# HEALTH OVERVIEW AND SCRUTINY COMMITTEE

**THURSDAY, 27 JUNE 2019**

**10.00 AM COUNCIL CHAMBER, COUNTY HALL, LEWES**

**MEMBERSHIP** - East Sussex County Council Members
Councillors Colin Belsey (Chair), Phil Boorman, Angharad Davies, Ruth O'Keeffe, Sarah Osborne, Peter Pragnell (Vice Chair) and Alan Shuttleworth

District and Borough Council Members
Councillor Mary Barnes, Rother District Council
Councillor Johnny Denis, Lewes District Council
Councillor Johanna Howell, Wealden District Council
Councillor Amanda Morris, Eastbourne Borough Council
Councillor Mike Turner, Hastings Borough Council

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

## AGENDA

1. **Minutes of the meeting held on 28 March 2019** *(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. **Clinical Commissioning Groups (CCGs) financial and governance plans** *(Pages 17 - 28)*

6. **Urgent Care - Out of Hours Home Visiting Service procurement** *(Pages 29 - 34)*

7. **Ear, Nose and Throat (ENT) Services Reconfiguration - Update** *(Pages 35 - 42)*

8. **HOSC future work programme** *(Pages 43 - 58)*

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

PHILIP BAKER
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County Hall, St Anne's Crescent
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19 June 2019

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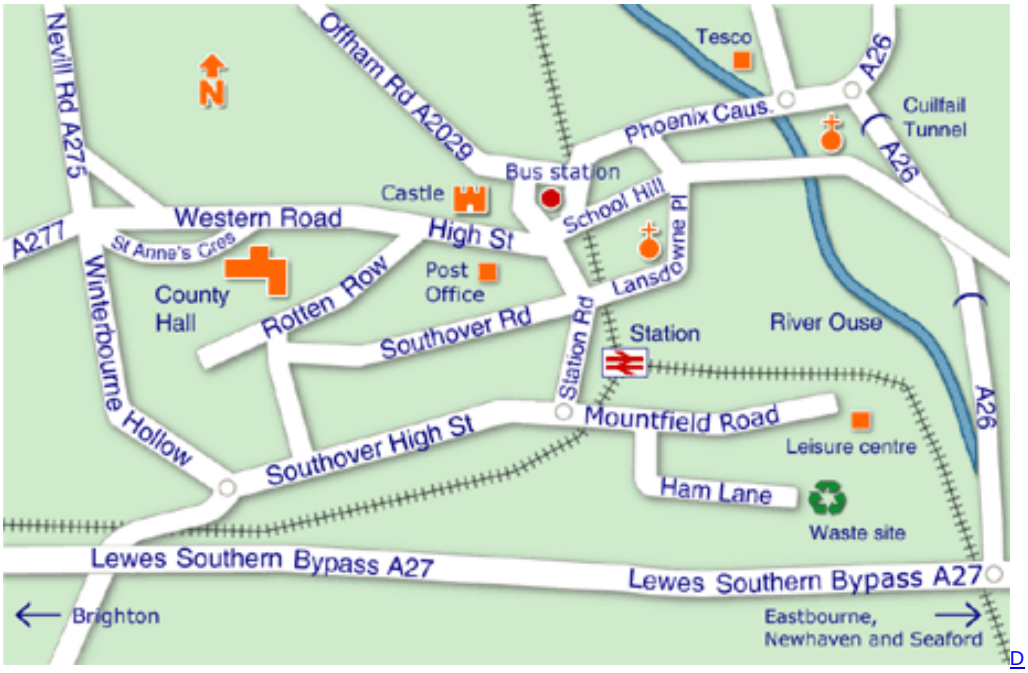


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HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Lewes on 28 March 2019

PRESENT:

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

WITNESSES:

James Pavey, Regional Operations Manager, South East Coast Ambulance Foundation NHS Trust
Jayne Phoenix, Deputy Director for Strategy & Business Development, SECAmb
Ray Savage, Strategic Partnerships Manager, SECAmb
Jessica Britton, Managing Director, Eastbourne, Hailsham and Seaford Clinical Commissioning Group (CCG) / Hastings and Rother CCG
Dr Adrian Bull, Chief Executive, East Sussex Healthcare NHS Trust
Jonathan Reid, Director of Finance, East Sussex Healthcare NHS Trust
Ashley Scarff, Director of Commissioning and Deputy Chief Officer, High Weald Lewes Havens CCG
Steph Hood, Communications and Engagement Advisor, Kent and Medway STP

LEAD OFFICER:

Harvey Winder, Democratic Services Officer

## 23. MINUTES OF THE MEETING HELD ON 29 NOVEMBER

Cllrs Davies and Osborne were present for items 5 and 6.

23.1 The minutes of the meeting held on 29 November were agreed as a correct record.

## 24. APOLOGIES FOR ABSENCE

24.1 Apologies for absence were received from:

- Cllr Ruth O'Keeffe (substitute: Cllr Charles Clark)
- Cllr Janet Coles
- Jennifer Twist.

## 25. DISCLOSURES OF INTERESTS

25.1 Cllr Belsey declared a personal interest as an long-time acquaintance of Ray Savage.

## 26. URGENT ITEMS

26.1 There were no urgent items.

## 27. NHS FINANCIAL RECOVERY

27.1. The Committee considered a report providing an update on the Clinical Commissioning Groups' (CCG) and East Sussex Healthcare NHS Trust's (ESHT) expected financial outturn for 2018/19 and their future financial plans.

27.2. The Committee received a number of responses to its questions from the witnesses in attendance.

**Areas targeted for savings**

27.3. Jessica Britton, Managing Director, Eastbourne, Hailsham and Seaford CCG (EHS CCG)/ Hastings and Rother CCG (HR CCG), explained that Quality, Improvement, Productivity and Performance (QIPP) savings made by the CCGs are designed to help improve patient care and at the same time make healthcare more cost effective. Jessica Britton provided some examples of QIPP savings for 18/19:

- a communities pathway programme that involves training community-based staff to treat certain ailments that frail people are often admitted to hospital for that could better be treated in their home, for example, a blocked catheter, or non-injury fall;

- a programme to target and case manage persistent users of A&E (who often use it for non-medical reasons) to keep them out of hospital and better support them at home; and

- a programme to ensure that GPs are referring patients to hospital outpatient appointments appropriately using the best possible clinical evidence to avoid instances of outpatient diagnostics being carried out unnecessarily.

27.4. Jessica Britton added that medicine management is an area that can deliver £3-5m of savings per year whilst also providing a better service for patients through, for example, introducing medicine reviews for patients. QIPP savings have been identified in this area.

27.5. Keith Hinkley, Director of Adult Social Care and Health, East Sussex County Council, said that there is a continued commitment in 19/20 towards a comprehensive programme of integration across community health and social care in East Sussex that will help significantly increase productivity and use the available funding more efficiently by managing people in the community; responding more quickly to people in crisis in their own homes; and facilitating speedier discharge from hospital. A report setting this out will go through the governance process of the CCGs and the Council in the next few months.

27.6. Jonathan Reid, Finance Director, ESHT, said that Cost Improvement Plan (CIP) savings are also aimed at providing a better quality service whilst reducing costs. He said CIP savings include:

- better recruitment, retention, and workforce plans to reduce the reliance on costly agency staff;

- increasing productivity of community staff by rolling out laptops to them, allowing them to do more for less; and

- recruiting a Head of Procurement who looks for the best possible deal for purchasing medical supplies.

**Risk assessment of savings plans**

27.7. Jessica Britton confirmed that the CCGs QIPP schemes all go through a both an Equality Impact Assessment, and a Quality Impact Assessment that are shared with the governing bodies to help them when taking a decision about a proposed QIPP scheme. All QIPP schemes for 18/19 went through this process as will all those for 19/20.

27.8. Jonathan Reid confirmed that the £18m of Cost Improvement Plan (CIP) savings identified by ESHT for 18/19 were risk assessed and represent the total amount of the potential 'raw savings' that can be made safely from the trust's budget.

**Risk of controversial plans**

27.9. Jessica Britton said that there are no elements of the CCGs QIPP plans that are likely to be controversial. She said that the proposals for 19/20 would be in a similar vein to those of 18/19. If there were any proposed changes to services, they would be discussed with local residents and the HOSC.

27.10. David Cryer, Chief Finance Officer, Central Sussex and East Surrey Commissioning Alliance, added that although the QIPP savings are challenging, they are made in the context of £930m spend across the three CCGs. Within that scale the savings are more manageable.

27.11. Dr Adrian Bull, Chief Executive, ESHT, said that there are no major, controversial plans included in the trust's 19/20 CIP plans, however, he said it would be rash to assume that any of the Trust's proposed CIP plans would not cause controversy – even those that have the full support of HOSC. He gave the example that some people would consider that assessing a patient's social care needs in an intermediate bed rather than in hospital under the care of a consultant is controversial, despite the evidence that it provides better outcomes for patients. He added that any proposed changes to services would include early notification and discussion with stakeholders, including HOSC.

**Receiving central funding for achieving financial targets**

27.12. Dr Adrian Bull explained that Provider Sustainability Funding (PSF) is only paid to trusts if they reach a control total deficit set by NHS Improvement. For the last two years that PSF has been available, ESHT has been too far from the control total to receive it. He said that the PSF model is changing and will be phased out within two years. Therefore, during 2019/20 some of the money earmarked for PSF funding will instead be put into increasing the tariff paid to hospital trusts for services they provide, and some will be put into a new Financial Recovery Fund (FRF), which will be paid to providers that agree a control total in the form of one-off in-year funding to help maintain financial sustainability. If the Trust achieves its control total in 19/20 it will receive PSF/FRF monies of £24m, making its net deficit £10m.

27.13. David Cryer explained that Commissioner Sustainability Funding (CSF) was introduced in 2018 to help CCGs achieve their statutory duty to break even. The CCGs in East Sussex received £43m of CSF for 18/19 that has enabled the three CCGs to break even. He said that CSF funding is also being removed and is being replaced through an increased initial funding allocation to CCGs. CSF will be £28m for 19/20 and is contingent on achieving the financial plan each quarter. He said that unfortunately this will still leave the CCGs with a deficit of £3.8m at the end of 19/20, as NHS England adjusted the rules for receiving CSF by limiting it to no more than 4% of turnover.

**Allocation of additional NHS funding**

27.14. David Cryer confirmed that the East Sussex healthcare system has been allocated a portion of the additional £20bn allocated to the whole NHS up to 2023/24. He confirmed that the CCGs' reduced control total for 19/20 was partly the result of this additional funding.

27.15. Mr Cryer said that the financial planning guidance for CCGs for 19/20 was more prescriptive than in previous years. The guidance requires that a higher percentage of the funding allocation must be spent in community services, mental health services and on the additional funding for the new Primary Care Networks (PCNs). This is a central NHS policy designed to shift resource away from acute care and into support for people in the community. He said that local attempts to focus on community-based care in the past were done in the context of a central NHS policy requiring that resources be spent in acute care to reduce waiting lists, for which much has been done over the past 15 years. He added that the purpose is not to reduce acute spending but constrain demand for it by increasing expenditure in other areas.

27.16. Jonathan Reid said that ESHT will allocate its share of the additional funding to expand the ambulatory care units at both hospitals' A&E departments to operate seven days per week. This is expected to help meet the expected growth in demand for emergency care.

**Cost of borrowing**

27.17. Jonathan Reid explained that the Trust holds more than £140m of historical debt to the Government with interest rates varying between 1% and 6%, depending on the period the loans were taken out and the national policy on borrowing at the time. The average interest rate is 3.5%. He said that the Government is currently reviewing whether there is a way of rebalancing NHS trusts' debt to give a more sensible set of interest rates and repayment profiles.

**Workforce challenges and solutions**

27.18. Adrian Bull, Chief Executive, ESHT, said that whilst there is a national shortage in certain clinical and nursing roles that affect all trusts, improvements can still be made locally. ESHT has done so by:

- changing the structure and skill mix of teams that face challenges with recruiting clinical staff by developing roles such as nurse practitioners, therapists, consultant pharmacists, and surgical care practitioners that support or carry out some of the work of middle grade doctors, where clinically appropriate to do so;

- encouraging existing staff to train into new roles, for example, training existing healthcare assistants to become associate practitioners and nurse practitioners;

- recruiting over 120 apprentices across the trust including maintenance, clinical, and corporate teams.

27.19. Dr Bull said that the trust's staff turnover rate has fallen from more than 16% in 2016 to 9.5% (the national rate is 15%); and senior and middle grade doctor positions at both emergency departments are now fully recruited to and all midwife student vacancies have been filled.

**Shortage of GPs impacting on trusts**

27.20. David Cryer explained that the NHS Long Term Plan has introduced the requirement to develop PCNs in order to enable GPs to share expertise and support each other within a footprint of around 30-50,000 people. PCNs will not solve the GP shortage but will enable practices to alleviate the issue by sharing their resources. It will also enable greater integration with community and social care services based within the footprint of the PCNs.

27.21. Jessica Britton said that PCNs build on work already undertaken in East Sussex to improve primary care capacity in the face of GP shortages, such as encouraging the recruitment at GP practices of paramedic practitioners, pharmacists, and advanced nurse practitioners.

**Mergers of the three CCGs in East Sussex**

27.22. David Cryer confirmed there was a process of dialogue between the CCGs in the Sussex and East Surrey Sustainability and Transformation Partnership (STP) area. The CCGs' discussions include the creation of CCGs that better align with the local authority boundaries, and whether East Surrey CCG should move into the Surrey Heartlands STP. These changes could result in a Sussex-wide STP with three CCGs – East Sussex, West Sussex and Brighton and Hove CCG. Any decision would be need to be made by each of the CCGs' Governing Bodies and they are expected to do so at their Board meetings during June.

27.23. The Committee RESOLVED to:

1) Request the final outturn for the CCGs for 18/19 be circulated by email; and

2) Request a future report on the finalised QIPP plans for 19/20 and an update on proposals relating to CCG governance arrangements.

28. SOUTH EAST COAST AMBULANCE NHS FOUNDATION TRUST: UPDATE ON QUALITY AND PERFORMANCE

28.1. The Committee considered a report providing an update on the quality and performance of services provided by South East Coast Ambulance NHS Foundation Trust (SECAmb).

28.2. The Committee received a number of responses to its questions from the witnesses in attendance.

**Category 3 wait times**

28.3. James Pavey, Regional Operations Manager, explained that the Ambulance Response Programme (ARP) Categories are nationally set and are designed to ensure that those patients who are the sickest get the quickest response, but also the most appropriate response and are then conveyed to the most appropriate place of care. This means that during periods of high demand on the service there can be a backlog of less urgent calls (category 3 or 4) which is the result of prioritising the more serious calls and, as identified in the Demand and Capacity review, it is at these times there is insufficient resource to send a response to all calls. He agreed that it is not acceptable that patients triaged to category 3 or 4 have to wait too long and he apologised for the excessive waits that some patients experience, however, he said the additional funding from the Demand and Capacity review would help to address response times in the longer term.

28.4. Mr Pavey explained that there are escalation plans in place for when the backlog of calls reaches a certain level of approximately 70-80 calls across the Kent, Surrey and Sussex region. This occurs when there are more calls than resources, the service is under severe pressure, and there is a high level of patients waiting for an ambulance, including patients who may not need one. It is during these times the trust does quite a bit of 'no sending' to deal with those patients who do not need an ambulance by giving them advice over the phone on other alternative sources of care available to them. He explained that staff will try and give the right advice to these patients over the phone where it appears that they do not need an ambulance, however, sometimes it is difficult to tell what is happening over the phone and it is necessary to dispatch a clinician to visit the patient and determine what care they require.

**Falls**

28.5. James Pavey explained that falls are initially categorised under Category 3 (response time of 2 hours) provided there are no other serious symptoms such as shortness of breath. The Trust also carries out welfare call backs for patients who are waiting, and their category will be upgraded if they are displaying more serious symptoms.

**Hear and treat**

28.6. It was explained that only about 60% of patients seen by ambulance crews need to be conveyed to hospital, so it is possible to diagnose and treat some patients over the phone through a process called Hear and Treat. James Pavey explained that Hear and Treat uses a national NHS Pathways programme (the programme used to help diagnose over the phone) and is backed up by clinicians within the control room who can offer advice over the phone. He said that it is a challenge to diagnose over the phone compared to in person, but it is a necessary step to help manage demand by sifting out less urgent calls and directing them to other services where necessary. He added that NHS Pathways is a very safe, risk averse programme and patients are more likely to get seen by an ambulance crew than not when they call 999. People sometimes only dial 999 for advice and when they do call handlers are able to direct them to other suitable services.

**Stopping the clock on category 1 calls**

28.7. James Pavey confirmed that in the case of a Category 1 call SECAmb does not deploy Community First Responders (CFR) to simply 'stop the clock' on the 7-minute average response time. A CFR's role is to provide vital lifesaving procedures such as defibrillation to a patient until the ambulance crew/paramedics arrive. It is the ambulance crew/paramedic's role to stabilise and convey the patient to hospital. However, appropriately trained and equipped CFR's attendance time is valid under the national standards if the patient does not require conveying. A bystander with a public access defibrillator does not count towards meeting the national standards.

**Rural vs Urban response times**

28.8. James Pavey clarified that SECAmb is commissioned to deliver a single response time across the whole of Kent, Surrey and Sussex and not different response times in different areas. However, the difference in urban and rural response times was not a new phenomenon, is a national issue, and has no easy answer. Some of the reasons for the discrepancy included:

- the health service was constructed around hospital sites that ambulances convey patients to and they are based in urban centres, meaning that further travel times to hospital sites from rural areas are inevitable. Over the past 20-30 years hospital sites have been concentrated into fewer and fewer larger hospitals;

- SECAmb organises its resources to match concentrations of people, and because the trust receives most of the 115-120 daily calls across the region for category 1 calls in urban areas the trust focuses its resources there; and

- the low number of rural category 1 calls makes their location quite random, meaning it is difficult to allocate resources in rural areas effectively.

28.9. He said that some mitigating actions have been taken, such as installing public defibrillators in public buildings in rural areas and training local volunteers to be CFRs.

28.10. Ashley Scarff added that the HWLH CCG is mindful that its area has the worst response times. The issue is regularly discussed at the CCG's Governing Body and Quality and Safety Committee meetings, and the CCG reviews individual cases to determine what effect the additional travel time may have had on a patient's clinical outcomes.

**Demand and Capacity Review**

28.11. Jayne Phoenix, Deputy Director for Strategy & Business Development, explained that the Demand and Capacity Review identified the need for additional investment by CCGs in the

trust enable it to meet the ARP response time targets. The trust has developed a detailed transformation programme to ensure that it is able to meet its ARP category targets by Q4 of 20/21 using the additional funding. The achievement of the ARP targets, however, relies on the additional funding helping to deliver a new model of care that involves a number of initiatives including a paramedic recruitment programme; increasing the size of the ambulance fleet – including the recent purchase of 100 new ambulances of which the first few have arrived – and the development of a 'non-emergency' transport fleet to enable the trust to respond to some of the patients waiting longer for an ambulance.

28.12. Jayne Phoenix said that the trust is also piloting different ways to respond to calls involving falls or mental health issues, where it is recognised that alternative pathways to waiting for an ambulance may be more appropriate. In Surrey the trust has been conducting a new pilot involving a non-emergency vehicle with a paramedic and occupational therapist on board responding to falls.

**Delivering the recruitment programme**

28.13. James Pavey explained that the recruitment programme involves an increase in the percentage of paramedics from about 40% to 70% of the workforce. He agreed that achieving this would be a risk but was necessary. He said that it is possible for people to join the trust in a more junior position, e.g. an Emergency Care Support Worker, and work their way up to a paramedic. Local recruitment for Emergency Care Support Workers in areas like Polegate and Hastings is possible because the positions are on a lower pay scale, and they can be filled because there is still an attractiveness about working in the paramedic profession. He added that it is important to work collaboratively with system partners when developing recruitment plans to avoid losing staff to other organisations.

28.14. Jayne Phoenix added that retention was also important and has improved considerably since 2016. The much better response from staff to the NHS Staff Survey also demonstrated improved staff satisfaction, which is likely to improve retention rates. Initiatives to retain staff include improved career development pathways, and a pilot for staff to rotate within the service (on the road and in the control room) and into primary care.

**Hospital Handover times**

28.15. James Pavey explained that a delay occurs in a handover of a patient from the paramedics to a hospital A&E department where it takes longer than 15 minutes. Delays are a national issue and significant delays occur across the region SECAmb operates in, although many hospital trusts have made improvements in tackling the issue. This is demonstrated through a 30% year on year improvement during Q3 in terms of hours lost due to hospital handover delays. James Pavey highlighted ESHT as having made dramatic improvements in handover times through working closely with SECAmb, NHS England and NHS Improvement; although not all other hospitals have made as much progress.

28.16. James Pavey explained that a handover involves a handover of clinical information to give the hospital staff a picture of the reasons why the patient was conveyed to the hospital. The hospital may then triage the patient to the appropriate service within the hospital. Dr Adrian Bull added that ESHT does not try to replicate the ambulance team's assessment but does take their information on board in their triage. He said that paramedics may call ahead to triage over the phone and be able to attend the surgical assessment unit or the acute medical unit rather than go straight to A&E and wait for a handover to clinicians there.

28.17. Jayne Phoenix added that all paramedics now have access to a patient's summary care record via iPads, which are issued to all staff. The level of detail is dependent on who put the detail in and can vary a lot, however, it can assist paramedics attending calls where, for

example, a patient may have an end of life care plan in place that includes a 'do not resuscitate' request.

**Violence against staff**

28.18. James Pavey said that violence against staff is a continuing issue in the NHS and that staff are taught methods of conflict resolution as a means of protection. SECAmb also offers support to staff through a staff welfare and wellbeing hub; records and monitors all incidents of physical and verbal abuse against staff; and will prosecute members of the public who attack staff. Staff also have personal radios to call for help, and body worn cameras may be introduced in the future.

**Collaboration with other Trusts**

28.19. Jayne Phoenix explained that the main focus of the collaboration with the West Midlands and South Western Ambulance Trusts, will be around improving procurement practices based on the recommendations of the Lord Carter report. She clarified that it is not a plan to merge or to share staffing. It also helps to maintain national resilience by ensuring that the trusts have the same systems so that in an event of a major incident, for example, they can more easily support each other.

28.20. The Committee RESOLVED to:

1) Request further details on the Trust's transformation and delivery programme to be circulated by email; and

2) Request a further report to include details of how SECAmb and hospital trusts are collaborating, including in relation to hospital handover times and the sharing of patient records.

29. KENT AND MEDWAY STROKE REVIEW

29.1. The Committee considered a report about 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.

29.2. The Committee received a number of responses to its questions from the witnesses in attendance.

**Number of patients affected by changes**

29.3. Ashley Scarff, Director of Commissioning Operations, HWLH CCG, confirmed that modelling by the CCGs had indicated the total number of patients in East Sussex affected by the planned changes would be approximately 50 per year. These comprise patients who currently use Pembury Hospital in Tunbridge Wells and who would in future use Eastbourne District General Hospital (EDGH).

**Additional capacity at the Eastbourne District General Hospital**

29.4. Dr Adrian Bull confirmed that ESHT has modelled the likely impact of the additional patients and considers it relatively small compared to the number of patients currently served by the EDGH Hyper Acute Stroke Unit (HASU). He confirmed the additional patients could be accommodated.

**Travel Times**

29.5. James Pavey explained that SECAmb is effective at identifying whether someone describing their symptoms over the phone (or the symptoms of someone else) is having a stroke. Someone suspected of having a stroke will be placed in a Category 2 response call, which has a target response time of 18 minutes. The ambulance crew will assess the patient on arrival to check that they are having a stroke and they will be then taken to the closest appropriate hospital with a stroke unit. There is a two-hour 'call to needle' time for patients who need to go to a stroke unit and receive thrombolysis (if it is a clot causing the stroke) and SECAmb is confident it can achieve this timescale. He added that strokes are one of the most straightforward conditions to identify clinically, which is a real advantage when determining which hospital to convey a patient to.

29.6. James Pavey confirmed that it will depend on the individual case and will be decided on-scene, but as a general rule an ambulance would convey a patient straight to a HASU first time. An ambulance crew would not take the patient to the nearest hospital in order to have them stabilised before moving them on to a specialist centre. He explained that this was because:

- taking patients to the nearest hospital may add further delays in treatment when transferring them on to a specialist unit; and

- an ambulance crew can manage the straightforward medical needs of a patient with a stroke – such as keeping airways clear – on the way to a specialist unit, so this would not need to be performed at an intermediary hospital.

29.7. He compared the conveyance straight to a HASU as analogous to other medical conditions where it is more important to go to the right place first time such as serious trauma cases where the ambulance will take patients to either the Royal Sussex County Hospital (RSCH) or London hospitals.

29.8. Steph Hood, Comms and Engagement Advisor, added that there is a natural fear about the time taken to get to hospital and, although it is an important factor, the likelihood of good outcomes is more dependent on being on a specialist unit with consultant-led care for the first 72 hours. The model developed in Kent and Medway is designed to be able to deliver this level of care 24/7.

**View of the JHOSC members**

29.9. In speaking about the views of the East Sussex members of the JHOSC, Cllr Howell explained that she had initially been in favour of the two proposed options that would have ensured that stroke service remained at Pembury Hospital in Tunbridge Wells. However, in light of the evidence that it is important to get patients to the right hospital first time, and evidence that this model had worked elsewhere in Sussex, she urged the Committee to support the decision of the Joint Committee of CCGs.

29.10. The Committee RESOLVED to:

1) Agree that the decision of the Joint Committee of CCGs to reconfigure stroke services in Kent and Medway is in the best interests of health services in East Sussex;

2) Agree to submit the recommendations made by the East Sussex JHOSC members to the CCGs for consideration when implementing the decision; and

3) Request a future update on the implementation of the stroke services reconfiguration.

Cllr Turner abstained from resolution 1.

30. HOSC FUTURE WORK PROGRAMME

30.1 The Committee considered its work programme.

30.2 The Committee RESOLVED to agree the work programme subject to the addition of reports identified during previous items and a report at an appropriate time in relation to the East Sussex response to the NHS Long Term Plan.

The meeting ended at 12.40 pm.

Councillor Colin Belsey
Chair

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| **Report to:** | **East Sussex Health Overview and Scrutiny Committee (HOSC)** |
| **Date of meeting:** | **27 June 2019** |
| **By:** | **Assistant Chief Executive** |
| **Title:** | **Clinical Commissioning Groups' (CCGs) Financial and Governance plans** |
| **Purpose:** | **To provide HOSC with an update on the Clinical Commissioning Groups' financial plans for 19/20 and the proposed merger of the three East Sussex CCGs** |

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***RECOMMENDATIONS***

**The Committee is recommended to:**

**1) consider and comment on the report; and**

**2) identify any proposals that require further scrutiny.**

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## 1. Background

1.1. The Health Overview and Scrutiny Committee (HOSC) learned at its meeting on 28 March 2019 meeting that the Clinical Commissioning Groups (CCGs) in East Sussex achieved their financial targets for the 2018/19.

1.2. The Committee requested a further update for its June meeting on the proposed Quality, Improvement, Productivity and Performance (QIPP) savings plans that will be required for the CCGs in East Sussex to hit their financial target for 2019/20.

1.3. The Committee has also learned that the CCGs in East Sussex are planning to merge and requested further details.

## 2. Supporting Information

### Quality, Improvement, Productivity and Performance (QIPP) plans for 2019/20

2.1. The three CCGs in East Sussex – High Weald Lewes Havens CCG (HWLH CCG); Eastbourne, Hailsham and Seaford Clinical Commissioning Group (EHS CCG) and Hastings and Rother Clinical Commissioning Group (HR CCG) – achieved their financial 'control total' for 2018/19 of a combined deficit of £42.7m – comprising £10.7m for HWLH CCG and £32m for EHS & HR CCGs. In return, they received Commissioner Sustainability Funding (CSF) from NHS England of the same amount, taking the overall deficit to £0.

2.2. Achieving the control total required the delivery of Quality, Innovation, Productivity and Prevention (QIPP) savings of £9.2m by HWLH CCG and £18m by EHS/HR CCGs. This amounted to around 3% of their total expenditure. The QIPP savings included 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).

2.3. The CCGs informed HOSC at the 28 March that control totals for 2019/20 had been set at £31.5m deficit - £7.6m for HWLH CCG and £23.9m for EHS and HR CCGs combined – which would be partly achieved through the delivery of QIPP savings.

2.4. The details of these QIPP savings were not yet finalised by the time of the March committee meeting and the HOSC requested that they be provided at the subsequent meeting. Details are now attached as **Appendix 1.**

**Merger of CCGs**

2.5. The NHS Long Term Plan, published in January 2019, calls for the establishment of Integrated Care Systems (ICS) by 2021. NHS England also requires CCGs to find 20% back office savings by 2020. Many CCGs around the country have now begun the process of merging in order to meet these requirements.

2.6. **Appendix 2** is a copy of a letter sent by Adam Doyle, Chief Executive of the eight CCGs in Sussex and East Surrey, to stakeholders outlining the plans for mergers across the area.

2.7. The three East Sussex CCGs are proposing – subject to agreement by their Governing Bodies and member GP practices – to merge to form an East Sussex CCG coterminous with East Sussex County Council. The CCG will be one of three CCGs – alongside Brighton & Hove CCG and a new, merged West Sussex CCG – within a Sussex-wide ICS, with East Surrey CCG expected to leave and join the Surrey Heartlands ICS.

2.8. The Governing Bodies of the three CCGs will consider proposed merger plans on 26 June and 3 July. The reports will be available on the CCGs' websites. If agreed, the CCG will assume shadow form from this autumn with the full merger expected to be completed by April 2020.

2.9. A presentation providing more detail on these proposals will be provided by Adam Doyle at the HOSC meeting on 27 June.

**3. Conclusion and reasons for recommendations**

3.1 HOSC is recommended to consider and comment on the report and agree any further areas of scrutiny.

**PHILIP BAKER**
**Assistant Chief Executive**

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## 1. East Sussex health and care system: year-end financial position 2018/19

1.1. For 2018/19, the East Sussex System has ended the year with an over spend of £0.8m – subject to completion of year end audits. This includes: East Sussex Healthcare NHS Trust; Eastbourne, Hailsham and Seaford CCG; Hastings and Rother CCG; High Weald Lewes Havens CCG; and East Sussex Council.

1.2. This represents a significant improvement on previous years, building on partnership work across the system and has triggered payment of £42.7m Commissioning Sustainability Funding from NHS England, moving the overall system deficit to £45.7m.

| **Table 1: 2018/19 Position** | | | |
|---|---|---|---|
| | Plan | Actual | Variance |
| | £000 | £000 | £000 |
| East Sussex County Council | 0 | -1,167 | -1,167 |
| East Sussex Healthcare NHS Trust | -44,900 | -44,800 | 100 |
| East Sussex CCG's | -42,700 | -42,394 | 306 |
| System Position | -87,600 | -88,361 | -761 |
| | | | |
| *Memo:* | | | |
| Commissioning Sustainability Funding (CSF) | 42,700 | 42,700 | 0 |
| System Position after CSF | -44,900 | -45,661 | -761 |

1.3. It should be noted that the local authority deficit against plan will be funded through Council reserves, but highlights the significant pressures faced across adult social care.

## 2. East Sussex health and care system financial plan and transformation programme approach: 2019/20

2.1. All organisations are working together as a Health and Care System to deliver sustainable financial recovery. The East Sussex Health and Care Transformation Programme builds on our significant work in partnership to date. This programme will enable the health and social care system to:

- Make best use of resources and restore financial balance
- Maintain high quality services for patients based on local need
- Ensure delivery of national operational standards, and access to care in the most appropriate setting.

2.2. To achieve this, the health system is working collaboratively, with joint ownership of system wide plans. There are three distinct shared work streams that are overseen by the East Sussex Health and Care Executive which are:

- Urgent Care – to reduce unnecessary unplanned admissions and A&E attendance, with ambulatory care pathways that meet the needs of the aging population and pathway redesign at the A&E front door.

- Community and Primary care – to develop community based pathways to care for people outside of the acute hospital and to enable supported discharge when people have been in hospital
- Planned Care – to reduce unnecessary outpatient appointments and planned hospital stays with alternative pathways and support to GPs.

2.3. In addition to our shared system-wide programmes, each partner's organisation has an internal financial recovery programme in place to make best use of resource with appropriate controls on all expenditure and all spend is reviewed to ensure that each year we are investing our resources in a way that has the greatest impact on access, quality and outcomes for local people.

## 3. Summary of the financial plan 2019/20 and governance arrangements

The 2019/20 plan agreed by Regulators is for a deficit of £65.5m as summarised in table 1. If this is achieved the system will receive £51.6m NHS Commissioner and Provider Sustainability funding reducing the deficit to £13.9m.

To achieve plan the system needs to deliver £58.8m of savings as summarised in table 2.

**Table 1: 2019/20 Plan**

| | **Planned deficit** |
|---|---|
| | £000 |
| East Sussex County Council | 0 |
| East Sussex Healthcare NHS Trust | -34,033 |
| East Sussex CCG's | -31,500 |
| System Position | -65,533 |
| | |
| *Memo:* | |
| Commissioning and Provider Sustainability Funding (CSF/PSF) | 51,608 |
| System Position after CSF | -13,925 |

**Table 2: 2019/20 Savings**

| | **Savings** |
|---|---|
| | £000 |
| East Sussex County Council | -730 |
| East Sussex Healthcare NHS Trust | -20,600 |
| East Sussex CCGs - QIPP ESHT | -11,100 |
| East Sussex CCG's QIPP Other | -26,361 |
| System Position | -58,791 |

3.1. A robust process is in place with clear accountability for all plans and clinical leadership across all programmes of work. All plans are therefore guided clinically with a clear evidence base and a financial assessment made subject to quality and equality impact assessments.

Where service change is proposed detailed CCG commissioning project documentation is maintained and Equality and Quality impact assessments undertaken. Quality Impacts are undertaken by the Nursing Directorate at an early stage of the planning process as follows:

Quality Team review the proposal against set criteria encompassing the Duty of Quality, the NHS Outcomes framework and access. Process summarised as follows:

- Clarification of any points where required
- If the score is within set criteria then the plans are approved from a quality perspective
- If the score is negative then the QIA will be escalated to the relevant Quality Committee (JQGC) for further scrutiny with either a decision not to proceed or further action required
- Plans are then developed in partnership and dependant on the nature of the change wider stakeholder engagement is undertaken to fully develop plans and commence implementation.

3.2. The system plan is overseen by the East Sussex Health and Care Executive Group, and is supported by three key Programme Boards – Urgent Care, Planned Care, and Community and Primary Care. Delivery is supported by the East Sussex Chief Finance Officers Group and Programme Management Offices. This system governance reports into each constituent organisation as appropriate to local governance.

3.3. Annex 1 provides a schedule of schemes with a high level financial summary at annex 2. The schemes are split into the following broad categories:

- Trust Cost Improvement Programmes (CIP)
- Urgent care – managing growth in demand in A&E and unplanned admissions through service redesigns and alternative clinical pathways.
- Planned care – reducing unwarranted variation in referrals for planned care.
- Medicine Management – Implementing prescribing best practice and reducing unwarranted variation in prescribing practices.
- Corporate – clinical commissioning reform and effective partnering to reduce running costs

## 4. Conclusion

The East Sussex system has robust plans in place to deliver planned control totals for 2019/20, with a shared programme of work to support improvements and efficiencies. The emphasis remains on ensuring high quality, safe services, that focus on ill health prevention, promoting independence and supporting people to be cared for within their local communities.

Appendix 1 - High level description of schemes

| **These are specific schemes relating to ESHT, however positive progress and joint working on care pathways continues.** | |
|---|---|
| **Urgent Care Projects** | **Description** |
| High Intensity Users | Care for patients who attend A&E to seek wider support than urgent direct health needs. Cohorts of patients are referred to dedicated case workers to prevent unnecessary attendance. |
| Frailty Front door | Revised 'frailty' ambulatory pathways at A&E front door to prevent longer stay Non Elective admissions. |
| Respiratory Locally Commissioned Service (LCS) | LCS is in place for respiratory care, to offer community based care as an alternative to A&E attendance and admission |
| 5 pathways | SECAMB enable patients to access community based Crisis Response services as an alternative to A&E for 5 agreed pathways. Namely: Non injury falls, blocked catheter, UTI, pneumonia/influenza and cellulitis. |
| Extended Frailty model | Extending the out of hospital frailty model building the role of frailty practitioners and increasing workforce. |
| Care homes | Preventing unnecessary admission from care homes. This concept is being developed in collaboration between CCGs, ESCC and ESHT. |
| Ambulatory Care | Development and implementation of Ambulatory Care pathways based on best clinical practice to enable patients to return home the same day if clinically indicated. |
| Falls and fracture prevention | Drawing on STP wide work for falls prevention and frailty fractures with community based support. |

| Community & Primary Care Projects | Description |
|---|---|
| Home First Pathway 1 | Patients assessed for care needs at home. to ensure that patients are assessed and offered a care package that meets their needs in a safe environment. |
| Home First Pathway 4 | Patients assessed for care needs in intermediate care not acute hospital to ensure care meets their needs in a safe environment. |
| Locality based Integrated Care | Co-location of teams and Multi disciplinary Team approach community nursing, OT and social care practitioners to offer local fully integrated care. |
| Rapid Response | Multi disciplinary team to respond rapidly to care needs in the community to enable a smooth discharge and reduce unnecessary A&E attendances. |
| **Planned Care Projects** | **Description** |
| Diabetes service redesign | Improving care, reducing amputations by optimising diabetes pathways overseen by an integrated local team. |
| Muscular Skeletal | Reduce unwarranted variation in hip and knee surgery in line with clinical best practice to avoid unnecessary surgery if other options are clinically indicated. The MSK Programme Board has representation from a range of stakeholders and covers the whole of East Sussex. |
| Outpatient referrals | Reduce unnecessary out patient appointments with support at practice level to: utilise advice and guidance, peer review, embed pathway protocols, and shared decision making with patients. This is fully aligned with a wider out patient programme at ESHT to improve productivity across services. In addition reducing unnecessary pathology tests. |
| Radiology non obstetric ultrasound | Embed agreed protocols to prevent unnecessary ultrasound tests – this saves money and releases pressure on services |
| Evidence based interventions (EBI) | Ensure that national guidance for Evidence Based Interventions is reflected locally. |
| Cardiology | Implement national guidance in cardiology building on STP wide clinical pathways, and options for community based cardiology services. |

| CCG Only Projects | Description - The following CCG QiPP plans are not overseen the 3 shared work streams. They are monitored by the CCG PMO and the same planning principles applied. A similar approach is being taken across all SES CCGs. |
|---|---|
| Medicines management - Best practice prescribing | Working directly with practices to ensure all prescribing is evidence based and reviewed regularly at practice level. This includes direct ordering of prescriptions. |
| Medicines management - Diabetic redesign | Based on national best practice diabetes prescribing linked to wider diabetes pathway redesign |
| CHC - Case Reviews | Completion of the review of high cost packages in line with recognised good practice. Plans to strengthen CHC commissioning are also underway to reduce a reliance on spot purchasing. |
| Contractual – Review of all contracts | Review of all contracts to ensure accurate invoicing, financial control and standard contractual control. |
| Corporate – Running costs | Reduction in CCG running costs including property review. |

## Annex 2 - Summary financial table

| Saving Schemes | £000 | Details |
|---|---|---|
| **East Sussex County Council** | 730 | Agreed by the County Council through the Reconciling Policy Performance Resources process |
| **East Sussex Healthcare NHS Trust (ESHT):** | | |
| Contract Income | 5,488 | |
| Other Income | 506 | |
| Pay | 2,589 | |
| Non Pay | 3,871 | |
| Pipeline schemes | 8,149 | |
| | | |
| **Hastings and Rother / Easbourne Hailsham and Seaford CCGs** | | |
| Urgent Care - ESHT | 5,442 | Respiratory - Primary care locally commissioned service to reduce non elective activity |
| | | A&E frailty pathways at front door to prevent longer non elective activity |
| | | Focus on high intensity users of A&E |
| | | 5 pathways |
| Planned Care - ESHT | 4,000 | Diabetes pathway redesign |
| | | Reducing unwarranted variation in OP referrals |
| | | Non obstetric ultrasound - implementation of referral protocols |
| | | Reduction in direct access to pathology tests |
| | | Reduce unwarranted variation for hip and knee surgery |
| Medicines Management - ESHT | 1,650 | Bio similars switching / high cost drugs |
| MSK | 522 | Contract efficiencies on MSK |
| Primary Care prescribing | 3,244 | Best Practice in prescribing |
| Diabetes redesign | 507 | National best practice in diabetes prescribing |
| Continuing Health Care high cost packages review | 366 | Strengthening of CHC commissioning |
| Running Costs | 491 | Reduction in running costs including estates |
| Budgetary savings | 1,932 | Non contract activity controls and technical accounting adjustments |
| Pipeline schemes | 7,020 | Currently underdevelopment |
| | | |
| **High Weald Lewes Havens CG** | | |
| Continuing Health Care high cost packages review | 600 | Strengthening of CHC commissioning |
| GP Prescribing | 1,179 | Best Practice in prescribing |
| Medicines Management - Prescription Ordering Direct | 491 | Minimizing waste in prescribed drugs |
| MSK | 248 | Contract efficiencies on MSK |
| Other budgetary savings | 43 | |
| Biosimilar (Humira) | 600 | Bio similars switching / high cost drugs |
| Pipeline schemes | 9,200 | Currently underdevelopment |
| | | |
| Total | 58,868 | |
| Required | 58,791 | |
| Difference | 77 | |

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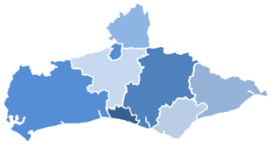

**Sussex and East Surrey**
**Clinical Commissioning Groups**

NHS

Dear colleague,

## Proposed new commissioning arrangements for CCGs

I am writing to outline to you proposals that are being discussed around the future commissioning arrangements for Clinical Commissioning Groups (CCGs) across Sussex and East Surrey.

The Governing Bodies of the eight CCGs – Brighton and Hove; Coastal West Sussex; Crawley; East Surrey; Eastbourne, Hailsham and Seaford; Hastings and Rother; High Weald Lewes Havens; and Horsham and Mid Sussex - have been exploring how commissioning can be done more effectively to bring greater benefits for our populations.

This includes the following options that would see some CCGs merge to create commissioning bodies working across our local authority footprints:

- Coastal West Sussex, Crawley and Horsham and Mid Sussex CCGs would merge to become one CCG for West Sussex;
- High Weald Lewes Havens, Eastbourne, Hailsham and Seaford and Hastings and Rother CCGs would merge to become one CCG for East Sussex;
- Brighton and Hove would remain as a single CCG but, due to its relatively small size, would work closely with the CCGs in East Sussex, through joint committees and teams.
- East Surrey CCG would formally integrate with the Surrey Integrated Care System and no longer working within the management structure of our CCGs.

These proposals will be discussed by the Governing Bodies in June with a view of making recommendations that will then be discussed with the CCG GP memberships.

For Sussex, this proposed new configuration of CCGs would be run and overseen by a single strategic commissioner management structure and supporting functions that will form part of the Integrated Care System (ICS) across the footprint.

For Surrey, discussions are ongoing around how East Surrey CCG will work within the Surrey Heartlands ICS but the exploration work that has already taken place has been very positive and we are confident that we will have a clearer picture of how the system can work effectively in the coming months.

We believe these proposals would provide the foundation to develop a new model of commissioning that focuses on more integrated work with local authorities to improve population health outcomes and a reduction in health inequalities.

Working in this way will enable us to commission more effectively and efficiently for local populations across established and recognisable boundaries, while also being able to commission and plan strategically across wider county-wide footprints.

## Why these changes are being considered now

There are three main reasons why these changes are being considered now.

Firstly, it is widely recognised that individual CCGs are no longer able to operate and commission effectively and efficiently for the changing needs of our populations. This is due

to the relatively small size of CCGs, which has meant that across our health and care system there have been inconsistency in how services have been commissioned, there has been unnecessary duplication in work, it has been difficult to commission at scale when needed, and it has been increasingly difficult to recruit and retain specialist expertise and skills among our staff.

Secondly, our local health and care system has to respond to the expectations of the NHS Long-Term Plan, which outlines a fundamental shift in how CCGs will work and how future commissioning will be done. This involves the expectation of greater integration with local authorities and other partners, with commissioning arrangements and configurations that will support the formation of Integrated Care Partnerships (ICPs) and Primary Care Networks (PCNs).

Thirdly, all CCGs across the country are required by NHS England to reduce their running costs by 20% by April 2020. This represents a significant proportion of the running costs for each of our individual CCGs and it is clear they will no longer be able to work as independent organisations in the future. Changing the configurations of the CCGs and streamlining our processes and ways of working will help us achieve the required cost reduction, while also being able to commissioning effectively for our populations.

## The benefits of integrated commissioning arrangements

We believe that developing a new commissioning model that focuses on population health will bring greater focus on wellness and prevention to improve outcomes for the people we serve. To be able to do this, it is clear there needs to be a joined-up approach between NHS organisations and partners and collaboration with local authorities is particularly important as local government are responsible for public health spending and a wide range of services that influence people's health.

Our CCGs, partners and local authorities already work together to deliver a number of services jointly and over the last few years have been developing local plans to transform services to give patients more joined-up care. There is now the expectation that this work will develop further and we have been discussing with partners how best to take this forward.

## Next steps

We will be continuing to discuss these potential changes with the CCG Governing Bodies and partners over the weeks ahead, with the view of agreeing recommendations to apply to NHS England for approval for the mergers. We will continue to keep you updated as these discussions develop.

If you have any concerns of issues around these proposed changes, please do contact me directly.

Yours sincerely

Adam Doyle
**Chief Executive Officer**
**Sussex and East Surrey Clinical Commissioning Groups**

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

**Date of meeting:** **27 June 2019**

**By:** **Assistant Chief Executive**

**Title:** **Urgent Care – Out of Hours Home Visiting Service**

**Purpose:** **To update HOSC on the procurement of an Out of Hours Home Visiting Service as part of the wider redevelopment of urgent care in East Sussex**

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***RECOMMENDATIONS***

**The Committee is recommended to consider and comment on the report**

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## 1 Background

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

1.2 Following a national review in 2014, NHS England set out clear commissioning standards to ensure future urgent and emergency care services are integrated and offer a consistent service. In March 2017, NHS England and NHS Improvement published the *Next Steps on the NHS Five Year Forward View* which highlighted the importance of delivering integrated urgent care services to help address the fragmented nature of out-of-hospital services. The *NHS Long Term Plan* published in January 2019 reiterated the need to reform urgent care. There are 10 nationally set key deliverables in relation to urgent and emergency care including:

- the roll out of standardised new 'Urgent Treatment Centres' (UTCs) which will be open 12 hours a day (minimum), seven days a week, integrated with local urgent care services by December 2019;
- the commissioning of the nationally mandated increase in Extended Primary Care Access (access to GP appointments outside core hours and at weekends) by October 2018.
- the re-procurement of NHS 111 as a service that includes the ability to book patients into UTCs and to have a Clinical Assessment Service (CAS) that can hear and treat patients over the phone.

1.3 The Committee has considered several reports, most recently in September 2018, providing an update on various elements of the urgent care redevelopment in East Sussex. The CCGs requested to provide an update to the Committee on the development of the procurement of an Out of Hours (OOH) Home Visiting service.

## 2. Supporting information

2.1. Currently, South East Coast Ambulance Service NHS Foundation Trust (SECAmb) provides the NHS 111 service that undertakes the initial phone triage. If the call requires further clinical input in the out of hours period it is passed to the Out of Hours (OOH) provider (IC24) for a phone conversation. This may lead to either an appointment in an OOH base or a home visit, if appropriate.

2.2. The NHS 111 service currently being re-procured will include a CAS that will enable patients to be diagnosed over the phone by a clinician and either treated or passed onto the necessary service, including the OOH Home Visiting Service.

2.3. The seven Clinical Commissioning Group (CCGs) Governing Bodies agreed that the OOH Home Visiting Service would be run as a separate procurement to the rest of the NHS 111-CAS procurement. **Appendix 1** sets out the details of the proposals for the Home visiting service, which include:

- The service will run from 18:30pm – 08:00am.
- As there is no direct route into the OOH Home visiting service for patients, all calls will go via the NHS111-CAS service.
- Patients will be clinically assessed in the CAS by either a GP or suitably skilled healthcare professional with access to their GP medical record/summary.
- The information from this assessment will be passed directly to the OOH Home Visiting service, so there should be no need to re-triage.
- The OOH Home Visiting Service will be a GP led multi-disciplinary team, which is expected to consist of GPs, Paramedic Practitioners, Advanced Care Practitioners and Prescribers.
- The OOH Home Visiting service Key Performance Indicators (KPIs) include that 95% of patients receive a face-to-face consultation within their home residence within the specified period: 1hr (emergency), 2hrs (urgent), 6hrs (non-urgent).

2.4. The OOH Home Visiting Service is being commissioned across the whole of Sussex and is expected to go live from 1 April 2020.

2.5. The NHS 111-CAS procurement will be considered by this Committee at the September meeting.

## 3. Conclusion and reasons for recommendations

3.1 This report provides HOSC with an update on developments in relation to some aspects of a wider urgent care reconfiguration across East Sussex and the Sussex and East Surrey Sustainability and Transformation Partnership (STP) as mandated by NHS England through the NHS Long Term Plan. Future updates on the NHS 111 re-procurement; the UTC at Lewes Victoria Hospital; and a report of the findings of the HOSC review board currently looking at the proposals for UTCs in Eastbourne and Hastings are planned for the next HOSC meeting in September.

3.2 HOSC is recommended to consider and comment on the updates.

**PHILIP BAKER**
**Assistant Chief Executive**

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# Out of Hours Visiting Service – Update report to East Sussex HOSC, June 2019

## Background:

In March 2017, NHS England and NHS Improvement published the Next Steps on the NHS Five Year Forward View. This document highlighted the importance of delivering a functionally integrated urgent care service to improve patient care.

In November 2018, the seven Sussex CCG Governing Bodies agreed that the Out of Hours (OOH) Home Visiting Service would be run as a separate procurement to the NHS111/Clinical Assessment Service (CAS) Procurement.

Currently, South East Coast Ambulance NHS Foundation Trust (SECAmb) provides the 111 service that undertakes the initial phone triage. If the call requires further clinical input in the out of hours period, the call is passed to the Out of Hours provider for a phone conversation. This may lead to either an appointment in an out of hours base or a home visit if appropriate.

From 1st April 2020 the model will change so that there will be one contract that responds to patients as part of the phone call, as opposed to passing someone around the system. Patients if needed to will be seen in a local urgent care setting or if appropriate will have a home visit.

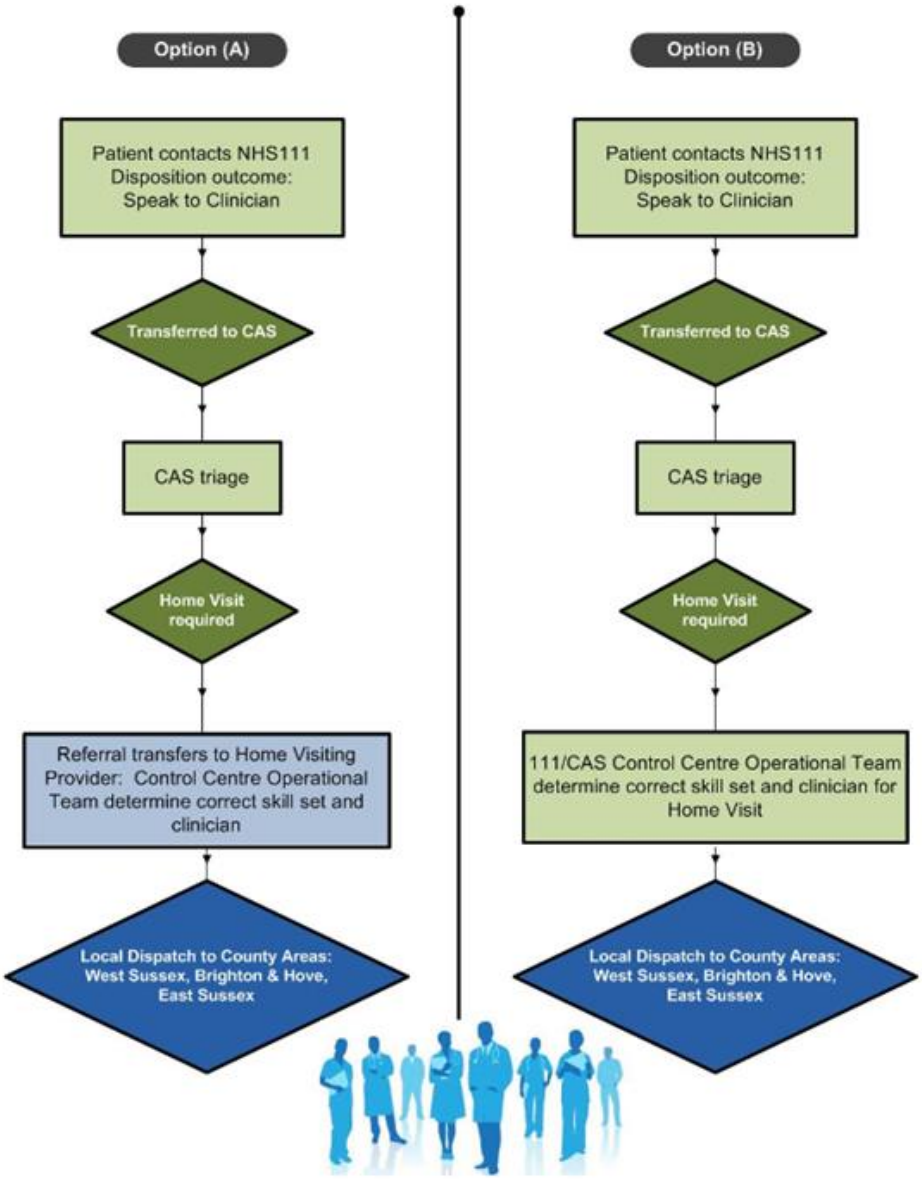
An interim contract to deliver this service has been negotiated with current providers (SECAmb and IC24) and commenced in April 2019. A full procurement of these services is underway, with service due to go live in April 2020. The GP Out of Hours Visiting service(s) will be commissioned separately as a pan-Sussex service. This will follow an open tender procurement process with service mobilisation by April 2020

## The Sussex Out of Hours Home Visiting Service:

The new OOH Home Visiting Service for Sussex will go live from 1 April 2020. The service will run from 18:30pm – 08:00am and will be managed through NHS111-CAS. What this means is there should no longer be a need or requirement to re-triage. This has been a consistent complaint from patients around having to repeat information two or three times. Patients will be clinically assessed in the CAS by either a GP or suitably skilled healthcare professional.

As there is no direct route into the OOH Home visiting service for patients, all calls will go via the NHS111/CAS service.

We have been working with data from our current provider and our Clinical Leads to create two options for an operating model, see image below:




We will procure a high quality, patient-centred, safe and effective clinical out of hours home visiting service in the Sussex area, working with all other local providers, local authorities and commissioners to foster an environment where care can flourish through quality reviews, shared support and adapt to meet the future needs of a fully integrated urgent care system.

**Access to records:**

Access to patients GP records, starts in 111-CAS. This will be the first point of contact where a suitable healthcare professional is able to carry out a comprehensive telephone assessment with the patient by accessing their GP medical record/summary. The information from this assessment will be passed directly to the Out of Hours Home Visiting service, which is why there's no need to re-triage. During the visit itself the clinician may also need to access to the patients GP medical record/summary which is the future direction for the service.

**Workforce:**

86% of the Out of Hours home visits during 2017/18 were to patients over the age of 65yrs, 46% of which were over the age of 85yrs. We have an aging population in Sussex with complex medical needs, and the skills of our workforce need to reflect this.

The Out of Hours Home Visiting Service will be a GP led multi-disciplinary team, which we would expect to consist of GP's, Paramedic Practitioners, Advanced Care Practitioners and Prescribers. Robust GP clinical oversight will provide the governance, quality, and assurance to the other healthcare professionals in the team enabling them to utilise their skills appropriately and safely to manage our patient's urgent care needs in their own homes.

**Performance Indicators:**

The sooner a patient receives treatment, the better the outcome, which is why the 111-CAS triage assessment is essential in determining the level of urgency. The Out of Hours Home Visiting service KPI's are part of the Integrated Urgent Care Key Performance Indicators and Quality Standards 2018 which states that 95% of patients receive a face-to-face consultation within their home residence within the specified period: 1hr (emergency), 2hrs (urgent), 6hrs (non-urgent).

This isn't the only area we measure through KPI's. Other areas may include; Prescribing, Incidents, Complaints, Workforce, Training, Quality & Safeguarding, Performance, Equality & Diversity, Friends & Families, Audit, etc., aimed at improving efficiency, realize value for money and achieve the best outcome for the patient.

**The Procurement Process:**

The OOH Visiting Service will be procured for all of Sussex.

The pan-Sussex model will allow for better patient outcomes and offer a more sustainable workforce balance. A market engagement event for this service was held on 7 May 2019 where we received positive feedback from the market. We are working to the following timeline for this procurement:

| **Date** | **Activity** |
|---|---|
| July 2019 | Procurement advert goes live via the procurement portals |
| September 2019 | Procurement closes and evaluation starts PQQ and ITT process |
| December 2019 | Contract Award |
| December 2019 - March 2020 | Mobilisation |
| 1 April 2020 | Service go-live |

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

**Date of meeting:** **27 June 2019**

**By:** **Assistant Chief Executive**

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

**Purpose:** **To provide an update on the progress of the reconfiguration of ENT services provided by East Sussex Healthcare NHS Trust (ESHT).**

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***RECOMMENDATIONS***

**The Committee is recommended to consider and comment on the report**

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## 1 Background

1.1 Ear, Nose and Throat (ENT) services are hospital services that treat problems related to those areas of a patient's body. This may include hearing loss, sinus problems, and thyroid surgery, amongst many others. ENT services are provided for the majority of residents in East Sussex by East Sussex Healthcare NHS Trust (ESHT).

1.2 In November 2018, HOSC considered and noted proposals by the Trust to reconfigure the service on the grounds that the existing configuration was clinically and financially unsustainable.

1.3 The proposals have now been implemented and this report provides an update on the ENT service.

## 2. Supporting information

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

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

2.2. ESHT reported to HOSC on 28th November 2018 that the service has had continuous challenges over a number of years in providing clinically effective care due to medical staffing shortages. These shortages included:

- three consultants covering the two sites, whereas there should be five or six, with one of the three consultants having retired and returned on an almost full time basis;
- a shortage of middle grade doctors – with no registrars or training grade doctors to fill the six middle grade rota posts. The service was instead relying on four speciality doctors, one of whom acts up to the consultant rota. They were also close to retirement age and could potentially hand in their notice, despite the work they were doing 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; and

- two trainee ENT doctors who were at risk of the Kent Surrey and Sussex Deanery removing them unless the Trust could provide them with more training opportunities.

2.3. Whilst the Trust safeguarded patient safety in the short term through the use of an ad hoc temporary workforce and staff working additional hours, it argued that the service was unsustainable: ESHT operated the service at a deficit of £1.7million in the year ending March 2018 – a deterioration from a deficit of £987,000 in 2016/17. HOSC also learned that the ENT service had, despite the higher costs, admitted fewer patients in the past year up due to not having a sufficiently large consultant team to admit as many patients as the trust would like.

2.4. The proposed reconfiguration would therefore provide a safe and sustainable service that would cost less and be able to provide more activity. This would be achieved by addressing the workforce challenges through the following changes:

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

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

2.6. HOSC resolved to note the proposals at its meeting on 28th November 2018 and request an update at its 27th June 2019 meeting.

2.7. The update attached as **appendix 1** explains how ESHT had implemented the proposals by 29 April 2019. The Trust reports that the reconfiguration has had a positive impact on the stability of the service and there have been no reports of adverse outcomes for patients.

2.8. The proposals were implemented as set out to HOSC in November with the addition of two full ENT operating lists per month remaining at Conquest – one day case for adults and one paediatric operating list for children requiring a planned overnight stay following ENT Surgery. This is to enable the retention of an appropriate level of skill and expertise at the Conquest in response to concerns raised during the consultation process.

2.9. ESHT also reports that agreement was reached with Brighton and Sussex University Hospital (BSUH) that any out of hours paediatric cases that are stable and may require surgery can be transferred to the Royal Alexandra Children's Hospital, following a consultant to consultant referral; and

2.10. Whilst the Trust has recruited to Specialist and Associate Specialist (SAS) Grade vacancies, and feedback from trainees is positive, the number of consultants makes delivering ENT challenging and there is an ongoing reliance on temporary staff.

2.11. The Trust is currently advertising to recruit to the consultant post. Conversations are also due to take place between ESHT and lead clinicians at BSUH to review pathways, discuss additional support, and expedite recruitment of joint consultant appointments working between ESHT and BSUH.

2.12. Key metrics, including patient feedback, will be monitored at quarterly intervals and reported internally at ESHT through performance reviews. The first report is expected three months after the reconfiguration of services.

## 3. Conclusion and reasons for recommendations

3.1 The Committee is recommended to consider and comment on the report.

**PHILIP BAKER**
**Assistant Chief Executive**

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East Sussex Healthcare NHS Trust

# Ear Nose and Throat Briefing Paper - June 2019

## 1. Introduction

HOSC received a paper in November 2018 that provided an overview of proposed changes for the delivery of Ear Nose and Throat Services (ENT) within East Sussex. This paper provides a briefing on the changes made.

## 2. Reconfiguration

After further engagement with staff groups and stakeholders, the ENT service completed the proposed reconfiguration on 29th April 2019, by co-locating the majority of ENT surgery and adult inpatient services to Eastbourne District General Hospital (EDGH) from the Conquest Hospital.

Two full ENT operating lists per month remain at Conquest, one day case for adults and one paediatric operating list for children requiring a planned overnight stay following ENT Surgery. There have been no changes to outpatient services which remain at both Conquest and EDGH.

## 3. Service Improvements

### 3.1 Inpatients

As part of the service reconfiguration, we have increased access to theatre, to support emergency pathways. The change, which was effective from 29th April, has resulted in ENT operating lists being readily accessible Monday to Friday at EDGH.

Through maintaining operating lists each month at Conquest hospital we have retained an appropriate level of skill and expertise. This has addressed concerns raised during the consultation process.

### 3.2 Outpatient

Outpatient services continue to be provided in full at both Conquest and EDGH. Through successful recruitment to Specialist and Associate Specialist (SAS) Grade medical vacancies we have increased the number of outpatient clinics delivered from Conquest. This enables the provision of clinics every weekday, and increases the availability of ENT expertise to provide additional support on Kipling Ward for children who require ENT input as part of their inpatient stay.

3.3 Emergency Pathways

Emergency Pathways have been reviewed, developed and circulated within the Trust. There has been no change to the SECamb ambulance pathways. ENT patients are treated and transferred as required and ENT medical staff continue to provide emergency cover at either emergency department; travelling to the patient as clinical need requires.

Any emergency adult patient who requires admission will be transferred to EDGH, once clinically safe to do so. This pathway has not altered.

Agreement was reached with Brighton and Sussex University Hospital (BSUH) that any out of hours paediatric cases that are stable and may require surgery, can be transferred to the Royal Alexandra Children's Hospital, following a consultant to consultant referral. Since 29th April, this has not been necessary but will it will continue to be monitored.

3.4 Accessibility to training opportunities

The changes implemented have enabled the development of a varied and compliant training programme for junior doctors to meet their needs as outlined by the Kent Surrey and Sussex Deanery.

Trainees have the opportunity to access a range of outpatient and theatre activities and due to the consolidation of inpatients on the EDGH site, there is senior cover available to provide the supervision required. Feedback is provided and reviewed weekly providing assurance that our training and supervision is robust.

## 4. Monitoring

Key metrics, including patient feedback, will be monitored at quarterly intervals and reported internally through performance reviews. The first report is expected 3 months after reconfiguration of services. There have been no reported adverse outcomes for patients since the changes were implemented.

## 5. Further collaboration with BSUH

Whilst we have recruited to the SAS Grade vacancies, and feedback from trainees is positive, ESHT remains challenged in terms of consultant numbers to deliver the ENT services and there is on-going reliance on temporary staff.

Conversations are due to take place with lead clinicians at BSUH to review pathways, discuss additional support and expedite recruitment of joint consultant appointments working between ESHT and BSUH.

## 6. Conclusion

The measures implemented on 29th April have had a positive impact on the stability of the service and there have been no adverse outcomes for our patients as a result of the changes. Staffing challenges at consultant level will, in the medium term, continue to compromise delivery of a compliant rota. We are currently advertising to recruit to the post required and intend to develop partnership working with BSUH to increase the viability of the service longer term.

The Trust risk register reflects the challenges highlighted within this report and as outlined key metrics will be monitored through internal governance processes.

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

**Date of meeting:** **27 June 2019**

**By:** **Assistant Chief Executive**

**Title:** **Work Programme**

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

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**RECOMMENDATIONS**

**The Committee is recommended to**

1) **agree the work programme;**
2) **Agree the appointment of a replacement member to both the Brighton & Sussex University Hospital NHS Trust (BSUH) and Sussex Partnership NHS Foundation Trust (SPFT) working groups;**
3) **agree to appoint a replacement member of the Sussex and East Surrey Joint HOSC; and**
4) **agree to appoint a replacement member to the HOSC Urgent Treatment Centres (UTCs) Review Board.**

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## 1 Background

1.1 The work programme contains the proposed agenda items for future HOSC meetings and is included on the agenda for each committee meeting.

1.2 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. It was set up originally to scrutinise BSUH's response to the findings of recent CQC inspections and the Trust's wider performance and quality improvement plans, however, the Trust is now rated good by the CQC and Members agreed to change the focus of the working group to horizon-scanning, and identifying new initiatives and issues. Meets approximately twice per year. Membership: Cllrs Belsey and Howell. The last meeting was on 2 April and minutes are attached as appendix 2. The next meeting is planned for later in the year.

Sussex Partnership NHS Foundation Trust (SPFT)

- A joint Sussex HOSCs sub-group set up originally to scrutinise SPFT's response to the findings of CQC inspections and the Trust's wider quality improvement plan. The Trust is now rated as good by the CQC so the Members have agreed to reduce the frequency of meetings and change the focus of the working group to horizon-scanning, and identifying new initiatives and issues. Meets at least annually. Membership: Cllrs Belsey and Osborne. The last meeting was on 11 September and the next meeting is planned for 27 September.

2.3. Both working groups currently have a vacancy, so the Committee is recommended to appoint a Member to each.

**Joint Sussex and Surrey HOSC**

2.4. 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.

2.5. 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, and Osborne, and Geraldine Des Moulins but other members may be co-opted to sub-committees considering specific substantial variations.

2.6. There is a high likelihood that Surrey CCG will leave the STP and, if so, there will be a need to amend the membership of the JHOSC in the terms of reference to reflect Surrey HOSC leaving the process.

2.7. There are no agreed meeting dates of the JHOSC but it is expected to meet in the autumn.

2.8. There is currently a vacancy on the JHOSC, so the Committee is recommended to appoint a new member.

**Urgent Treatment Centres Review Board**

2.9. 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.

2.10. 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.

2.11. The CCGs are developing their outline business case and public consultation plans and the HOSC Review Board is expected to meet in the coming weeks to consider both of them.

2.12. Membership: Cllrs Belsey (Chair), Turner, Barnes and Jennifer Twist. There is currently a vacancy on the review board so the Committee is recommended to appoint a new member.

## 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.

3.3 There are also a number of vacancies that need to be filled and the Committee is recommended to make appointments to these bodies.

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**Assistant Chief Executive**

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# Health Overview and Scrutiny Committee – Work Programme

| Current Scrutiny Reviews | | |
|---|---|---|
| **Title of Review** | **Detail** | **Proposed Completion Date** |
| 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.<br><br>The JHOSC comprises three voting members and one non-voting member from each of the four local authority areas.<br><br>The JHOSC is expected to be established by each of the local authorities ahead of consideration of any SViS. The East Sussex HOSC approved its establishment in November 2018.<br><br>Membership: Cllrs Belsey and Osbourne; and Geraldine Des Moulins (and vacancy) | Ongoing |

| | | |
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| 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.<br><br>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.<br><br>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.<br><br>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.<br><br>Membership: Cllrs Belsey (Chair), Turner, Barnes and Jennifer Twist (and vacancy). | TBC 2019 |
| **Initial Scoping Reviews** | | |
| **Subject area for initial scoping** | **Detail** | **Proposed Dates** |
| 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.<br><br>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.<br><br>Membership: Cllrs Belsey and Howell (and vacancy) | Last meeting: 31 October 2018<br><br>Next meeting: TBC 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.<br><br>Membership: Cllrs Belsey and Osborne (and vacancy) | Last meeting: 11 September 2018<br><br>Next meeting: 27 September 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.<br><br>Membership: HOSC Chair (Cllr Belsey) and officer | Last meeting: 21 November 2018<br><br>Next meeting: 10 July 2019 |

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| 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<br><br>Membership: HOSC Chair (Cllr Belsey) and officer | Last meeting: 4 December 2018<br><br>Next meeting: 10 July 2019 |
| **Reports for Information** | | |
| **Subject Area** | **Detail** | **Proposed Date** |
| NHS 111 | An update on the progress of the procurement of NHS 111 services was circulated in March 2019. The Committee will receive an update at the September Committee meeting | Update circulated in 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.<br><br>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. | Mid 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. | Mid 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 | May 2019 |

| Training and Development | | |
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| **Title of Training/Briefing** | **Detail** | **Proposed Date** |
| New Member induction | One to one induction sessions to be arranged with new Members of the Committee. | May/June 2019 |
| 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 |
|---|---|---|
| **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. | Representatives of East Sussex CCGs |
| Urgent Treatment Centre (UTC) proposals in Lewes | An update on the development of the UTC at the Lewes Victoria Hospital | Representatives of East Sussex CCGs |
| 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) |
| 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. This report will set out performance across East Sussex and what is being done to improve it. | Representatives of East Sussex CCGs |
| NHS Long Term Plan | To consider the local NHS long term strategy, required as part of the NHS Long Term Plan. | Representative of East Sussex CCGs |

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| Child and Adolescent Mental Health Services (CAMHS) | To consider a report on the outcomes of a system-wide review of CAMHS provision.<br><br>*Note: Timing is provisional depending on outcome of review* | Representative of East Sussex CCGs |
| 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.<br><br>To include:<br><br>Agreement of revised Joint HOSC terms of reference subject to Surrey County Council leaving the Sussex and East Surrey Sustainability and Transformation Partnership (STP) | Democratic Services Officer |
| **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. | Representatives of EHS/HR CCGs |
| 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.<br><br>*Note: Timing is provisional depending on the NHS decision making process.* | Representative of Sussex Partnership NHS Foundation Trust (SPFT) |
| 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 |
| **TBC** | | |
| Implementation of Kent and Medway Stroke review | To consider the implementation of the Hyper Acute Stroke Units (HASUs) in Kent and Medway and progress of rehabilitation services in the High Weald area. | Representatives of HWLH CCG |

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| South East Coast Ambulance NHS Foundation Trust (SECAmb) transformation plans | To consider an update on the implementation of SECAmb's plans to develop a new model of care, including the use of non-emergency transport and enhanced hear and treat services.<br><br>To also include plans to improve hospital handover times. | Representatives of SECAmb |

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# Joint Sussex HOSC Working Group: BSUH

**Date: 02 April 2019**
**Time: 9.30am to 1.30pm**
**Room 181 Hove Town Hall**

**Attending**

| Name | From |
|---|---|
| Pete Landstrom | Chief Delivery & Strategy Officer, BSUH |
| Nicola Ranger | Chief Nurse, BSUH |
| Cllr Ken Norman | Chair, B&H HOSC |
| Cllr Colin Belsey | Chairman, ESCC HOSC |
| Cllr Johanna Howell | Member, ESCC HOSC |
| Dr James Walsh | Vice-Chairman, WS HASC |
| Mr Bryan Turner | Chairman, WS HASC |
| Mrs Anne Jones | Member, WS HASC |

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| **1** | **Notes of the last meeting 31.10.18** |
| | • The notes were agreed.<br>• It was also agreed that the planned visit to the Royal Sussex, which had been cancelled at the request of HOSC and HASC members, be rescheduled. |
| **2** | **Update on CQC** |
| | • PL told members that the 2019 CQC inspection report showed significant progress. For example, there had been 64 'must do' recommendations in the 2016 report, but only two in the 2019 report. However, whilst there have been very concrete improvements in many areas, there is much still to do.<br><br>• NR noted that the Trust is doing much better in terms of its use of resources, but BSUH still remains in deficit and still struggles to meet national performance targets.<br><br>• NR also noted that the CQC inspectors had pushed really hard on the storage of hazardous liquids (following the serious incident that led to the death of a patient), but had found no breaches in policy. This is testament to how engaged staff are. This is also reflected in numbers of staff filling in the staff survey: BSUH is the most improved acute trust in England in terms of staff engagement and morale.<br><br>• The CQC's findings are largely reflected in patient feedback also.<br><br>At **RSCH:**<br>• A&E is rated good, although there are still issues with waiting times<br>• The Royal Alex and End of Life Care were not inspected<br>• The CQC noted that the leadership team in Outpatients (OP) needed strengthening. The Trust has addressed this via recruitment and also by making OP a directorate; formerly individual disciplines managed their own OP services.<br><br>At **PRH:**<br>• The CQC had worries in terms of Out of Hours (OOH) assessment of patients and evening staffing levels. The BSUH executive team challenged these findings, arguing that too little account had been taken of joint working arrangements |

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| | between RSCH and PRH which mean that the most urgent/complex emergency cases are directed to RSCH. However the Trust is looking at how staff are deployed across the whole day – e.g. potentially amending shift start and finish times to ensure that everyone is working when they are most needed. PL also noted that the CQC had focused on input (staffing levels) here rather than output (outcomes); there is nothing in terms of clinical outcomes to suggest that OOH staffing at PRH is a concern..<br><br>• PL told members that social care support post-discharge remains a major issue; despite all partners working positively together, significant delays still occur. NR added that this is a national as well as a local issue. It is crucial that services are aware of people's home circumstances at an early stage of their admission, but this does not always happen as it should.<br><br>• The working group members commended the Trust on the progress made and passed on their congratulations to all BSUH staff. |
| **3** | **Update on Quality** |
| | • NR told members that the Trust has performed well re: infection control: outbreaks of Noro have been contained and there had been no patient to patient transmission of flu.<br><br>• There have been significant issues in maternity where the new system for independently reviewing serious incidents, following the Morecambe and Shrewsbury enquiries, has led to unacceptably long delays in getting reports back.<br><br>• There was a spike in falls earlier in the year, but figures have subsequently improved. The BSUH figures for falls are in fact very low. However, this is in part due to the Nightingale ward layout still in use in the Barry Building, which is good for observation of patients, but poor in many other respects. There will be a challenge for the Trust in maintaining low levels of falls in a post 3Ts environment where the majority of patients will be in single rooms.<br><br>• Falls primarily occur when patients make toilet visits, and there may be scope to better identify and support the most vulnerable patients at an early stage and to signpost them to falls support.<br><br>• There has been a much improved response rate for family & friends forms. The Trust is now focusing on improving those wards with the fewest patient/family recommendations.<br><br>• Problems remain with mixing sexes on wards, but the use of mixed accommodation is now consistently being reduced in situations other than where acuity is the major driver. |
| **4** | **Update on Performance** |
| | PL noted that hospital admissions have only increased by 1% from this time last year. However, there has been a significant spike in (RSCH) Urgent Care Centre attendance from Brighton & Hove residents. The walk-in centre near Brighton Station has also seen increased attendances. These figures are likely to relate to problems in accessing primary care – e.g. people struggling to get timely GP appointments, or large numbers of |

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| | patients who are not registered with a GP. The local GP OOH service has been enhanced, but this does not help address general GP capacity problems.<br><br>The Trust has generally maintained its 4 hour performance, albeit this is still below the national target. BSUH also measures and does relatively well in the time it takes patients requiring treatment by a senior consultant to receive it. This is a more accurate measure at how well a hospital is actually doing in providing timely treatment to the most acutely ill patients.<br><br>RSCH is operating at almost 100% bed occupancy, which is undesirable. The Level 11 Trauma ward opened in February 2019 and has functioned well. There have been no recent 12 hour breaches and improvement against the 4 hour target is improving. The Trust has found that it doesn't need to use its escalation areas (within elective care) so frequently, meaning that it has less need to cancel elective operations to accommodate emergency patient overflow.<br><br>Performance against the 2 week cancer target is much improved as is performance against treatment standards. This is not reflected in recent performance figures as services are still catching up on previous breaches, but performance figures will improve over time. Challenges remain in colorectal cancer and endoscopy, although there has been significant recent investment in modernising endoscopy. Demand for endoscopy services has exceeded capacity and this is being addressed through weekend working and additional capacity agreed with commissioners. A harm review of all patients who have breached the 104 day wait target has to date found no material harm, but this does not mean that delays in this target are acceptable.<br><br>Some of the Trust's issues with RTT (18 week referral to treatment target for electives) are related to software that supports OP booking. BSUH is working with NHS Digital to deliver improvements here and is making progress. The Trust has also successfully negotiated some additional capacity with commissioners which should help with RTT performance. |
| **5** | **Financial update** |
| | The Trust is on target to deliver a £60M deficit in 19/20. This is clearly not ideal, but the direction of travel has now been reversed (it would have been £100M+ if the previous trajectory had been continued) and the Trust has a good understanding of why the deficit developed. If BSUH meets its -£60M control total, this will trigger additional capital funding.<br><br>The Trust successfully made £30M of savings in 18/19 and plans to make a further £27M in 19/20. Being out of financial Special Measures means that BSUH can draw on NHS sustainability funding and also that it can borrow at favourable rates, both of which should help on the journey to sustainability.<br><br>The current big spending pressures are for medical staffing, loan repayments (the Trust is in discussion with the Department of Health about restructuring some loans), and sub-optimal staffing efficiency caused by the current layout of RSCH (the latter also impacts on productivity).<br><br>When 3Ts is completed, this should help with productivity and costs. However, maintenance costs on the 3Ts buildings will be £20M+ p.a. and the Trust will need to talk with Government as how this will be funded in the long term. |

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| **6** | **AOB** |
| | There was none |
| **7** | **Date and focus of next meeting** |
| | • It was agreed that meetings should henceforth be six monthly and that the agenda should focus on horizon-scanning, new initiatives etc. rather than just quality and performance.<br><br>• The next meeting will be arranged for Sep 2019. |