HEALTH OVERVIEW AND SCRUTINY COMMITTEE

THURSDAY, 28 MARCH 2019

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, Ruth O'Keeffe, Sarah Osborne and Alan Shuttleworth

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

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

AGENDA

1. **Minutes of the meeting held on 29 November** *(Pages 7 - 16)*

2. **Apologies for absence**

3. **Disclosures of interests**

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

4. **Urgent items**

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

5. **NHS Financial Recovery** *(Pages 17 - 22)*

6. **South East Coast Ambulance NHS Foundation Trust: Update on Quality and Performance** *(Pages 23 - 42)*

7. **Kent and Medway Stroke Review** *(Pages 43 - 76)*

8. **HOSC future work programme** *(Pages 77 - 92)*

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

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

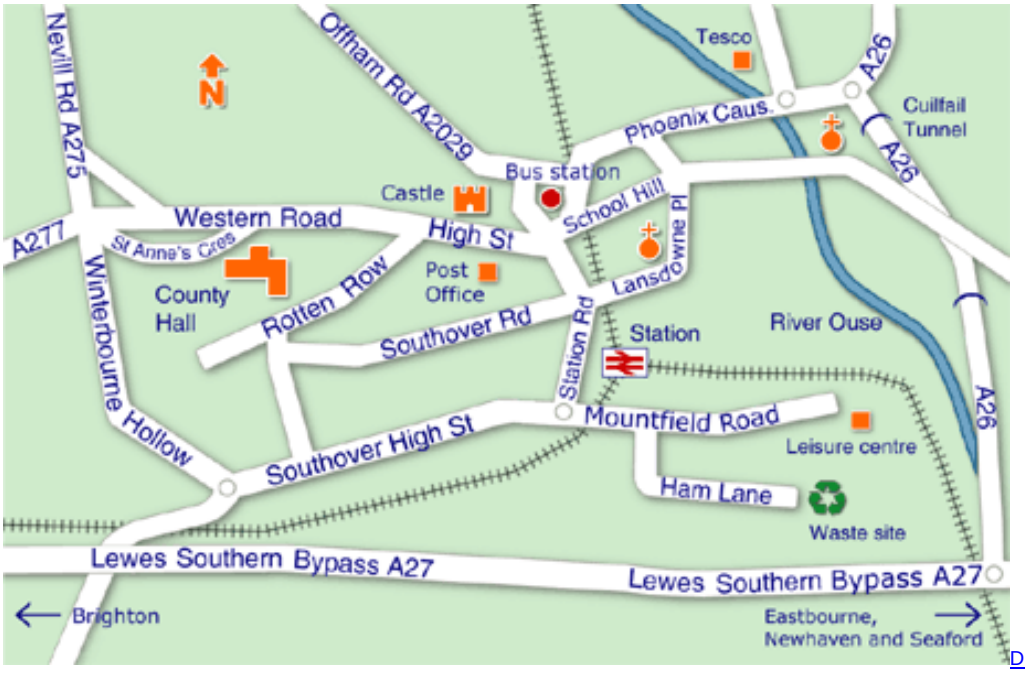
20 March 2019

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

Next HOSC meeting: 10am, Thursday, 27 June 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:
www.eastsussex.gov.uk/yourcouncil/webcasts

Map, directions and information on parking, trains, buses etc
Map of County Hall, St Anne's Crescent, Lewes BN7 1UE



County Hall is situated to the west of Lewes town centre. Main roads into Lewes are the A275 Nevill Road, the A2029 Offham Road and the A26 from Uckfield and Tunbridge Wells. The A27 runs through the South of the town to Brighton in the West, and Eastbourne and Hastings in the East. Station Street links Lewes train station to the High Street.

Visitor parking instruction

Visitor parking is situated on the forecourt at County Hall – please ensure you only park in this bay

If we have reserved a space for you, upon arrival press the buzzer on the intercom at the barrier and give your name. This will give you access to the forecourt.

Visitors are advised to contact Harvey Winder on 01273 481796 a couple of days before the meeting to arrange a space. Email: harvey.winder@eastsussex.gov.uk

By train

There is a regular train service to Lewes from London Victoria, as well as a coastal service from Portsmouth, Chichester & Brighton in the West and Ashford, Hastings & Eastbourne in the East, and Seaford and Newhaven in the South.

To get to County Hall from Lewes station, turn right as you leave by the main exit and cross the bridge. Walk up Station Street and turn left at the top of the hill into the High Street. Keep going straight on – County Hall is about 15 minutes walk, at the top of the hill. The main pedestrian entrance to the campus is behind the Parish Church of St Anne, via the lane next to the church.

By bus

The following buses stop at the Pelham Arms on Western Road, just a few minutes walk from County Hall:

28/29 – Brighton, Ringmer, Uckfield, Tunbridge Wells

128 – Nevill Estate

121 – South Chailey, Chailey, Newick, Fletching

122 – Barcombe Mills

123 – Newhaven, Peacehaven

166 – Haywards Heath

VR – Plumpton, Ditchling, Wivelsfield, Hassocks, Burgess Hill.

The main pedestrian entrance to the campus is behind the Parish Church of St Anne, via the lane next to the church.

Disabled access

There is ramp access to main reception and there are lifts to all floors. Disabled toilets are available on the ground floor.

Disabled parking

Disabled drivers are able to park in any available space if they are displaying a blue badge. There are spaces available directly in front of the entrance to County Hall. There are also disabled bays in the east car park.

This page is intentionally left blank

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Lewes on 29 November 2018

PRESENT:

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

WITNESSES:

Jessica Britton, Managing Director, Eastbourne, Hailsham and Seaford Clinical Commissioning Group (CCG) / Hastings and Rother CCG
Mark Angus, Winter Director, Sussex and East Surrey CCGs
Dr Adrian Bull, Chief Executive, East Sussex Healthcare NHS Trust
Joanne Chadwick-Bell, Chief Operating Officer, East Sussex Healthcare NHS Trust
Andy Cunningham, Head of Assessment & Care management, East Sussex County Council

LEAD OFFICER:

Harvey Winder, Democratic Services Officer

15. MINUTES OF THE MEETING HELD ON 27 SEPTEMBER

15.1 The minutes of the meeting held on 27 September were agreed.

16. APOLOGIES FOR ABSENCE

16.1 Apologies for absence were received from Cllr Janet Coles.

17. DISCLOSURES OF INTERESTS

17.1 There were no disclosures of interest.

18. URGENT ITEMS

18.1 There were no urgent items.

19. WINTER PLANNING IN EAST SUSSEX

19.1. The Committee considered a report providing an update on planning across East Sussex to deal with seasonal surges in demand, extreme weather and other issues associated with the winter months.

19.2. Ashley Scarff, Director of Commissioning Operations – High Weald Lewes Havens CCG; Jessica Britton, Managing Director of East Sussex Better Together CCGs; Mark Angus, Winter Director, Sussex and Surrey CCGs; Andy Cunningham, Head of Care Management (Hospitals), (in attendance from the Adult Social Care Department); Dr Adrian Bull, Chief Executive, East Sussex Healthcare NHS Trust (ESHT) and Joe Chadwick-Bell, Chief Operating Officer, ESHT, provided answers to a number of questions from HOSC.

Maintaining 85% bed capacity over the winter period

19.3. Mark Angus explained that 85% is recognised nationally as the ideal occupancy rate for beds in an acute hospital. However, it is also recognised that occupancy rates will usually be higher than 85% over winter months due to the fact that, whilst the number of admissions are not necessarily much higher, patients who are admitted tend to be sicker and therefore are admitted for longer periods. He said that the winter resilience plans aim to manage this period of generally higher occupancy safely and effectively within hospitals, whilst also ensuring that the whole healthcare system can respond in a co-ordinated way to individual surges in demand.

Avoiding unnecessary readmissions due to early discharge of patients

19.4. Mark Angus said that the healthcare system in East Sussex performs relatively well in relation to readmission rates. This is due to a number of checks and balances that are made during the discharge process that ensure patients are only discharged when ready to leave hospital. He confirmed that this process does not change during the winter period. Joe Chadwick-Bell added that figures showed that since introducing same-day ambulatory care at the A&E Departments readmissions rates had not risen. This demonstrated that whilst patients were receiving a shorter period of care than they would if admitted as an emergency inpatient they were not experiencing worse outcomes.

Personal Management Plans for patients with chronic conditions

19.5. Joe Chadwick-Bell explained that patients with a long term condition generally have a shared care plan agreed between their consultant and GP that clinicians will have access to. The East Sussex Better Together (ESBT) Alliance has amended the care pathways for five long term conditions so that should a patient with one of these conditions be in crisis they are referred to the ESBT Crisis Response Team and managed in the community, where possible.

Readiness of NHS 111 over winter and ability to book appointments

19.6. Mark Angus said that there is a detailed plan for NHS 111 over the winter based on lessons learned from last year, including ensuring that there is sufficient workforce in place to meet expected demand. Recruitment to 111 has been encouraged by introduction of a national career framework, which clearly defines the career path opportunities for both non-clinical and clinical call-handlers to improve the attractiveness of the role of call-handler and clinical assessors.

19.7. Mark Angus confirmed that the CCGs were working with 111, the primary care extended access providers, the out of hours GP service (provided by IC24), and the providers of the three Urgent Treatment Centres (UTCs) running in Sussex (including Lewes Victoria Hospital) to put in place the ability to book urgent care appointments via 111 by Christmas. He said that

appointments may not be directly bookable as the necessary ICT systems are not yet available, so this would be an interim telephone-based system.

Flu vaccination rates for staff and vulnerable groups

19.8. Mark Angus confirmed that there was no deadline by which hospital trusts must vaccinate their staff but all were making good progress. Mr Angus said that vaccination rate as at the end of October for Brighton & Sussex University Hospital NHS Trust (BSUH) was 44%; for Maidstone and Tunbridge Wells NHS Trust (MTW) was 45%; and for East Sussex Healthcare NHS Trust (ESHT) was 63%, which was within the top 10 in the country. Dr Adrian Bull confirmed that the vaccination rate at ESHT is now 70%. Mark Angus added that uptake amongst over 65 year olds as of the end of October was around 50%, which is the result of an ongoing programme to vaccinate more vulnerable groups.

Delays in GP practices receiving flu vaccinations

19.9. Mark Angus confirmed that there is a sufficient supply of vaccines but there were some teething problems with the new ordering system used by GP practices. He said that lessons will be learned for next year, for example, ensuring GP practices are aware of how the ordering system works and encouraging GP practices to share stock. Ashley Scarff added that some GP practices had arranged vaccination clinics correctly at the beginning of October but, regrettably, the vaccine stock did not arrive on time, resulting in the clinics being cancelled at short notice. He confirmed this issue has now been addressed.

Communications plans for urgent care

19.10. Mark Angus said that the overarching message being communicated is 'help us help you' and is primarily aimed at making sure people know about available urgent care services, such as UTCs and extended access GP services. He said that the communications plan would continue to be refined around the principle of promoting these alternatives to A&E, which will become easier as awareness of these services grows in the medium to long term. The success of this communication plan could be measured if an increase in usage of these services is observed at the same time as a drop in A&E attendance. He said that the national campaign to raise awareness of NHS 111 over the autumn led to a 7% increase in usage of the service, which is an example of a successful campaign.

19.11. He clarified it was not about 'telling people off' for using A&E but understanding that, once the elements of urgent care in place, calling 111 would result in receiving a responsive service that can facilitate the patient seeing someone in a timely fashion and that the patient's care needs will be met either over the phone, or where possible by referral to appropriate services, rather than attend A&E.

Communications plans for adult social care

19.12. Andy Cunningham said that East Sussex County Council:

- provides winter communications to domiciliary care organisations working in the county, in particular around encouraging flu uptake amongst their workforce and elderly vulnerable clients;

- asks that staff working for domiciliary care organisations and community nurses report any instances where patients either do not have working heating or are not using it; and

- provide some extra funding to domiciliary care companies to enable their staff to spend more time with elderly patients immediately following their discharge from hospital, for example, ensuring they have put the heating on, made a meal for them and ensured they are settled down safely.

Reasons for high A&E visitation for women aged 19-29

19.13. Mark Angus explained that initial data analysis of A&E visits indicated women aged 19-29 were a group with higher attendance levels than expected. This was an initial study and further work will be done in the future to understand the reasons for it.

System resilience over the winter

19.14. Mark Angus explained that the CCGs are working to ensure that there is continuous out of hours cover over Christmas and the New Year. Ashley Scarff added that the CCG is developing system resilience over the winter period by ensuring rotas are in place allowing for sickness cover so that if an out of hours doctor is not available, for example, someone else within the healthcare system can fill their position.

19.15. Jessica Britton said that the CCGs are as assured as they can be going into the winter period that the healthcare system has sufficient resilience to support local people over the coming months. She added that there has been some success in recruiting more GPs, particularly in the Hastings & Rother area, which has added to the resilience of the service.

Reasons for resilience of ESBT LAEDB

19.16. Mark Angus confirmed that the winter planning last year by the Local A&E Development Board (LAEDB) for the ESBT area has been shared across the region. The plan was seen as one of the more resilient because it involved activities such as daily executive-level calls across the health and social care system, and weekly face-to-face meetings, allowing for quick learning and adaption of patient discharge plans. It also saw the development of multi-agency discharge events involving senior social care workers and senior nurses going into wards and working through the issues causing DTOC with the teams on the ground. Joe Chadwick-Bell explained that these DTOC reduction plans are carried out throughout the year but are carried out with more regularity during winter.

Delayed Transfer of Care (DTOC)

19.17. Joe Chadwick-Bell said that DTOC are classified as being due to social care or health reasons, for example, health reasons may include patients waiting to have NHS delivered therapy and rehabilitation in place; whereas the small number of social care delays tend to be due to very complex social care patients who need individual care plans in place before discharge.

19.18. Joe Chadwick-Bell added that the trust is also reviewing on a weekly basis the top 15 longest staying patients to see whether anything can be done to discharge them sooner. As a result over the last two years the longest length of stay has reduced from around 100 days to 60-70 days, and these patients are mostly still medically unfit to be discharged.

Preparedness of ESHT for winter

19.19. Joe Chadwick-Bell confirmed that all medical staff rotas for the winter period are filled across ESHT; nursing rotas are in the process of being filled; and all wards at Eastbourne District General Hospital (EDGH) will be opened over the winter period. The Trust is also holding weekly assurance meetings with each of the division heads to ensure robust plans are in place. Ms Chadwick-Bell explained that the trust will ensure that minimum safe staffing levels are maintained across the winter period, for example, by reducing levels of planned activity and putting incentives in place for staff to work on peak days. Nevertheless she anticipated that there are likely to be periods of challenge, particularly between Christmas and New Year.

19.20. Dr Bull added that recruitment levels are in a better position than two years ago, for example, consultant posts across the A&E Departments are now fully staffed. He said that the overall vacancy rate is less than 10% and turnover is at 11%, both better than comparative trusts. However, recruitment and retention issues remain in some specialities and the trust is working with oversees recruitment consultants to increase recruitment levels further, which has had a positive effect over the past 6 months.

Ward rounds in care homes

19.21. Ashley Scarff said that Enhanced Care in Care Homes and Nursing Homes is a service commissioned by HWLH CCG involving GPs proactively going into care and nursing homes to assess patients and provide support to staff. This is instead of the traditional system whereby a care home would only have reactive contact with the healthcare system when making a 999 call for an ambulance or an urgent GP visitation for a resident, often leading to a hospital admission. Initial results of the service in its effect on admissions to A&E have been very encouraging and it is being rolled out further to other care and nursing homes.

Mental Health services over winter

19.22. Mark Angus said that there are an increasing number of patients presenting at A&E with mental health issues, which has a considerable impact on the departments. The Sussex and East Surrey Sustainability and Transformation Partnership (STP) Executive has met to consider whether the winter resilience plans in place are sufficient to manage the increase in people presenting with mental health issues over the winter period, and it was agreed that some additional work needs to be undertaken.

19.23. Mr Angus said that last year there were some patients who required medical admission to A&E who also needed admitting to an inpatient mental health facility. However, there was insufficient capacity at the Sussex-based inpatient facilities to admit them resulting in a number of out of area placements, sometimes a significant distance away. Work has been undertaken over the past 12 months to develop ways of freeing up beds in these inpatient facilities, which are often at very high occupancy levels due to instances of Delayed Transfer of Care (DTOC). This work includes multi-disciplinary working between health and social care teams, such as regular reviews of individual DTOC by senior staff, and a fortnightly chief executives meeting about inpatient mental health beds in the local system. Dr Bull added that a number of other innovative services have been developed in support of mental health in Sussex, including the street triage teams in Eastbourne and Hastings, which is available seven days a week for adult patients.

19.24. The Committee RESOLVED to:

1) note the report; and

2) request an update via email on the outcome of the winter planning in April 2019.

20. EAST SUSSEX HEALTHCARE NHS TRUST EAR, NOSE AND THROAT (ENT) SERVICES RECONFIGURATION

20.1. The Committee considered a report providing details of the proposed reconfiguration of Ear, Nose and Throat (ENT) services currently provided by East Sussex Healthcare NHS Trust (ESHT).

20.2. Joe Chadwick-Bell, Chief Operating Officer, explained that the proposed reconfiguration is driven by workforce challenges, in particular:

- A shortage of ENT consultants. There are currently three consultants covering the two sites, whereas there should be five or six. This makes it very hard to recruit any additional consultants as they would have to be on call on a 1-in-4 or 1-in-3 basis. One of the three consultants has retired and returned on an almost full time basis.

- A shortage of middle grade doctors. There are currently no registrars or training grade doctors to fill the six middle grade rota posts. Instead there are four speciality doctors, one of whom acts up to the consultant rota. They are also close to retirement age and could potentially hand in their notice, despite the current work they are doing now to support the service

- Reliance on the ad hoc support of 10 Sussex-based doctors, particularly at the A&E department at the Conquest Hospital.

- There are two trainee ENT doctors but there is a risk that the Deanery could remove them without providing them with more training opportunities.

20.3. Dr Adrian Bull, Chief Executive, and Joe Chadwick-Bell provided answers to a number of questions from HOSC.

Emergency ENT pathway

20.4. Joe Chadwick-Bell explained that patients currently present as emergency ENT patients either by calling 999 or attending A&E. South East Coast Ambulance NHS Foundation Trust (SECAmb) know to bring such patients to the Eastbourne District General Hospital (EDGH) where emergency admissions are currently located. Self-presenters at Conquest Hospital can mostly be dealt with on site but those few patients who need the intervention of an ENT surgeon would be transferred across via ambulance.

Ensuring Supportive Professional Activities (SPA) for consultants

20.5. Dr Adrian Bull said that Supportive Professional Activities (SPAs) are part of a consultant's contract and the Trust is committed to protecting SPA time as an important part of the training process.

Recruitment difficulties due to sub-specialisation

20.6. Dr Bull explained that recruitment rates are improving across the trust except for in areas where there is an increasing tendency towards sub-specialisation, rather than generalisation, and in which there are more frequent on-call requirements; the ENT service is faced with both of these issues. Therefore, the future service needs to be attractive to surgeons who are looking to specialise in ear issues, nose issues, or throat issues, given the increasingly few number of ENT generalists.

Impact on deprived communities

20.7. Dr Adrian Bull said that he did not believe deprivation was relevant to the proposals, as the key consideration of the Trust is to provide a service that provides the right quality of care to residents of East Sussex. In addition, outpatient services would continue as before at Conquest Hospital so access to the opinion of an ENT consultant, who can provide an assessment and diagnosis for the residents of Hastings would continue. The difference is that patients who needed to receive planned surgery – the majority of which are day case patients or patients staying less than 2 days – would need to travel to the EDGH.

Impact on other services at Conquest Hospital

20.8. Dr Bull explained that local community groups and individuals from both Eastbourne and Hastings have expressed concerns to him about the majority of their town's hospital services being moved to the other hospital, demonstrating it is a major concern in both towns. He said, however, that whilst the two major hospital sites would not be run as 'mirror images' of each other, the trust is committed to providing acute services across both sites. Dr Bull added that there is no prospect of acute services being removed from Hastings due to the geographical remoteness of the town, requiring the Conquest Hospital to be designated as a trauma unit, and provider of a number of other specialist services, for the population of the area. He assured the Committee that the reconfiguration of ENT services was absolutely not the first step in the removal of hospital services there.

Financial performance of the trust

20.9. Joe Chadwick-Bell explained that the ENT service had admitted fewer patients in the past year due to not having a sufficiently large consultant team to admit as many patients as the trust would like. The increase in the cost of the service during the same period was due to the reliance on the ad hoc hiring of staff from across Sussex to fill gaps in the rota, which is more costly than if they were substantive staff. The proposed reconfiguration would therefore cost less and be able to provide more activity.

Paediatric planned and emergency pathways

20.10. Joe Chadwick-Bell explained that paediatric day cases who did need to be admitted to the Conquest paediatric ward overnight would be admitted to the paediatric ward under the supervision of ENT consultants, if clinical judgement felt it was safe to do so, and as is currently the case. In addition, the ward at EDGH would be opened until 9pm to allow paediatric day case patients a little more recovery time; and children would be operated earlier in the morning, starting at around 8.30am, to reduce the need for cross-site transfers. She confirmed that this element of the pathway would continue to be refined during the detailed analysis stage.

20.11. Dr Bull explained that under the proposals if a child attended the A&E at the Conquest and it was judged to be an ENT condition requiring emergency admission, then they would be admitted to the specialist centre at the Royal Alexandra Children's Hospital in Brighton.

The Committee RESOLVED to:

1) note the report; and

2) request an update on implementation of the proposals at the June 2019 meeting.

21. ESTABLISHMENT OF A JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE (JHOSC) ACROSS SUSSEX AND SURREY

21.1 The Committee considered a report recommending the establishment of a Joint Health Overview and Scrutiny Committee (JHOSC) along with Brighton & Hove, West Sussex and Surrey for the purposes of considering possible future substantial variations to services affecting two or more local authority areas, as required under health legislation.

3.2 The Committee RESOLVED to:

1) Agree to establish a JHOSC 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 Cllrs Colin Belsey, Bob Bowdler, and Sarah Osborne as voting members and Geraldine Des Moulins as a non-voting member to the JHOSC to represent the East Sussex Health Overview and Scrutiny Committee.

22. WORK PROGRAMME

22.1 The Committee considered a report on its work programme which included an update on the progress of the Urgent Treatment Centre reconfiguration (UTC) in the Eastbourne and Hastings area.

22.2 The Committee RESOLVED to:

1)) agree the work programme subject to the addition of:

- A further report on the performance of cancer services in East Sussex to be circulated by email in the new year, with a report to the committee, if necessary, in June;
- A report on the outcome of the Children and Adolescent Mental Health Services (CAMHS) review at a future meeting; and

2) note the delay in the UTC reconfiguration process and continued work of the UTC Review Board.

The meeting ended at 11.50 am.

Councillor Colin Belsey
Chair

This page is intentionally left blank

Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date of meeting:	**28 March 2019**
By:	**Assistant Chief Executive**
Title:	**NHS Financial Recovery**
Purpose:	**To provide HOSC with an update on the Clinical Commissioning Groups' and East Sussex Healthcare NHS Trust's expected financial outturn for 2018/19 and future financial plans**

RECOMMENDATIONS

The Committee is recommended to:

1) consider and comment on the report; and

2) identify any proposals that require further scrutiny.

---

1. Background

1.1. The Health Overview and Scrutiny Committee (HOSC) considered a report at its 27 September 2018 meeting on the financial performance of local NHS commissioners and the main acute provider in East Sussex, East Sussex Healthcare NHS Trust (ESHT).

1.2. The Committee requested a further update towards the end of the financial year on:

- The expected financial outturn for 2018/19 of the three Clinical Commissioning Groups (CCGs) in East Sussex; and
- the Five-Year Financial Improvement Plan of ESHT and Eastbourne, Hailsham and Seaford Clinical Commissioning Group (EHS CCG)/Hastings and Rother CCG (HR CCG) that was due to be agreed at the end of 2018.

2. Supporting Information

2.1. The three CCGs in East Sussex – High Weald Lewes Havens CCG (HWLH CCG); EHS CCG, and HR CCG – and ESHT ended the 2017/18 financial year with a combined £102m deficit.

2.2. EHS and HR CCGs ended 2017/18 with a combined financial deficit of £37m, which was the first time they had been in deficit in four years. The underlying financial position had deteriorated in part due to a £22m increase in the cost and frequency of services being provided to patients by acute hospitals, which the CCGs are required to pay for under Payment by Results contracts.

2.3. The two CCGs agreed with NHS England to end the 2018/19 financial year with a 'control total' of a £32m combined deficit. If the CCGs achieve this control total they would receive a payment of £32m from the national Commissioner Sustainability Fund (CSF) that would reduce their deficit for the year to zero.

2.4. In order to reach the control total the CCGs will need to deliver Quality, Innovation, Productivity and Prevention (QIPP) savings of £18m, amounting to around 3% of their total expenditure. The QIPP savings include both schemes that deliver improved quality and efficiency and drive transformation, and a 5% reduction in non-acute budgets (excluding Primary Care and Mental Health). The QIPP savings fall across five key categories, Medicines Management, Planned Care, Urgent Care, Community, and Running Costs.

2.5. The Committee was informed at its September meeting that the savings plans as of quarter 2 were on course for delivery, with most of the savings having been identified and in the process of being implemented.

2.6. HLWH CCG ended 2017/18 with a deficit of £9m. The CCG agreed with NHS England a control total of £10.7m deficit through the delivery of £9.2m of QIPP savings, amounting to roughly 3% of total expenditure.

2.7. HWLH CCG informed HOSC in September that it was on course to deliver its savings at the end of quarter 2, albeit £2.3m of unmitigated risks remained, i.e. savings that had not yet been identified or that had a significant risk to delivery.

2.8. NHS England placed EHS and HR CCG into legal directions in July 2018 and appointed a single System Improvement Director team to the area. As part of these legal directions, the two CCGs were required to develop a joint Five-Year Financial Improvement Plan with ESHT, which is also in financial special measures. The plan was submitted to the System Improvement Director in December 2018 and signed off by ESHT's Trust Board and the CCG Governing Bodies in that month. The Plan will be finalised in April 2019 in light of the organisations having received their control totals and planning guidance for 19/20. It will also be extended to reflect key elements of East Sussex County Council's financial plan.

2.9. The latest report attached as **Appendix 1** explains that at the end of March 2019 the East Sussex health system is now anticipating – after CSF payments – a combined deficit of £44.9m (compared to £102m the year before). The forecast delivery of the planned deficit for 2018/19 has been achieved through the full delivery of the CCGs' QIPP programme and the equivalent Cost Improvement Programme (CIP) at ESHT.

2.10. For 19/20 control totals have been set by the regulators of £34m deficit for ESHT, £7.6m for HWLH CCG, and £23.9m for EHS and HR CCGs. After central funding payments this would result in a total £13.9m deficit. Plans for QIPP and CIP savings for 19/20 are being finalised and overseen by the East Sussex Health and Social Care Executive Group (which comprises executive team members from health and social care across East Sussex).

3. Conclusion and reasons for recommendations

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

PHILIP BAKER
Assistant Chief Executive

Contact Officer: Harvey Winder, Democratic Services Officer
Tel. No. 01273 481796
Email: Harvey.winder@eastsussex.gov.uk

Eastbourne, Hailsham and Seaford CCG
Hastings and Rother CCG
High Weald Lewes Havens CCG
East Sussex Healthcare NHS Trust

East Sussex Health Services – delivering financial recovery

1. Background

1.1 This paper summarises the financial performance of the East Sussex Better Together system - East Sussex Healthcare NHS Trust and Eastbourne, Hailsham and Seaford & Hastings and Rother CCGs - and in order to reflect a clear picture of our working across East Sussex as a whole, also includes High Weald Lewes Havens Clinical Commissioning Group (CCG) position as integral to the report.

1.2 The East Sussex health system reported a combined deficit of £102m at the end of March 2018 (£92m ESBT and £10m HWLH CCG), with all the Clinical Commissioning Groups (CCGs) and (ESHT) reporting significant variances against their plans.

1.3 In June 2018, a System Improvement Director was appointed jointly by NHS Improvement and NHS England to enact the Financial Special Measures regime for the ESHT and in recognition also of the Legal Directions for two of the three East Sussex CCGs (Eastbourne, Hailsham and Seaford and Hastings and Rother). The purpose was to provide holistic regulatory support to the local system to assist it in returning to financial balance over an appropriate time period.

1.4 The ESBT system was supported to develop a shared five year financial improvement plan, which was described to the Health Overview and Scrutiny Committee in September 2018. This plan was submitted to the regulators within the required timescales in December 2018 and signed off by ESHT Trust Board and the CCG Governing Bodies in December 2018. It was recognised that the plan would have a further iteration once organisations had received their control totals and planning guidance before becoming final.

1.5 Separately, HWLH CCG agreed a Financial Recovery Plan with its Regulator in June 2018 and developed £9.2m of schemes to deliver the planned financial position.

1.6 2018/19 is the first year of the five year financial improvement plan. At the end of the 2018/19 year (March 2019), the East Sussex health system is now anticipating a combined deficit of £44.9m – a significant improvement on March 2018. In 19/20 control totals have been set by the regulators of £34m deficit for ESHT, £7.6m for HWLH CCG and £23.9m for EHS and HR CCGs.

1.7 For 2019/20 – ending in March 2020 - the planned combined deficit is £13.9m subject to achieving the control totals. The system is on a trajectory over five years to deliver a sustainable financial recovery, alongside continued improvements in quality and safety. This paper provides more detail on the work in train to deliver this improvement in financial performance and recovery.

Note – these year-end numbers are net of centrally supported STF/CTF payments of £42.7m in 18/19 and £51.6m in 19/20 which are triggered by achievement of the control totals.

2. Purpose of this report

2.1 This paper describes the system financial performance for 2018/19, and the emerging financial plans for 2019/20. It notes that the five year plan is to be refreshed in April 2019, and will be extended to reflect key elements of the ESCC financial plan.

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

3. Improving in 2018/19

3.1 The system is forecasting delivery of the planned deficit of £44.9m as at March 2019. It should be noted that this figure includes £32m of commissioner sustainability funding (central funding). Notwithstanding this funding, the system achieved an improved outturn over last year and therefore has already been delivering significant improvements on the road to sustainability. This has been delivered through a Cost Improvement Programme (CIP) at ESHT and a Quality Innovation, Productivity and Prevention (QIPP)[1] Programme at the CCGs. For both programmes, close working and collaboration with system partners – including East Sussex County Council – has been key to delivery. The table below sets out anticipated performance, which includes full delivery of the Trust CIP and CCG QIPP programmes.

	2018/19		
	Plan	**Forecast**	**Variance**
	£000	**£000**	**£000**
East Sussex Healthcare NHS Trust	(44,900)	(44,900)	0
East Sussex Better Together CCGs	(32,000)	(32,000)	0
High Weald Lewes Havens CCG	(10,700)	(10.700)	0
System Financial Position	**(87,600)**	**(87,600)**	**0**
Memo:			
Central Funding (CTF)	42,700	42,700	0
Net System Position	**(44,900)**	**(44,900)**	**0**

3.2 The Trust and the CCGs described the comprehensive systems of Quality Impact Assessment at the October 2018 session with the Committee. During this financial

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

year, the overall level of system performance has improved across key metrics, including national access standards and referral to treatment times. For example our system in East Sussex is in the upper quartile for A&E performance, waiting list and referral to treatment times have improved. This continued improvement demonstrates that quality can be maintained whilst delivering an improvement in the financial position. This approach – of clinically-led improvement will be continued into 2019/20 and over the life of our financial recovery plans.

4. Planning for 2019/20

4.1 The Trust and the CCGs are seeking to deliver an improved financial performance in 2019/20, in line with control totals (targets) issued by NHS Improvement and NHS England. The control totals are £34m for ESHT and £31.5m for the CCGs. There is work to do across all organisations to finalise the financial plans, to ensure that these are aligned, and to quality impact assess each and every scheme in the Cost Improvement Programme and the QIPP Programme. This work is in train, and is overseen by the East Sussex Health and Social Care Executive Group[2]. The table below shows the current plan:

	2018/19	**2019/20**
	Outturn	**Plan**
	£000	**£000**
East Sussex Healthcare NHS Trust	(44,900)	(34,033)
EHS and HR CCGs	(32,000)	(23,900)
High Weald Lewes Havens CCG	(10,700)	(7,600)
System Financial Position	**(87,600)**	**(65,533)**
Memo:		
Central Funding (CTF)	42,700	51,608
Net System Position	**(44,900)**	**(13,925)**

4.2 The Trust and CCGs are working together to deliver the system plan and there is both collective and individual plans to deliver efficiencies next year. We are committed to investing in new models of care including improved ways of supporting frailty and the ambulatory care unit.

4.3 Both the Trust and the CCG have robust systems in place to ensure that we have been addressing financial recovery in a way that improves pathways and efficiency to release savings. This includes measures to reduce the rate of increase of demand for acute hospital care by further strengthening community and primary care services. We have ensured these are developed and delivered in a way which does not adversely impact on quality and safety – with an established Quality Impact Assessment process, led by the Chief Nurse and the Medical Director for the Trust, and the Chief Nurse for the CCGs. The Trust's Quality and Safety Committee is focused on continuing to press for improvements in quality and safety across the organisation, and maintains a

[2] This is a leadership group comprising executive team members from Health and Social Care across East Sussex that is focussed on our shared transformation plans

rigorous review process for potential adverse consequences of cost improvements on quality. The CCGs have similar committees.

4.4 Both programmes are driven by evidence and analytical information (from national tools such as the Model Hospital, as well as detailed benchmarking of services) and are aimed at reducing the underlying financial deficit in a sustainable way over time. Delivery in our organisations is supported though focused financial recovery leadership and by a Recovery Director, and through a Programme Support Office. This is co-ordinated through the East Sussex Finance Directors Group.

5. Refreshing the Five Year Financial Plan for the System

5.1 The national System Improvement Director's team have provided key support to the ESBT team in achieving the improved financial performance of the system. The Trust and the CCGs now have an aligned and robust five year financial model, which reflects activity trends and population growth. This is used for all financial planning, and to test where and how financial improvement can be delivered. Following the conclusion of our business planning for 2019/20, the model will be updated in April 2019. This model supports discussion with key local stakeholders and national bodies around the right trajectory for financial recovery and the right support for our services, including capital funding.

5.2 HWLH CCG five year financial recovery plan from 2018/19 onwards, demonstrates a sustainable position within the term of the plan. A refresh of all system plans are to be submitted in the autumn.

6. Next steps

6.1 The scale of the challenge facing our system is significant, but the longstanding clinical programme of change, coupled with the more recent and joint financial recovery programme, is starting to impact positively. The 2018/19 financial position indicates that financial recovery can be delivered without adverse impact on quality, and this requires robust and constant vigilance over the key quality issues for the local health system. Demonstrating continued improvements in clinical quality and safety, and ensuring appropriate safeguards to services, will continue to be the priority for us all.

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

Date of meeting: **28 March 2019**

By: **Assistant Chief Executive**

Title: **South East Coast Ambulance NHS Foundation Trust: Update on Quality and Performance**

Purpose: **To consider an update on the quality and performance of services provided by South East Coast Ambulance NHS Foundation Trust**

RECOMMENDATIONS

The Committee is recommended to consider and comment on the report

---

1. Background

1.1. South East Coast Ambulance NHS Foundation Trust (SECAmb) provides emergency ambulance services across Sussex, Surrey and Kent.

1.2. This report provides Members with an update on SECAmb's service quality and performance as well as outlining some important recent developments at the Trust.

2. Supporting information

2.1. Emergency ambulance services provided by SECAmb are commissioned jointly across the Sussex, Surrey and Kent area with North West Surrey Clinical Commissioning Group (CCG) acting as Lead Commissioner, although each CCG is accountable for services in its area.

2.2. HOSCs have a duty to monitor the performance of local NHS providers. SECAmb was placed in special measures following an inspection by the Care Quality Commission (CQC) in September 2016 that rated the Trust as inadequate. As the Trust covers an area encompassing six local HOSCs, it was agreed by each Committee that monitoring of the Trust's Quality Improvement Plan would be undertaken via a working group comprising the Chairs of each Committee meeting with SECAmb's executives, and that this group would report its findings to the individual HOSCs.

2.3. The group met five times between December 2016 and March 2018. This arrangement was subsequently discontinued in Summer 2018 by mutual agreement following improvements to the Trust's performance and it was agreed that future scrutiny would be undertaken by individual HOSCs. Following the publication of its latest CQC inspection in November 2018, SECAmb executives have now provided updates to the majority of the individual HOSCs in its area of operation.

2.4. SECAmb's report (attached as Appendix 1) updates the committee on:

- the CQC report published in November 2018, which rated the Trust as 'requires improvement' overall (the full report is available online);
- the NHS Staff Survey 2018 results, which show significant improvements when compared to last year's;
- updates on the status of recruitment to the trust's Executive Board;
- the Ambulance Response Programme (ARP) re-categorisation of 999 call priorities to Categories 1-4 and the Trust's performance in relation to them;
- the trust's Demand and Capacity review and delivery of this model through the Service Transformation and Delivery (STAD) Programme implementation;
- the expansion of the trust's ambulance fleet;

- Handover delay figures and SECAmb's system wide programme to reduce handover delays at hospital sites;
- The trust's estate and development of Make Ready Centres and Ambulance Response Posts;
- Developing an Alliance with West Midlands and South Western Ambulance Services designed to deliver efficiency savings to invest in front line services;
- Winter Planning, including that planning for the key weeks over Christmas and New Year were successful; and
- the trust's financial control total and Cost Improvement Plan for 18/19.

3. Conclusion and reasons for recommendations

3.1. The Committee is recommended to consider and comment on the report and identify any future areas of scrutiny in relation to the issues discussed.

PHILIP BAKER
Assistant Chief Executive

Contact Officer: Harvey Winder, Democratic Services Officer
Tel. No. 01273 481796
Email: Harvey.winder@eastsussex.gov.uk

EAST SUSSEX COUNTY COUNCIL
HEALTH OVERVIEW AND SCRUTINY COMMITTEE
28TH MARCH 2019
SOUTH EAST COAST AMBULANCE SERVICE UPDATE

Report from: Jayne Phoenix, Deputy Director Strategy and Business Development

Author: Ray Savage, Strategy & Partnerships Manager, SECAmb

This report updates the committee on the South East Coast Ambulance Service CQC report, Executive leadership development, the Ambulance Response Programme, the Demand and Capacity review and resulting Service Transformation and Delivery Programme, alongside other strategic performance updates and local performance for East Sussex.

1. Background

1.1 SECAmb during the past two years has undergone a significant period of transformation following the initial CQC visit of 2016, resulting a in a number of key programmes of transformation and service delivery.

2. CQC Update

2.1 Following the CQC published report on the 29th September 2017, the result of which saw the Trust rated as 'inadequate' and to continue in special measures, SECAmb has been on an improvement trajectory. Further unannounced visits from the CQC saw their formal recognition of the progress that the Trust was making, largely achieved through a comprehensive work programme overseen by the Trust's Programme Management Office (PMO).

2.2 The Trust was inspected by CQC in July and August 2018 and the subsequent report published on 8th November 2018 (**Annex A** shows key excerpts). The Trust's rating moved from 'inadequate' to 'requires improvement'. **Annex B**

2.3 Whilst the Trust is rated as 'requires improvement', the CQC acknowledged a number of areas where the Trust has made significant progress and again rated the care given by staff to patients as good, with several other areas recognised as outstanding.

2.4 Some of the key areas of feedback are:

2.4.1 Staff cared for patients with compassion. All the staff inspectors spoke with were motivated to deliver the best care possible. Feedback from patients and those close to them was positive.

2.4.2 The Trust promoted a positive culture that supported and valued staff. Inspectors found an improved culture across the service since the last inspection. Most staff felt the culture had improved and felt able to raise concerns to their managers.

2.4.3 Medicines management was robust and effective with a marked improvement since the previous inspection. Inspectors found elements of outstanding medicine management, for example, the way the Trust handled Controlled Drugs.

2.4.4 An external review also recognised the impressive turnaround in performance.

2.4.5 A new Well-Being Hub, which enables staff to access support in a variety of areas. The service was widely commended by staff during the inspection.

2.4.6 A significant improvement in the process for investigating complaints and the quality of the Trust's response to complaints since the previous inspection

2.4.5 SECAmb continues to align practice between its 111 service and the 999 Emergency Operations Centre through learning from its good practice and combined management structure.

2.5 Following the publication of the report and its findings, the Trust has been working with its Project Management Office (PMO) on a delivery plan to continue the progress and improvements required (**Annex A** shows the Must Do and Should Do areas required).

3 NHS Staff Survey 2018

3.1 The results from last years (2018) NHS staff survey recently published, resulted in positive results for SECAmb compared to previous years surveys.

3.2 The results of individual questions, grouped into 10 key themes, represents the best ever scores for SECAmb since they were introduced in 2014, and when compared to last year's scores, shows significant improvements in every area where comparison is possible.

3.3 The Trust had a response rate with 53% of staff completing the survey compared to a sector average of 49%.

3.3 Areas of improvement included in the themes of safety culture, morale and quality of care. Compared to 2017, more staff look forward to going to work and staff are more enthusiastic about their jobs. The number of staff who

would recommend SECAmb as a place to work has risen nearly 20 per cent in a year. Please see **Annex C.**

4 Executive Board Recruitment

4.1 SECAmb has continued to recruit to Executive and Non-Executive team.

4.1.1 Steve Emerton appointed to the role of Executive Director of Strategy and Business Development on 2nd January 2018.

4.1.2 Ed Griffin appointed to the role of Executive Director for HR on 7th March 2018 has recently announced his resignation to take up a post at the Institute for Employment Studies heading up HR Consulting and Research. Recruitment for Ed's replacement has already begun.

4.1.3 Bethan Haskins, appointed to the role of Executive Director of Nursing and Quality and started on the 1 April 2018.

4.1.4 Dr Fionna Moore has been appointed as the Trusts Substantive Executive Medical Director, following an interim period of the past 14 months.

4.1.5 Following the departure of the Trusts Chairperson, Richard Foster, David Astley was appointed in September 2018.

4.1.6 In November 2018, the Trust announced that Chief Executive, Daren Mochrie, would be leaving SECAmb to take up a new role as Chief Executive of the North West Ambulance Service from 1 April 2019. Following the recent recruitment process, a successor has been appointed, but the Trust is unable to announce who will replace Daren at this moment in time as the process has not fully concluded.

4.1.7 The Trust has 9 Non-Executive Directors (including the Chair) who have a breadth and wealth of experience across different sectors as well as the NHS.

5 Ambulance Response Programme

5.1 Following the NHS England commissioned review of urgent and emergency care in 2013, it was recognised that the ambulance service response standards, (England), had not been fully reviewed since the mid 1970's. There was however an earlier review with new standards introduced in March 2001 where a move away from the Rural/ Urban ORCON standards saw Cat A, B and C prioritisation introduced. The Ambulance Response Programme (ARP) has superseded this.

5.2 In 2015, NHS England commissioned Sheffield University to undertake a study into ambulance responses. The result of this study was the introduction of the Ambulance Response Programme (ARP).

5.3 The ARP is a change to the way in which ambulance services (in England) receive and respond to emergency calls. On 22nd November 2017, ARP went live at SECAmb.

5.4 A key element of ARP was the re categorisation of 999 call priorities, whilst maintaining a clear focus on the clinical needs of patients and ensuring that the right resource is dispatched. **Annex D**

6 Demand and Capacity Review

6.1 During 2017- 2019, following the identification of a gap in funding, for SECAmb to deliver its existing model and achieve all performance targets, Commissioners and SECAmb jointly commissioned (with the Support of NHS England and NHS Improvement), Deloitte and ORH to undertake a review of existing and future operating models.

6.2 The approach from Deloitte and ORH was in the form of a 'Demand and Capacity' review to understand the relationship between resources, performance, and finances.

6.3 The focus of the review was on two operating models: 1) Paramedic Led Ambulance Model and 2) The Targeted Dispatch Model. Both identified a requirement to increase not only the number of front line staff, but also the fleet resource.

6.4 The conclusion of this review to recommend the 'Targeted Dispatch Model', which focused on getting clinically appropriate resources to patients by using specialist paramedics in cars, paramedics on ambulances and the introduction of a lower acuity mode of ambulance to specifically support those patients that fall into category 3 & 4 calls. Non-Emergency Transport (NET) vehicles have since been procured and are being rolled out across the Trust by March 2019.

6.5 The NET vehicles will support The Trust to improve response to patients who are not in a serious or life-threatening condition. Primarily they will serve patients who have been assessed by a Health Care Professional, such as a Paramedic or GP and who require non-emergency urgent transport to a healthcare facility. However, all NET vehicles will be equipped with essential life-saving equipment and will be able to attend as a first response to life-threatening calls. The NETs will be crewed by Emergency Care Support Workers, Associate Ambulance Practitioners and Ambulance Technicians.

6.6 Another key element of the 'Targeted Dispatch Model' is that it builds on our work with the wider system to enable and facilitate alternatives to conveyance to an Emergency Department. That is, increase 'hear and treat' and 'see and treat' or refer into jointly developed and clear care pathways to deliver continued benefit to patients and the system.

6.7 Work has already begun on the delivery of this model through the Service Transformation and Delivery (STAD) Programme implementation with staff recruitment and fleet procurement underway. A key part of the delivery is that Q1 2019/20 will see C1 performance achievement on a sustainable basis, and the introduction of the full model for all categories of performance, with sustainability fully achieved by Q4 2020/21.

6.8 The Emergency Operations Centres (EOC) will also see an increase in its staffing levels with an uplift from 308 full time equivalents (FTE) to 398 by Q4 2020-21. This uplift will ensure that call-answering times are at 95% of calls answered within 5 seconds.

6.9 An increase in the EOC's of Clinical supervisors will see an improvement of 'Hear and Treat' from the current 6% to 10% early 2019-20.

7 Fleet

7.1 SECAmb has invested in a 101 new ambulances with a vehicle roll out programme during the next 12 months. July saw the first of 42 new ambulances, 'Mercedes Sprinters', being rolled out at a rate of 3 to 4 per week and will replace some of the Trust's older vehicles by October. The Trust is also in the process of trialling 16 new Fiat van conversion ambulances across the Trust.

7.2 In addition and to further support ARP, the Trust has invested in 30 second-hand Fiat ambulances, operating at Non-Emergency Transport (NET) vehicles, which are converted to attend the lower acuity non-life threatening calls and will carry slightly different equipment. These vehicles are being introduced in a phased approach commencing mid December 2018: full operational roll out is expected to be complete by March 2019.

7.3 During 2019/20 further investment is planned in up to a further 50 ambulances as well as a replacement programme for the Trust's rapid response cars and 4x4 vehicles.

8 Handover Delays

8.1 SECAmb is leading on a system wide programme of work focusing on reducing ambulance hours lost at hospital sites due to handover delays and led by a Programme Director appointed by SECAmb who prior to this appointment worked for a community trust.

8.2 Some good progress has been made overall, and for the month of February 2019, the total ambulance hours lost (Amb Hrs Lost at Hosp >30 mins) was 5,335 which is equivalent to 444, 12-hour ambulance shifts for the month. This is a reduction when compared to the same period last year (5,704 hours) but remains of significant concern. Most hospital sites are losing fewer hours than in February last year, but there are some significant outliers where hours lost are greater when compared to the same time last year.

8.3 East Sussex Healthcare NHS Trust (ESHT) saw a slight increase of 1.5% for the month (599) when compared to 2018 (590). However, this is still a significant improvement when compared to 2016 (640) and 2017 (815) and reflects the 'joined up' working and determination of both SECAmb and ESHT's operational teams to reduce ambulance time lost at both the Eastbourne district General and Conquest Hospitals.

8.4 A key part of the work stream has been to develop together (SECAmb and each acute hospital); a handover action plan to streamline the process of handover delays including best practice e.g. dedicated handover nurse and admin, Fit2Sit, front door streaming and direct conveyance to non-ED destinations.

8.5 A number of live conveyance reviews have also taken place where a representative from the ambulance service, hospital, primary care, community trust, and CCG have reviewed all decisions to convey to hospital with an aim to ensuring that all existing community pathways are maximised.

8.6 The reviews undertaken so far, have given a clear indication that community pathways are being maximised where they are in place. The results are being presented for further discussion with local system partners in order to explore new community pathways, where required.

8.7 Peer reviews looking at the handover process at individual sites have also taken place at some hospitals, where the Chief Operating Officer (COO) from another acute hospital, supported by a member of the Emergency Care Intensive Support Team (ECIST), visits another hospital and reviews the ambulance pathway through the department. The ESHT COO has been a part of this programme. The peer reviews have been received positively and have been a good way to share best practice across hospital sites.

9 Estate

9.1 The Polegate and Hastings, and Brighton Operating Units primarily cover East Sussex with an overlap across the county's borders from the Paddock Wood (Kent) and Tangmere (West Sussex) Operating Units. Both Polegate and Hastings have established Make Ready Centres with Polegate being the more recent development. They are supported by a number of strategically placed 'Ambulance Response Posts', some of which have facilities for crews to use and are where ambulances are posted during a shift to give a wider spread of operational cover.

9.2 The recent announcement by the Secretary of State for Health & Social Care, Matt Hancock of a £5.52m grant for the new Make-Ready Centre at Falmer and development work has recently started on the site with completion anticipated in late 2019 and full occupation in early 2020.

9.3 The concept of the 'Make Ready Centre' is to ensure that ambulance crews, when arriving on shift have a vehicle ready for them that has been prepared by a specialist team who will clean, restock and refuel the vehicle to minimise the time the arriving crew have between 'booking on shift' and being available to respond to an incident.

10 Trust-wide Performance

10.1 The variance in performance for SECAmb across the three counties (Kent, Surrey and Sussex) is minimal, however, the Trust recognises that achieving C1, C2, C3 and C4 performance measures continues to be challenging. Further details are included in **Annex E**

10.2 C1 performance for ambulance services in England during January was 07:08 minutes (mean). Six ambulance trusts achieved performance within the 7-minute performance measure. SECAmb achieved 07:58 and was positioned 10th. The Demand and Capacity review and STAD programme (section 6) is addressing this performance concern through the increase in resource (workforce and fleet) and implementation of the 'Targeted Dispatch Model' with an increase in the number of Clinical staff (Health Care Professionals) based in the Emergency Operations Centre, providing support to the Emergency Medical Advisors and clinical triage.

10.3 C2 performance for ambulance services in England was 22:58 minutes during January. Two-ambulance services performance below the 18-minute performance measure with SECAmb achieving 20:59 and positioned 4th accordingly.

10.4 C3 and C4 performance (90th percentile) for SECAmb has seen the trust continue to perform below the national average (England) of 2:40 and 3:16 respectively. SECAmb achieved 3:55 hours for C3 and 4:22 hours for C4. January saw four trusts achieve the C3 2-hour measure and five achieve the C4 3-hour measure.

10.5 In all performance areas, SECAmb continues to review its delivery and is working with Commissioners to drive overall compliance with ARP standards across the Trust.

11 East Sussex Performance

11.1 East Sussex comprises three Clinical Commissioning Groups (CCG's):

- High Weald Lewes and Havens
- Eastbourne, Hailsham and Seaford
- Hastings and Rother.

11.2 The geography across the three CCG's is a combination of urban and rural areas. There are variances in how SECAmb is performing against each CCG area **(Annex F)** with Eastbourne, Hailsham & Seaford CCG's achieving both C1 and C2 performance 'year to date'. The Trust has not achieved these

categories across the remaining CCG's in East Sussex and C3 and C4 performance is being addressed through the targeted use of new additions to the workforce and fleet.

11.3 A complete review of the resources currently operating from both the Brighton and the Polegate and Hastings Operating Units has resulted in an increase in both front line staffing levels as well as an increase in fleet numbers. New rotas for operational staff will also be implemented during April 2019, to ensure that the profile of resource availability aligns with current demand/case mix and the achievement of ARP.

11.4 The result of this review will be an improvement in performance across East Sussex.

11.5 SECAmb's East Sussex clinical leads continue to work with system partners to improve and increase the number of alternative pathways available to ambulance crews to maintain and improve the current numbers of patients referred to local services and avoid conveyance to the acute hospitals.

11.6 Overall performance Trust-wide, reflects the challenges that SECAmb has with its current capacity (but within the context of an improving picture) to achieve ARP. The 'Demand and Capacity Review' focused on the resources that the Trust had in place to meet ARP. The review concluded that there were insufficient resources to achieve ARP therefore the Trust required significant investment to expand its resource base, staff and fleet (section 6).

11.7 The Service Transformation and Delivery programme (STAD) is the delivery vehicle for implementing the recommendations outlined in the 'Demand and Capacity Review' (section 6).

11.8 The Trust (and East Sussex CCG's) will benefit from this increase in resources as performance overall will improve in line with the trajectory outlined in the Demand and Capacity Review.

11.9 This approach aims to enable the right clinical response to be sent 'first time' and aligns to the 'Targeted Dispatch Model' of the Demand and Capacity Review (section 6).

12 Five-Year Strategy

12.1 The Trust has developed a strategic plan for the next 5 years and is focussed on the delivery of four strategic themes; Our People, Our Patients, Our Partners, and Our Enablers. **Annex G**. We are currently refreshing our strategy to take account of internal and external developments since publication in July 2017. This will be presented to our Trust Board jn May 2019.

13 Alliances

13.1 On 22 November 2018, the Trust announced that it was working to form an alliance with West Midlands and South Western Ambulance Services that will see us working closely together to deliver efficiency savings to invest in front line services.

13.2 The alliance expects to deliver savings through initiatives such as the joint procurement of supplies, including equipment and fuel. In addition, we will work collaboratively to share best practice for the benefit of patients and staff and will work on improving resilience between the organisations for planned events and major incidents.

13.3 The work will draw upon existing benchmarking and evidence from the National Audit Office investigation into ambulance services, and more recently, the report from Lord Carter into efficiency and productivity.

13.4 It is important to stress that there are no plans to merge services or re-structure existing operations, but the alliance will mean that the three Trusts can make every pound of taxpayers' money work as efficiently as possible.

13.5 This is very much the start of the process and further work will follow overcoming months through our Board and governance framework. However, by forming this partnership, we will be able to bring together the knowledge and experience of the three Trusts to explore ways to reduce variation and develop new joint initiatives

14 Winter Planning

14.1 In approach to winter preparedness SECAmb has a proven methodology through the use of historic data and current activity trends, combined with 'lessons learnt' from prior years.

14.2 An overarching Trust winter plan was developed, supported by a tactical plan, as well as local 'Operating Unit' (OU) plans. The local OU plans feed in to local system plans.

14.3 The SECAmb 111 winter plan covers North and West Kent as well as Surrey and Sussex (excluding East Kent). The Winter Plan Structure Framework in shown in **Table 4**.

14.4 The planning for the key weeks over Christmas and New Year were successful with sufficient resources planned to manage the expected increase in activity. Key shifts offered as 'incentivised' shifts resulting in full cover.

14.4.3 During this key period (Christmas and New Year), the Trust had in place its Strategic Hub operating 24/7 and covered by the Senior Management Team.

14.5 For the period November 1st to March 31st, the Senior Operations Leadership Team (SOLT) will constantly review the level of resource available against

predicted demand enabling the Trust to predict, monitor and mitigate to maintain service delivery during surges in demand or reduced capacity.

14.6 In line with Trust policy, the level of annual leave was reduced to 50% of normal levels across the two-week Christmas/ New Year period and as in previous years.

15 Finances

15.1 At the year-end (2017/18), the Trust achieved its control total of £1.0m deficit, this includes the agreed Sustainability and Transformation Funding (STF) of £1.3m. In addition, the Trust achieved a further STF (incentive plus bonus) of £1.4m and a CQUIN risk reserve of previously held by commissioners of £0.8m, resulting in a reported surplus of £1.3m.

15.2 The Trust also achieved Cost Improvements of £15.5m. This was greater than the target of £15.1m.

15.3 For 2018/19, the Cost Improvement Plan (CIP) target is £11.4m. As at February 2019, £9.6m has been delivered to date, in line with plan. It is projected that the full year target will be met. ‘CIPs’ represent increased efficiency and are never a reduction of resources to provide front line services.

15.4 The Trust also on target to deliver its control total for 2018/19 of £0.7m surplus, including Provider Sustainability Funding (PSF) of £2.7m.

ANNEXES

ANNEX A: CQC REPORT SUMMARY FINDINGS – 8th November 2018

Overall trust

Our rating of the trust improved. We rated it as requires improvement because:

- In both the emergency operations centre (EOC) and emergency and urgent care (EUC) we rated safe, effective, responsive and well-led as requires improvement and rated well-led in resilience as requires improvement.
- We rated safe, effective and responsive in the trust's resilience core service as good. We rated caring as good across all three core services.
- In rating the trust, we took into account the current ratings of the 111 service, which was not inspected this time.
- We rated well-led for the trust, overall, as requires improvement.

Ratings

Overall rating for this trust	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

1 South East Coast Ambulance Service NHS Foundation Trust Inspection report 08/11/2018

Outstanding practice

Emergency Operations Centre

- Support for maternity patients was excellent. A new pregnancy advice and triage line for pregnant women had been introduced within the Crawley EOC.

Emergency and Urgent Care

- The Crawley triage scheme, which had led to a reduction in conveyancing to hospital for people with mental health conditions from 53% to 11%.
- We found elements of outstanding medicine management, for example the way the trust handled Controlled Drugs (CD's). We found suitable audit and quality control processes to ensure the high standards achieved by the organisation were continuously monitored.
- The trust initiative to provide physical and mental health support for staff through the 'wellbeing hub' was widely commended by staff during the inspection.
- There was a multidisciplinary multiagency approach to training in the Kent area. This meant staff were training to deal with unexpected situations should they occur.

- Brighton station had a dedicated homeless lead who took responsibility for and oversight of this vulnerable group. This role included undertaking outreach work, as well as working with local services to meet the needs of these patients.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve services in both the emergency operations centre and in emergency and urgent care.

- The trust **must ensure** that their processes to assess, monitor and improve the quality and safety of services and also to assess, monitor and improve the assessment of risk relating to the provision of the service are operating effectively.

Action the trust SHOULD take to improve the emergency operations centre

- The trust **should ensure** they take action to continue to have effective systems and processes to assess the risk to patients and people using the services and they do all that is reasonably practicable to mitigate those risks, specifically in relation to the risk assessment of patients awaiting the dispatch of an ambulance.
- The trust **should ensure** they continue to monitor the effectiveness of the clinical safety navigator role to ensure continued oversight on the safety of patients waiting for an ambulance.
- The trust **should ensure** there are a sufficient number of clinicians in each EOC to meet the needs of the service.

Action the trust SHOULD take to improve emergency and urgent care

- The trust **should ensure** the processes for providing staff with feedback from safeguarding alerts is improved to strengthen and develop learning.
- The trust **should ensure** that maps in all vehicles are current, up to date and replaced regularly.
- The trust **should ensure** that all staff adhere to the trust policy on carrying personal equipment and the regular servicing of such equipment.
- The trust **should ensure** that pain assessments are carried out and recorded in line with best practice guidance.
- The trust **should ensure** response times for category three and four calls is improved.
- The trust **should consider** producing training data split by staff group and core service area for better oversight of training compliance.

Action the trust SHOULD take to improve Resilience

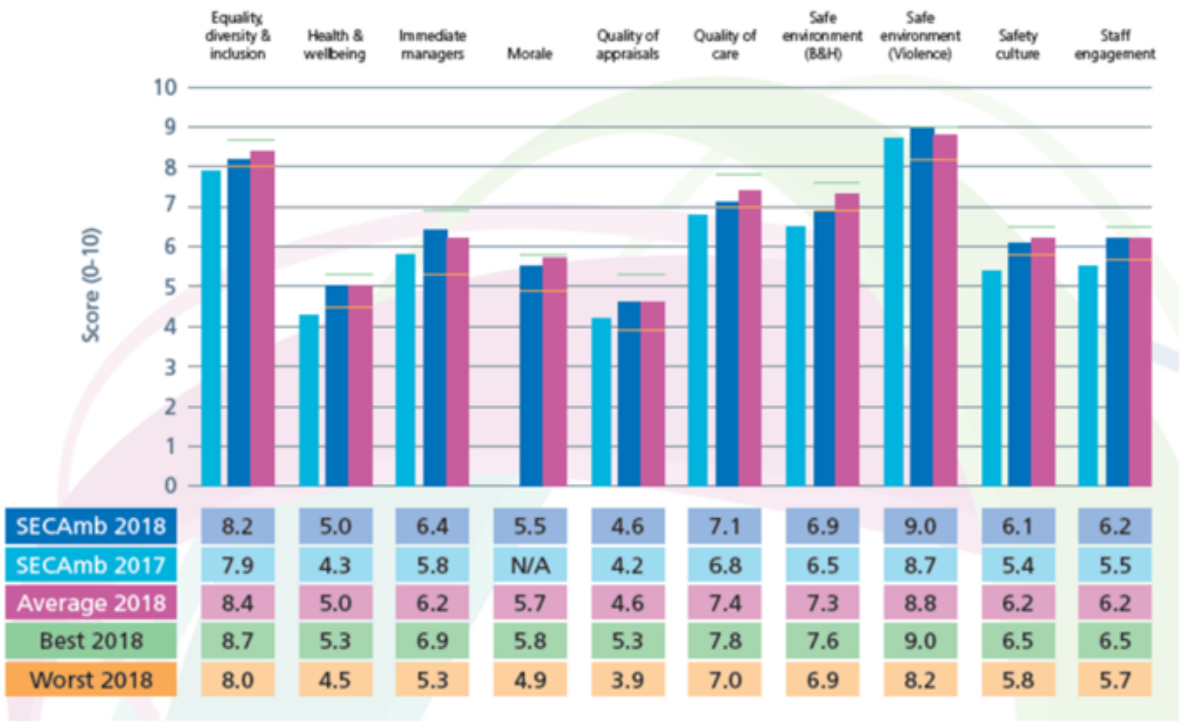
- The trust **should ensure** they collect, analyse, manage and use data on meeting response times for Hazardous Area Response Team (HART) incidents.

Annex B:

2016		2017		2018	
Domain	**2015/16**	**Domain**	**2016/17**	**Domain**	**2017/18**
Safe	**Inadequate**	Safe	**Inadequate**	Safe	**Requires Improvement**
Effective	**Requires Improvement**	Effective	**Requires Improvement**	Effective	**Requires Improvement**
Caring	**Good**	Caring	**Good**	Caring	**Good**
Responsive	**Requires Improvement**	Responsive	**Requires Improvement**	Responsive	**Requires Improvement**
Well-led	**Inadequate**	Well-led	**Inadequate**	Well-led	**Requires Improvement**
Overall	**Inadequate**	Overall	**Inadequate**	Overall	**Requires Improvement**

Annex C:

Results of individual questions in the survey are grouped into 10 key theme areas



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment (B&H)	Safe environment (Violence)	Safety culture	Staff engagement
SECAmb 2018	8.2	5.0	6.4	5.5	4.6	7.1	6.9	9.0	6.1	6.2
SECAmb 2017	7.9	4.3	5.8	N/A	4.2	6.8	6.5	8.7	5.4	5.5
Average 2018	8.4	5.0	6.2	5.7	4.6	7.4	7.3	8.8	6.2	6.2
Best 2018	8.7	5.3	6.9	5.8	5.3	7.8	7.6	9.0	6.5	6.5
Worst 2018	8.0	4.5	5.3	4.9	3.9	7.0	6.9	8.2	5.8	5.7

Annex D:

ARP Performance Categories

Category	Types of Calls	Response Standard	Likely % of Workload	Response Details
Category 1 (Life-threatening event)	**Previous Red 1 calls and some Red 2s including** • Cardiac Arrests • Choking • Unconscious • Continuous Fitting • Not alert after a fall or trauma • Allergic Reaction with breathing problems	**7 Minute response** (mean response time) **15 Minutes 9 out of 10 times** (90th Centile)	Approx. 100 Incidents a day (8%)	Response time measured with arrival of first emergency responder Will be attended by single responder and ambulance crews
Category 2 (Emergency, potentially serious incident)	**Previous Red 2 calls and some previous G2s including** • Stroke Patients • Fainting, Not Alert • Chest Pains • RTCs • Major Burns • Sepsis	**18 minute response** (mean response time) **40 minute response** (90th centile)	(48%)	Response time measured with **arrival of transporting vehicle** (or first emergency responder if patient **does not** need to be conveyed)
Category 3 (Urgent Problem)	• Falls • Fainting Now Alert • Diabetic Problems • Isolated Limb Fractures • Abdominal Pain	**Maximum of 120 minutes** (120 minutes 90th centile response time)	(34%)	Response time measured with arrival of **transporting vehicle**
Category 4 (Less Urgent Problem)	• Diarrhoea • Vomiting • Non traumatic back pain	**Maximum of 180 minutes** (180 minutes 90th centile response time)	(10%)	May be managed through hear and treat Response time measured with arrival of **transporting vehicle**

Annex E: National ARP AQI's January 2019

	C1	Mean
	England	**00:07:08**
1	North East	00:06:18
2	London	00:06:21
3	South Western	00:06:44
4	West Midlands	00:06:44
5	South Central	00:06:45
6	Yorkshire	00:06:59
7	East Midlands	00:07:40
8	East of England	00:07:42
9	North West	00:07:52
10	South East Coast	00:07:58
11	Isle of Wight	00:10:13

	C1	90th
	England	**00:12:20**
1	London	00:10:30
2	North East	00:10:54
3	West Midlands	00:11:34
4	South Central	00:12:00
5	South Western	00:12:01
6	Yorkshire	00:12:08
7	North West	00:13:07
8	East Midlands	00:13:35
9	East of England	00:13:54
10	South East Coast	00:14:15
11	Isle of Wight	00:19:58

	C2	Mean
	England	**00:22:58**
1	West Midlands	00:12:11
2	South Central	00:16:27
3	Yorkshire	00:19:49
4	South East Coast	00:20:59
5	Isle of Wight	00:21:18
6	London	00:21:34
7	East of England	00:24:56
8	North West	00:26:24
9	North East	00:26:54
10	South Western	00:29:20
11	East Midlands	00:30:52

	C2	90th
	England	**00:47:39**
1	West Midlands	00:22:09
2	South Central	00:32:37
3	Isle of Wight	00:38:25
4	South East Coast	00:39:57
5	Yorkshire	00:41:16
6	London	00:46:07
7	East of England	00:51:28
8	North East	00:56:20
9	North West	00:57:00
10	South Western	01:01:45
11	East Midlands	01:05:48

	C3	Mean
	England	**01:07:42**
1	West Midlands	00:35:17
2	Yorkshire	00:47:38
3	South Central	00:49:41
4	London	01:05:20
5	Isle of Wight	01:06:56
6	East of England	01:17:11
7	North West	01:17:39
8	South Western	01:18:18
9	East Midlands	01:26:58
10	North East	01:38:48
11	South East Coast	01:42:14

	C3	90th
	England	**02:40:10**
1	West Midlands	01:19:50
2	South Central	01:55:52
3	Yorkshire	01:58:10
4	Isle of Wight	02:35:43
5	London	02:41:49
6	South Western	02:58:23
7	North West	03:04:07
8	East of England	03:07:26
9	East Midlands	03:29:58
10	South East Coast	03:55:06
11	North East	04:02:36

	C4	Mean
	England	**01:25:43**
1	West Midlands	00:51:40
2	East Midlands	00:51:58
3	Yorkshire	01:09:38
4	London	01:12:32
5	South Central	01:15:20
6	East of England	01:16:59
7	North East	01:28:32
8	North West	01:41:53
9	South Western	01:43:54
10	Isle of Wight	01:49:28
11	South East Coast	02:08:41

	C4	90th
	England	**03:16:00**
1	West Midlands	02:05:52
2	East Midlands	02:21:54
3	South Central	02:46:45
4	Yorkshire	02:47:48
5	London	02:51:28
6	East of England	03:14:45
7	North West	03:39:26
8	North East	03:45:38
9	South Western	03:52:21
10	Isle of Wight	04:24:23
11	South East Coast	04:27:24

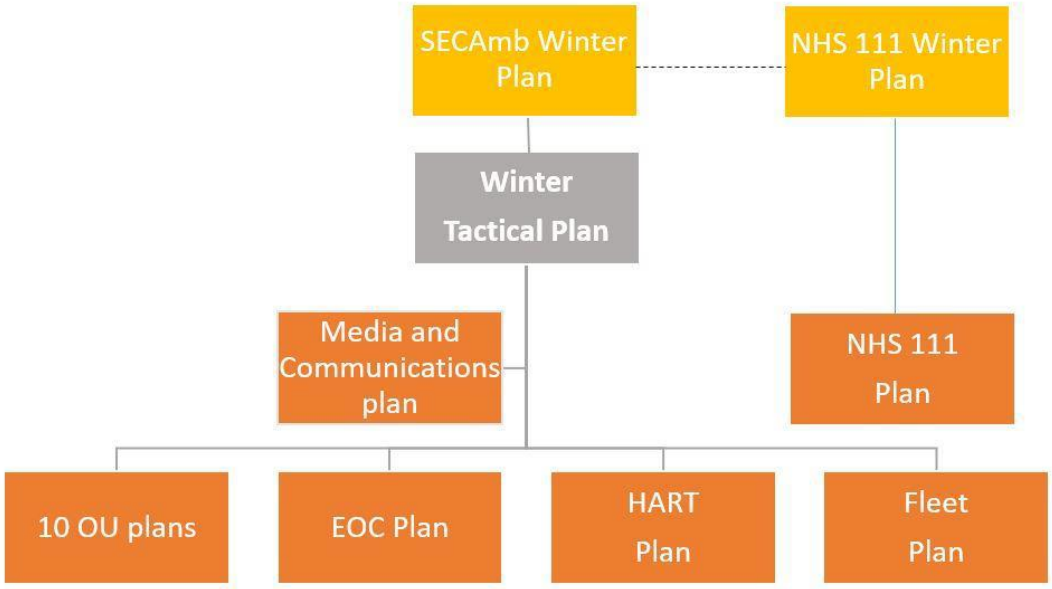
Annex F: SECAmb Performance Year to Date

Apr 18 - Feb 19	Cat 1 Mean Response Time (00:07:00)	Cat 1 90th Centile (00:15:00)	Cat 2 Mean Response Time (00:18:00)	Cat 2 90th Centile (00:40:00)	Cat 3 90th Centile (02:00:00)	Cat 4 90th Centile (03:00:00)
NHS Brighton & Hove CCG	00:05:06	00:08:59	00:13:31	00:26:30	02:42:48	04:09:28
NHS Eastbourne, Hailsham and Seaford CCG	00:06:48	00:12:11	00:17:25	00:34:12	03:09:07	04:06:34
NHS Hastings & Rother CCG	00:07:31	00:13:52	00:18:44	00:36:49	03:13:58	04:30:17
NHS High Weald Lewes Havens CCG	00:11:53	00:19:47	00:22:23	00:37:33	03:20:20	04:09:25
NHS Horsham and Mid Sussex CCG	00:08:51	00:16:11	00:22:10	00:40:25	03:12:57	04:42:13
Sussex & East Surrey STP**	00:07:16	00:13:49	00:18:04	00:34:48	02:58:38	04:11:19
SECAmb	00:07:43	00:14:13	00:19:16	00:36:47	03:22:46	04:30:15

Annex G:

Annex H:

Winter Plan Structure Framework



This page is intentionally left blank

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

Date of meeting: **28 March 2019**

By: **Assistant Chief Executive**

Title: **Kent and Medway Stroke Review**

Purpose: **To consider whether the decision of the Joint Committee of Clinical Commissioning Groups in relation to stroke services in Kent and Medway is in the best interest of health services in East Sussex, taking into account the comments of the Joint Health Overview and Scrutiny Committee**

RECOMMENDATIONS

The Committee is recommended to:

1) consider the comments of the Joint Health Overview and Scrutiny Committee in relation to the proposed reconfiguration of stroke services in the Kent and Medway area; and

2) consider whether the decision of the Joint Committee of Clinical Commissioning Groups in relation to stroke services in Kent and Medway is in the best interest of health services in East Sussex.

---

1. Background

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

1.2 NHS Clinical Commissioning Groups (CCGs) in Kent and Medway, through the area's Sustainability and Transformation Partnership (STP), undertook a review of how acute stroke services are provided across the area with a view to making changes to improve care. The proposals involved the reconfiguration of stroke units into three Hyper Acute Stroke Units (HASUs) on three hospital sites. This would mean not all hospitals would provide acute stoke care.

1.3 This Health Overview and Scrutiny Committee (HOSC) and the equivalent committees in Kent, Medway, and the London Borough of Bexley all resolved that the proposals constituted a substantial variation in services (SViS) requiring formal consultation with the HOSCs under health scrutiny legislation. Legislation also required that, because the SViS affected more than one local authority area, a Joint HOSC (JHOSC) was established for the purposes of commenting on the proposals.

1.4 Following several years of engagement, consultation and development of a decision-making business case (DMBC), a Joint Committee of Clinical Commissioning Groups (JCCCG), including representatives of High Weald Lewes Havens CCG (HWLH CCG), decided on the 14 February to reconfigure the stroke services to three HASUs to be located at Maidstone General Hospital, Darent Valley Hospital in Dartford, and the William Harvey Hospital in Ashford.

1.5 The JHOSC then met on 26 February and resolved to recommend to the relevant individual local authority committees to support the JCCCGs' decision.

1.6 The relevant individual committees of the four local authorities, including the East Sussex HOSC, must now consider whether the CCGs' decision is in the best interest of health services, taking into account the views of the JHOSC.

2. Supporting information

Background to HASUs

2.1 Many CCGs in England have in recent years have centralised existing stroke services in their areas into specialised HASUs. Unlike many locally-based Acute Stroke Units (ASUs), HASUs provide 24/7 consultant cover and more speedy access to vital medical interventions like brain scans and thrombolysis (clot-busting drugs) upon arrival at hospital, albeit this may lead to greater travel times to the HASUs for some patients. HASUs also have the potential to support more advanced stroke treatments such as mechanical thrombectomy (surgery to remove blood clots).

2.2 The recently published NHS Long Term Plan highlights the advantages of specialist stroke units and commits the NHS in England to:

> *reconfigure stroke services into specialist centres, improve the use of thrombolysis and further roll out mechanical thrombectomy. This will ensure 90 percent of stroke patients receive care on a specialist stroke unit and that all patients who could benefit from thrombolysis (about 20 percent) receive it, up from just over half of eligible patients now.*[1]

2.3 Arguments put forward by the CCGs developing HASUs in their local area include that HASUs have generally seen improved health outcomes such as reduced length of stay and lower mortality rates; and the specialised nature of the service is more attractive to staff, making recruitment easier. As there is usually a dedicated team who receives patients away from the main A&E immediately upon arrival, the 'call to treatment' times of a HASU (the time from when 999 is dialled to when the patient receives an appropriate treatment) can be less than for a more locally based ASU, despite the longer travel times for some patients.

2.4 The performance of stroke units is measured using the Sentinel Stroke National Audit Programme (SSNAP) run by Kings College London, with stroke units measured overall on a grading of A to E based on a number of performance measures, including the proportion of patients given a brain scan within one hour of arrival, and the proportion admitted to a stroke unit within four hours of arrival. Stroke services provided by East Sussex Healthcare NHS Trust (ESHT) and Brighton & Sussex University Hospital NHS Trust (BSUH) have in recent years been reconfigured to HASUs and have both seen improvements in their SSNAP performance.

Reconfiguration of stroke services in Kent and Medway

2.5 The CCGs in Kent and Medway have undertaken a four-year programme to reconfigure stroke services in Kent and Medway. Due to the impact on patient flows in East Sussex and the London Borough of Bexley, HWLH CCG and Bexley CCG subsequently joined the JCCCG, which was established by the CCGs as the decision-making board for the Kent and Medway stroke review.

2.6 The CCGs identified a case for change based on the fact that:

- most hospitals in the area do not meet national standards and best practice and SSNAP data showed all units were rated D or E;
- consultants, brain scans and thrombolysis aren't consistently available 24/7
- one in three stroke patients are not getting brain scans in the recommended time
- the hospitals had only 1/3 of the stroke consultants needed to deliver best practice
- half of appropriate patients were not getting clot busting drugs in the recommended time
- only one stroke unit saw enough stroke patients for its staff to maintain their skills (based on the recommended minimum of 500 patients per year).

2.7 The CCGs plan to deliver a new model of care based around three HASUs (with co-located specialist ASUs) able to operate 24 hours a day, 7 days a week, and staffed by teams of stroke specialist doctors, nurses and therapists.

[1] The NHS Long Term Plan, NHS England, 2019. p.65

2.8 The CCGs believe that this service will provide a 'call to needle' time of within 2 hours for 95% of patients within 6 months of their go live date. Currently only around 50% of patients are diagnosed or treated with thrombolysis within one hour of getting through the door (with additional travel times on top of that figure).

2.9 From February to April 2018 the CCGs undertook an 11 week public consultation on five possible options for how the three HASUs would be configured. The CCGs did not identify a 'preferred option' but all five options included retaining William Harvey Hospital in Ashford. Options D and E included the retention of Tunbridge Wells Hospital. During this time the East Sussex HOSC submitted its comments to the public consultation (see **Appendix 1**).

2.10 Following the consultation period, the CCGs continued to refine the data and evaluation criteria against which the five options would be rated. A CCG workshop was held on 13 September 2018 (at which the Chair of East Sussex HOSC was present as an observer). It was here that Option B (Darent Valley Hospital, Maidstone General Hospital, and William Harvey Hospital) was identified as the preferred option (using anonymised data) based on higher score against the workforce criteria, ability to deliver, confidence in the go live date, and quality of the implementation plan.

2.11 A Decision Making Business Case (DMBC) for Option B was then developed over the next few months. The JCCCG unanimously agreed to the proposed acute stroke service model set out in the DMBC at its meeting on 14 February 2019 (see **Appendix 2)**.

2.12 The HASUs are expected to go live from March 2020 at Maidstone and Darent Valley Hospitals, and from Spring 2021 at William Harvey Hospital, where a new-build ward is required to house the unit.

Impact on East Sussex

2.13 Significant parts of East Sussex fall into the catchment area for stroke services provided at hospitals in Kent, particularly a large part of HWLH CCG area, but also part of Hastings and Rother CCG area.

2.14 The total East Sussex population falling into the catchment areas for Tunbridge Wells and William Harvey Hospitals is approximately 90,000. The CCGs are forecasting that once the configuration of HASUs is completed 94 additional patients from East Sussex per year will travel to the Eastbourne District General Hospital (EDGH); 14 East Sussex patients will travel to Maidstone General Hospital; and 51 patients will travel to the William Harvey Hospital in Ashford.

2.15 The additional patient flows to EDGH will require a further 4 beds (1 HASU and 3 ASU). East Sussex Healthcare NHS Trust (ESHT) has indicated to the CCGs that it will be able to support this additional capacity.

Role of HOSC and the JHOSC

2.16 Under health scrutiny legislation, NHS organisations are required to consult HOSCs about a proposed service change which would constitute a 'substantial development or variation' to services for the residents of the HOSC area. When a proposed service change is considered 'substantial' by more than one HOSC, there is a legal requirement that the affected committees form a joint HOSC to respond to the NHS consultation.

2.17 Individual local authorities may retain the power to refer the change to the Secretary of State for Health if it is ultimately not considered to be in the best interests of health services for the residents of their area. It was agreed that this power would not be devolved to the JHOSC and would remain with the four participating authorities.

2.18 At the 29 March 2018 meeting, the Committee agreed that the proposed options constituted a substantial variation to services and agreed to join the JHOSC also comprising Kent, Medway and London Borough of Bexley. Kent and Medway each had four Members and Bexley and East Sussex had two. The East Sussex Members were Cllrs Belsey and Howell, with Cllr Davies acting as a substitute member.

2.19 The JHOSC met on five occasions between 5 July 2018 and 26 February 2019 to consider the proposals, including the outcome of the public consultation and the CCGs' DMBC. The

JHOSC met for a final time on 26 February to consider the decision of the JCCCG and to recommend a course of action to the relevant committees of the four participating authorities. The JHOSC made the following resolution:

> *This committee recommends that the relevant committees of the partaking authorities support the decision of the Joint Committee of CCGs subject to the NHS making an undertaking to review the provision of acute and hyper acute services should demographic changes require it.*

2.20 The appropriate committees of Kent, Medway and Bexley are in the process of considering whether the decision of the JCCCG is in the best interest of health services in their area. The Kent HOSC is due to consider the decision at its 22 March meeting; the London Borough of Bexley's Communities Overview and Scrutiny Committee will consider it on 3 April; and Medway's Health and Adult Social Care Overview and Scrutiny Committee agreed to refer the decision to the Secretary of State at its meeting on 12 March.

2.21 The Committee is now recommended to consider whether the decision of the JCCCG is in the best interest of health services in East Sussex, taking into consideration the recommendation of the JHOSC. If HOSC considers the decision is not in the best interests of health services in East Sussex the Committee could consider whether or not to refer the matter to the Secretary of State. Such a referral would need to demonstrate efforts made to resolve the issue locally and would need to be accompanied by evidence of the grounds for making the referral.

Additional Recommendations

2.22 During the process the elected members from each of the participating authorities were encouraged to submit their comments to the JCCCG to consider alongside the DMBC. The comments and recommendations of the East Sussex members are attached as **Appendix 3** and the responses from the CCGs in **Appendix 4**.

3. Conclusion and reasons for recommendations

3.1. The Committee is recommended to consider whether the decision to reconfigure stroke services in Kent and Medway is in the best interests of health services in East Sussex, taking into account the recommendation of the JHOSC.

PHILIP BAKER
Assistant Chief Executive

Contact Officer: Harvey Winder, Democratic Services Officer
Tel. No. 01273 481796
Email: Harvey.winder@eastsussex.gov.uk

East Sussex Health Overview and Scrutiny Committee (HOSC)

Response to public consultation on improving stroke services in Kent and Medway

Background

East Sussex HOSC has been formally consulted by the Joint Committee of Clinical Commissioning Groups (CCGs) on the proposals to reconfigure acute stroke services provided in Kent and Medway due to the significant impact on residents in the north of East Sussex. As the proposals also affect residents in three other HOSC areas a Joint HOSC (JHOSC) has been formed to respond to the consultation in line with the requirements of health scrutiny legislation. The JHOSC will respond formally to the CCGs in due course under that statutory process.

Alongside statutory consultation with HOSCs, the CCGs are undertaking a process of public and stakeholder consultation. This document represents East Sussex HOSC's response to that consultation process as a local stakeholder and does not represent the view of the JHOSC.

Comments on the proposals

The proposal is to reduce the number of hospitals in Kent and Medway providing acute stroke services, replacing the existing seven sites with three Hyper Acute Stroke Units (HASUs). The consultation also outlines five options for the location of the three HASUs.

Creation of HASUs

East Sussex HOSC understands the reasons for the proposed reduction in sites providing acute stroke services and the move to fewer HASUs. In recent years HOSC has supported similar reconfigurations within East Sussex Healthcare NHS Trust and Brighton and Sussex University Hospitals NHS Trust which were based on a similar rationale. Since implementation of these reconfigurations HOSC has seen evidence of improved quality of service as demonstrated by Stroke Sentinel National Audit Programme (SSNAP) data. HOSC notes that current SSNAP data for the existing stroke units in Kent and Medway shows significant potential for improvement and that there are considerable workforce challenges in achieving such improvement across seven sites. HOSC also notes the considerable clinical support for the proposed reconfiguration. **HOSC therefore supports the proposal to establish three HASUs in Kent and Medway.**

The disadvantages of the proposed reconfiguration primarily relate to increased travel time for patients and their families/carers. For patients, who will primarily travel by ambulance, this disadvantage is considerably offset by the improved quality of service available at a HASU, particularly if this includes swifter access to scanning, thrombolysis, specialist stroke staff and admission to the HASU. From our knowledge of other reconfigurations it may be possible to effectively 'cancel out' some of the increased travel time through improved speed of treatment on arrival at the hospital/HASU. Travel and transport over longer distances is considerably more problematic for families and carers, particularly those with a long term limiting illness or disability, on a low income and/or reliant on public transport. From previous assessments of stroke reconfigurations HOSC understands that families will prioritise the quality of care for the patient and improved outcomes, but will also expect everything possible to be done to support visiting families and carers, particularly given the importance

of family support and advocacy for patients who are vulnerable from the after effects of stroke.

HOSC suggests that the following issues are taken into account when developing implementation plans for the creation of three HASUs in Kent and Medway:

- Ensuring maximum public awareness of stroke symptoms and the need to treat stroke as a '999' emergency – e.g. running a FAST awareness campaign linked to the implementation of HASUs – to ensure minimum delay in patients reaching hospital.
- Maximising speed of treatment on arrival at hospital to offset additional travel time for patients – for example creating a separate receiving area for stroke patients in A&E, with a dedicated senior stroke specialist nurse to receive patients, enabling fast and efficient transfer to scan facility, in order to achieve brain scan within 1 hour of arrival.
- Ensuring a sufficient number of dedicated stroke beds are provided within the HASUs.
- Ensuring that good practice from the existing stroke units is identified and learning transferred to the establishment of new HASUs, particularly if a HASU is located at a hospital with lower performance on key SSNAP indicators.
- Ensuring the impact on the ambulance service of longer journey times is recognised and provided for, that there is a dedicated stroke lead within the ambulance service, and that clear protocols are in place for ambulance conveyance of stroke patients to the nearest HASU.
- There must be support for access by families and carers e.g. provision of travel information, flexible visiting arrangements, provision of telephone contact with HASU and patients, with full discharge information for carers
- Onward rehabilitation/early supported discharge services should be reviewed and improved in conjunction with the implementation of HASUs. This must ensure patients are able to return home or to more local inpatient rehabilitation/intermediate care as soon as possible. This should include dedicated stroke rehabilitation team (rather than generic teams), including speech therapists and psychological counsellors. There should be effective links to rehabilitation and other support services provided outside of Kent and Medway.
- There must be a proactive workforce plan in place to support the transition, focussed on retaining existing staff as well as recruiting new staff, particularly consultants, given the national shortage of specialist stroke and therapy staff.
- CCGs should require all HASUs to submit SSNAP data and any other national requirements which will support maintenance of high standards and best practice.

The options

HOSC has reviewed the documentation provided in relation to the shortlisting of the five options, the Integrated Impact Assessment and the comparative information provided in the consultation document. **The committee makes the following observations in relation to the five evaluation criteria:**

- **Accessibility** – **HOSC believes that access will be a key concern for our residents**. The Committee notes that option D appears to offer the greatest accessibility in terms of travel by ambulance and car within 30 minutes across the whole population affected.
- **Ability to implement** – Clearly it is desirable to implement the reconfiguration of acute stroke care without undue delay, given the potential improvements in quality of care and outcomes. However, all options have been deemed to be implementable via the shortlisting process, therefore HOSC believes that this should be a secondary factor with the focus being on the best service model for the long term in terms of quality and sustainability.

- **Value for money** – Assuming that the levels of capital investment required are achievable across all options, HOSC believes the focus in terms of value for money should be on long term affordability and benefit. HOSC notes that options A, D and E yield the highest levels of net present value.
- **Quality of care** – **HOSC believes this will also be a key concern for our residents**. All options are anticipated to deliver the benefits of HASUs over the current configuration. HOSC is aware of the emergence of mechanical thrombectomy as a treatment for stroke and the committee believes that any configuration should be 'future-proofed' as far as possible by offering the ability to deliver this service in the near future. HOSC notes that option D is ranked most positively in this regard.
- **Workforce** - HOSC notes the challenges in attracting and retaining specialist stroke staff which will apply across all options, helped to some extent by the attraction of newly established HASUs. The committee believes the focus here should be on the development and implementation of a proactive workforce strategy across medical, therapy and nursing staff whichever option is chosen.

Conclusion

East Sussex HOSC supports the proposed reconfiguration of stroke services and the creation of three HASUs in Kent and Medway. In terms of the five options for locating the HASUs the committee believes that accessibility and quality of care are the key priorities for our residents. On both these factors option D rates most highly.

Cllr Colin Belsey
Chair
East Sussex Health Overview and Scrutiny Committee
20 April 2018

This page is intentionally left blank

Transforming health and social care in Kent and Medway

NHS

Minutes

Meeting	**Joint Committee of Clinical Commissioning Groups for the Review of Urgent Stroke Services in Kent and Medway**
Date and time	14th February 2019
Location	Hilton Hotel, Bearsted
Chair	Dr Mike Gill – Independent Chair of the JC CCG

Discussion points and key decisions

This meeting was held in public to consider the Decision-Making Business Case for establishing hyper acute stroke units (HASUs) at Darent Valley, Maidstone and William Harvey hospitals, each with an acute stroke unit (ASU) alongside the HASU

Papers for the meeting can be found on the stroke webpages at www.kentandmedway.nhs.uk/stroke/dmbc

Welcome and introductions

Mike Gill welcomed all committee members and the public to the meeting. He drew attention to the meeting etiquette which had also been drawn to the attention of members of the public who registered to attend.

The members of the committee introduced themselves.

The process so far

RJ then talked through the slides in the Joint Committee of Clinical Commissioning Groups (JCCCG) slide pack that had been circulated for the meeting describing, at a high level, the process to date, a summary of the case for change and the proposed new model of care. She went on to describe the process of applying evaluation criteria, which were refined at each stage, from all possible options, to a long list (127), to a medium list (13), to a short list (five), to a recommended preferred option. She then described the updates and refinements to the evaluation criteria between the short list and the selection of recommended preferred option.

There were interruptions from protesters in the public audience which made it difficult to continue.

RJ confirmed to the audience that all questions that had been submitted, alongside other forms of feedback that had been received, would be discussed in the committee discussion section of the agenda.

RJ then went on to describe the format of the workshop which has resulted in the recommendation of the preferred option. She explained the process of eliminating options from the five that were shortlisted (as per the public consultation), where there was

consensus among attendees exclude two options, then consensus to exclude a further option and then, finally, consensus on a recommended preferred option.

The public consultation

SH described the public consultation process including promotion, engagement, the breadth of the responses, receiving and agreeing the consultation reports. She confirmed further work had been undertaken with Black, Asian and minority ethnic groups to ensure representation from these groups in the feedback.

Questions comments and feedback throughout the process

RJ described the key themes from the feedback throughout the process were:

- General agreement that stroke services need to change
- General support for having hyper acute stroke units
- Concerns about travel times and people want journeys to be as short as possible
- Many people said they would want a fourth HASU or a HASU in Thanet
- People felt levels of deprivation and population size in specific areas should be taken into account
- Concerns about staffing: will there be enough and has enough been done to attract staff
- People want to know that good a quality rehabilitation services will be in place.

RJ then gave more detail on each of those key themes, including the number of responses in which each theme was referenced and also the JCCCG response as outlined in slides 18 to 25.

During this section there was a significant level of interruption from some of the protesters in the audience. RJ had to stop several times until the calling out diminished in order that the committee members could hear the information.

RJ then went on to detail the areas of feedback provided from the four councils (East Sussex, Kent County, Medway and Bexley) who are members of the Joint Health Overview and Scrutiny Committee (HOSC), and the responses submitted by the Stroke Programme to the Joint HOSC January 2019 meeting.

Questions and comments submitted to the meeting

MG confirmed that all JCCCG members had received a comprehensive pack including all of questions submitted by the public, the Joint HOSC feedback from the January 2019 meeting, the Medway Council Minority Report and the significant amounts of other correspondence. This included, but was not limited to, SONIK correspondence including their report, a paper on mechanical thrombectomy, CHEK letters, Medway MP letters, Thanet MP letters and acute Trust provider letters.

SH outlined the questions that had been submitted from members of the public as:

- Concern of distances and consideration of mobile stroke units
- Mechanical thrombectomy paper and how it would be considered
- BMA report on medical recruitment

Discussion points and key decisions

- Travel times from Thanet/Dover/Deal in relation to patient outcomes
- Hospitals that lose HASUs will also be at more risk of losing other services
- Four not three HASUs
- Transport for family and friends
- Keeping the stroke services open in Thanet
- Provision of rehabilitation services.

RJ also summarised the feedback from the Joint HOSC including the Medway Council minority report for the committee members and confirmed that all of those areas of concern and feedback would be considered in the Committee discussion section of the agenda.

Developing the Decision-Making Business Case

RJ described the final Decision-Making Business Case (DMBC) and changes in each chapter from the Pre-Consultation Business Case (PCBC), reflecting where feedback had been incorporated. She talked through the assurance of the recommended preferred option to date, the implications of the recommended preferred option and consideration of the Integrated Impact Assessment.

She went on to describe the implementation plan including the concerns raised by the Joint HOSC around the recommended phased approach and the resulting changes to the DMBC and, finally, the proposed benefits of the change.

Committee discussion

The minutes do not represent every comment made but are a summary of the discussion. The full audio recording of the discussion is available on the stroke website

https://kentandmedway.nhs.uk/stp-workstreams/stroke/audio-recordings-of-stroke-joint-committee-meeting/

PG commenced the discussion by raising concerns around deprivation, recognising that people from deprived communities are often ill earlier and for longer. He referenced the importance of prevention to support the reduction of health inequalities. He asked would it make any difference to patient outcomes if HASUs were in areas of deprivation.

DH responded that relationship is between deprivation and prevalence rather than incidence and that the most important factor is frailty which is not correlated with deprivation. CT confirmed that the most important factors with regard to deprivation is prevention, rehabilitation and longer term care.

There was significant disruption from protesters in the audience.

BB asked RJ to describe in detail the amendments to the evaluation criteria. She used slide 9 to describe the updates and rationale from the PCBC evaluation criteria. BB then asked if these changes had influenced the preferred option. PG clarified that he understood that the most up to date data had been used. RJ confirmed it had. SD asked if there had been good reason (evidence) to make the updates and RJ explained the detail for each amendment. She also clarified that amendments and refinements have been made at every evaluation

Discussion points and key decisions

stage and that this is a required part of the process. The most important thing is that any amendments are evidenced and transparent. JB asked if evidence from urban areas is being applied to rural areas. RJ confirmed there was also evidence from areas with rural populations such as Greater Manchester and Northumbria. DH confirmed Northumbria had seen an improvement of 26 minutes in the time from arrival to thrombolysis.

DH responded around the guidance from the South East Coast (SEC) Clinical Senate and confirmed to the committee, in response to a comment shouted from the audience, that he was not the chair of SEC Clinical Senate, the chair is Dr Lawrence Goldberg.

During the discussion there was significant disruption from the audience and MG asked if members of the committee could hear the discussion. They confirmed they could. MG asked for quiet from the audience, but this was met with a verbal refusal.

JM asked about the impact of increased travel times from Thanet. DH responded that despite hard working staff, the unit is one of the worst in the country and across K&M there are a number of very poorly performing units.

The disruption from the audience reached a point where MG asked the committee if they could hear and they confirmed they could not.

He asked several times for some members of the audience who were disrupting the meeting to sit down and be quiet in order that the meeting could continue. His repeated requests were ignored and rejected by a number of protesters in the audience. He confirmed that he would adjourn the meeting if the committee were going to be continued to be prevented from undertaking their meeting and gave several reminders that this was a meeting in public, not a public meeting.

MG adjourned the meeting and the committee members left the room.

The meeting reconvened with members of the media present and live audio available via a teleconference number. The recording of the meeting has subsequently been uploaded to the stroke web pages.

MG reopened the meeting and asked DH to continue with his response in regard to the impact of travel times on patient outcomes.

DH further explained that longer travel times will more than be mitigated by the provision of HASUs. It is getting patients to a 24/7 well-staffed unit where rapid diagnostics and early treatment that deliver improved outcomes.

SD asked how the committee could be reassured that the HASUs can be adequately staffed. RN responded that the Stroke Programme is aware of the workforce gap and that a number of things were already planned enhance recruitment including recruitment workshops, defining new roles, work with existing staff, the assurance that there would be additional roles to ensure the services will truly be seven days per week. He confirmed that reconfiguration offers both challenge and opportunity and that the Stroke Programme would be following a competency-based approach. He also confirmed that the Stroke Programme would be running a national and international campaign in line with the Global Learners Programme. Education and training will also be provided across the stroke network. He

Discussion points and key decisions

reflected that strong governance will be in place to monitor all aspects of workforce development. SD asked for assurance that this would link with other workforce programmes across the STP. RN confirmed it already was linked in. NK asked about the impact on the current stroke workforce. RN confirmed, once a decision was made, further engagement with the current workforce would take place. RJ added that all staff have already been told that they have a job either in stroke or another specialty. SD asked about the impact of the proposed medical school. CT responded that there was good evidence that the medical school is likely to attract new people to K&M and that is was very positive that it was not just focussed on doctors.

A question was raised about the use of mobile stroke units and DH responded that the current evidence to support these is poor and it is not likely to help the NHS in Kent and Medway cope with the geographical challenges. The Stroke Programme will certainly make sure it learns from the pilots and are already undertaking an ambulance telemedicine pilot in east Kent. He confirmed the Stroke Programme will embrace all new development/technologies as they emerge now and in the future.

MD raised a question as to the viability of four HASUs. DH responded that there are currently two stroke units in east Kent (Thanet and Ashford) and, despite everyone's best efforts they are poorly performing units (Sentinel Stroke National Audit Programme (SSNAP) rated D and C respectively). He also reflected that not all sites have the ideal co-adjacent services and that is particularly relevant if looking to deliver mechanical thrombectomy for the future. RJ confirmed that if future demand increases beyond that currently predicted or guidance/best practice changes then the network would reconsider a fourth HASU in the same way it will embrace future technologies.

FA asked about how isolated communities (e.g. Swale, Romney Marsh etc) have been considered and asked what ideas are coming from the Travel Advisory Group (TAG).

RJ confirmed that the initial feedback suggested that two TAGs would be needed and that has already been actioned and the initial meeting has taken place. She confirmed that local populations will input into local solutions and examples already suggested include:

- Fuel vouchers
- Thorough review of currently available public transport
- Review of voluntary transport opportunities
- Subsidised taxis
- Free skype/face time with relatives from GPs or local care hubs

RJ confirmed that the TAGs would make recommendations to the Joint Committee and it may well be that different mitigations are required in different geographies.

DR asked for assurance from South East Coast Ambulance Service (SECAmb) on ambulance response times. RS confirmed that the significant investment recently agreed, and the further investment set out in in the DMBC would help ensure that emergency response times meet the required standard.

JN asked about the provision of rehabilitation. RJ confirmed that the provision of rehab is

Discussion points and key decisions

fundamental to ensuring the HASU/ASU units can function to their full potential. She described the public feedback that it should be as close to home as possible and must be in place at the go-live of the HASU/ASU model. She also confirmed the business case would ensure services were available seven days a week.

JM asked about the appropriateness of a two phase implementation plan given the experience in Manchester. RJ confirmed she would ask DH to comment on Manchester however she described the three possible options and reasons why the clinicians were strongly supporting a two phase approach of Darent Valley and Maidstone Hospitals going live together in March 2020 and Ashford going live as soon as the unit was built in spring 2021. DH described the phasing in Manchester which was around stroke type rather than geography. He also explained further the clinical rationale for a two phase approach. Finally, RJ confirmed that there would be a wider stakeholder conversation to finalise the approach, following concern raised by the Joint HOSC, once the decision was made.

JH asked for confirmation that Ashford could not go-live earlier with more money. GD responded that this was not the case and that Ashford go-live was determined by the time to build.

SD asked what would happen to stroke services in east Kent if the east Kent reconfiguration resulted in a major emergency centre in Canterbury. GD responded that a public consultation will be required for any significant service change in east Kent and stroke would be part of that. He also confirmed that the likely timeline for a new hospital in Canterbury would be eight to ten years and that the NHS in Kent and Medway needed to improve stroke services much sooner than that.

NK asked how the SECAmb investment will be used. RS responded by outlining the extensive work on demand and capacity undertaken by SECAmb that has informed the investment. He confirmed that stroke required a ‘category 2’ response (18 minutes) and the additional money in the DMBC was a reflection of the increased journey times and mitigation to provide resource to help ensure there is not a negative impact on ambulance availability.

MG asked if there was a risk that HASU hospitals might undermine the future of non HASU hospitals. IA responded that the consolidation of stroke services would do nothing to destabilise hospitals that will no longer provide stroke services.

FA wanted assurance of how she can be sure the consultation was robust, and the feedback has been taken into account. SI responded that Healthwatch advised that his organisation had worked closely with the stroke programme throughout and he confirmed they believed it had been a very robust consultation. He also reflected that the Joint HOSC had applauded the consultation as good practice.

PG asked for assurance that the bed capacity was sufficient. RJ described the no growth assumptions in the PCBC and the challenge by the SEC Clinical Senate based on a recent European study on stroke and the ageing population. She talked through the additional work undertaken by Medway Public Health Intelligence Unit which indicated the NHS may need to plan for a growth in stroke admissions. To this end a further 22 beds have been confirmed available across the network and the Stroke Programme has confirmed a three-day

reduction in length of stay by 2024/25. These mitigations will support the network to meet the predicted increases in capacity until at least 2030. RJ also confirmed further work has been done on population growth related to new housing and that is has already been included and has no further impact. A review of actual activity from Ebbsfleet has also been undertaken to confirm this.

NK asked about the impact of Brexit. The SECAmb medical director, Fionna Moore, confirmed that they were planning for the impact of Brexit specifically around ambulance journeys. She also confirmed that, given the timeline for go-live, the impact of Brexit will have been managed by then. GD confirmed that was his understanding.

JM asked about when thrombectomy could start and DH responded that the appropriate staff would need to have the right competencies for the service to commence safely. He confirmed that they are hoping to commence a pilot and working with the national team but that it was vital to have a HASU model in place.

DR asked about relatives and carers travel times/arrangements. RJ confirmed the TAGs would look at both patient discharge and relatives/carers travel and referenced her earlier detailed response.

SH confirmed that the discussion had covered most of the areas where questions had been raised and there two issues outstanding which were: CCG duties on health inequalities and FAST/prevention.

SM asked enough is being done around prevention as this was the most important area of focus to reduce health inequalities recognising that many of health determinants for stroke are also factors in other diseases such as heart disease and cancer. RJ described the prevention input into the programme and the atrial fibrillation identification scheme which has already started. All agreed prevention must be targeted at specific populations, such as deprived areas, to be most effective.

PG asked about inequalities and it was confirmed that there are inequalities in the provision of care now and standardising the acute response to the best care for all patients would result in a better outcome for all.

MG asked all committee members if their questions had been answered and they confirmed they had no further questions. He then moved to the resolutions taking each one in turn

Resolutions

Taking into account all of the evidence that has been made available to JCCCG members, the JCCCG is recommended to agree the following resolutions on the basis that, taken together, they represent the most effective way of providing high quality acute stroke care for the patients in and the residents of Kent and Medway.

1. To agree and adopt the acute stroke services model with three HASU/ASUs as described in section 3 – **Unanimously AGREED. No abstention.**
2. To agree the establishment of these joint HASU/ASUs at Darent Valley Hospital, Maidstone Hospital and William Harvey Hospital as described in section 6.4 - **Unanimously AGREED. No abstention.**

Discussion points and key decisions
3. To agree that when HASU/ASUs are developed that acute stroke services will no longer be commissioned at Medway Hospital, Tunbridge Wells Hospital, Queen Elizabeth the Queen Mother Hospital and Kent & Canterbury Hospital - **Unanimously AGREED. No abstention. There was a recommended word change with the word 'developed' changed to 'operational'.** 4. To note the Integrated Impact Assessment of the preferred option as set out in section 8.4 and agree the establishment of a Transport Advisory Group to make recommendations on travel issues as part of implementing the plans - **Unanimously AGREED. No abstention.** 5. Agree the current financial impact and confirm a review of long-term financial sustainability will be undertaken as part of implementation - **Unanimously AGREED. No abstention.** 6. To agree the key performance benefits as set out in section 10.4 and agree to set up the benefits monitoring system outlined in section 10.5 - **Unanimously AGREED. No abstention.** 7. To agree that a business case for stroke rehabilitation is needed as a matter of urgency and will be presented to the JCCCG no later than spring 2019 - **Unanimously AGREED. No abstention. The committee wished to add that improved rehabilitation will be in place when the HASU/ASU model goes live.** 8. To agree the adoption of the governance model and resourcing plan set out in section 9.3 - **Unanimously AGREED. No abstention.** The committee then proposed an additional resolution around the importance of prevention specifically in regard to reducing health inequalities. It was proposed the additional resolution was: **1.** To agree that a prevention business case will be presented to the JCCCG as soon as possible - **Unanimously AGREED. No abstention.** MG closed the meeting.

Actions: to be reviewed at the next meeting

Action	Owner	Deadline
Meeting notes to be circulated	RJ	22nd February 2019
DMBC resolutions to be amended	RJ	22nd February 2019
Written response to all questions submitted	RJ	22nd February 2019
Set up a Stroke Prevention working group to develop the business case	NS	10th April 2019

Attendance and apologies

Attendees

Title	First name	Surname	Job title	Organisation	Initials
Independent chair					
Dr	Mike	Gill	Chair	JCCCG	MG
Voting members					
Dr	Jonathan	Bryant	GP and Clinical Chair	South Kent Coast CCG	JB
Dr	Bob	Bowes	GP and Clinical Chair	West Kent CCG	BB
Dr	Peter	Green	GP and Clinical Chair	Medway CCG	PG
Dr	Ethan	Harris-Faulkner	GP/CCG clinical representative	Bexley CCG	EHF
Dr	Simon	Dunn	GP and Clinical Chair	Canterbury Coastal CCG	SD
Dr	Fiona	Armstrong	GP and Clinical Chair	Swale CCG	FA
Dr	Mark	Davies	GP/CCG clinical representative	Ashford CCG	MD
Dr	Siddharth	Deshmukh	GP and Clinical Chair	Bexley CCG	SD
Dr	Navin	Kumpta	GP and Clinical Chair	Ashford CCG	NK
Dr	Sarah	MacDermott	GP and Clinical Chair	Dartford Gravesham and Swanley CCG	SD
Dr	Jihad	Malasi	GP and Clinical Chair	Thanet CCG	JM
Dr	John	Neden	GP/CCG clinical representative	Thanet CCG	JN
Dr	David	Roche	GP/CCG clinical representative	High Weald Lewis Havens CCG	DR
Dr	Andrew	Roxburgh	GP/CCG clinical representative	West Kent CCG	RA
Non-voting members					
Mr	Ian	Ayres	Managing Director	North and West Kent and Medway CCGs	IA
Mr	Glenn	Douglas	CCG Accountable Officer	All Kent and Medway CCGs	GD
Ms	Steph	Hood	Comms and Engagement Advisor	Kent and Medway STP	SH
Mr	Steve	Innett	Chief Executive	Healthwatch	SI

Ms	Rachel	Jones	Acute Strategy Programme Director	Kent and Medway STP	RJ
Mr	Ashley	Scarff	Deputy Chief Officer	High Weald Lewis Havens CCG	AS
Ms	Caroline	Selkirk	Managing Director	East Kent CCGs	CS
Ms	Nicola	Smith	Stroke Programme Lead	Kent and Medway STP	NS
Ms	Paula	Wilkins	Chief Nurse	North and West Kent and Medway CCGs	PW
Expert advisors to the committee					
Dr	David	Hargroves	Stroke consultant and Chair of the Kent and Medway Stroke Clinical Reference Group	East Kent Hospitals University Foundation Trust	DH
Mr	Rob	Nicholls	Programme Director for Clinical Workforce	Kent and Medway STP	RN
Mr	Ray	Savage	Strategy and Partnerships Manager	South East Coast Ambulance Service	RS
Dr	Chris	Thom	Stroke Consultant	Maidstone and Tunbridge Wells NHS Trust	CT

Not in attendance

Title	First name	Surname	Job title	Organisation	Initials
Dr	Mike	Beckett	Independent Governing Body Member	Dartford Gravesham and Swanley CCG	MB
Dr	Mick	Cantor	GP/CCG clinical representative	Swale CCG	MC
Dr	Chris	Healy	GP/CCG clinical representative	Canterbury and Coastal CCG	CH
Dr	Satvinder	Lall	GP/CCG clinical representative	Medway CCG	SL
Dr	Qasim	Mahmood	GP/CCG clinical representative	South Kent Coast CCG	QM
Dr	Peter	Birtles	GP/CCG clinical representative	High Weald Lewes Havens CCG	PB

Kent and Medway Stroke Review

Statement from East Sussex JHOSC Members

HASUs

East Sussex JHOSC members understand the reasons for the proposed reduction in sites providing acute stroke services and the move to fewer HASUs. In recent years the East Sussex HOSC has supported similar reconfigurations within East Sussex Healthcare NHS Trust and Brighton and Sussex University Hospitals NHS Trust which were based on a similar rationale. Since implementation of these reconfigurations the Committee has seen evidence of improved quality of service as demonstrated by Stroke Sentinel National Audit Programme (SSNAP) data. We note that current SSNAP data for the existing stroke units in Kent and Medway shows significant potential for improvement. There are also considerable workforce challenges in achieving such improvement across even three sites. We also note the considerable clinical support for the proposed reconfiguration.

The East Sussex HOSC Chair attended the Joint CCG workshop in September as an observer and is satisfied that the process that was undertaken to identify a preferred option was fair.

We recognise that all options had similar scores for quality and access but that Option B scored higher on the workforce, ability to deliver, and affordability criteria. Nevertheless, the East Sussex JHOSC members are disappointed that Option D – which included the upgrade of Tunbridge Wells Hospital to a HASU – was not chosen as the preferred option.

Finally, we believe that it is unfortunate that during the consultation stage Option D had higher scores for the finance and ability to deliver criteria compared to those considered at the Joint CCG Workshop. However, we note the explanation that the process is iterative and changes over time as additional information is gathered.

Recommendation 1:

East Sussex JHOSC Members support the proposal to establish three HASUs in Kent and Medway, and are satisfied that the process in determining a preferred option was fair.

Travel Times

The disadvantages of the proposed reconfiguration primarily relate to increased travel time for patients and their families/carers. Under the preferred option, ‘blue light’ travel times for patients in East Sussex who would currently be taken to the Tunbridge Wells Hospital will increase but will remain at 60 minutes or less, which falls within the South East Strategic Clinical Network Stroke and TIA Service standards for ‘call to hospital door time’. We have seen the improved ‘door to needle time’ that a HASU can provide at both the Royal Sussex County Hospital and the Eastbourne District General Hospital (EDGH), primarily due to the swifter access to

scanning, thrombolysis, specialist stroke staff and admission to an inpatient bed, as well as the 24/7 consultant cover, that HASUs offer. We believe that the trade-off between increased travel times to hospital and an improved and timelier quality of care upon arrival ultimately benefit patients.

Clearly under the preferred option families and carers will have to travel further to see their loved ones at either Maidstone General Hospital or the EDGH. Travel and transport over longer distances is considerably more problematic for families and carers, particularly those with a long term limiting illness or disability, on a low income and/or reliant on public transport. From previous assessments of stroke reconfigurations we understand that families will prioritise the quality of care for the patient and improved outcomes, but will also expect everything possible to be done to support visiting families and carers, particularly given the importance of family support and advocacy for patients who are vulnerable from the after effects of stroke.

Recommendation 2:

In the event that the preferred option is agreed by the Joint Committee of CCGs there must be support for access by families and carers e.g. provision of travel information, flexible visiting arrangements, provision of telephone contact with HASU and patients, with full discharge information for carers.

Recommendation 3:

The HASUs must be able to demonstrate how they will maximise the speed of treatment of patients on arrival at hospital to offset additional travel time for patients– for example, a separate receiving area for stroke patients in A&E, with a dedicated senior stroke specialist nurse to receive patients, enabling fast and efficient transfer to scan facility, in order to achieve a brain scan within 1 hour of arrival.

Impact on Eastbourne District General Hospital (EDGH)

East Sussex JHOSC Members note that implementation of the preferred option will result in an increase in activity for the EDGH requiring an additional four beds at the HASU there. We want the CCGs to ensure that the hospital can cope with the additional patients.

Recommendation 4:

Prior to the implementation of any changes to the existing stroke services, the Joint Committee of CCGs must seek assurance that the East Sussex Healthcare NHS Trust (ESHT) Hyper Acute Stroke Unit (at Eastbourne District General Hospital) is able to accommodate and treat patients who would otherwise have gone to Tunbridge Wells Hospital.

Preventative and rehabilitation services

We recognise that an increasing elderly population and further travel times for patients requires improved preventative services to reduce the number of people

having a stroke, and improved seven-day community rehabilitation services for patients being discharged from the three HASUs.

There is a commitment to develop these services in the Kent and Medway area, but it is vital that patients in East Sussex affected by the reconfiguration also receive the same proposed improvements to preventative and community rehabilitation services by the time the HASUs go live in early 2021. This means that similar public health campaigns around smoking and obesity should be available in East Sussex. It also means that a similar community rehabilitation model to that recommended by the South East Coast Clinical Senate, which includes an integrated community stroke team with speech therapists and psychological counsellors, must be operating 7 days per week within the High Weald Lewes Havens area of East Sussex by 2021. This is particularly pressing in the High Weald area as the community neurological rehabilitation team commissioned for that area is not yet operating and patients are relying on a generic team for community stroke support.

Recommendations: 5

Prior to the implementation of any changes to the existing stroke services, the Joint Committee of CCGs must seek assurance that:

a. **A full community neurological rehabilitation team is in place in the High Weald Lewes Havens CCG area of East Sussex.**
b. **The proposed discharge pathways to these community services have been considered, tested and agreed with the relevant community provider, Sussex Community NHS Foundation Trust.**

Recommendation 6:

Residents in the affected area of East Sussex should receive improved preventative services including appropriate public health campaigns and awareness campaigns that highlight the need to treat stroke as a '999' emergency – e.g. running a FAST awareness campaign.

This page is intentionally left blank

Transforming health and social care in Kent and Medway

NHS

Response to JHOSC feedback and recommendations

1st February 2019.

Transforming health and social care in Kent and Medway is a partnership of all the NHS organisations in Kent and Medway, Kent County Council and Medway Council. We are working together to develop and deliver the Sustainability and Transformation Plan for our area.

East Sussex Council

East Sussex Feedback	Response
There must be support for access by families and carers e.g. provision of travel information, flexible visiting arrangements, provision of telephone contact with HASU and patients, with full discharge information for carers.	Agreed. The HASU/ASU's will operate as a single network as described in the DMBC. Communication and information will be reviewed with patients, relatives and carers. This will be developed and formalised during implementation. Measures such as flexible visiting and phone contact will be agreed as part of implementation.
The HASUs must be able to demonstrate how they will maximise the speed of treatment of patients on arrival at hospital to offset additional travel time for patients	Agreed. This is demonstrated in the commitment to deliver the acute pathway at pace (section 3.3) including to deliver door to needle in 2 hours (section 3.2). SSNAP data will demonstrate this is achieved.
Prior to the implementation of any changes to the existing stroke services, the Joint Committee of CCGs must seek assurance that the East Sussex Healthcare NHS Trust (ESHT) Hyper Acute Stroke Unit (at Eastbourne District General Hospital) is able to accommodate and treat patients who would otherwise have gone to Tunbridge Wells Hospital.	Agreed. ESHT have been involved throughout the process and have confirmed their support. The preferred option has a minimal impact on patients attending ESHT as demonstrated in Appendix L.

East Sussex Council continued

East Sussex Feedback	Response
Prior to the implementation of any changes to the existing stroke services, the Joint Committee of CCGs must seek assurance that: A full community neurological rehabilitation team is in place in the High Weald Lewes Havens CCG area of East Sussex. The proposed discharge pathways to these community services have been considered, tested and agreed with the relevant community provider, Sussex Community NHS Foundation Trust.	Agreed. This has been discussed with the Responsible Executive Officer for High Weald Lewes Havens CCG who has confirmed that the review and development of rehabilitation should include representatives from the community provider.
Residents in the affected area of East Sussex should receive improved preventative services including appropriate public health campaigns and awareness campaigns that highlight the need to treat stroke as a '999' emergency – e.g. running a FAST awareness campaign	Agreed. The FAST campaign is a national initiative and will continue to be promoted. The prevention plans will be shared across all CCG's as described in section 3.

Kent County Council Feedback

Kent Feedback	Response
With only one HASU based in East Kent, we have concerns about the travel times for the deprived communities in Romney Marsh and Thanet and would like to see further detail on how this will be mitigated.	Agreed. This has been highlighted by feedback from the public consultation and through the preferred option IIA specifically (Appendix SS). Additional detail has been added in section 8.3.3. A second IIA workshop is being arranged in east Kent and will be taken forward in implementation.
Across the whole of East Kent, we have concerns about what mitigations will be put in place in this part of the County as a result of the introduction of the HASU coming later than the HASUs in West Kent. While we understand the practical challenges, this will potentially lead to Kent residents experiencing an unequal level of service in different parts of the County during any transition period.	The concern is understood. The DMBC (section 9) has been amended to reflect the clinical proposal for implementation is a 2 phase approach. This will be tested, following a decision, with a wide stake holder group review.

Kent County Council continued

Kent Feedback	Response
As a basic principle, we would like to be assured that local rehabilitation services were established and ready to run on the same day that any HASU becomes operational.	Agreed. This is described in section 3.4. The rehabilitation pathways will be in place to coincide with the go-live of the HASU/ASU's. A rehabilitation business case is under development with a county wide audit currently taking place. The business case is due for completion in spring 2019.
As raised at JHOSC meetings, some financial information was changed at a late stage in the consultation process and we have concerns about the revised information being fed into it at a late stage.	The DMBC was updated with the most recent information in all applicable areas as outlined in section 6 and the detailed provider presentations are available at Appendix K. The letter from NHS E setting the investment expectations is available in Appendix T.

Medway Council Feedback

Medway Feedback	Response
Medway council do not consider Option B represents the best option and are concerned the process for selection had flaws in it.	The process has been clearly laid out in the DMBC in sections 4 and 6. At each the process and information were rigorously tested with sub groups of the stroke programme governance and with attendees of decision making meetings.
Medway are concerned about the phased approach for implementation having a detrimental impact on east Kent patients	The concern is understood. The DMBC (section 9) has been amended to reflect the clinical proposal for implementation is a 2 phase approach. This will be tested, following a decision, with a wide stake holder group review.
Medway are concerned about how and where patients will be cared for if they are unable to return home after the acute hospital stay	Agreed. The pathway for transfer of care from hospital to the community is described in section 3.4.1. The rehabilitation and early supported discharge pathways will be in place for go live.
No response has yet been received to the Medway Council letter dated 8th November to Ivor Duffy from NHS England.	The response has now been provided from Rachel Jones, SRO for Stroke.

Medway Council continued

Medway Feedback	Response
Medway are concerned that the public consultation is not being re-run particularly with regard to the inclusion of the PRUH.	The flows to hospitals outside of K&M were included in public consultation document. The impact in both Bexley and East Sussex was visible and both areas were formally included in the public consultation and both council's joined the JHOSC.
From the externally commissioned report: Option B may not be able to meet expected increases in demand.	Following these concerns and a recommendation to review the stroke admission projection from the SEC Clinical Senate a further piece of work was commissioned. Details of this can be found in section 7.2.3 (6 P11). The mitigations for any increased demand have been approved by the CRG, SPB and JCCCG.
Option B carries the significant risk that bed capacity will be taken up by South East London residents at the expense of K&M residents.	London have already reconfigured stroke services and patients have access to a number of units within 30 minutes. SEL commissioners and London Ambulance Service have confirmed they do not wish to change their commissioning or current transfer protocols. Bexley CCG have confirmed patients will flow as they do now.

Medway Council continued

Medway Feedback	Response
Option B unnecessarily and disproportionately affects areas of higher deprivation	The full range of impacts are identified in the Integrated Impact Assessment (Appendix SS) and the IIA workshops will develop specific mitigations. Travel and access has been highlighted and the Travel Advisory Group will make recommendations to the JCCCG to ensure all mitigations to support local communities are put into place.
Medway Council is concerned about changes to the evaluation criteria and methodology: • Criteria priority order was removed • Additional sub criteria were added • Scoring keys were changed • Composite methodology was changed • The impact of the PRUH were not appropriately considered.	Detailed responses to these concerns and questions have been responded to separately. The detail of the selection of the preferred option is detailed in section and this has been expanded to detail the amendments (section 6.1) and a log of changes has also been included in Appendix QQ.
Medway are concerned that the location of HASU's outside of Medway will increase health inequalities.	The evidence from all other implementations have demonstrated a reduction of health inequalities and an improvement in all patients outcomes. This is also supported in the IIA report at Appendix SS.

Medway Council continued

Medway Feedback	Response
The changes appear to have been made to provide assistance to areas outside of K&M.	The purpose of stroke review has always been to improve services for all patients who have a stroke or suspected stroke and would attend a hospital in Kent and Medway.
The PRUH failed to deliver an implementation plan	The PRUH did deliver a plan and attended the Delivery Panel held on 4th September. The plan they submitted can be found at Appendix W.

Bexley Council Feedback

Bexley Feedback	Response
We consider that the decision-making business case could be strengthened even further if it were clearer on the significance of the impacts of the stroke review on the PRUH. Given that the hospital is outside the Kent and Medway STP area, the link between the ability of the PRUH to cope with any increased activity and the deliverability of the options may not be immediately clear, but this is a key issue.	Agreed. The PRUH response to the Deliverability Panel process has been included in Appendix W. The impact of that information is demonstrated in section 6.2.
We think the impacts of future population growth should be carefully considered as part of the decision making process and that the Bexley aspect needs further narrative within the documentation being used as part of the final decision making process.	Agreed. We have undertaken further work on future population growth, specifically in relation to the ageing population and potential impact on stroke admissions to K&M HASU/ASU's. This additional work can be found at Appendix EE and in section 7.2 (6 P11)

Bexley Council continued

Bexley Feedback	Response
We hope that both the SEL STP and LAS will be collaboratively engaged in discussions to agree the postcodes for the DVH catchment and to agree protocols for conveying Bexley patients to DVH and any ambulance transfers that may subsequently be required.	Agreed. The SEL STP and LAS have engaged with the programme and have considered the travel time modelling. Bexley CCG and LAS have confirmed they would expect their patients to flow as they do now. They LAS and London commissioners will continue to be involved during implementation to ensure detailed plans, including catchment postcodes are agreed.
We note that there is a work stream to consider the rehabilitation model across Kent and Medway and would hope that LB Bexley's Director of Adult Social Care will be engaged as these discussions continue as clearly there will need to be some understanding or alignment of processes across Kent, Medway and SE London.	Agreed. The rehabilitation work stream will include representatives from Bexley. It is worth noting that London has already delivered HASU and ASU and K&M are working with them on lessons learned, including the development of rehabilitation as referenced in section 7.2.

This page is intentionally left blank

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

Date of meeting: **28 March 2019**

By: **Assistant Chief Executive**

Title: **Work Programme**

Purpose: **To agree the Committee's work programme**

RECOMMENDATIONS

The Committee is recommended to agree the work programme.

---

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.

HOSC Working groups

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

Brighton & Sussex University Hospitals NHS Trust (BSUH)

- A joint sub-group with West Sussex and Brighton and Hove HOSCs set up to scrutinise BSUH's response to the findings of recent CQC inspections and the Trust's wider performance and quality improvement plans. Meets approximately 4 times per year. Membership: Cllrs Belsey, Howell and Murray. The last meeting was on 31 October and minutes are attached as appendix 2. The next meeting is planned for 2 April.

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 plans for 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 have been circulated to Members. 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 Sussex and Surrey HOSC

2.3. A Joint HOSC is in the process of being established to look at potential future substantial variations in services resulting from the Clinically Effective Commissioning (CEC) programme and

other workstreams of the Sussex and East Surrey Sustainability and Transformation Partnership (STP). However, no substantial variations have yet emerged.

2.4. Membership includes representatives from Surrey, West Sussex and East Sussex. Brighton & Hove may also join in the future. The nominated members from East Sussex are Cllrs Belsey, Bowdler and Osborne, and Geraldine Des Moulins but other members may be co-opted to sub-committees considering specific substantial variations.

2.5. There are no agreed meeting dates of the JHOSC but it is expected that it may meet over the summer.

Urgent Treatment Centres Review Board

2.6. 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 to health services' requiring the Clinical Commissioning Groups (CCGs) to formally consult with the Committee.

2.7. 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 three times so far.

2.8. 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.

2.9. The HOSC Review Board met in March to consider an update on the CCGs' plans and will meet again in the coming months to consider the proposed reconfiguration options and public consultation plans.

2.10. Membership: Cllrs Belsey (Chair), Turner, Barnes and Coles and Jennifer Twist.

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

Contact Officer: Harvey Winder, Democratic Services Officer
Tel. No. 01273 481796
Email: Harvey.winder@eastsussex.gov.uk

Health Overview and Scrutiny Committee – Work Programme

Current Scrutiny Reviews		
Title of Review	**Detail**	**Proposed Completion Date**
Kent and Medway Stroke Review Joint Health Overview and Scrutiny Committee	A Joint Health Overview and Scrutiny Committee (JHOSC) was established in March 2018 comprising two members of East Sussex HOSC, plus representatives from Kent County Council, Medway Council and the London Borough of Bexley to consider the NHS proposals to reconfigure stroke services in Kent and Medway. The proposals involve reconfiguring six existing Acute Stroke Units (ASU) in Kent and Medway to three Hyper Acute Stroke Units (HASUs). The NHS consulted on five options for configuration between February and April 2018 and took the decision on 14 February to agree to Option B – which involves the creation of HASUs at William Harvey Hospital in Ashford, Maidstone General Hospital, and Darent Valley Hospital in Dartford. The JHOSC agreed at its final meeting on 26 February to recommend "that the relevant committees of the partaking authorities support the decision of the Joint Committee of CCGs subject to the NHS making an undertaking to review the provision of acute and hyper acute services should demographic changes require it." HOSC will consider the JHOSC's recommendation along with the CCGs' final decision at its 28 March 2019 meeting and will take a decision on whether the proposals are in the best interests of the health service for East Sussex residents. Membership: Cllrs Belsey and Howell (Sub: Cllr Davies)	28 March 2019

Sussex and Surrey Joint Health Overview and Scrutiny Committee	A JHOSC is in the process of being established to consider potential future substantial variations in service (SViS) resulting from both the Clinically Effective Commissioning (CEC) programme and the Sussex and East Surrey Sustainability and Transformation Partnership (STP), although no specific SViS have yet been confirmed. The JHOSC comprises three voting members and one non-voting member from each of the four local authority areas. The JHOSC is expected to be established by each of the local authorities by March 2019. Membership: Cllrs Belsey, Bowdler and Osbourne; and Geraldine Des Moulins	Ongoing
Urgent Treatment Centres (UTC) in Eastbourne and Hastings	The Committee agreed in March 2018 that proposals to establish UTCs by relocating the walk-in centres from Eastbourne Station and Station Plaza in Hastings to the Eastbourne District General Hospital (EDGH) and Conquest Hospital, respectively, constituted a 'substantial variation to health services' requiring the Clinical Commissioning Groups (CCGs) to formally consult with the Committee. The Committee established a Review Board to consider the UTC proposals in more detail and consider the outcomes of the proposed public consultation. The Review Board has met twice so far. 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. The HOSC Review Board met in March to consider an update on the CCGs' plans and will meet again in the coming months to consider the proposed reconfiguration options and public consultation plans. Membership: Cllrs Belsey (Chair), Turner, Barnes and Coles and Jennifer Twist.	TBC 2019

Initial Scoping Reviews		
Subject area for initial scoping	**Detail**	**Proposed Dates**
Cancer Care Performance	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. The Government has announced a new cancer strategy and new performance indicators that will begin to be reported against in 2019. The Committee has requested a further performance report to be emailed for information in the new year and will then consider whether to look at the issue at a Committee meeting.	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. A system-wide review of CAMHS is currently underway and the outcome is due to be considered by the Committee in June. This may provide opportunities for further scrutiny.	After June 2019

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 Hospitals (BSUH) NHS Trust HOSC working group	A joint Sussex HOSCs working group to scrutinise the BSUH response to the findings of recent Care Quality Commission (CQC) inspections and the Trust's wider improvement plan. Membership: Cllrs Belsey, Murray and Howell	Last meeting: 31 October 2018 Next meeting: 2 April 2019
Sussex Partnership NHS Foundation Trust (SPFT) HOSC working group	Regular meetings with SPFT and other Sussex HOSCs to consider the Trust's response to CQC inspection findings and other mental health issues, including ongoing reconfiguration of dementia inpatient beds in East Sussex. Membership: Cllrs Belsey, Bowdler and Osborne	Last meeting: 11 September 2018 Next meeting: TBC 2019
The Sussex and East Surrey Sustainability and Transformation Partnership (STP) HOSC working group	Regular liaison meetings of HOSC Chairs in the STP footprint with STP Executive Chair and Communications and Engagement lead to update on STP progress. Membership: HOSC Chair (Cllr Belsey) and officer	Last meeting: 21 November 2018 Next meeting: TBC 2019
Regional NHS liaison	Regular (approx. 4 monthly) liaison meetings of South East Coast area HOSC Chairs with NHS England Area Team and other regional/national organisations as required e.g. NHS Improvement, NHS Property, CQC Membership: HOSC Chair (Cllr Belsey) and officer	Last meeting: 4 December 2018 Next meeting: TBC 2019

Reports for Information		
Subject Area	**Detail**	**Proposed Date**
NHS 111	An update on the progress of the procurement of NHS 111 services. The CCGs have indicated that the Committee may wish to receive an update at the September Committee meeting	March 2019
Patient Transport Service (PTS)	The Committee received email updates on the first year's performance of the PTS following a contract transfer to South Central Ambulance Service in April 2017. The final performance update was circulated in July 2018 along with a report by Healthwatch on PTS. Overall improvement is shown but with some continued areas for improvement. The Committee will consider any future reports by Healthwatch before determining if further scrutiny is required.	Ongoing monitoring of Healthwatch reports
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	Early 2019
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. The Trust is currently revising its policy and a copy will be circulated via email once available.	Early 2019
Winter Planning	The Committee requested a report to be circulated by email providing an update on the outcome of the winter period 2018/19	April 2019
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 Mid 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.	Democratic Services Officer
27 June 2019		
Cancer Care Performance	The Committee has been receiving email reports on the performance of the local healthcare organisations against nationally reported cancer care targets. The reports continue to show performance for 62 Day referral to treatment times are not being met at any of the acute trusts. National targets are now being revised. The Committee has requested an email update in early 2019 followed by a possible report to the Committee meeting in June. *Note: Timing is provisional depending on performance against national targets.*	Representatives of East Sussex CCGs
Ear, Nose and Throat (ENT) Services	To consider an update report on the implementation of a reconfiguration of ENT services at the hospital sites run by East Sussex Healthcare NHS Trust (ESHT). *Note: Timing is provisional depending on the implementation of changes.*	Chief Operating Officer, ESHT
Mental Health Inpatient redesign in East Sussex	To consider Sussex Partnership NHS Foundation Trust's plans to develop inpatient mental health services in East Sussex. *Note: Timing is provisional depending on the NHS decision making process.*	Representative of Sussex Partnership NHS Foundation Trust (SPFT)
26 September 2019		
Urgent Treatment Centres (UTCs) proposals in Eastbourne and Hastings	To consider the outcome of the HOSC review board's review of UTC proposals in Eastbourne and Hastings. *Note: Timing is provisional depending on progress of CCGs' UTC reconfiguration*	Representatives of EHS/HR CCGs

	plans.	
NHS 111	To consider a report on the outcome from the procurement of the new NHS 111 service and its mobilisation plans.	Colin Simmons, 111 Programme Director (Sussex)
Child and Adolescent Mental Health Services (CAMHS)	To consider a report on the outcomes of a system-wide review of CAMHS provision. *Note: Timing is provisional depending on outcome of review*	Representative of East Sussex CCGs
28 November 2019		
Urgent Treatment Centres (UTCs) proposals in Eastbourne and Hastings	To consider the decision by the CCGs in relation to the proposed development of UTCs in Eastbourne and Hastings. *Note: Timing is provisional depending on progress of CCGs' UTC reconfiguration plans.*	Representatives of EHS/HR CCGs

This page is intentionally left blank

Joint Sussex HOSC Working Group: BSUH

Date: Wednesday 31st October 2018
Time: 9.30am to 1.30pm
Room 181 Hove Town Hall

Attending

Name	From
Ben Stevens	Deputy Chief Delivery & Strategy Officer, BSUH
Nicola Ranger	Chief Nurse, BSUH
Cllr Ken Norman	Chair, B&H HOSC
Cllr Louisa Greenbaum	Member, B&H HOSC
Cllr Colin Belsey	Chairman, ESCC HOSC
Cllr Johanna Howell	Member, ESCC HOSC
Harvey Winder	Officer, ESCC
Cllr Edward Belsey	Co-opted Member, WS HASC
Dr James Walsh	Vice-Chairman, WS HASC
Cllr Bryan Turner	Chairman, WS HASC
Helena Cox	Officer, WSCC
Nuala Friedman	Officer, B&H

1	**Notes of the last meeting 04.04.18**
	The notes were agreed.
2	**Media update**
	NR used the opportunity to update the group on recent press coverage involving the Trust and TB. The Trust had approximately 60 TB cases per year. A patient treated in December 2016 was diagnosed with TB, subsequently a nurse also tested positive for TB in January 2018. Both had a specific strain (Beijing) which had responded to medication. The cases had been declared to PH England and RIDDOR. The Trust had undertaken work to ensure that 341 patients and 1600 staff were tested, those who had an inflammatory response have been treated successful with medication. Not all who have been contacted have taken up the blood test, so secondary letters will be sent. The Trust was consulting with a hospital in Birmingham who had experienced similar issues. Pathways had been altered so those presenting with specific symptoms would be treated in isolation rather than on the respiratory ward. Staff communications would continue emphasising that the strain is completely treatable.
3	**Update on CQC / Quality**
	24/25/26 September – CQC inspection in all domains **16/17 October – 'Well-Led' inspection** Large team of over 50 inspectors split across the two sites In April 2016 the Trust had gone into special measures and could not come out without a well-led inspection. A previously divisional structure had made it difficult to collaborate which had been changed to improve communications. CQC visited: critical care, A&E, medicine and surgery.

	Each division had prepared an overview of where they were before and where they thought they were now, what has been implemented, challenges, what still needed to be done etc**.** **ACTION: It was agreed that the overview documents would be shared electronically with members of the group** The incident where a patient had accidentally drunk cleaning fluid from a water jug had resulted in stricter protocols including the removal of green drinking jugs and swipe card access to cleaning cupboards. COSHH compliance was checked and was described as exemplary. Initial feedback on engagement of staff was also very positive. The Trusts Equality Action Plan had also impressed the CQC. Well-led review report was due in January 2019. The management team were hopeful that BSUH would come out of special measures. Positives: CQC was impressed with the preparation. Core inspection could probably not have gone better. Other positive comments included improvements in cleanliness, staff keen to showcase positive things they have done. Compliments also on the culture and the work being done on the equality action plan. Members asked what was considered as areas of possible weakness: NR highlighted the following areas of paediatrics at PRH, Cancer performance, A&E small for the level of activity and was not included in the 3Ts project; bed shortage on the County site. **ACTION: It was agreed that members of the group would visit the County site to see the development of the 3Ts project.**
4	**Update on Performance**
	Members highlighted their frustration that more up to date reports had not been made available for the meeting. NR gave an assurance that this would not happen in future. NR provided updates to the July 2018 Board reports which had been circulated: • Mortality overview – lot of work had been done on evaluating deaths, with a clear process that the Trust could share with members. • Key issue was falls but the Trust was performing well on prevention of falls nationally. • Infection Control and CDifficile - Protocol for use of side-rooms, limited number so staff had to prioritise the use of these depending on diagnosis. • Monthly audits including what patients present with, falls. High number of patients coming into hospital with tissue damage, working with partners to try and work with causes and reduce. Members asked if the Trust held data relating to the numbers of patients with dementia who fall. In response members were informed that this was often the case but not always. Demographic is actually younger than Eastbourne or Worthing. • Family & Friends test (national NHS test) - Only 11% of patients responded to this previously but since April 2018 this has been automated and the Trust are now above national average of response rate at 38%. As a result the recommendation rate has decreased as the Trust was asking higher numbers. Getting some good data on this. Feedback is at 90%, nationally it is 88%. Only slightly lower in post-

	natal ward. Good response rate for outpatients. The Trust had commissioned an outside company to managing and review the data. • Admittance of people with Stroke – 88% seen within 4 hours, improvement since last report. Some figures have dipped. <u>Points from June performance</u> A&E there were 2 numbers reported: 1. system as a whole including walk in centres, and 2. just BSUH performance. BSUH was 85% against the 95% target of patients being seen within 4 hours In June the Trust were above trajectory, so 3 or 4 months of improvement. May and June PRH achieved above the standard. Through July, August and September there had been an increase in 8.2% of patients attending, plus an increase in acuity of patients coming through, so this has meant a dip in performance of around 3%. Heat wave would have contributed to these figures. <u>In response to a question relating to areas of growth,</u> mental health presentations were going up, which brought challenges to the system as patients were waiting longer for follow on care. This can be a challenge for staff to manage these patients in crisis. The number of people with eating disorders was also increasing. A change in the law meant that the Police could not detain someone until assessed by a mental health team. Difficulty in providing separate units as combination of mental health and physical health is necessary. Higher attendances at walk in centres, particularly around the heat wave during the summer months. This also contributed to higher attendances from people residing in care homes due to dehydration. DTOC (Delayed Transfers of Care) numbers were high with an increase of 8% over the summer, so a summit meeting had been arranged to help with acute trusts and local authorities discuss delayed transfers of care and a suite of actions had been agreed, subsequently the Trust was close to reaching the 3.5% target. Contributory issues include staffing in domiciliary care. <u>Elected Performance – update on main constitutional standards</u> Standard to meet is 92% seen within 18 weeks. Currently the Trust was meeting the performance from March 2018. 52 week wait: this had been high for years but had been reduced to 1 (a patient who chose to wait). <u>Cancer Performance</u> 62 day standard for referral to treatment: figures are in arrears - September report has July data. 71% against target of 81%. This was a national issue and improvement plans were in place so the Trust was hoping to see improvements in coming months. Patients referred from a screening programme – performance low. This was due to resourcing issues but the number of patients was low (18). Improvements were already being made.
5	**Update on New Build**
	Expected to be completed in 2020 / 2021. Services provided from the Barry Building would move when stage 1 was completed. Work was underway to finalise stage 2. The

	position of A&E was to be decided. As previously noted, members expressed an interest in visiting the new build in the New Year. Heli deck - Build works coming to conclusion, next phase would be licences and it would then come into use. Agreed hours of operation are 7am to 7pm. Helicopter currently lands at East Brighton Park and ambulance transfer to Hospital. BSUH could provide figures of numbers of helicopters landing in park to members if requested.
6	**Winter planning**
	In terms of winter planning there was a bed deficit on the county site and 3Ts would not be complete until early 2021. 18 beds would be added to the outpatient site in early 2019. The county site had a high occupancy rate which was frequently above 90% but the Trust was working hard to mitigate issues in the meantime. There was an overarching system plan of support for winter months.
7	**Financial update**
	Financial targets - total at month 6 was delivered as expected. Although the Trust was in deficit, it was out of financial special measures, this had meant that interest rates available to the Trust had dropped. There was a robust SIT plan. Members were informed that the necessary assurances financial plan were in place.
8	**AOB**
	The following points were noted in response to member questions: *Staffing* – BSUH was in top quartile in UK for staffing levels, with around 300 staff vacancies currently. *A&E handovers* – this continued to be an issue but there had been improvement in the last 2/3 months as work continued with partners. There was a discussion regarding services being contracted by private companies at a local level and the impact that this had had. There was a drop in orthopaedics. *Where does BSUH stand with the newly modified CCGs in STP?* - There needed to be closer working and a need to collaborate better. This was challenging as a system as organisations were still regulated individually.
9	**Date and focus of next meeting**
	ACTION: NF to contact the Trust for dates from mid to late January 2019 for a tour and presentation at the County site and for a further meeting at Hove Town Hall in April 2019. **ACTION: NR** would confirm when the CQC report would be available – this was expected to be by mid-January 2019. **ACTION: NF** to get the up to date Board reports and circulate to members.

This page is intentionally left blank