to commission healthcare locally where it is safe to do so. He added that the CCGs feel it important that GPs refer people locally as it benefits local healthcare providers and the local economy, and is best for a patient's experience. However, if the patient chooses to receive care elsewhere it is enshrined in the NHS Constitution that they can do so.

12.34. The Committee RESOLVED to:

- 1) request a further update on the ESBT Alliance's Financial Recovery Plan at the next meeting;
- 2) request that the proposed savings include the total budget of each service area to indicate the extent of their impact;
- 3) invite the new CCG Chief Accountable Officer, Adam Doyle, and the System Improvement Director of the ESBT area to attend the next meeting;
- 4) request that the specific savings proposals for HWLH CCG be circulated by email; and
- 5) request figures for the uptake amongst patients of Personal Health Budgets.

13. URGENT CARE

13.1. The Committee considered a report providing an update on the progress of the NHS 111 re-procurement; the Urgent Treatment Centres (UTCs) redesign in Eastbourne and Hastings; and the progress of the roll out of Primary Care Extended Access across East Sussex.

13.2. The Committee considered reports on these areas from Ashley Scarff, Director of Commissioning Operations, HWLH CCG; Hugo Luck, Deputy Director of Primary and Community Care, HWLH CCG; Jessica Britton, Managing Director for ESBT CCGs; and Mark Angus, Urgent Care System Improvement Director for ESBT CCGs.

NHS 111

Revised model of service

13.3. Ashley Scarff explained that the existing NHS 111 service has huge demand on it that has in many ways outstripped the planned activity of the service. The new service will be based on increasing clinical engagement with patients over the phone via a clinical assessment service (CAS) that will help to reduce the number of onward referrals to A&E and GP practices.

13.4. Mark Angus explained that over the past year a greater understanding has developed of what an integrated urgent care system should look like. This has helped commissioners articulate to the market more clearly what is wanted from an NHS 111 service and has helped providers develop a greater understanding of what is required for delivering a successful service. There has also been improvement in the detail of key performance indicators required of the new service model. Ashley Scarff confirmed NHSE has oversight of the procurement process and approves of it.

Penalties for not hitting national deadline

13.5. Mark Angus clarified that the new NHS 111 service will be in place by April 2020 but CCGs are due to have delivered the nine mandatory NHS urgent care outcomes by March 2019. Work is ongoing to ensure that the current providers are able to deliver those outcomes to patients by March next year.

Urgent Treatment Centres (UTCs)

Viability of UTC and walk-in centre

13.6. Mark Angus explained that two main factors will be taken into consideration when designing options for the proposed UTC service:

- The majority of people who access current walk-in centres do so because they find access to GP practices both in and out of hours difficult. To assist with this, the CCGs' primary care extended access service will provide out of hour's access to GPs at five hubs in the Eastbourne area and four in the Hastings area from 1 October.
- The CCGs estimate that 7% of patients using the Hastings walk-in centre and 16% of people using the Eastbourne walk-in centre would benefit from the additional services of a UTC.

13.7. Mark Angus explained that feedback, including feedback around the viability of a primary care hub at Hastings Station Plaza, has been used to identify different potential options for the UTCs. The next step is to do due diligence to test the financial and clinical viability of the different options in the next few weeks before returning to HOSC in due course with final proposals.

Location of UTC at Conquest Hospital

13.8. Dr Bull confirmed that the additional area within the Conquest A&E is for the Primary Care Streaming Service – which is still in early days of development – and may be converted to a UTC at a future date.

Primary Care Extended Access

GP role

13.9. Hugo Luck confirmed that it is the responsibility of the CCGs to commission the primary care extended access service not for GP practices to agree amongst themselves how to provide it, although they could agree to do so. A GP practice's core hours are stipulated in their General Medical Contract and primary care extended access falls outside of this agreement.

Location of hubs

13.10. Hugo Luck said that the primary care hubs in the High Weald Lewes Havens area will be either GP practices or minor injury units. One hub will be in Lewes, one is likely to be in Crowborough, and one is likely to be in Uckfield. The Uckfield hub will provide GP out of hours on a Sunday, which will only be at one location due to the difficulty in recruiting workforce on that day, and the lack of patient demand on Sundays in other pilots elsewhere in the country.

Advertising

13.11. Hugo Luck explained that publicity for primary care extended access will be largely limited to within GP practices or when on the phone to NHS 111 to ensure it is clear it is an improvement or extension of the existing GP practice service and not a separate, new service.

Staffing the primary care hubs

13.12. Hugo Luck explained that the hubs will be staffed by:

- existing GPs as an extension of their service;
- the provider's range of own bank staff; and
- paramedics overseen by GPs from the provider's partnership with South East Coast Ambulance NHS Foundation Trust (SECAmb).

13.13. The Committee RESOLVED to:

- 1) resume the work of the HOSC sub-group considering UTCs proposals in the ESBT area;
- 2) request an update on the potential options for the UTCs in the ESBT area at the next meeting; and
- 3) request confirmation of the location of the extended access hubs in each CCG area.

14. WORK PROGRAMME

14.1 The Committee considered its work programme and RESOLVED to:

- 1) add a report to the November meeting to agree the terms of reference for a Joint HOSC to consider potential future Clinically Effective Commissioning (CEC) proposals;
- 2) request the policy for prevention of smoking within the hospital boundary at ESHT is circulated to the Committee by email.

The meeting ended at 1.20 pm.

Councillor Colin Belsey
Chair

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

Date of meeting: 29 November 2018

By: Assistant Chief Executive

Title: Winter Planning in East Sussex

Purpose: To provide an update on planning across East Sussex to deal with seasonal demand surges, extreme weather and other issues associated with the winter months.

RECOMMENDATIONS

The Committee is recommended to consider and comment on the local preparations for winter pressures

1 Background

1.1 Health services come under greater pressure during the winter period due to the ill effects of colder weather on people's health. Local health commissioner and provider organisations work together through a Local A&E Delivery Board (LAEDB) to develop plans to mitigate against this increase in demand for their services.

1.2 The issues facing the health service in recent years – such as an aging population, tightening funding, and difficulties with the recruitment and retention of staff – have led to increasingly severe pressure on health services across the country during the winter period.

1.3 At the September 2018 HOSC meeting, members agreed to request a report on how NHS organisations in East Sussex are planning to deal with additional pressures over the 2018-19 winter period.

2. Supporting information

2.1. Winter planning is co-ordinated by a LAEDB. Patient flows mean that the East Sussex population is the responsibility of the East Sussex Better Together LAEDB as well as the Brighton and Hove LAEDB and Maidstone and Tunbridge Wells LAEDB.

2.2. A LAEDB's core responsibilities are as follows:

- Developing plans for winter resilience and ensuring effective system wide surge and escalation processes exist;
- Supporting whole-system planning (including with local authorities) and ownership of the discharge process
- Participating in the planning and operations for local ambulance services
- Participating in the planning and operations of NHS 111 services including oversight of local Directory of Services development
- Agreeing deployment of any winter monies.

2.3. Each LAEDB is responsible for developing a comprehensive plan for winter and the development of these plans starts immediately following the previous winter on a continual cycle. All LAEDBs submit their winter plans to the NHS England Regional team in August for assurance review. The plans are then finalised and signed off by all LAEDBs by 30 November 2018.

2.4. The report attached at appendix 1 sets out the LAEDBs plans, including in relation to:

- Lessons learned from last winter
- Key actions and additional capacity being put in place across East Sussex for the winter for primary care, acute hospitals, community services, adult social care, mental health services, and other services.
- Managing Delayed Transfers of Care (DToc) and long length of stay patients
- Managing flu over winter
- Winter communications plan
- The system capacity and surge management plans.

3. Conclusion and reasons for recommendations

3.1 HOSC is recommended to consider and comment on the LAEDB plans to deal with winter pressures as set out in **Appendix 1**.

PHILIP BAKER

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East Sussex – Winter Planning

<i>Jessica Britton</i>	<i>Managing Director, East Sussex Better Together CCGs</i>
<i>Ashley Scarff</i>	<i>Director of Commissioning Operations, High Weald Lewes Havens CCG</i>
<i>Mark Angus</i>	<i>Winter Director, Sussex and East Surrey CCGs</i>

This paper provides an update on the plans in place across the East Sussex health and social care system to prepare for winter, to ensure system resilience and maintain patient safety and operational performance over the winter period.

1. Winter Planning

1.1. Role of Local A&E Delivery Boards

In respect of winter planning Local A&E Delivery Boards (LAEDBs) core responsibilities are as follows:

- Developing plans for winter resilience and ensuring effective system wide surge and escalation processes exist;
- Supporting whole-system planning (including with local authorities) and ownership of the discharge process
- Participating in the planning and operations for local ambulance services
- Participating in the planning and operations of NHS 111 services including oversight of local Directory of Services development
- Agreeing deployment of any winter monies

The East Sussex population is the responsibility of the following three LAEDBs:

- East Sussex Better Together LAEDB
- Brighton and Hove LAEDB
- Maidstone and Tunbridge Wells LAEDB

Each LAEDB is responsible for developing a comprehensive plan for winter and the development of these plans starts immediately following the previous winter and is a continual cycle.

The above LAEDBs have worked over the course of the spring and summer months to develop whole system plans that ensure the provision of sufficient service capacity across health and social care over the winter period and to ensure that the system plans are resilient to anticipated demand surges and periods of pressure during winter.

1.2. NHS England winter planning assurance process

All LAEDBs were required to submit their winter plans to the NHS England South East regional team in August for assurance review against set criteria, which are attached as annex 1. Following the feedback received from NHS England plans have been further updated and reviewed by the respective LAEDBs and will be finalised and signed off by all LAEDBs by 30 November 2018.

1.3. Lessons learnt from last winter

Each LAEDB has reviewed the effectiveness of the previous year's winter plans to ensure that lessons learnt are captured to inform future planning. In addition a South East regional workshop was held where local systems collectively had an opportunity to share lessons learnt and what worked well in their respective systems over winter.

For East Sussex an example of some of the key lessons learnt from last winter are set out below:

- Need to involve primary care earlier in winter planning process;
- Further develop the pathways to stream patients away from the A&E department;
- Further develop capacity and demand planning tools to include community and adult social care service capacity;
- Further improvements in the level of weekend discharges and discharges earlier in the day;
- Commission additional winter capacity in a targeted way to support agreed patient pathways as opposed to spot purchasing capacity in response to demand pressure;
- Need to better align local communications plan with the national campaign and develop a more targeted approach to our communication plans.

Whilst last year winter was challenging at a both a national and local level there were a number of positive outcomes from last year's winter plan that were also identified by the LAEDBs and the ESBT system was identified by NHS Improvement as one of the three most resilient systems in South East region over last Winter.

1.4. System winter capacity planning

Detailed system capacity planning has been undertaken by each LAEDB to confirm the capacity required to manage expected demand over Winter and to be able to manage demand surges during the period.

A summary of the key actions being taken and additional capacity being put in place across East Sussex for Winter.

1.4.1 Primary Care

- 100% Coverage of Extended Primary Care Access
- Enable direct booking into extended access via NHS 111

- Additional walk in centre capacity on bank holidays and over Christmas and New Year.
- Proactive care home ward rounds
- Development of the Lewes Health Hub – Three Lewes GP practices to provide a GP led acute care team with telephone triage at Lewes Victoria Hospital.
- Text reminder system in place to remind patients to attend for seasonal flu injections and to order repeat prescriptions.

1.4.2 Acute Hospital Capacity

- 75 additional winter escalation beds (28 at EDGH and 28 at Conquest, 18 Royal Sussex County Hospital, 11 Newhaven Downs)
- Action plan in place to deliver further reductions in length of stay, which is currently on track to deliver
- System supported accelerated discharge events to be held throughout the winter period
- Continued system focus on reducing long length of stay patients and sustaining Delayed Transfers of Care (DTOC) performance through daily and weekly patient level reviews and system escalation.

1.4.3 Community Services

- 32 additional winter community escalation beds (12 at Bexhill and 5 at Rye Hospital, 15 in Brighton & Hove).
- Admission avoidance schemes including the implementation of High Intensity User Service and revised community pathways for 5 priority conditions (UTIs, Non Injury Falls, Cellulitis, Flu/Pneumonia, Catheter related issues) and the establishment of an overnight referral management service.
- Frailty Nurse Specialists have been recruited to support the community nursing teams in the High Weald Lewes Havens area and this service already exists in across ESBT.
- Early supported discharge pathway for stroke patients in High Weald Lewes Havens was introduced in August 2018 and will be fully operational for the winter period.
- Improve the occupancy of community hospitals to at least 90% - 95% through standardising admission criteria.
- Focus on reducing length of stay in community hospitals to improve system flow through implementation of the nationally recognised patient *SAFER* flow and *Red2Green* principles.

1.4.4 Adult Social Care

- 27 additional discharge to assess beds to be commissioned by East Sussex County Council on behalf of the East Sussex CCGs over the winter period.
- 104 additional care hours to be pre-booked for the 3 week Christmas and New Year period.
- Proposals have been identified about the use of the £2,586k East Sussex share of the national winter allocation to local authorities for social care, recently announced by the Secretary of State. This will be discussed by partners at the relevant LAEDBs before being considered by the East Sussex County Council Cabinet in December.

1.4.5 Mental Health Services

- Implementation of 14 High Impact actions to support reduction in mental health inpatient DTOCS.
- Hospital liaison, crisis resolution and home treatment teams will be fully operational 24 hours a day throughout the winter period.
- Senior mental health nurse to be co-located with the mental health liaison team at Royal Sussex County Hospital to provide blue light response to Sussex Police and South East Coast Ambulance NHS Foundation Trust service in liaison with street and ambulance triage.
- The urgent care lounge based at Eastbourne District General Hospital will be open 24 hours a day 7 days a week over the winter period (currently closes overnight).

1.4.6 Other services

- Hospital site dedicated additional non urgent patient transport capacity to support hospital discharge during winter
- Increased coverage of NHS Urgent Medicine Supply Advanced Services through local pharmacists.

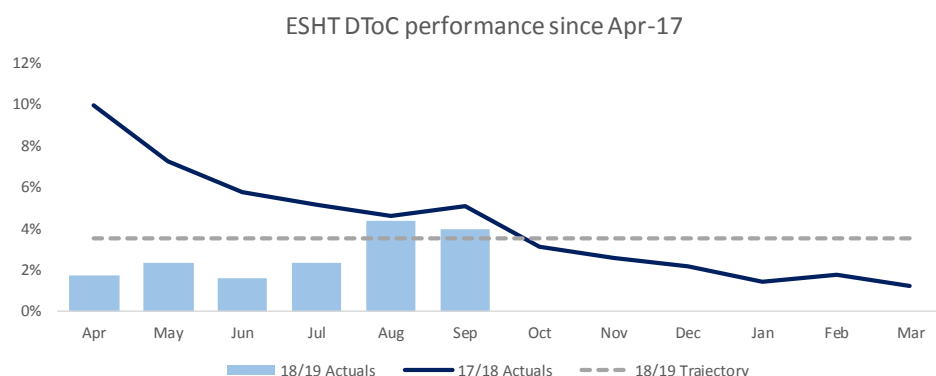
Further detail on the LAEDB Winter plans can be made available to HOSC at the end of November.

1.5. Delayed transfers of care (DTOC)

Maintaining low levels of DTOCs throughout the winter period is an important success criteria to ensure that acute and community bed capacity is available for the patients that require that level of care.

Good progress has been made sustaining improvement in the level of DTOCs across East Sussex and plans are in place to ensure that this improvement is sustained throughout winter.

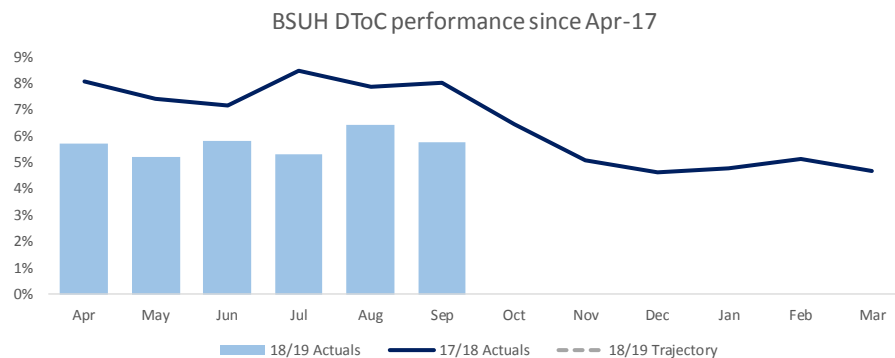
Figure 1 – East Sussex Healthcare NHS Trust DTOCs



ESHT

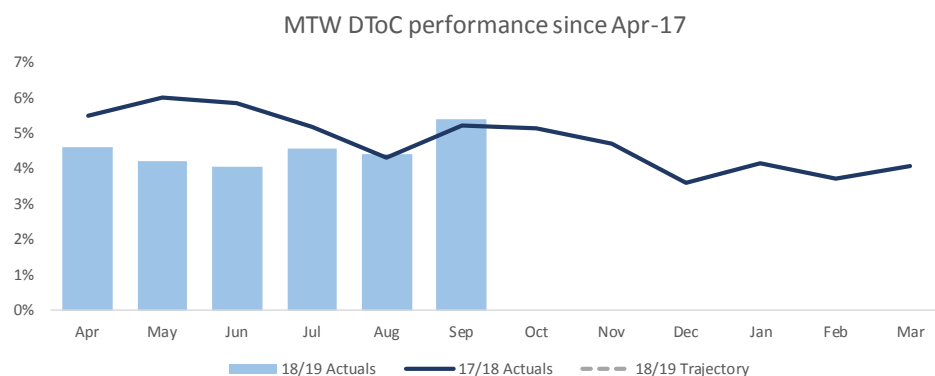
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19 Trajectory	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%
18/19 Actuals	1.7%	2.3%	1.6%	2.3%	4.4%	4.0%						
17/18 Actuals	10.0%	7.2%	5.7%	5.2%	4.6%	5.1%	3.1%	2.6%	2.2%	1.4%	1.8%	1.2%
National Target	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%

Figure 2 – Brighton Sussex University Hospitals NHS Trust DTOCs



BSUH												
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19 Trajectory												
18/19 Actuals	5.7%	5.2%	5.8%	5.3%	6.4%	5.8%						
17/18 Actuals	8.1%	7.4%	7.1%	8.5%	7.9%	8.0%	6.5%	5.1%	4.6%	4.8%	5.1%	4.7%
National Target	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%

Figure 3 – Maidstone and Tunbridge Wells NHS Trust DTOCs



MTW												
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19 Trajectory												
18/19 Actuals	4.6%	4.2%	4.1%	4.5%	4.4%	5.4%						
17/18 Actuals	5.5%	6.0%	5.9%	5.2%	4.3%	5.2%	5.1%	4.7%	3.6%	4.2%	3.7%	4.1%
National Target	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%

1.6. Long length of stay patients

In addition to the focus on ensuring that DTOCs remain low there is a national ambition to ensure that nationally is a 25% reduction in patients who stay in hospital for more than 20 days by 1st December 2019.

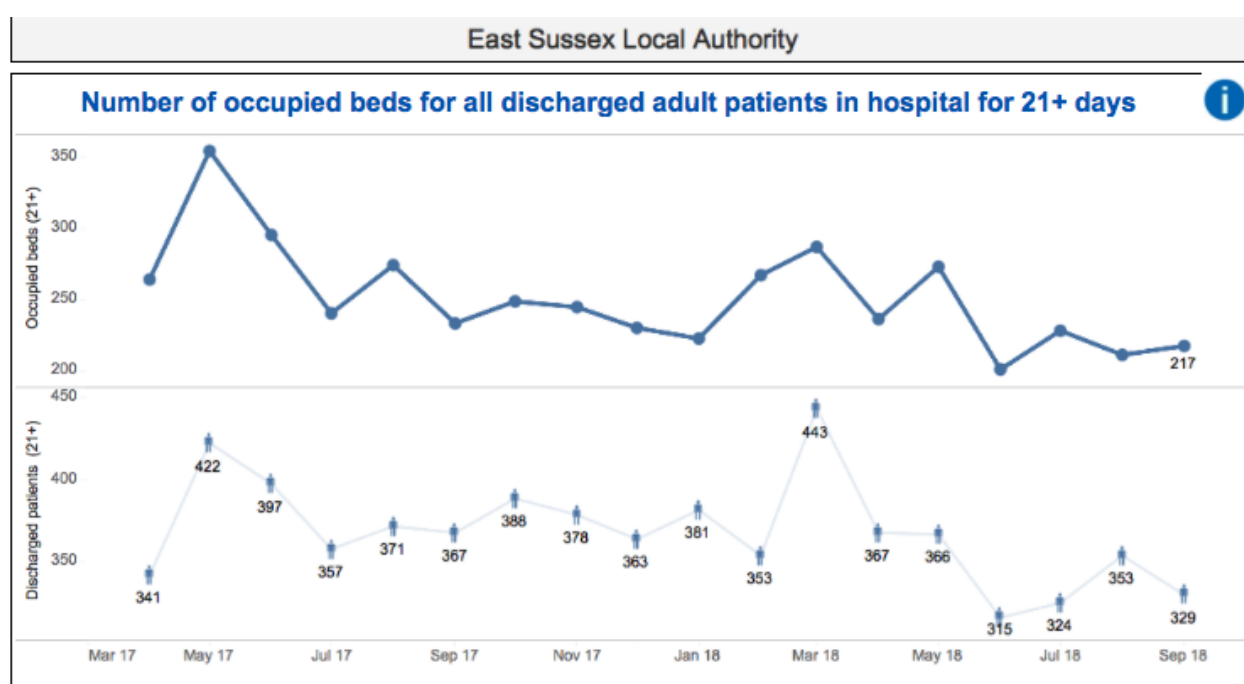
There are a significant cohort of patients who occupy acute hospital beds who are medically fit but do not necessarily meet the official definitions of a DTOC. The national ambition to reduce long stay patients is aimed at ensuring that patients are in

the best environment to meet their needs, ideally their own home, at the earliest opportunity and without delay.

In achieving this national ambition local systems and acute hospitals will be able to release acute bed capacity to enable those who require acute to be admitted without delay.

Overall good progress is being made across the East Sussex Health and Wellbeing footprint to achieve the national ambition of no more than 192 patients with a length of stay of more than 20 days by 1 December 2018.

Figure 4 – Number of occupied beds for discharged adult patients in hospital for 21+ days



Each LAEDB has plans in place, informed by NHS Improvement best practice guides on Focus on Improving patient flow¹ and the Guide to reducing long hospital stays² to achieve the national long length of stay ambition as this is seen as a key enabler to support the local system winter capacity plans.

1.7. Managing flu over winter

Influenza is an acute infection of the respiratory tract caused by the influenza A and B viruses. Influenza occurs in a seasonal pattern with epidemics in the winter months, typically between December and March. The severity of the illness can vary from asymptomatic infection to life-threatening complications. In the UK, the average

¹ Good practice guide: Focus on improving patient flow - https://improvement.nhs.uk/documents/1426/Patient_Flow_Guidance_2017_13_July_2017.pdf

² Guide to reducing long hospital stays - https://improvement.nhs.uk/documents/2898/Guide_to_reducing_long_hospital_stays_FINAL_v2.pdf

number of deaths attributed directly to influenza is approximately 600 in non-epidemic years and between 12,000 and 13,800 deaths in epidemic years.

The Sussex and East Surrey CCGs have jointly developed an STP wide flu plan working in partnership with social care, providers and primary care colleagues.

The expected outcomes of the plan are as follows:

- NHS providers to achieve a minimum 75% clinical staff vaccination rate;
- NHS providers to offer long stay patients Influenza vaccinations;
- Increase in compliance with Influenza national vaccination programmes for social and primary care staff;
- Continued system focus on increasing vaccination programme uptake for high risk patient groups within primary care;
- Implementation of near patient testing in A&Es to improve out of hours testing
- Commissioning of out of season flu outbreak service to assess and provide antiviral treatment and prophylaxis in an out of hours;
- Clear outbreak Management process for all adult social care settings to include escalation pathway to Public Health England for guidance and support;
- Infection control champions programmes to promote Influenza vaccination and the management of outbreaks.
- Supporting the national Influenza campaign at a local level and supplementing this with local STP communications.

This year there is a separate flu campaign out to run in parallel with our main winter campaign to give it specific and more sustained focus. This was a lesson learned from last year's winter campaign when the rate of flu vaccinations declined from the middle of November as the focus was moved to other themes.

With a dedicated focused plan and approach to flu separately to the winter communications plan will support an improvement in take up of this year's vaccine.

1.8. Winter communications plan

A proactive Sussex and East Surrey STP wide winter communications plan has been developed, aligned to the preventative "Help us, help you, stay well this winter" national campaign, to encourage the public to use A&E responsibly, to promote self-care and other NHS services that may better meet the needs of patients based on their condition.

The objectives of the plan are as follows:

- To raise the awareness among the public of the alternative local services to A&E and explain when to use them.
- To ensure information is easily accessible through a range of channels and meet accessibility standards of the alternative services, such as, GP Improved Access, Urgent Treatment Centres and Walk-ins.
- To raise awareness among the public of when they should use GP services and what alternative Primary Care services are available to them.

- To raise awareness of NHS 111 and Pharmacist and explain how they can help you this winter.
- To raise awareness of the benefits of self-management and to provide information that encourages and supports patients to self-care.
- To establish channels of feedback that will help to better inform why people access A&E and GP services, which can be used to shape and adapt services in the future.

Throughout the winter period, we will proactively be promoting NHS 111- with the key theme being 'NHS 111 is more than a helpline'.

In addition there will also be following the NHSE Campaign focus around using pharmacists, with the strapline 'don't wait until you feel worse, ask us first'

The national and local themes will be:

2018

October: Flu vaccines

October – November: NHS 111 – Urgent Care Services

November – December: Pharmacists

December: GP improved access

2019

January - February: NHS 111 Online

March: Pharmacy

2. System winter resilience plans

2.1. LAEDB system capacity and surge management plans

There is a national NHE England Operational Pressures Escalation ³Levels (OPEL) - Framework that all LAEDB systems have implemented to assess pressure across the system and the associated level of risk and escalation response required.

Each LAEDB has developed and agreed a local system based demand and capacity surge escalation plan. These plans are reviewed at least annually and are aligned to the national OPEL framework that set out clearly the actions required by each part of the system in response to the level of escalation and the specific risks identified.

Each individual organisation within the local health and social care system has in place its own surge and escalation plan, which sets out the internal actions required and the individuals or roles responsible for implementing the actions in response to actual or predicted risk.

³ The National Operational Pressures Escalation Levels Framework can be found at the following link: <https://www.england.nhs.uk/wp-content/uploads/2012/03/operational-pressures-escalation-levels-framework.pdf>

2.2. SHREWD (Single Health Resilience Early Warning Database) Resilience

To support local system demand and capacity surge management plans a well-established web based system is commissioned across both the Kent & Medway and Sussex and East Surrey STPs

SHREWD resilience provides a real time view of pressure and enables front line teams and operational leaders to identify 'where' pressure is across the health system very quickly. Within three clicks users can get to the granular detail and root cause of 'why' the system is under pressure. Data is captured live or in real time wherever possible and shared with all providers across the health economy via a web interface and smartphone app.

2.3. Surrey and Sussex CCGs winter operating model

This winter the eight Surrey and Sussex CCGs, which are now under the single leadership of a single accountable officer have jointly appointed a winter director to co-ordinate planning for winter and the response to local system pressures that require broader system support and to co-ordinate the commissioners response to common pressures or themes that require a more strategic level response.

2.4. Local system daily conference calls

Throughout the winter period between December and March each local AEDB system will be holding system wide daily conference calls involving commissioner, providers and adult social care and supported by access to SHREWD Resilience to enable a full assessment of system pressure and to identify and agree actions to mitigate any risks identified. These calls will take place 7 days a week and will be chaired by senior operational leads for each LAEDB system by executive level leads or a CCG Director on-call (out of hours) when a system is in escalation.

3. Impact of Quality, Innovation, Productivity and Prevention (QIPP) on winter preparedness

The CCGs QIPP programmes have all had quality impact assessments completed and there have no negative impacts on the LAEDB winter plans have been identified.

In the main the individual QIPP schemes agreed by the CCGs are fully supportive of the LAEDB winter plans as they are focused on reducing demand on our acute hospitals and ensuring that patients are able to access the services that best meet their individual needs.

4. Recommendations

The committee are recommended to:

- **Note** the update on the East Sussex winter plan and system resilience.

Mark Angus, Winter Director, Sussex and East Surrey CCGs

29th November 2018

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

Date of meeting: 29 November 2018

By: Assistant Chief Executive

Title: East Sussex Healthcare NHS Trust Ear, Nose and Throat (ENT) Services Reconfiguration

Purpose: To provide details of the proposed reconfiguration of ENT services currently provided by East Sussex Healthcare NHS Trust (ESHT).

RECOMMENDATIONS

The Committee is recommended to:

- 1) consider and comment on the ENT proposals;
 - 2) establish a Review Board to scrutinise the proposals in more detail and submit comments to the ESHT Board meeting on 5 February 2019; and
 - 3) request an update on implementation of the proposals at the June 2019 meeting.
-

1 Background

1.1 Ear, Nose and Throat (ENT) services are hospital services that treat problems related to those areas of a patient's body. This may include hearing loss, sinus problems, and thyroid surgery, amongst many others.

1.2 ENT services are provided for the majority of residents in East Sussex by East Sussex Healthcare NHS Trust (ESHT). The Trust proposes to reconfigure the service on the grounds that the current configuration is clinically and financially unsustainable.

1.3 The Trust's engagement process around the reconfiguration plans includes presenting them to HOSC for consideration. The proposals are outlined in **appendix 1** to this report.

2. Supporting information

2.1. The ENT service is currently split across Eastbourne District General Hospital (EDGH), Conquest Hospital, Hastings and Uckfield Community Hospital in the following configuration:

- Emergency ENT services at both main hospital sites with Emergency admissions at EDGH
- Adult inpatient services at EDGH
- Paediatric emergency/ inpatient services at Conquest Hospital (except for under 2s or children weighing less than 15kg).
- Outpatient services at both main hospital sites
- Planned day case surgery at all three sites; and
- Planned inpatient surgery at both main hospital sites.

2.2. ESHT's report indicates that the service has had continuous challenges over a number of years in providing clinically effective care due to medical staffing shortages. The Trust says this has had an impact on the ENT service out of hours and the capacity to manage waiting times effectively. It has also, the Trust indicates, compromised the delivery of effective training and supervision to trainee doctors, resulting in the loss of trainees which has further impacted on the long term viability of the service. Whilst the Trust has put pathways in place to safeguard patient

safety for the short term, through the use of an ad hoc temporary costly workforce and staff working additional hours, it argues that the current service is unsustainable. In addition, ESHT operated the service at a deficit of £1.7million in the year ending March 2018; a deterioration from a deficit of £987,000 in 2016/17.

2.3. The proposed reconfiguration aims to make the service safe and sustainable by addressing the workforce challenges through the following changes:

- Adult and paediatric day case and planned inpatient surgical activity currently undertaken at Conquest Hospital will be moved to EDGH (affecting approximately 494 patients per year, including 68 children).
- The emergency paediatric pathway will be redesigned so that children presenting with an ENT emergency requiring admission at either site will be diverted to the Royal Alexandra Children's Hospital in Brighton (affecting approximately 9 patients per year).

2.4. In terms of the profile of those who would be affected, the 494 patients receiving planned surgery at Conquest in 2017/18 comprised 311 day cases and 183 elective inpatients who stayed on average less than one day. A total of 1,301 patients had planned surgery across the three sites that year.

2.5. The Trust plans to develop mitigating actions to reduce the impact of the proposed changes on the affected patients. These are set out in **appendix 1** (along with more details of the proposed changes) and include ensuring children attending EDGH for their planned surgery will be seen more frequently and in the mornings, reducing the need for transfer back to the paediatric ward at Conquest for an overnight stay.

2.6. The current timeline is for the ESHT Trust Board to agree the proposals at its meeting on 5 February 2019, and by the end of April 2019 all adult and children (paediatric) day case and planned surgical activity currently undertaken at Conquest Hospital will be transferred to EDGH.

2.7. This means that the proposals will be close to implementation by the next HOSC meeting on 28 March 2019. If the Committee wishes to look at the issue in greater detail before then it could agree to establish a Review Board for that purpose. The Board could then submit its comments to the ESHT Board ahead of its decision on 5 February.

2.8. The Clinical Commissioning Groups, as commissioners of the service, have indicated support for the trust's plans.

3. Conclusion and reasons for recommendations

3.1 The Committee is recommended to consider and comment on the ENT proposals set out in Appendix 1.

3.2 The Committee is also asked to consider whether a Review Board should be established to look at the proposals in more detail, including speaking with clinicians at both hospital sites where ENT services are currently provided. The Review Board could submit its comments to the ESHT Trust Board meeting on 5 February 2019.

PHILIP BAKER
Assistant Chief Executive

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HOSC Outline briefing paper

Ear Nose and Throat (ENT) services

1. Introduction

East Sussex Healthcare NHS Trust (ESHT) provides Ear, Nose and Throat (ENT) services at both Eastbourne District General Hospital (EDGH) and Conquest Hospital in Hastings. The service has had continuous challenges over a number of years in providing clinically effective care due to medical staffing shortages. This has had an impact on the ENT service out of hours and the capacity to manage waiting times effectively. It has also compromised the delivery of effective training and supervision to trainee doctors, resulting in the loss of trainees which has further impacted on the long term viability of the service. Whilst pathways have been put in place to safeguard patient safety for the short term, through the use of an ad hoc temporary costly workforce and staff working additional hours, the current service is unsustainable. In addition, the service operated at a deficit of £1.7million in the year ending March 2018; a deterioration from a deficit of £987,000 in 2016/17.

We need to consider how we transform our services to address the challenges.

2. Vision/Proposal

Our aim is to provide a safe and sustainable ENT service for the people of East Sussex. In order to address the workforce challenges (recruitment and retention, supporting junior doctor training, provision of sustainable out of hours rotas) and the waiting times for patients the proposal is:

2.1 The ENT adult inpatient ward remains located at EDGH as does emergency ENT for adult patients across the county.

2.2 By end April 2019, to transfer all adult and children (paediatric) day case and planned surgical activity currently undertaken at Conquest Hospital (circa 494 patients a year) to EDGH:

- Theatre lists will be more frequent and planned to ensure that children have their surgery scheduled in the mornings and the short stay children's ward at EDGH (Friston) will be open until 9pm to provide clinically-led post-operative care as per current pathway, for children having their surgery at EDGH. This will help to minimise the risk of children needing to remain in hospital overnight.
- In the event that any child day-case requires an overnight stay, they will be managed under a shared care agreement with the paediatric team on the children's ward (Kipling) at Conquest Hospital in line with the Trust's current pathway.
- An elective paediatric operating list will be provided on a four weekly basis at Conquest Hospital. This list will be protected for children with sleep apnoea conditions who require an overnight bed following Surgery.

- Clear post-operative guidance will continue to be issued to patients on discharge for the management of post-operative emergency.
- Any child presenting with post-operative clinical needs requiring admission will be admitted to Kipling children's ward at Conquest Hospital as per current pathway.
- There will be small numbers of patients who will continue to be offered treatment at Uckfield. These patients are selected for Uckfield and are clinically considered very low risk/and require minimal intervention surgery who generally walk in/walk out of the unit with little recovery time, and do not require access to an acute hospital bed eg. patients being treated for removal of skin lesions/and insertion of grommets.

2.3 To develop the partnership working with Brighton and Sussex University Hospitals NHS Trust (BSUH) to commence FY20/21 through a collaborative model and jointly recruit senior medical posts.

2.4 To continue to provide outpatients services both at EDGH and Conquest.

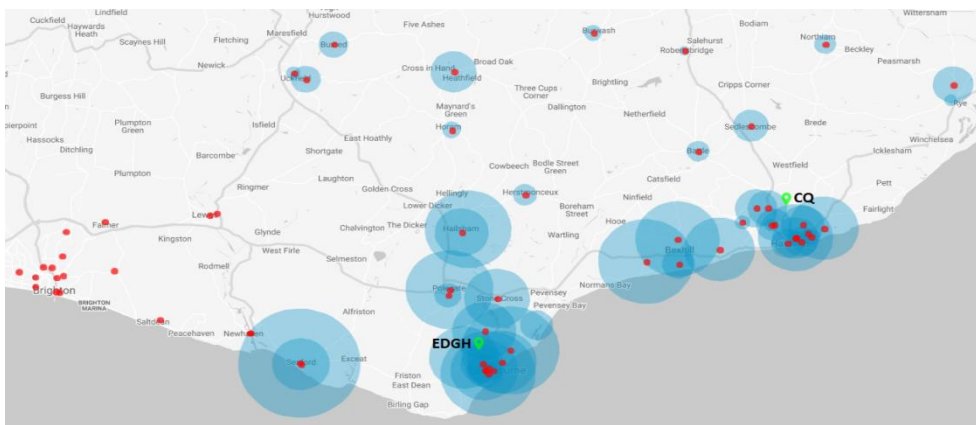
2.5 We are proposing that children presenting with an ENT emergency requiring admission (approximately 9 patients per year) will be diverted to the Royal Alexander Children's Hospital at BSUH. At the time of writing this paper the pathway was being discussed with BSUH.

2.6 Proposed changes to emergency pathways are detailed in Appendix 1 below.

3. Source of ENT referrals

The map below shows the source of GP referrals to ENT at ESHT throughout 2017/18. The service received 11,946 outpatient referrals last financial year, of these 1301 had planned surgery, 494 were conducted at Conquest. These would need to be moved to EDGH as outlined in the proposal above.

- Red circles indicate the location of GP surgeries.
- Blue bubbles, and their relative sizes, represent the number of referrals received in ENT from that source. The larger the bubble, the more referrals received.
- Green location markers show the locations of EDGH and Conquest



4. ENT patients admitted

The table below shows a breakdown of the above ENT admitted patients for day case, planned surgery, and emergency activity, by site. Adult inpatients are admitted to the ward at EDGH.

	2016/17					2017/18			
	Conquest	EDGH	Uckfield	Total		Conquest	EDGH	Uckfield	Total
Day case	325	480	231	1,036		311	493	95	899
Planned	199	230		429		183	219		402
Emergency	20	580		600		11	547		558
Total	544	1,290	231	2,065		505	1,259	95	1,859

The table shows that 1301 patients had planned surgery in 2017/18 of which:

- 899 were day cases
 - 493 day cases at EDGH
 - 311 day cases at CQ
 - 95 day cases at Uckfield
- 402 were planned inpatient surgery cases who stayed an average of less than one day (0.99):
 - 219 inpatients at EDGH stayed an average of 1 day (1.05 bed days)
 - 183 elective inpatients at Conquest stayed an average of less than one day (0.93)
- 558 emergency admissions stayed an average of 2.43 days, of which 547 were at EDGH.

5. ENT children admitted

All children requiring an inpatient stay are currently admitted to the children's inpatient ward (Kipling) at the Conquest Hospital, under shared care with Paediatrics. The table below shows a breakdown of the number of children admitted for day case surgery, planned surgery and emergency at Conquest Hospital.

Children's day case surgery is currently provided at both EDGH and the Conquest. Day case children at EDGH who convert to an overnight stay require transfer to Conquest under the shared care arrangement above.

Children Admitted to Kipling 2017/18		
	Conquest	Length of Stay (LOS)
Day case	4	
Planned	64	60 admissions LOS 1 night
Emergency	9	4 admissions LOS 1 night, 4 admissions LOS 3 nights
Total	77	

The table shows that of the 77 children seen, only 8 children had a length of stay of over 1 night; and 4 of these were emergency admissions.

- 4 of the paediatric admissions were already completed as day cases.
- 64 paediatric admissions were for planned inpatient surgery, and 60 of these had LOS less than 1 day.

Under the proposed changes, seeing children for their planned surgery as part of the morning list at EDGH would facilitate some of these cases being completed as day cases,

negating the need for transfer. Children who require an unplanned inpatient stay would follow the current pathway, requiring transfer to the children's ward at Conquest. Children with sleep apnoea diagnosis will be listed for ENT Surgery on a four weekly paediatric list at Conquest, and cared for post operatively under the current shared care agreement with the paediatricians.

It has been discussed with BSUH that all emergency attendances for children who require admission (9 children in 2017/18) would be transferred to Brighton under the new proposal, with the exception of children attending with a post-operative problem for surgery conducted at ESHT. Post-operative complications would continue to follow the current emergency pathway.

For example, emergency conditions that are likely to present that would need transfer to Brighton are children with tonsillitis; mastoiditis; neck abscess; sinusitis; and peri-orbital cellulitis. Not all of these cases will require surgery. Post-operative complications, such as bleeding following tonsillectomy, would be treated and admitted to Conquest and not transferred to Brighton. Children under 2 and under 15kg would continue to be transferred to Brighton as is currently the pathway.

The current and proposed emergency pathways are provided in Annex 1.

6. Options considered and discounted:

6.1 Maintaining status quo

This option was discounted for the reasons outlined above, namely; medical staffing shortages, having ENT inpatients on two acute sites, an unsustainable out of hours rota, insufficient capacity to manage waiting times, and the inability to deliver effective training and supervision to trainee doctors. In addition, the service is also financially unsustainable in its current form.

6.2 Locating service at Conquest hospital

This option was discounted as locating the service at Conquest does not allow us to address our difficulties in medical staffing and rotas. The Trust is planning to address this by furthering its partnership with BSUH, who are willing to work collaboratively. This makes EDGH more operationally viable given the proximity of EDGH to Brighton. Additionally, the majority of the current ENT workforce are based at EDGH, the adult ENT inpatient areas are already at EDGH, and the specialist nursing skills exist at EDGH in order to manage airways problems safely. The Surgical hospital at night rota at EDGH is reliant on the ENT junior doctors to provide adequate numbers to support other surgical specialties at EDGH.

7. Conclusion

ESHT has experienced a long term issue with the recruitment of the ENT medical workforce that has resulted in the inability to provide a sustainable ENT service across East Sussex. The links with the local tertiary centre will provide the succession planning and workforce sustainability required for East Sussex and the proposals detailed above provide will enable this.

In order to maintain the local ENT service for East Sussex patients, this proposal requires the transfer of the remaining elective activity from Conquest Hospital, whilst

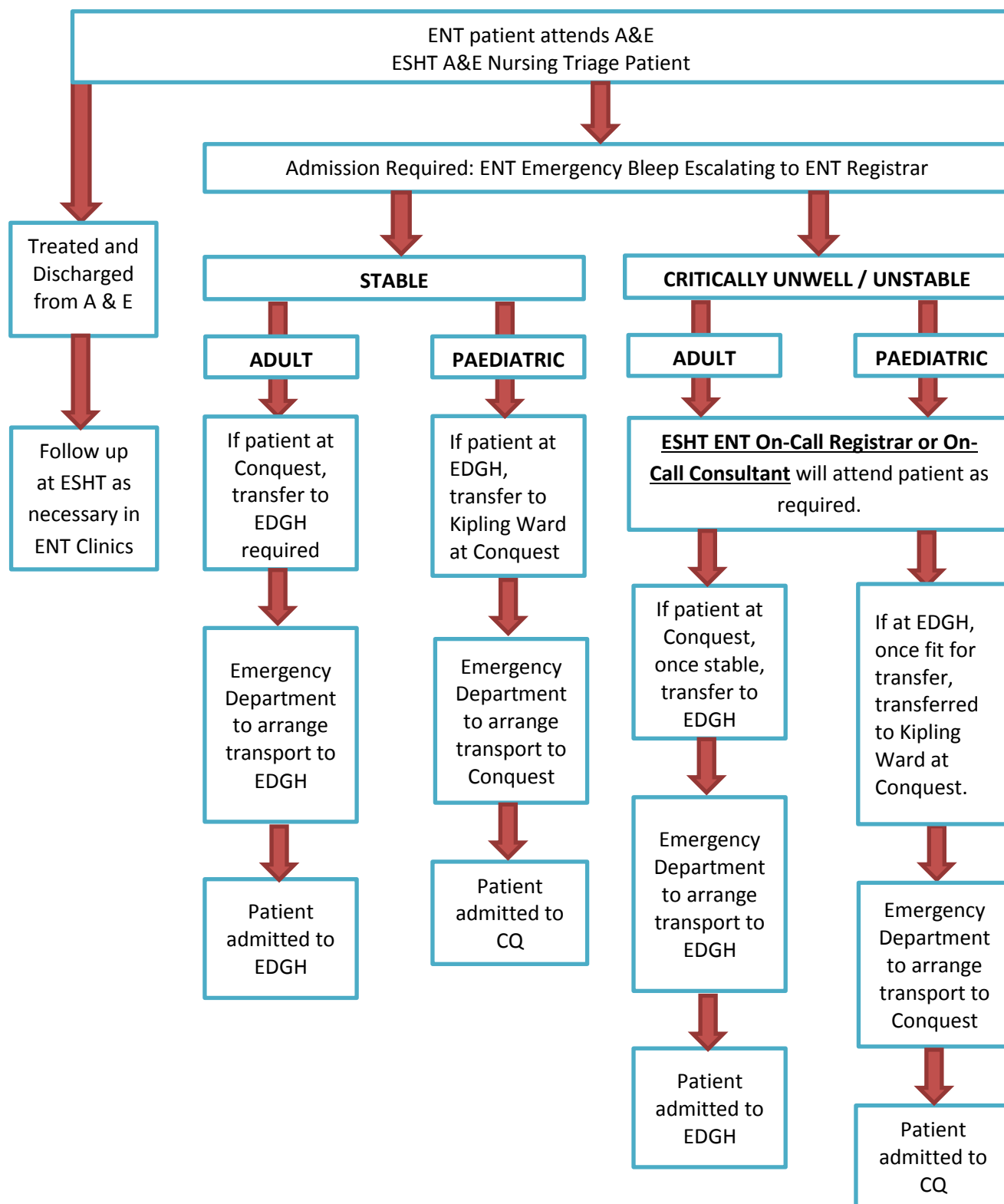
maintaining outpatient activity at both acute hospitals and the collaboration with BSUH on workforce. This will enable workforce sustainability, increase the quality of training for junior doctors, secures further trainees to deliver resilience in on-call rotas, and will be an enabler to reduce waiting times for patients. This should result in improving the clinical and financial sustainability of the specialty.

The proposed changes will be incremental following further and detailed conversations with BSUH, the ambulance trust, and other internal and external stakeholders, external, including patient representatives. A copy of the full case for change will be available, and the final copy of the proposed Business Plan will be submitted through the internal trust governance process.

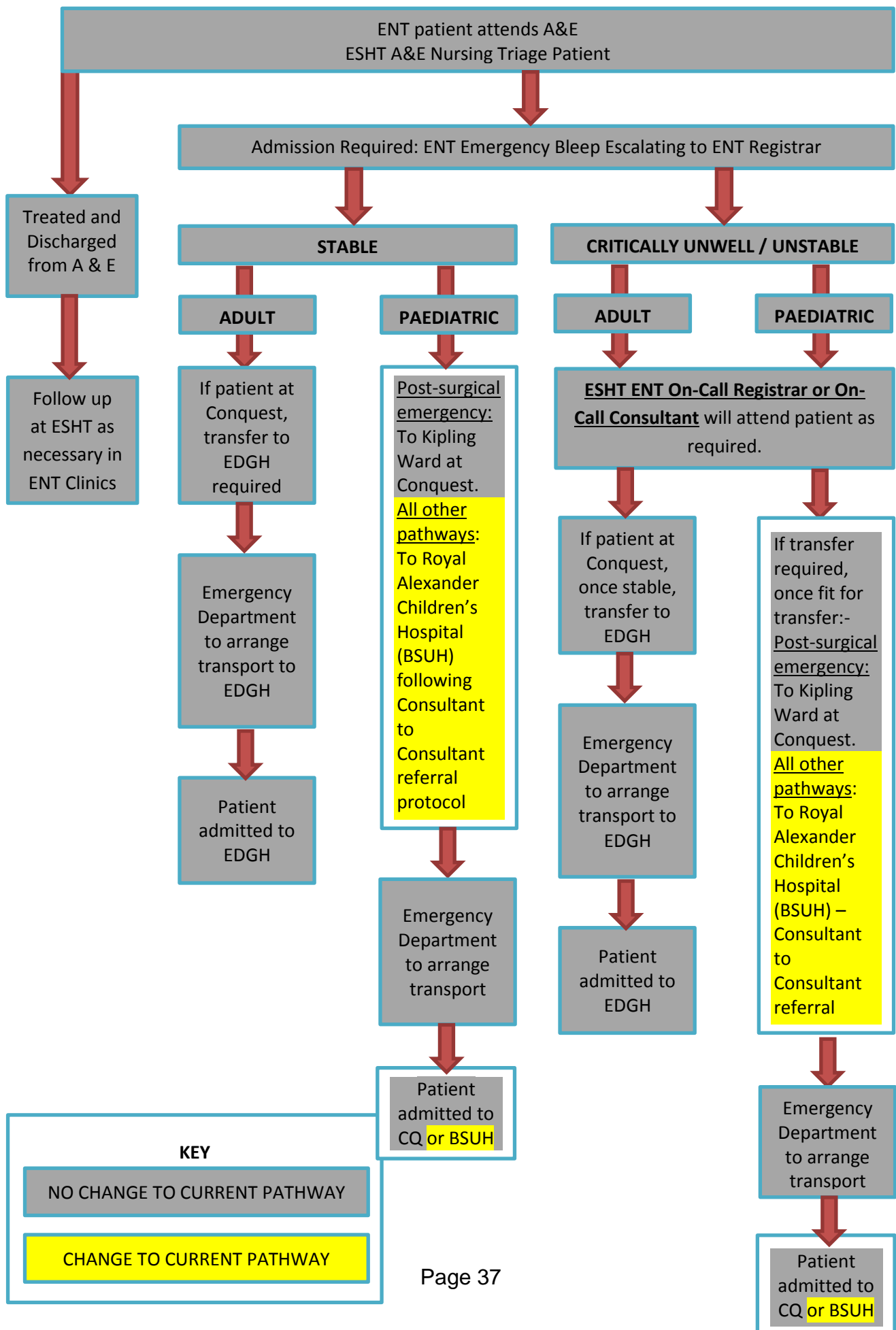
Joe Chadwick-Bell

Chief Operating Officer

ESHT ENT EMERGENCY CARE PATHWAY (CURRENT)



ESHT ENT EMERGENCY CARE PATHWAY (PROPOSED – CHANGES HIGHLIGHTED)



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

Date of meeting: 29 November 2018

By: Assistant Chief Executive

Title: Establishment of a Joint Health Overview & Scrutiny Committee (JHOSC) across Sussex and Surrey

Purpose: To provide details of the proposed JHOSC and request agreement from the Committee to establish it

RECOMMENDATIONS

The Committee is recommended to:

- 1) Agree that a Joint Health and Overview Scrutiny Committee (JHOSC) be established with membership from Brighton & Hove City Council, East Sussex County Council, Surrey County Council and West Sussex County Council;
 - 2) Agree the JHOSC Terms of Reference and rules of procedure attached at Appendices 1 and 2;
 - 3) Appoint three voting members to the JHOSC and one non-voting co-opted member to represent the East Sussex Health Overview and Scrutiny Committee
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1. Background

1.1. The Health & Social Care Act (2001) and its regulations established local authority health overview and scrutiny committees (HOSCs), granting them statutory powers to scrutinise significant NHS plans for service change (Substantial Variation in Service: SViS). The Act also sets out that, when a SViS relates to services provided across two or more upper-tier local authority areas, a Joint HOSC (JHOSC) must be established to scrutinise the plans. The most up to date regulatory framework is provided by the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, but JHOSC responsibilities remain relatively unchanged.

1.2. A JHOSC is typically convened to scrutinise a single NHS reconfiguration plan, although some areas have successfully introduced 'standing' JHOSCs, particularly where a series of major changes are anticipated over several years. JHOSCs are delegated statutory powers by their constituent HOSCs in relation only to the matters that the JHOSC is concerned with. This means that individual HOSCs may not scrutinise an issue that is being examined by the JHOSC. It also means that the JHOSC has no powers to scrutinise issues that lay outside its remit.

2. Supporting information

Clinically Effective Commissioning (CEC)

2.1. CEC is a Sussex-wide NHS initiative which aims to improve the effectiveness and value for money of healthcare services by ensuring that commissioning decisions across the region are consistent, that they reflect best clinical practice, are in line with the available evidence, and that they represent the most sensible use of limited resources. This Committee received a presentation on the programme in September 2017 and an update at its last meeting in September 2018. Although CEC entails local CCGs working together, any service changes will be made by individual CCGs at local level. However, since the aim of CEC is to standardise commissioning approaches across the county, any SViS arising from CEC for East Sussex will also constitute a substantial

change for West Sussex and Brighton & Hove. In consequence, any substantial change generated by the CEC will potentially require scrutiny by a JHOSC.

2.2. To date, CEC has reviewed a number of clinical procedures. It is the CCGs' view that none of the plans agreed to date constitutes a SViS requiring formal consultation with HOSCs/JHOSC. However, as was reported to this Committee at its last meeting, the CCGs believe that some of the plans in the CEC pipeline are likely to constitute SViS; and, as they will also apply across local authority boundaries, they will therefore need to be formally considered by a JHOSC.

2.3. There is currently no information on which specific service change plans the JHOSC will be asked to scrutinise, since establishing the pipeline of procedures for CEC is an ongoing process. However, establishing a JHOSC takes time, as it requires coordination between several local authorities, and it is therefore necessary to begin preparations now in order to be ready to scrutinise plans in several months' time.

Sustainability and Transformation Partnership (STP) – Sussex and East Surrey

2.4. The emergence of the STP as a regional NHS planning footprint that is larger than any single local authority area means that it is likely that there may be more cross-border NHS change plans emerging in the near future, either as formal STP initiatives or otherwise. Establishing separate JHOSCs for each cross-border SViS would be very time-consuming. It is therefore proposed that a single JHOSC is established between Brighton & Hove City Council, East Sussex County Council, Surrey County Council and West Sussex County Council to consider all cross-boundary SViS. The JHOSC would set up subgroups to scrutinise issues that do not involve the whole membership (e.g. CEC plans would be scrutinised by a sub-group of Brighton & Hove, East Sussex and West Sussex members, as Surrey is engaged in a parallel Surrey-wide process rather than in CEC). Additional councils could also be co-opted to specific sub-groups if plans affect a larger footprint than the STP area. The JHOSC would be time-limited (existing for a maximum of four years).

JHOSC Terms of Reference (ToR)

2.5. A draft JHOSC ToR is attached as Appendix 1 to this report. The Chairs of the four health scrutiny committees involved have been consulted and have approved in principle the ToR as set out and that they be presented to each of the committees for formal approval. HOSC is able to suggest amendments to the ToR, but any changes it proposes would need to be unanimously approved by all the committees involved (hence in part the need to begin preparations at an early point). The attached TOR have already been agreed by West Sussex HOSC on 15 November 2018.

2.6. It is proposed that each HOSC appoints three councillors to the JHOSC and one non-voting co-opted member (for East Sussex – one of the two Speak-Up representatives).

2.7. When a JHOSC is established, HOSC statutory powers to refer SViS to the Secretary of State for Health can be retained by individual HOSCs or delegated to the JHOSC. In this instance it is not proposed to delegate powers of referral to the JHOSC. Should this JHOSC believe that a referral is required, it would make a recommendation, backed by evidence, to its constituent local authorities. Each local authority would then individually decide whether to refer.

Resources

2.8. Administration and venues for meetings of the JHOSC will be met from current health scrutiny support arrangements within the constituent authorities.

3. Conclusion and reasons for recommendations

3.1 The Committee is recommended to agree that a JHOSC across East Sussex, Brighton & Hove, West Sussex and Surrey is established to consider any SViS which may arise from CEC and the STP, as set out in the report and the Terms of Reference attached at Appendix 1.

PHILIP BAKER
Assistant Chief Executive

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JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE TERMS OF REFERENCE

1.1 The Sussex and Surrey Joint Health Overview and Scrutiny Committee is established by the Local Authorities of **Brighton & Hove City Council, East Sussex County Council, Surrey County Council** and **West Sussex County Council (constituent areas)** in accordance with s.245 of the NHS Act 2006 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

1.2 It will be a standing Joint Overview and Scrutiny Committee or a sub-committee thereof which will undertake scrutiny activity in response to a particular reconfiguration proposal or strategic issue affecting some, or all of the constituent areas.

1.3 The length of time a specific matter / proposal will be scrutinised for will be determined by the Joint Committee or Sub Committee.

1.4 The purpose of the Standing Joint Committee is to act as a full committee or commission sub-committees to consider the following matters and carry out detailed scrutiny work as below:

(a) To engage with Providers and Commissioners on strategic sector wide *proposals* in respect of the *configuration* of health services affecting some or all of the area of Brighton & Hove, East Sussex, Surrey or West Sussex (constituent area).

(b) Scrutinise and respond to the consultation process (including stakeholder engagement) and final decision in respect of any reconfiguration proposals affecting some, or all of the constituent areas.

(c) Scrutinise in particular, the adequacy of any consultation process in respect of any reconfiguration proposals (including content or time allowed) and provide reasons for any view reached.

(d) Consider whether the proposal is in the best interests of the health service across the affected area.

(e) Consider as part of its scrutiny work, the potential impact of proposed options on residents of the reconfiguration area, whether proposals will deliver sustainable service change and the impact on any existing or potential health inequalities.

(f) Assess the degree to which any proposals scrutinised will deliver sustainable service improvement and deliver improved patient outcomes.

(g) Agree whether to recommend to its constituent areas that the local authorities individually use their statutory powers of referral to refer either the consultation or the final decision in respect of any proposal for reconfiguration to the Secretary of State for Health.

(h) As appropriate, review the formal response of the NHS to the Committee's consultation response.

1.5 The Joint Committee will consist of three Councillors and one co-opted member nominated by each of the constituent areas and appointed in accordance with local procedure rules, and with regard to the requirement for nominees to statutory joint committees to be proportionate to the political make-up of the constituent authority. Each Council can appoint named substitutes in line with their local practices.

1.6 Appointments to the Joint Committee will be made annually by each constituent area with in-year changes in membership confirmed by the relevant authority as soon as they know.

1.7 The life of the Joint Committee will be for a maximum of four years.

1.8 The JHOSC is being established to scrutinise NHS change plans that affect two or more councils within the Sussex and East Surrey STP footprint. In the event of the footprint changing so that one of the constituent JHOSC bodies is no longer part of the footprint, that council is free to resign from the JHOSC. Should the JHOSC Chairman or Vice Chairman represent such a council, the JHOSC will elect replacements.

1.9 For each specific piece of scrutiny work undertaken relating to consultations on reconfiguration or substantial variation proposals affecting all or some of the constituent areas, the Joint Committee will either choose to act as a full Committee or can agree to commission a sub-committee to undertake the detailed work and define its terms of reference and timescales. This will provide for flexibility and best use of resource by the Joint Committee.

1.10 In determining how a matter will be scrutinised, the Joint Committee can choose to retain decision-making power or delegate it to a sub-committee.

1.11 The overall size of each sub-committee will be determined by the main Committee and must include a minimum of 1 representative per affected constituent area.

1.12 Where a proposal for reconfiguration or substantial variation covers some but not all of the constituent areas, in establishing a sub-committee, formal membership will only include those affected constituent areas. Non affected constituent areas will be able to nominate members who can act as 'observers' but will be non-voting.

1.13 The Committee and any sub-Committees will form and hold public meetings, unless the public is excluded by resolution under section 100a (4) Local Government Act 1972 / 2000, in accordance with a timetable agreed upon by all constituent areas and subject to the statutory public meeting notice period.

1.14 The JHOSC will be responsible for determining whether any specific NHS change plan which impacts on two or more of the JHOSC members constitutes a Substantial Variation in Service (SViS) such that it requires formal consultation

with the JHOSC.

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**BRIGHTON & HOVE, EAST SUSSEX, SURREY & WEST SUSSEX JOINT
HEALTH OVERVIEW AND SCRUTINY COMMITTEE (JHOSC)**

RULES OF PROCEDURE

1. Membership of Committee and Sub-Committees

1.1 Brighton & Hove City Council, East Sussex County Council, Surrey County Council and West Sussex County Council will each nominate three Councillors to the JHOSC, appointed in accordance with local procedure rules and with the relevant statutory regulations.

1.2 Appointments will reconfirmed annually by each relevant authority.

1.3 Individual authorities may change appointees in accordance with the rules for the original nomination.

1.4 Individual authorities will be strongly encouraged to nominate substitutes in accordance with local practice.

1.5 In commissioning Sub-Committees, membership will be confirmed by the JHOSC and can be drawn from the main Committee or to enable use of local expertise and skill, from other non-Executive members of an affected constituent area (excluding Health & Wellbeing Board members).

1.6 The membership of a sub-committee will include at least one member from each affected constituent areas. An affected constituent area is a council area where the proposals will impact on residents. Non affected areas can appoint 'observer' members to sub-committees but they will be non-voting.

1.7 The JHOSC, may as appropriate review its membership to include authorities outside the JHOSC boundaries where those authorities are equally affected by a SViS. Members of such local authorities may be appointed to serve as members of relevant sub-committees.

2. Chairman

2.1 The JHOSC will elect the Chairman and Vice Chairman at the first formal meeting. A vote will be taken (by show of hands) and the results will be collated by the supporting Officer.

2.2 The appointments of Chairman and Vice Chairman will be reconfirmed annually.

2.3 Where a sub-committee is commissioned, at its first meeting a Chairman and Vice-Chairman will be appointed for the life of the sub-committee.

3. Substitutions

3.1 Named substitutes may attend Committee meetings and sub-committee meetings in lieu of nominated members. Continuity of attendance is strongly encouraged.

3.2 It will be the responsibility of individual committee members and their local authorities to arrange substitutions and to ensure the supporting officer is informed of any changes prior to the meeting.

3.3 Where a named substitute is attending the meeting, it will be the responsibility of the nominated member to brief them in advance of the meeting.

4. Quorum

4.1 The quorum of a meeting of the JHOSC will be the presence of one member from any three of the four participating constituent areas.

4.2 The quorum of a meeting of a Sub Committee of the JHOSC will be the presence of members representing two or more constituent areas.

5. Voting

5.1 Members of the JHOSC and its sub Committees should endeavour to reach a consensus of views and produce a single final report, agreed by consensus and reflecting the views of all the local authority committees involved.

5.2 In the event that a vote is required, each member present will have one vote. In the event of there being an equality of votes the Chairman of the JHOSC or its sub-committee will have the casting vote.

6. JHOSC Role, Powers and Function

6.1 The JHOSC will have the same statutory scrutiny powers as an individual health overview and scrutiny committee that is:

- accessing information requested
- requiring members, officers or partners to attend and answer questions.

However, the power to refer to the Secretary of State for Health will be retained by the constituent areas rather than being delegated to the JHOSC. Should the JHOSC believe that there is a case for referral, it will make an evidenced recommendation to refer to its constituent areas.

6.2 The JHOSC can choose to recommend to constituent areas that they refer to the Secretary of State for Health for a particular scrutiny matter or delegate this function to an established sub-committee.

7. Support

7.1 The lead governance and administrative support for the JHOSC will be

shared by constituent areas.

7.2 The lead scrutiny support for sub-committees will be provided by constituent areas on a per issue basis to be agreed by the sub-committee.

7.3 Meetings of the JHOSC and its sub-committees will be rotated between participating areas.

7.4 The host constituent area for each meeting of the JHOSC will be responsible for arranging appropriate meeting rooms and ensuring that refreshments are available.

7.5 Each constituent area will identify a key point of contact for all arrangements and Statutory Scrutiny Officers will be kept abreast of arrangements for the JHOSC.

7.6 All costs of the JHOSCs will need to be met from within existing HOSC budgets: there is no additional funding for the JHOSC. Any decision to apply to the constituent areas for additional funding would need to be unanimously agreed by the JHOSC.

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

Date of meeting: 29 November 2018

By: Assistant Chief Executive

Title: Work Programme

Purpose: To consider the committee's work programme and note the update on the Urgent Treatment Centres (UTCs) reconfiguration

RECOMMENDATIONS

The Committee is recommended to:

- 1) agree the work programme; and
 - 2) note the delay in the UTC reconfiguration process and continued work of the UTC Review Board.
-

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 This report also provides an update on other work going on outside the Committee's main meetings.

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](#).

Urgent Treatment Centres (UTCs)

2.2. At its last meeting in September HOSC requested a report on progress with the development of Urgent Treatment Centres (UTCs) in Eastbourne and Hastings from Eastbourne, Hailsham and Seaford Clinical Commissioning Group (CCG) and Hastings and Rother CCG for this meeting. The CCGs have advised that there is currently no update in respect of their proposals for UTCs. Since the last meeting work has continued to finalise proposals and the proposed timescale is that a refreshed outline business case should be available for consideration by the CCG Governing Bodies in mid-December with a likely consultation starting in the new year. The CCGs have indicated that they are keen to ensure HOSC remains fully informed of developments and will share this when it is available. The CCGs would welcome a meeting with the HOSC Review Board following the meeting of the Governing Bodies in order to discuss developments and engagement plans more fully. In light of this, the HOSC Chair agreed that it was therefore not the best use of the CCG officers' or the Committee's time to consider a full update report at this meeting. The HOSC Review Board will continue to scrutinise the CCGs' proposals in the coming months, including raising queries on behalf other Committee members.

HOSC Working groups

2.3. 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 last meeting was on 31 October and minutes will be circulated to the Committee when available. The next meeting is planned for late January.

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 before the 29 November. It was agreed at the most recent meeting, in light of the improved performance of the Trust, to review the purpose and frequency of this working group.

Joint HOSC Kent and Medway Stroke Review

2.4. 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.

2.5. Over the summer, the CCGs consulted on five potential options for where the three HASUs would be located. On 13 September the Joint CCG workshop identified a 'preferred option' to reconfigure stroke services 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, including this Committee on 28 March.

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	<p>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.</p> <p>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.</p> <p>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.</p> <p>Membership: Cllrs Belsey and Howell (Sub: Cllr Davies)</p>	28 March 2019

Urgent Treatment Centres (UTC) in Eastbourne and Hastings	<p>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.</p> <p>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.</p> <p>The CCGs have resumed their UTC proposals following a pause over the summer to review the impact of the NHS 111 procurement pause and to revise their own plans. HOSC paused the review board during this time but has now resumed it following an update at its 27 September meeting.</p> <p>Membership: Cllrs Belsey (Chair), Turner, Barnes and Coles and Jennifer Twist.</p>	March 2019
Initial Scoping Reviews		
Subject area for initial scoping	Detail	Proposed Dates
Cancer Care Performance	<p>HOSC had a report on cancer care performance figures at local NHS trusts circulated by email in the autumn. The report showed performance for 62 Day referral to treatment times are not being met at any of the acute trusts.</p> <p>The Government has announced a new cancer strategy and the Committee may wish to consider the issue at a future meeting in 2019.</p>	Early 2019
Children and Adolescent Mental Health Services (CAMHS)	The Committee has expressed interest in receiving information about how CAMHS is commissioned and provided in East Sussex and the performance of the service	Initial research underway

List of Suggested Potential Future Scrutiny Review Topics		
Suggested Topic	Detail	
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	<p>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 awaited.</p> <p>Membership: Cllrs Belsey, Murray and Howell</p>	<p>Last meeting: 31 October 2018</p> <p>Next meeting: late-January 2019</p>
Sussex Partnership NHS Foundation Trust (SPFT) HOSC working group	<p>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.</p> <p>Membership: Cllrs Belsey, Bowdler and Osborne</p>	<p>Last meeting: 11 September 2018</p> <p>Next meeting: TBC 2019</p>
The Sussex and East Surrey Sustainability and Transformation Partnership (STP) HOSC working group	<p>Regular liaison meetings of HOSC Chairs in the STP footprint with STP Executive Chair and Communications and Engagement lead to update on STP progress.</p> <p>Membership: HOSC Chair (Cllr Belsey) and officer</p>	<p>Last meeting: 26 September 2018</p> <p>Next meeting: 21 November 2018</p>
Regional NHS liaison	<p>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</p> <p>Membership: HOSC Chair (Cllr Belsey) and officer</p>	<p>Last meeting: 10 May 2018</p> <p>Next meeting: 4 December 2018</p>

Reports for Information		
Subject Area	Detail	Proposed Date
Patient Transport Service (PTS)	<p>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.</p> <p>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.</p>	Ongoing monitoring of Healthwatch reports
High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG) savings proposals	The Committee requested that HWLH CCG provide details of specific savings proposals for 2018/19 to be circulated by email.	Circulated October 2018
Personal Health Budgets	The Committee requested figures on the uptake amongst patients of Personal Health Budgets following identification of savings proposals relating to the Continuing Health Care budget	TBC
Prevention of smoking on hospital premises policy	The Committee requested that the policy for prevention of smoking within the hospital boundary at ESHT is circulated by email	TBC
Training and Development		
Title of Training/Briefing	Detail	Proposed Date
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
28 March 2019		
ESBT Alliance Sustainability Plan	<p>To consider a further report on the system-wide savings proposals in the East Sussex Better Together (ESBT) Alliance area of East Sussex from the Clinical Commissioning Groups (CCGs) and East Sussex Healthcare NHS Trust (ESHT). The report to also include details of the ESBT Alliance's 5-year Sustainability Plan.</p> <p>The Committee will also consider the perspective of the System Improvement Director, appointed to the ESBT area by NHS England & NHS Improvement, and Adam Doyle, the new Chief Officer of all CCGs in the Sussex and East Surrey Sustainability and Transformation Partnership (STP).</p>	Chief Executive, ESHT; Managing Director; ESBT CCGs; Adam Doyle, Chief Officer, CCGs; Christopher Langley, System Improvement Director, NHSE & NHSI
Mental Health Inpatient redesign in East Sussex	<p>To consider Sussex Partnership NHS Foundation Trust's plans to develop inpatient mental health services in East Sussex.</p> <p><i>Note: Timing is provisional depending on the NHS decision making process.</i></p>	Representative of Sussex Partnership NHS Foundation Trust (SPFT)
Kent and Medway Stroke Review	<p>To consider the outcome of the Kent and Medway Stroke Review in terms of the CCGs' proposed service configuration.</p> <p><i>Note: Timing is provisional depending on the NHS decision making process.</i></p>	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.	Representative of South East Coast Ambulance Service NHS Foundation Trust (SECamb)

Urgent Treatment Centres (UTCs) proposals in Eastbourne and Hastings	To consider the report of the HOSC UTC review board on the proposed reconfiguration of UTCs in Eastbourne and Hastings.	Representatives of ESBT CCGs
27 June 2019		
Urgent Treatment Centres (UTCs) proposals in Eastbourne and Hastings	To consider the decision by the CCGs in relation to the proposed reconfiguration of UTCs in Eastbourne and Hastings.	Representatives of ESBT CCGs