HEALTH OVERVIEW AND SCRUTINY COMMITTEE

THURSDAY, 26 SEPTEMBER 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 Christine Brett, 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 27 June** *(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. **Urgent Care in East Sussex** *(To Follow)*

6. **Cancer Performance in East Sussex** *(Pages 17 - 32)*

7. **HOSC future work programme** *(Pages 33 - 40)*

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

PHILIP BAKER
Assistant Chief Executive
County Hall, St Anne's Crescent
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18 September 2019

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

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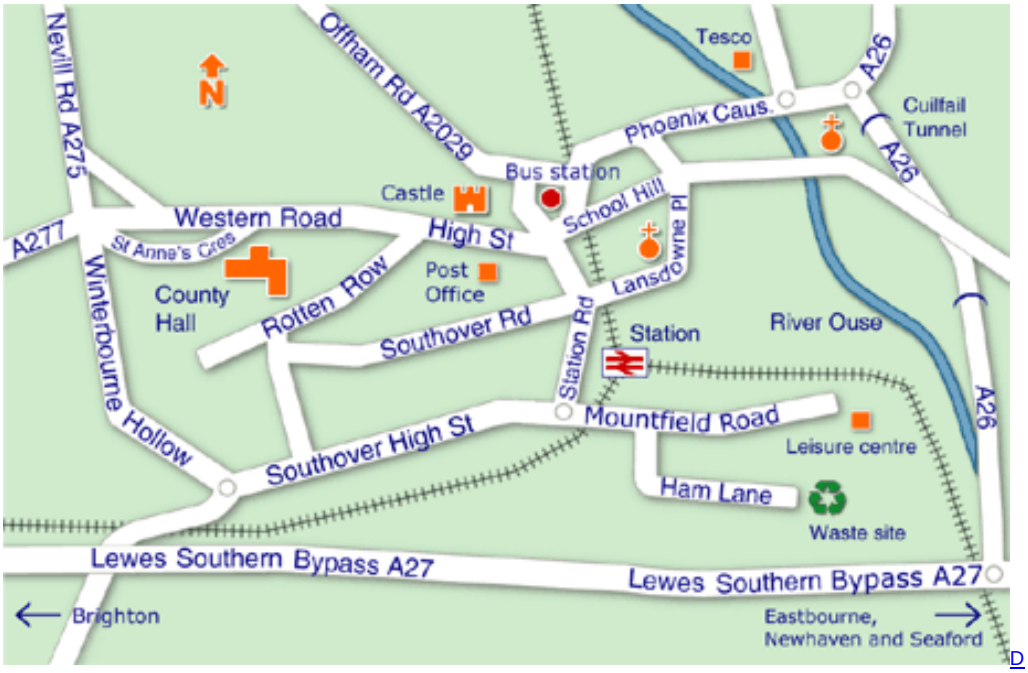

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HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Lewes on 27 June 2019

PRESENT:

Councillor Colin Belsey (Chair), Councillors Phil Boorman, Angharad Davies, Ruth O'Keeffe, Sarah Osborne, Peter Pragnell and Alan Shuttleworth (all East Sussex County Council); Councillor Johnny Denis (Lewes District Council), Councillor Amanda Morris (Eastbourne Borough Council), Councillor Mike Turner (Hastings Borough Council), Councillor Bob Bowdler (Wealden District Council) and Jennifer Twist (SpeakUp)

WITNESSES:

Adam Doyle, Chief Executive Officer, Sussex and East Surrey Clinical Commissioning Groups (CCGs)

Jessica Britton, Managing Director, Eastbourne, Hailsham and Seaford CCG / Hastings and Rother CCG

Ashley Scarff, Director of Commissioning and Deputy Chief Officer, High Weald Lewes Havens CCG

Colin Simmons, 111 Programme Director (Sussex), NHS Coastal West Sussex CCG

Aileen Phillip, Workforce Project Manager, Integrated Urgent Care (IUC) Transformation Programme, South East Coast Ambulance NHS Foundation Trust (SECAmb)

Dr Adrian Bull, Chief Executive, East Sussex Healthcare NHS Trust

LEAD OFFICER:

Harvey Winder, Democratic Services Officer

1. MINUTES OF THE MEETING HELD ON 28 MARCH 2019

1.1 The Committee RESOLVED to agree the minutes of the meeting on 28 March 2019.

2. APOLOGIES FOR ABSENCE

2.1 Apologies for absence were received from:

- Cllr Mary Barnes
- Cllr Johanna Howell (Substituted by Cllr Bob Bowdler)
- Geraldine Des Moulins

3. DISCLOSURES OF INTERESTS

3.1 There were no disclosures of interest.

4. URGENT ITEMS

4.1 There were no urgent items.

5. CLINICAL COMMISSIONING GROUPS (CCGS) FINANCIAL AND GOVERNANCE PLANS

5.1. The Committee considered a report and presentation on the financial plans of the three East Sussex Clinical Commissioning Groups (CCGs) for 19/20 and the proposal to merge into a single East Sussex CCG from April 2020. The Committee then asked the witnesses present a number of questions.

5.2. The Committee asked what Brighton & Hove CCG (BHCCG) was doing differently compared to the other CCGs in Sussex and East Surrey in order to achieve a 'green' rating on both the finance and leadership ratings given by NHS England (NHSE) to CCGs.

5.3. Adam Doyle, Chief Executive Officer, Sussex and East Surrey CCGs, explained that three years ago BHCCG was rated red by NHSE and was in financial difficulties. It was the first CCG he was appointed to as Accountable Officer in Sussex, and required a full change of governance, a refresh of its leadership team, and the development of a plan to deliver financial balance. Since then, the CCG has had a track record of achieving and sustaining its financial and leadership goals.

5.4. Mr Doyle added that all other CCGs in the Sussex and East Surrey Sustainability and Transformation Partnership (STP) had subsequently fallen into financial difficulties. Since taking over as the chief officer at each CCG in turn, he has enacted the operational principles applied to BHCCG and is confident that they are all improving and are closer to achieving financial targets than they were last year.

5.5. The Committee asked how local representation will be maintained on the proposed East Sussex CCG Governing Body.

5.6. Adam Doyle explained that the three CCG Governing Bodies are being asked for indicative approval of the merger during June and July. Discussions with local representatives will then take place over the summer about the constitution of a new East Sussex CCG, including how local representation will feature in the membership of its Governing Body. The current working view, which will be subject to this engagement process, is that GP members of the Governing Body will represent populations of about 100,000 residents. He added that, in order to safeguard localism within the larger organisation, each GP Governing Body member will need to have an infrastructure around them to ensure they can be made aware of and represent local views at governing body meetings.

5.7. The Committee questioned whether the additional infrastructure needed to support governing body members representing larger areas would not cancel out any potential savings from merging the three CCGs; and whether there was scope for voluntary organisations to provide this information.

5.8. Adam Doyle explained that running the eight statutory CCG Governing Bodies (across the whole STP) has a cost to it. He said he believed that the right operating model can be developed that will both meet the required 20% back office saving and provide the appropriate level of support the people on the new CCG governing bodies would need.

5.9. He said that this will be aided by the new Primary Care Networks (PCNs), which are required under the NHS Long Term Plan. PCNs will be in a position to gather information from their patients at a local level and feed it back it to the East Sussex CCG, and discussions are due to take place with the new Clinical Directors of the PCNs to discuss how this might be achieved. This was in addition to the existing Patient Participation Groups (PPGs), many of which are quite active and will need to be utilised by the proposed East Sussex CCG.

5.10. The Committee asked how the cost of any redundancies from the CCGs – required as a result of the 20% savings mandated by NHSE – would be covered.

5.11. Adam Doyle said that savings were predominantly coming from senior level management. The remainder would come from the infrastructure savings achieved from consolidating the governing bodies, and a process of considering which vacancies to recruit to was also in effect. He considered this to be the right approach to take to safeguard hard-working staff and enable them to continue to do their work.

5.12. He said he was not yet at the stage to declare to staff that there would be no redundancies, but this would become clearer after all eight CCG governing bodies had made a decision on their consolidation. Mr Doyle added that staff would be engaged over the summer about the proposed CCG model.

5.13. The Committee asked what the effect would be on health services from the 20% reduction in back office funding, and how confident the CCGs were that the reorganisation could be delivered.

5.14. Adam Doyle clarified that he had two budgets – one used to fund individual providers to deliver healthcare services, and a separate budget to run the CCGs. The 20% savings would come from the second budget and not from healthcare services. He was confident that the reorganisation of the CCGs could be delivered by April 2020.

5.15. The Committee asked what number of employees the 20% back office savings represented.

5.16. Adam Doyle said that it was difficult to calculate how many employees 20% would comprise as everyone was paid different amounts. It was more easily represented as a saving of just under £5m from a £40m budget across the eight CCGs. He reiterated that this figure could be reached with the smallest number of affected people by focussing on the senior management, who are more highly paid. Mr Doyle acknowledged that this decision was being taken with the requirement in mind of needing to discharge statutory functions effectively; he pointed to the improvements in the NHS England ratings as evidence that this approach was working but said it would remain under regular review.

5.17. The Committee asked how the CCG Governing Body will take into account the small areas of deprivation that exist across the county.

5.18. Adam Doyle said he believed that the best way to manage health inequalities was to manage them in the communities where those inequalities existed. The model of integrated care being developed – which he clarified did not yet exist as a finalised plan – should improve services to people in deprived areas, as it involved partner NHS and local authorities developing

preventative services and community-based care. He added that the organisational changes to the CCGs would help to enable the development of this integrated model of care.

5.19. The Committee asked how patients in the north of the county who tend to use Maidstone and Tunbridge Wells NHS Trust (MTW) services would be affected by changing services in East Sussex.

5.20. Adam Doyle explained that it is clear the health and social care integration plans in East Sussex do not include plans to change services based in Pembury Hospital in Kent that are used by patients in East Sussex. The CCG governing bodies have requested to receive assurance that patients within Sussex who use services in Kent, Surrey and Hampshire (which are areas that border the Sussex STP) will receive the same level of service as patients using services within the Sussex border. Early discussions are happening with Kent CCGs about ensuring this is the case.

5.21. The Committee asked how voluntary groups would be able to participate in the development of the CCG merger plans.

5.22. Adam Doyle explained that he was meeting with his leadership team to finalise the engagement plans for the wider stakeholder group, which would include the voluntary sector.

5.23. The Committee asked when the CCGs would be able to achieve financial balance without the need for Commissioner Sustainability Funding (CSF).

5.24. Adam Doyle said that all eights CCGs are improving their current financial position and he believed that the significant improvement of 2018/19 will be maintained again this year. He explained that the NHS financial position is in a state of flux and that the current financial framework for commissioners – where if a CCG meets an agreed financial target additional, non-recurrent CSF money is awarded to enable it to break even – is expected to be very different for 20/21. If this non-recurrent money is provided recurrently from 20/21 as part of the CCGs' allocated funds, he argued, it would be possible to demonstrate that the CCGs are achieving recurrent financial balance. He said that the financial framework details for 20/21 are expected to be announced in the Autumn.

5.25. The Committee asked whether continued local authority savings would affect the ability to develop out of hospital care, and whether once the CCGs have achieved a sustainable financial position they will have the resources to help subsidise the Adult Social Care Department (ASC) of ESCC.

5.26. Jessica Britton, Managing Director, Eastbourne, Hailsham and Seaford CCG (EHS CCG) & Hastings and Rother CCG (HR CCG) explained that there is a strong partnership in East Sussex across the CCGs, NHS providers and East Sussex County Council (ESCC), which put them in a better place to plan together. The response to the NHS Long Term Plan required from each area will provide a mechanism to understand the organisations' budgets and how best to use them together for best effect.

5.27. Adam Doyle said that it is quite clear based on its legal framework what services the NHS is responsible for delivering. He argued, therefore, that it would not be appropriate for the NHS to prop-up the ASC budget, which he considered a separate budget and one that has been denuded over quite some time. The solution, therefore, was at a national level and the NHS

should lobby alongside local government for additional funding for adult social care. He added that the NHS does, however, have a duty to deliver population healthcare, so there should be the ability to integrate well with the local authority to commission services that keep people healthy over the long term.

5.28. Adrian Bull added that East Sussex Healthcare NHS Trust (ESHT) now has strong operational integration with ESCC that will continue to be developed, for example, there are now mixed teams of social workers and district nurses managed by a single manager. In addition, the Better Care Fund (BCF), which is jointly managed by the CCGs and ESCC, dedicates quite considerable NHS resources into a common fund for use by ESCC and the CCGs. He added that ESHT is aware of ESCC's financial challenges and how they impact on joint care, such as through the closure of the intermediate care beds at Firwood House.

5.29. Ashley Scarff, Director of Commissioning Operations, High Weald Lewes Havens CCG (HWLH CCG), explained that CCGs recognise the importance of working in partnership with ESCC to avoid people arriving in A&E unnecessarily. This includes developing support packages of care for people living in care homes to reduce the likelihood of them needing hospital care in an unplanned way, and the continued development of preventative care. Adrian Bull pointed out that these initiatives have successfully reduced A&E attendances from care homes, particularly in HWLH area, whilst attendances from all other sources were increasing.

5.30. The Committee queried whether any of the pipeline Quality, Improvement, Productivity and Performance (QIPP) schemes have yet been identified and whether they would be implemented by the end of the financial year.

5.31. Jessica Britton clarified that the named QIPP plans were those that were in place and being actively delivered. Pipelines schemes, on the other hand, were either a QIPP scheme very close to moving into being delivered; or an emerging plan that does not yet have a finalised assessment of quality and financial impact attached to it and is therefore not yet agreed to move towards delivery. Adam Doyle added there will always be a pipeline of plans being generated that may then be delivered in future years to ensure the CCG remains on a stable financial footing.

5.32. HOSC asked whether QIPP savings in the area of prescribing can continue to be delivered year on year despite significant savings being made there in 18/19.

5.33. Jessica Britton said this is one of the areas where the CCGs are confident they can continue to deliver savings. Commissioning pharmacists continue to visit care homes, GP practices and work with hospital teams to ensure support and training is in place to undertake good medicine reviews and instil best practice in prescribing, resulting in better outcomes for patients and more cost-effective use of drugs. Given that national benchmarks for prescribing costs per number of population show East Sussex as doing well but able to do better, there is still room for improvement.

5.34. The Committee asked what impact assessments have been done on the prescribing costs increasing due to Brexit.

5.35. Adrian Bull said that there is a national NHS programme of preparation for Brexit. EHST has been fully involved locally through the appointment of one of its executive directors to a regional committee looking at risks to the supply of medicine. One of the key central messages

of the committee is that individual NHS organisations should not stockpile medicines, as this creates a crisis of its own making rather than addressing the issues at hand.

5.36. **The Committee asked whether reducing unwarranted reduction in hip and knee surgery would result in rationing surgery that individuals might need**.

5.37. Ashley Scarff explained that this QIPP saving plan involves adapting the Musculoskeletal (MSK) pathway to enable a relatively small number of people to consider informed options around alternatives to surgery, such as pain management, and rheumatology and physiotherapy support. This is based on data on patients' experience of hip and knee surgery that showed that with the benefit of hindsight a number of patients who had received surgery would have preferred to have done something different.

5.38. Adrian Bull added that the aim was not to prevent people who need surgery from having it, but to provide conservative management to those who will respond well to it and who would otherwise had surgery and put themselves at risk or face a disappointing outcome. He confirmed that the MSK pathway is still designed to ensure that where a patient meets the criteria for a surgical intervention it is offered to them, and the pathway changes will be subject to audit. Dr Bull said that some delays do occur for elective MSK surgery and that this needed to be improved.

5.39. The Committee RESOLVED to request:

1) A future report in November including governance arrangements for the new CCG; the role of PCNs; and financial plans for 20/21, including how central funding is expected to be allocated from 20/21; and

2) That the engagement plans for the CCG merger are circulated by email for information.

6. URGENT CARE - OUT OF HOURS HOME VISITING SERVICE PROCUREMENT

6.1. The Committee considered a report on the procurement of a Sussex-wide Out of Hours (OOH) Home Visiting Service. The Committee then asked the witnesses present a number of questions.

6.2. The Committee asked why the OOH Home Visiting Service was being procured separately to the new NHS 111 service.

6.3. Colin Simmons, Integrated Urgent Care Programme Director, Coastal West Sussex CCG, explained that the procurement that was paused last Summer had been for a Sussex-wide NHS 111 service. He said he could not go into all the reasons why it was stopped, due to procurement confidentiality, but it did include an OOH Home Visiting Service. The reason for the changes included:

- the proposed NHS 111 service now includes Kent, where there is a different home visiting arrangement in place; and

- separating out the service and commissioning a shorter contract for the Home Visiting Service allows testing of what model of home visiting works best with the new NHS 111 service.

6.4. The Committee asked whether there was a risk that recruitment to the service would interfere with attempts to recruit to other emerging urgent care services.

6.5. Colin Simmons agreed workforce recruitment and retention was an issue but was also an issue across the whole of the NHS. To tackle this issue, the OOH home visiting service will have a mix of clinical skill sets – whereas the current service is predominantly GP-based – enabling patients to see paramedics, or advanced nurse practitioners in certain circumstances. Plans are also being developed to use the workforce in the most flexible, constructive way, for example, establishing whether clinicians in the NHS 111 Clinical Assessment Service (CAS) could work for a different provider, i.e., the provider of the Home Visiting Service, to enable the clinician to vary their workload in a way that suits them.

6.6. The Committee asked how the CCGs can ensure that providers deliver on any promises to provide the workforce set out in the service specification.

6.7. Colin Simmons explained that part of the role of all commissioning organisations is to hold providers to account to deliver on their promises, but CCGs can also encourage providers to work together to help ease workforce issues.

6.8. The Committee asked how the service might overcome the issue of a shortage of GPs

6.9. Colin Simmons explained that the shortage of GPs would be overcome in part by developing a multidisciplinary team including paramedics, advanced nurse practitioners and GPs. Whilst GPs will still be required for certain clinical interventions, these other staff could help support the GPs' workload. It will also be necessary to develop ways of making the service seem more attractive to prospective GP, given the traditional issues with OOH services appearing unattractive employment opportunities.

6.10. The Committee asked about how oversight of this potentially complex urgent care system could be ensured.

6.11. Colin Simmons explained that the CCGs' role in ensuring different providers work together across the urgent care system will involve being clear about the expected outcomes of the new integrated urgent care system, as well as looking at the clinical governance arrangements for handing patients from the care of one provider to another are safe for patients.

6.12. The Committee asked how access to summary care records could be shared between the ICT systems of NHS 111 and the OOH Home Visiting Service

6.13. Colin Simmons explained that call-handlers for NHS 111 can currently access summary care records. In future the 111-CAS clinicians, if they need to look at further details, will be able to view full patient records, although they will require a patient's consent. There are a multitude of different ICT systems in use by the different urgent care providers and the current interim 111 contract for 19/20 involves testing out how these can best be linked together.

6.14. The Committee asked when new innovations are introduced how it can be ensured they work correctly

6.15. Colin Simmons agreed it was important to ensure new technology, such as video calling instead of face-to-face appointments, is used to help improve services for patients, but it also needs to be understood they will not be appropriate for all situations. Patients will also need to be made aware of such technologies and be comfortable using them, and some clinicians will also need to see the benefits demonstrated to them. he believed that there needs to be stakeholder engagement and plans to pilot some of these technologies.

6.16. The Committee asked whether the procurement timeline was short and whether there was confidence there were providers able to take on the service.

6.17. Colin Simmons agreed it was a tight timeline but the mobilisation period of three months was not considerable due to the size of the service. The 111-CAS, on the other hand, had an eight month mobilisation period in recognition of its size. Nine providers showed interest in the OOH Home Visiting Service during an engagement event, suggesting there is interest in the market to provide the service.

6.18. The Committee asked what will happens to patients assessed by the CAS

6.19. Colin Simmons explained that the 111-CAS will consider a patient's need over the phone and, if necessary, assign an appropriate time period in which the OOH Home Visiting Service will need to visit them. This will be either two, four or six hours. 111 will pass the referral on to the OOH Home Visiting Service with the response time indicated and the OOH service's target will be to respond within that time. 111 will then carry out comfort calling every so often during that period to check if the patient is ok and their needs have not changed.

6.20. The Committee RESOLVED to note the report.

7. <u>EAR, NOSE AND THROAT (ENT) SERVICES RECONFIGURATION - UPDATE</u>

7.1. The Committee considered a report providing an update on the progress of the implementation of the reconfiguration of Ear, Nose and Throat Services (ENT) provided by ESHT. The Committee then asked the witnesses present a number of questions.

7.2. The Committee asked for an update on any success with the recruitment of clinicians and whether consultants have sufficient time allocated to training junior doctors.

7.3. Dr Bull explained that the trust currently has an overall 10% vacancy rate compared to a national average of 16%. The turnover was 9.5% compared to an average of 15-16%. He added that there were variations around those numbers and difficulties remain recruiting to specialities, which included ENT. To help improve recruitment in ENT the two joint consultant posts are being advertised in conjunction with Brighton & Sussex University Hospital NHS Trust (BSUH). This will enable consultants to have access to both the tertiary work that goes on in Brighton and the district general work at Eastbourne District General Hospital (EDGH).

7.4. Adrian Bull said there is no doubt that the reputation of the trust is much better. As a result, he was mostly shortlisting two or three applicants for most advertised consultant specialities, except in those few areas where there were shortages, and a new generation of young consultants was beginning to develop at the trust. He added that many consultants were attracted to district general work generally, and East Sussex specifically, and not all wanted to go work in a tertiary centre and its associated academic pressures. Some, though, enjoyed exposure to both, and the relationship with BSUH and Kings College NHS Trust helps to attract those seeking this balance. ESHT also continues to support the medical schools at the University of Brighton and the emerging one in Kent.

7.5. The Committee asked for clarification whether the addition of an adult surgery list at Conquest Hospital didn't run against the proposal to centralise the service at EDGH

7.6. Dr Adrian Bull clarified that the original purpose of the reconfiguration was to centralise adult ENT surgery at EDGH, not the entire ENT service. The final configuration has adult inpatient surgery centralised at EDGH but with a monthly day list retained at Conquest Hospital. This was at the request of ENT surgeons who wanted to ensure that the theatre teams had the opportunity to practice the skill set required for ENT surgery so that in the event of an emergency procedure there was sufficient knowledge and resources in place. Dr Bull said it was possible to accommodate this additional day list and still address the issues of ENT medical staffing being over stretched over two sites because the previous planned surgery lists at Conquest included patients who needed an overnight stay at the Conquest, meaning that ENT doctors then had to travel from the EDGH inpatient ward to see them the next day.

7.7. Adrian Bull added that the paediatric list at the Conquest, on the other hand, was for children who needed to stay overnight following more complex surgery, such as for sleep apnoea, at the paediatric ward at that hospital site.

7.8. The Committee asked for confirmation whether the ENT staff were on board with the proposals

7.9. Adrian Bull confirmed that ENT staff supported the proposals. He said that early on some nursing staff had thought there were going to be no services available, but this was resolved quickly once they understood what the proposals were going to mean for them. The consultants are also all now supportive following their concerns about emergency care. he added that they are of the view that all ENT paediatric patients should, in the long term, be seen in a tertiary centre. This is not currently a national requirement, however, and they are satisfied that the current configuration is sufficiently safe.

7.10. The Committee RESOLVED to request that the Trust's performance reviews of ENT are circulated by email for information.

8. <u>HOSC FUTURE WORK PROGRAMME</u>

8.1 The Committee considered its work programme and the minutes of a joint HOSC working group meeting with Brighton & Sussex University Hospital NHS Trust (BSUH).

8.2 The Committee RESOLVED to:

1) note the work programme subject to removing the NHS Long Term Plan item and adding it as the subject of an away day to discuss potential future scrutiny subjects;

2) request a briefing providing the details of dentistry services in East Sussex is circulated by email.

The meeting ended at 11.53 am.

Councillor Colin Belsey
Chair

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

Date of meeting: **26 September 2019**

By: **Assistant Chief Executive**

Title: **Cancer Performance in East Sussex**

Purpose: **To update HOSC on developments in improving cancer care in East Sussex.**

RECOMMENDATIONS

1) To consider and comment on the report.

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

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1 Background

1.1. HOSC considered a report in November 2017 on cancer care services in East Sussex after the annual NHS England Improvement and Assessment Framework, rated two of the three Clinical Commissioning Groups (CCGs) in East Sussex as inadequate in relation to the metrics used for measuring cancer care performance, and the other CCG as requiring improvement. Since then, the Committee has considered two update reports via email.

1.2. The NHS Long Term Plan, published in January 2019, included improvement in cancer survival rates as a key priority and earlier diagnosis as one of the key methods of achieving it. In June 2019, a BBC report based on analysis of cancer performance data indicated that 94 of the 131 NHS hospital trusts were missing the target of 85% of patients receiving treatment within 62-days of an urgent GP referral, and that Maidstone and Tunbridge Wells NHS Trust (MTW), which provides cancer care services to residents in the north of East Sussex, at the time had the lowest percentage of timely referrals out of all hospital trusts. The Committee therefore agreed that it was an appropriate time to scrutinise what is being done to improve cancer services in East Sussex.

2. Supporting information

2.1. The CCGs are rated by NHS England via the NHS Improvement and Assessment Framework on a number of metrics on an annual basis, including four related to cancer:

- Cancers diagnosed at an early stage
- People with urgent GP referral having first definitive treatment for cancer within 62 days of referral
- One-year survival from all cancers
- Cancer patient experience.

2.2. The latest ratings from NHS England, published in August 2019, for the cancer metrics are 'requires improvement' for Eastbourne, Hailsham and Seaford (EHS) and High Weald Lewes Havens (HWLH) CCG and 'inadequate' for Hastings and Rother (HR) CCG.

2.3. The report attached at **appendix 1** sets out the performance of the three East Sussex CCGs against these four metrics along with actions being taken to improve them. The results show an improvement since last year in one-year survival rates from all cancers and an improved cancer patient experience, with performance in relation to cancers diagnosed at an early stage and treatment within 62 days more variable. Paragraph 2.1-2.9 of appendix 1 sets out the work of the CCGs to improve early diagnosis, which is one of the key aims of the NHS Long Term Plan.

2.4. Whilst NHS England publishes cancer performance based on CCG area, cancer services are provided by NHS hospital trusts and achievement of this target is the joint responsibility of

CCGs and trusts. The 62 day target is one of a number of targets published in the NHS Constitution around waiting times for cancer care that trusts are required to meet. NHS acute trusts' performance is measured against these targets on a monthly basis; they include:

- two week wait from urgent GP referral to see consultant – target: 93%
- 31 days from diagnosis (date of decision to treat) to first definitive treatment – target: 96%
- 62 days from urgent GP referral to first definitive cancer treatment – target: 85%
- 28 days from suspected cancer referral to diagnosis (shadow monitoring from April 2019 mandated April 2020).

2.5. The local trusts report that they face challenges in complying with these targets, as do most trusts in England. Partly this is due to a shortage of specialist staff, limited diagnostic capacity, and complex pathways, but there has also been an increase in the number of referrals to consultants as a consequence of the implementation of National Institute for Health and Care Excellence (NICE) guidance. This guidance recommends lowering the threshold for referrals to see a consultant for suspected cancer in order to improve early diagnosis rates, and has resulted in a growth in demand between 2017/18 and 2018/19 of between 5.88-17.47% across the three trusts. Further details are included in paragraphs 3.1-3.5 of appendix 1.

East Sussex Healthcare NHS Trust (ESHT)

2.6. The main provider of cancer care diagnosis and treatment for the Eastbourne and Hastings area is East Sussex Healthcare NHS Trust (ESHT).

2.7. ESHT is now predominantly meeting the NHS constitutional cancer waiting times targets with the exception of the 62 days from urgent referral to treatment. There are plans in place to improve performance. Further details are set out in paragraph 4.1-4.7 of appendix 1.

Brighton & Sussex University Hospitals NHS Trust (BSUH)

2.8. Brighton and Sussex University Hospitals NHS Trust (BSUH) provides cancer care to residents in the west of the county including Lewes and the Havens, as well as specialist cancer care across the .

2.9. Performance by BSUH against the NHS constitutional standards is set out in paragraph 5.1 of Appendix 1. The Trust is meeting the 31 days target, but not the 2 week wait and 62 day referral to treatment targets. Details of the BSUH improvement plan are set out in paragraph 5.3 to 5.6 of Appendix 1.

Maidstone and Tunbridge Wells NHS Trust (MTW)

2.10. MTW provides services to residents in the north of the HWLH area of the county including the High Weald and towns such as Crowborough.

2.11. Performance by MTW against the NHS constitutional standards is set out in paragraph 6.1 of Appendix 1. The Trust is also meeting the 31 days target, but not the 2 week wait and 62 day referral to treatment targets. Details of its improvement plan are set out in paragraph 6.2 of Appendix 1.

3. Conclusion and reasons for recommendations

3.1 This report provides HOSC with an update on the performance of NHS commissioner and provider organisations in relation to cancer care targets. HOSC is recommended to consider and comment on the report and to determine what further scrutiny is required.

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Assistant Chief Executive

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East Sussex CCGs: Cancer Performance

A progress update for the East Sussex Health and Overview Scrutiny Committee (HOSC)

September 2019

Contents **Page**

1. Background and Introduction

1.1 Further to previous papers produced for HOSC in November 2017, September 2018 and March 2019, this is to provide an update on cancer performance.

1.2 Based on data published over the course of the last two years, a Clinical Commissioning Group Improvement and Assessment Framework (IAF) has been published and this provides an initial baseline rating for six clinical priority areas; one of which is cancer.

1.3 The ratings are broken down by local Clinical Commissioning Groups (CCGs) and published on myNHS showing areas in need of improvement, and also highlighting areas of best practice.

1.4 The headline ratings by CCG of the cancer (Better Care) aspects of the IAF published July 2019 showed that local improvement is needed to maximise outcomes for local people. Eastbourne, Hailsham and Seaford CCG (EHS) was rated "requires improvement" (same as previous year). Hastings and Rother CCG (H&R) rating was "inadequate" (same as previous year). High Weald Lewes Havens CCG (HWLH) rating was "requires improvement" (same as the previous year).

1.5 Table 1 below shows latest performance by IAF cancer target (previous year position in brackets for ease of comparison):

Table 1	**2018/2019 CCG & England average performance by IAF cancer target**			
CCG	Cancers diagnosed at an early stage (62% by 2020)	Suspected cancer urgent referral to having first definitive treatment with 62 days (85%)	One year survival from all cancer (75% by 2020)	Cancer Patient Experience – average score given by patients asked to rate their care on a scale of 1-10 (10 being best)
EHS	49.65% (51.8%)	72.8% (77.1%)	71.8% (71%)	8.8 (8.7)
HR	51.64 (49.3%)	77.19% (71.3%)	70.9% (69.6%)	8.9 (8.7)
HWLH	50.25% (52.1%)	68.09% (76.2%)	73.1% (71.7%)	8.9 (8.6)
England average	52.2% (52.6%*)	82.08% (82.3%*)	72.8% (72.3%*)	8.8** (8.74*)

*Data taken from NHS England IAF reports

** Data from NCPES (2017) used as the basis of the 2018/19 IAF cancer target

1.6 The 62 day target continues to be a challenge however there is an overall improvement in one year survival and cancer patient experience.

1.7 The following sections of this paper provide information on current performance and action being taken to ensure sustainable improvement locally.

Table 2 shows the latest 62 day target performance available:

Table 2: 62 day target performance	
July 2019, 62 day performance Note data is available 2 months in arrears	**Target 85%**
EHS CCG	73.68%
H&R CCG	71.64%
HWLH CCG	80%
East Sussex Healthcare NHS Trust (ESHT)	77.1%
Brighton and Sussex University Hospitals NHS Trust (BSUH)	57.9%
Maidstone and Tunbridge Wells NHS Trust (MTW)	72.2%

1.8 Secondary care diagnosis and treatment for the East Sussex CCGs area is mainly provided by ESHT [host commissioner EHS CCG] with some patients being referred to BSUH [host commissioner Brighton and Hove CCG] and Maidstone and MTW [host commissioner West Kent CCG].

2. Cancer diagnosed at an early stage

2.1 When a patient is diagnosed with cancer, the extent of the cancer is determined by staging and is defined as being at stage 1, 2, 3 or 4. Stage 1 being at an early stage and Stage 4 being advanced cancer. This staging is recorded by secondary care providers. Providers are working to improve the quality and completeness of their data to ensure an accurate picture of all patients diagnosed and the stage at which they are diagnosed.

2.2 There is a range of ways to increase awareness and improve early diagnosis of cancer. Nationally, there are the screening programmes for bowel, cervical and breast cancers and these programmes are offered across the CCGs. Additionally, the national Be Clear on Cancer programme aims to improve early diagnosis of cancer by raising public awareness of signs and symptoms of cancer, and to encourage people to see their GP without delay.

2.3 The CCGs have implemented the June 2015 National Institute for Health and Care Excellence (NICE) guidance for Suspected Cancer: Recognition and Referral (NG12). This is part of delivering earlier diagnosis for cancer patients and hence improved survival. This guideline includes recommendations on the symptoms and signs that warrant investigation and referral for suspected cancer. The (previous) 2005 guidance indicated around 5% of patients referred would actually have a cancer diagnosis. The evidence base has developed since then and the 2015 guidance uses a threshold of 3%. Lowering the threshold for referral does mean an increase in referrals into secondary care for some types of cancer. It should help to improve the number of patients diagnosed earlier – at stages 1 or 2 rather than 3 or 4.

2.4 Educational events are held to raise awareness in the signs and symptoms of cancer among GPs. Consultants from different specialties present and engage with primary care teams to

raise awareness and improve communication and engagement between GPs and the multi-disciplinary teams. There are events across all three CCGs during September 2019.

2.5 Further to this, in order to address significant health inequalities, the Healthy Hastings and Rother (HHR) Programme, which aims to address health inequalities by improving the health and wellbeing of people in the most disadvantaged communities and reducing the life-expectancy gap between the most affluent and most deprived communities, continues.

2.6 Cancer is one of the main causes of premature death and a key contributor to inequalities in life expectancy in Hastings and Rother. Cancer incidence and prevalence rates are both significantly higher than England, with colorectal and lung cancers in particular showing worse outcomes. As part of the HHR, a Cancer Quality Improvement Programme has to date completed three projects:

- Cancer Research UK (CRUK) were commissioned during 2018 to provide GP practices with individualised support to improve cancer performance, especially early diagnosis and treatment rates. The results of this work included 20 GP Practices (95%) now having Cancer Action Plans. This completed in 2018. Additionally, as of September 2019, CRUK is providing a facilitator to work with East Sussex CCGs, to continue this work with an initial focus on EHS GP practices.

- A "Community Approaches to Promoting Early Awareness of Cancer" project was delivered by Unique Improvements aimed at promote public awareness of symptoms and the need for early presentation. The approach taken was building on community assets, recruiting, training and supporting teams of local volunteers to take action in their own communities. The project ended in September 2018 and by completion its achievements included: -

  - 769 volunteer hours;
  - 5,846 brief cancer conversations with residents;
  - 1,200 people had a follow up conversation specifically around cancer;
  - The proportion of volunteers who knew 'a great deal' or 'a lot' rose from 33% to 73% at the end of the project and 90% said their increased knowledge would be useful for talking to family and friends in the future and 86% said they would continue to actively talk to people about cancer.

- A CCG Locally Commissioned Service (LCS) provided by GP Practices, led to more than 14,000 people, who have not previously participated in national cancer screening programmes, being engaged by practices and encouraged to participate. An audit has been undertaken at one practice to determine how many people participated in the cervical screening programme following the contact, where there was a 34% increase in uptake.

2.7 In addition to the local roll out of national programmes, learning from the HHR programme will be shared across to East Sussex CCGs in order to understand where to target additional work as appropriate.

2.8 The Surrey and Sussex Cancer Alliance (SSCA) has funding to support improvement in cancer services. A project manager has been funded whose role is predominantly to focus on awareness and early diagnosis including:

- non-specific but concerning symptoms pathways,
- access to diagnostics, a review of capacity and demand with a gap analysis,
- supporting implementation of timed pathways especially lung,
- increasing the uptake of screening programmes.

2.9 SSCA has approved (September 2019) funding for the following proposals in line with the allocation including:

- An initiative to increase uptake of screening following learning from the H&R CCG LCS as previously mentioned. This will focus on EHS CCG based on the outcomes of the work carried out in H&R CCG. This will be developed working with Primary Care Networks.
- ESHT lung rapid diagnosis matron who will input to promote care coordination from the first investigation to diagnosis and beyond at the pre-diagnosis stages of the pathway and support implementation of the national timed pathway.
- ESHT Upper gastrointestinal (UGI) triage nurse who will work within the UGI Nursing team to develop and improve the UGI cancer pathway and enable the organisation to deliver the optimal timed pathway for the service which will result in an earlier detection of cancer for patients.
- ESHT Faster diagnosis trackers to support achieving the new faster diagnosis standard (FDS) 28 day target. This will be based on the Royal Bournemouth FDS pilot site and ESHT experience to date that one of the challenges is the tracking and discharge of patients without a malignant diagnosis by day 28 in the pathway.
- BSUH Divisional Level Patient Navigators to ensure patients are actively navigated along the care pathway.
- BSUH Upper GI and Lower GI Telephone Assessment Pathway nurses to prioritise and facilitate straight to test (STT) endoscopy procedures through 30 minute telephone assessment clinics undertaking full clinical assessment and review to enable more than 80% patients to access STT.

3. Cancer Waiting Times

3.1 The NHS constitutional (maximum) waiting time targets for suspected (and diagnosed) cancer patients include:-

- Two week wait from urgent GP referral to first appointment (2WW).
- Two week wait from general breast symptoms (where cancer is not initially suspected) GP referral to first appointment.

- 31 days from diagnosis (date of decision to treat) to first treatment (start date) (31 day).
- 31 days for subsequent treatments for new cases of primary and recurrent cancer where an anti-cancer drug regimen or surgery is the chosen treatment modality.
- 31 days for all subsequent treatments for new cases of primary and recurrent cancer where radiotherapy is the chosen treatment modality.

- 62 days from urgent GP referral to first treatment (start date) (62 day).
- 62 days from a cancer screening service to first treatment.
- 62 days from a consultant's decision to upgrade the urgency of a patient they suspect to have cancer to first treatment.

- 28 days from suspected cancer referral to diagnosis (shadow monitoring from April 2019 mandated April 2020).

3.2 The Sussex Cancer Board is now in place to support working across the system and providing the SSCA with a single point of coordination for engagement. The 2019/20 work plan includes delivering and sustaining the Cancer Waiting Times Standards as one of its top priorities.

3.3 Challenges to compliance include a number of interconnected reasons such as limited capacity as a result of workforce challenges, limited diagnostic capacity and complex pathways. There are actions to improve this and these are detailed in the Trust specific actions following.

3.4 There has also been an increase in 2WW suspected cancer referrals. There are a number of reasons for this including the implementation of NG12, lowering the threshold for referral, and various initiatives to raise awareness of signs and symptoms of cancer. However, bearing in mind issues such as diagnostic capacity and workforce, it is a challenge for provider Trusts to substantially increase their capacity to meet the growing demand. The increases from 2017/18 to 2018/19 were:

- EHS CCG: 14.2%
- HR CCG: 5.3%
- HWLH: 14.3%

- BSUH: 5.88%
- ESHT: 10.07%
- MTW: 17.47%

2019/20 activity shows the trend of increasing referrals is continuing. There are a number of initiatives to help to address the growing demand including primary care education to ensure appropriate referrals, Trusts are carrying out demand and capacity reviews and workforce planning. Further details are noted in the Trust specific sections below (sections 4, 5 and 6).

3.5 All patients who breach the 62 day standard and wait over 104 days are subject to a Clinical harm review process. All 104 day breaches are returned to the multi disciplinary team meetings for clinical harm discussion once their first treatment has occurred in line with national guidance. The anonymized details are shared with CCGs. To date, no harm due to 104 day breaches has been identified.

4. ESHT Cancer waiting times performance and progress

4.1 ESHT is now predominantly meeting the NHS constitutional cancer waiting times targets with the exception of the 62 days from urgent referral to treatment – see table 3 below

showing ESHT 2WW, 31 day and 62 day targets over the last year. There are plans in place to improve performance.

4.2 ESHT Cancer Waiting times' performance is shown in Table 3 below:

Table 3	**ESHT Cancer Waiting times' performance (%)**												
Target	July 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 18	Feb 18	March 19	April 19	May 19	June 19	July 19
2WW (93%)	96	91	83.7	96.8	96.5	96	93.8	96.3	96.4	96.4	94.9	94.7	94.6
31 day (96%)	95.7	90.7	90.4	91.2	92.7	96.7	98.6	98.4	96.1	96.1	96.7	94	97.4
62 day (85%)	73.4	68	59.7	66.3	69.8	80.7	72.9	80.3	75.5	81.6	77.1	73.1	77.4

4.3 The CCGs issued ESHT with a Contract Performance Notice in June 2018 with regard to the fact that they were not achieving 62 day target. ESHT produced a Cancer Recovery Plan which provides good assurance regarding targeted action to improve. This is regularly reviewed and the CCGs continue to work proactively with ESHT to ensure the actions in the plans continue to secure improvement and ensure sustainability of cancer services delivery. Actions include:

- Reviewing specialty pathways to ensure timing to support faster diagnosis and treatment and adoption of the recently produced national timed pathways for urology; lung and lower and upper gastrointestinal.
- Reviewing the breast cancer pathway to ensure full implementation of one-stop clinics and most appropriate follow up pathways.
- Implementation (February 2019) of new colorectal suspected cancer pathway incorporating FIT (faecal immunochemical test) and straight to test (endoscopy). Patients are being diagnosed and treated much earlier with some patients receiving treatment within 30 days.
- Implementation (June 2019) of a new Urology Investigation Suite enabling a one stop clinic incorporating diagnostics. This should take at least two weeks off the pathway. 62 day performance for urology in July was 85.7% - a 3.6% improvement on May.
- Implementation of straight to test for patients on a lung suspected cancer pathway.
- Continued review of trigger points used on patient tracking lists (PTLs) to ensure the patient pathway is pro-actively managed.
- Order Comms (an electronic requesting system) for radiology, is already rolled out to all GPs in the CCGs, and is progressing for roll out within ESHT during 2019.
- A comprehensive demand and capacity review for each specialty across the whole pathway.

4.4 As noted above, the 62 day target continues to be a challenge and a number of initiatives are in place to support improvement where this may relate to patient choice. For example, initiatives to help patients understand the importance of their appointments, such as the patient leaflet that GPs and ESHT give to patients who are referred on the suspected cancer 2WW pathway, and the recruitment of a nurse whose role is to contact patients who decline an appointment to talk through and help where possible. Examples of where this has helped include:

- talking more about the reason for the referral and what the patient can expect;
- understanding patients' personal issues so enabling arranging suitable appointments;
- liaising with care homes so that appointments are made when staff can be released to accompany patients;
- arranging transport;
- or simply a phone call the day before an appointment as a reminder.

4.5 Some issues such as workforce are more complex to address such as the shortage nationally of histopathologists, oncologists, radiologists and dermatologists. Filling posts locally to ensure improved performance is a challenge.

4.6 Suspected cancer referrals have increased. With the implementation of NICE guidance NG12 lowering the threshold and various initiatives to raise awareness this is as it should be. Treatments have increased too for example, ESHT is now providing an average of 143 (first) treatments per month (December 2018- May 2019) compared to 115 (first) treatments for the same period the previous year. Capacity work continues to meet this growing demand.

4.7 Diagnostic capacity is a challenge. The SSCA is leading work to develop nationally recommended Rapid Diagnostic Service. Demand and capacity modelling is underway across Sussex. Development of the rapid diagnostic service will be phased over the next 5 years starting with a rapid diagnostic service for concerning but not specific symptoms during 2020.

5. BSUH cancer waiting times performance and progress

5.1 BSUH continues to be challenged with respect to the 2 week wait and 62 day NHS constitutional cancer waiting times targets. Delays in diagnostics continues to be a contributory factor to non-compliance of the 62 day performance standard. Demand and capacity modelling is underway to identify how diagnostics can support the current 62 day pathway and future 28 day faster diagnosis standard.

5.2 Table 4 below shows BSUH waiting times' performance:-

Table 4	**BSUH Cancer Waiting times performance (%)**												
Target	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 18	Feb 18	Mar 19	April 19	May 19	Jun 19	Jul 19
2WW (93%)	85.6	84.7	80.8	80.7	85.8	89.9	89.3	90.2	87.8	82.3	77.8	88.8	88.1
31 day (96%)	99.2	98.7	97.5	96.7	96.5	99.5	95	96.2	95.3	92.7	91.9	93.2	96.0
62 day (85%)	70.9	71.4	74.1	71.6	75.2	65.7	63.8	60.2	72.9	63.3	63.2	64.1	57.9

The key issues that have led to the BSUH deterioration in performance include:

- Increase in 2 week wait referrals.
- Reduced diagnostic capacity due to staffing and equipment breakdown/damage.
- Workforce challenges.

5.3 The primary focus for the cancer improvement actions is to improve the management of the overall waiting list by:

- Targeted reduction of the overall patient tracking list (PTL) size.
- Reducing waits for patients to be seen on the 2 week wait pathway.
- Reducing the total number of patients waiting over 62 and 104 days.

5.4 Provider and CCG actions to deliver the improvement include:

- Joint transformation plan and alliance funding bids.
- Individual signed-off tumour site recovery plans.
- CT reporting backlog reduced through some outsourcing
- Reduction in the non obstetric ultrasound (NOUS) waiting list by outsourcing some activity.
- Upper GI consultant surgeon vacancy out to advert.
- Lower GI and UGI are utilising any theatre capacity at short notice.
- Daily and weekly escalation and patient level management has been reviewed and enhanced.
- Ongoing exploration of virtual clinics and stratified pathways.
- Implementation of times pathways for lung and colorectal.
- Faster diagnosis standard included in CCGs/BSUH contract with a focus on colorectal, lung, prostate and UGI.
- CCG/BSUH weekly conference calls to monitor progress and performance.
- Early diagnosis project manager, started July, with focus on rapid diagnostics.
- Faecal calprotectin – adoption of York pathways now agreed. This will increase the threshold for Faecal Calprotectin releasing colonoscopy capacity.

5.5 The positive impacts of the improvement plan are not yet reflected in the percentage performance however the improvement in overall waiting list can be seen below with reductions achieved in the total numbers of patients waiting longer than 62 and 104 days.

5.6 BSUH has a comprehensive recovery plan that should ensure compliance with all constitutional cancer standards by December 2019. BSUH is in the process of reviewing this recovery plan with senior management and clinical oversight to ensure not only recovery but sustainability too.

6. MTW cancer waiting times performance and progress

6.1 Table 5 below shows MTW waiting times' performance:-

Table 5	**MTW Cancer Waiting times' performance (%)**												
Target	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19
2WW (93%)	82.3	76.4	78.1	86.5	90.9	88.1	87.6	89.2	88.7	82.7	87.5	81.0	87.1
31 day (96%)	98.0	96.2	95.1	96.2	96.8	97.2	95.9	96.2	96.1	96.5	96.0	96.8	97.7
62 day (85%)	61.5	76.5	40.0	86.4	72.2	69.2	64.0	86.7	82.4	72.6	70.9	73.1	72.2

6.2 MTW have put in place a comprehensive recovery plan to improve performance. The impact has been a gradual and sustainable improvement in performance. Actions include:

- Breast (one-stop clinic capacity): consultant radiologist or Consultant Radiographer, trainee consultant radiographer, mammographers, nurses and radiology diagnostic assistant (RDA).
- Revised Clinical nurse specialist (CNS) team structure to include advanced practice/leadership roles and succession planning junior roles due to current workforce age profile.
- Increased endoscopy capacity.
- Gynaecology additional resource: physicians' associate or triage nurse.
- Gynaecology, testicular, head and neck, sarcoma additional resource: sonographer, RDA/administrative support, ultrasound machine and couch.
- Haematology physician's associate.
- Head and neck: CNS 2 week wait cancer co-ordinator.
- Lower and Upper GI administrative support workers for straight to test pathways.
- Lower and Upper GI and prostate pathway navigators.
- Lower and Upper GI and lung straight to test triage nurses.
- Lower GI additional clinics (consultant, theatre staffing and administration).
- Lung respiratory physiologist, lung function machine and increased support for Assistant General Manager.
- Management support team leaders and cancer performance general manager.
- Radiology: increased MRI and CT capacity – mobile scanner plus reporting or increased staffing establishment locally and roll out of home reporting across radiologists.
- Urology additional clinics (consultant, theatre staffing and administrative), nurses for Urology Investigation Unit and administrative support/typist.

7. One year survival from all cancers

7.1 The England average for one year survival rates from all cancers is 72.3% (2015). This is an increase from 71.6% in 2014.

The 2018/19 CCG IAF shows improvement for the CCGs in one year survival:-

- EHS are at 71.8% (71% previously)
- HR at 70.9% (69.6% previously)
- HWLH at 73.1% (71.7% previously).

8. Patient Satisfaction Survey

8.1 The National Cancer Patient Survey is carried out annually by Quality Health Ltd commissioned by the Department of Health (DoH).

8.2 There have been considerable improvements in recent years and despite some continued challenges, the outcome of the 2017 patient satisfaction survey is positive, with EHS

achieving 8.7, H&R 8.7 and HWLH 8.6 out of 10. There is variation nationally and the average is 8.7.

8.3 ESHT and MTW were rated 8.9 which is above the England average of 8.7. BSUH were 8.6 which is slightly lower than the England average.

9. Conclusion

9.1 There is much positive action in hand to continue to improve the experience and outcomes of people diagnosed with cancer. We will continue to implement actions and monitor cancer performance to ensure improvements across all the targets.

9.2 Focus remains on improving the CCG IAF targets and ensuring we continue to meet the NHS Constitution targets as well as ensuring action to achieve the 62 day target.

9.3 As part of this, we are working within the new Surrey and Sussex Cancer Alliance to support implementation of the cancer related recommendations in the NHS Five Year Forward View and the Department of Health Independent Cancer Taskforce Report: Achieving World-Class Cancer Outcomes 2015. These support improvement in the four cancer targets in the CCG IAF.

9.4 The Sussex Cancer Delivery Board is working with SSCA to delivery system-wide transformational change to work towards compliance with the aims of the Long Term Plan (2019). This will support improvement across cancer services.

9.5 The development of Integrated Care Systems should provide more improvement opportunities. With Primary Care Networks for example, working at scale and sharing ideas and using a shared workforce will be advantageous. This could help awareness and earlier diagnosis through setting up systems to chase screening non-engagers, having leads and processes ensuring suspected cancer referrals are more uniform and complete and training the wider workforce to help recognise potential cancer symptoms.

9.6 Cancer patient experience is high across East Sussex and is expected to continue to improve through the use of health needs assessments and the introduction of personalised care.

Lisa Elliott
Senior Commissioning Manager
NHS Hastings and Rother & NHS Eastbourne, Hailsham and Seaford CCGs

Imran Yunus
Cancer Commissioner
NHS High Weald, Lewes Havens CCG

17th September 2019
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Report to: **East Sussex Health Overview and Scrutiny Committee (HOSC)**

Date of meeting: **26 September 2019**

By: **Assistant Chief Executive**

Title: **Work Programme**

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

RECOMMENDATIONS

The Committee is recommended to agree the work programme.

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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, Boorman and Howell. The last meeting was on 2 September and the note will be circulated to members shortly. The next meeting is on 16 March 2020

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, Pragnell and Osborne. The last meeting was on 11 September 2018 and the next meeting is planned for 27 September 2019.

3 Conclusion and reasons for recommendations

3.1 The work programme sets out HOSC's work both during formal meetings and outside of them.

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.

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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 (JHOSC)	A JHOSC is in the process of being established to consider potential future substantial variations in service (SViS) resulting from both the Clinically Effective Commissioning (CEC) programme and the Sussex and East Surrey Sustainability and Transformation Partnership (STP), although no specific SViS have yet been confirmed. The JHOSC comprises three voting members and one non-voting member from each of the four local authority areas. The JHOSC is expected to be established by each of the local authorities ahead of consideration of any SViS. The East Sussex HOSC approved its establishment in November 2018. Membership: Cllrs Belsey, Pragnell and Osborne and Geraldine Des Moulins	Ongoing

Urgent Treatment Centres (UTC) in Eastbourne and Hastings	The Committee agreed in March 2018 that proposals to establish UTCs by relocating the walk-in centres from Eastbourne Station and Station Plaza in Hastings to the Eastbourne District General Hospital (EDGH) and Conquest Hospital, respectively, constituted a 'substantial variation to health services' requiring the Clinical Commissioning Groups (CCGs) to formally consult with the Committee. The Committee established a Review Board to consider the UTC proposals in more detail and consider the outcomes of the proposed public consultation. The CCGs have resumed their UTC proposals following a pause 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 updates from the CCGs. The HOSC Review Board met in July to consider an update on the CCGs' plans and will meet again to review the proposals in detail and consider the outcomes of public consultation. Membership: Cllrs Belsey (Chair), Turner, Barnes, Morris and Jennifer Twist	March 2020 TBC
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. A system-wide review of children's and young people's emotional health and wellbeing is currently underway and the outcome is due to be considered by the Committee when complete. This may provide opportunities for further scrutiny.	On completion of the review.

List of Suggested Potential Future Scrutiny Review Topics		
Suggested Topic	**Detail**	
Preventative aspects of integrated care in East Sussex	Possible item for future scrutiny identified at HOSC away day – February 2018.	
Scrutiny Reference Groups		
Reference Group Title	**Subject Area**	**Meetings Dates**
Brighton & Sussex University Hospitals (BSUH) NHS Trust HOSC working group	A joint Sussex HOSCs working group to scrutinise the BSUH response to the findings of recent Care Quality Commission (CQC) inspections and the Trust's wider improvement plan. Membership: Cllrs Belsey, Boorman and Howell	Last meeting: 2 September 2019 Next meeting: 16 March 2019
Sussex Partnership NHS Foundation Trust (SPFT) HOSC working group	Regular meetings with SPFT and other Sussex HOSCs to consider the Trust's response to CQC inspection findings and other mental health issues, including ongoing reconfiguration of dementia inpatient beds in East Sussex. Membership: Cllrs Belsey, Pragnell and Osborne	Last meeting: 11 September 2018 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. Membership: HOSC Chair (Cllr Belsey) and officer	Last meeting: 10 July 2019 Next meeting: TBC November 2019

Regional NHS liaison	Regular (approx. 4 monthly) liaison meetings of South East Coast area HOSC Chairs with NHS England Area Team and other regional/national organisations as required e.g. NHS Improvement, NHS Property, CQC Membership: HOSC Chair (Cllr Belsey) and officer	Last meeting: 10 July 2019 Next meeting: TBC November 2019
Reports for Information		
Subject Area	**Detail**	**Proposed Date**
NHS 111	An update on the outcome of the procurement of NHS 111 services was circulated in August 2019. The Committee will receive a full update at the September Committee meeting.	Update circulated in August 2019
Patient Transport Service (PTS)	The Committee received email updates on the first year's performance of the PTS following a contract transfer to South Central Ambulance Service in April 2017. The final performance update was circulated in July 2018 along with a report by Healthwatch on PTS. Overall improvement is shown but with some continued areas for improvement. The Committee will consider any future reports by Healthwatch before determining if further scrutiny is required.	Ongoing monitoring of Healthwatch reports
Personal Health Budgets	The Committee requested figures on the uptake amongst patients of Personal Health Budgets following identification of savings proposals relating to the Continuing Health Care budget.	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.	TBC 2019

Training and Development		
Title of Training/Briefing	**Detail**	**Proposed Date**
New Member induction	One to one induction sessions with new Members of the Committee.	As required
Committee away day – NHS Long Term Plan	The Committee requested an away day to look at the local NHS Long Term Plan that is currently under development. The Committee will use this to help plan its work programme for the following year.	TBC after publication of final draft Late 2019/early 2020
NHS Finance	Joint training session with neighbouring HOSCs on how the NHS is funded.	TBC November 2019

Future Committee Agenda Items		Author
28 November 2019		
Urgent Care proposals in Eastbourne and Hastings	To consider an interim report by the HOSC Review Board in relation to the proposals for Walk-in Centres in Eastbourne and Hastings.	Representatives of EHS/HR CCGs
CCG Merger update	To consider an update on the progress of the merger of the three East Sussex CCGs due to go live from 1 April 2020	Chief Executive Officer of Sussex and Surrey 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. To include:	Democratic Services Officer

	Agreement of revised Joint HOSC terms of reference to reflect East Surrey Clinical Commissioning Groups (CCGs) leaving the Sussex Health and Care Partnership.	
26 March 2019		
Urgent Care proposals in Eastbourne and Hastings	To consider whether the CCGs' decision relating to the proposed for Walk-in Centres in Eastbourne and Hastings are in the best interest of health services in East Sussex.	Representatives of EHS/HR CCGs
Sussex-wide review of emotional health and wellbeing support for children and young people	To consider a report on the outcomes of a Sussex-wide review of emotional health and wellbeing support for children and young people *Note: Timing is dependent on outcome of review*	Representative of East Sussex 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. *Note: Timing is provisional depending on the NHS decision making process.*	Representative of Sussex Partnership NHS Foundation Trust (SPFT)
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/ Kent and Medway CCGs
TBC		
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. To also include plans to improve hospital handover times.	Representatives of SECAmb