Brighton & Hove City Council

Health Overview & Scrutiny Committee

Title:	**Health Overview & Scrutiny Committee**
Date:	**6 December 2017**
Time:	**4.00pm**
Venue	**Hove Town Hall, Council Chamber - Hove Town Hall**
Members:	**Councillors:** K Norman (Chair), Allen, Bennett, Bewick, Deane, Gilbey, Greenbaum, Morris, A Norman and Wealls **Co-opted Members:** Zac Capewell (Youth Council), Caroline Ridley (Community Sector Representative), Fran McCabe (Healthwatch), Colin Vincent (Older People's Council)
Contact:	**Giles Rossington** Senior Policy, Partnerships & Scrutiny Officer 01273 295514 giles.rossington@brighton-hove.gov.uk

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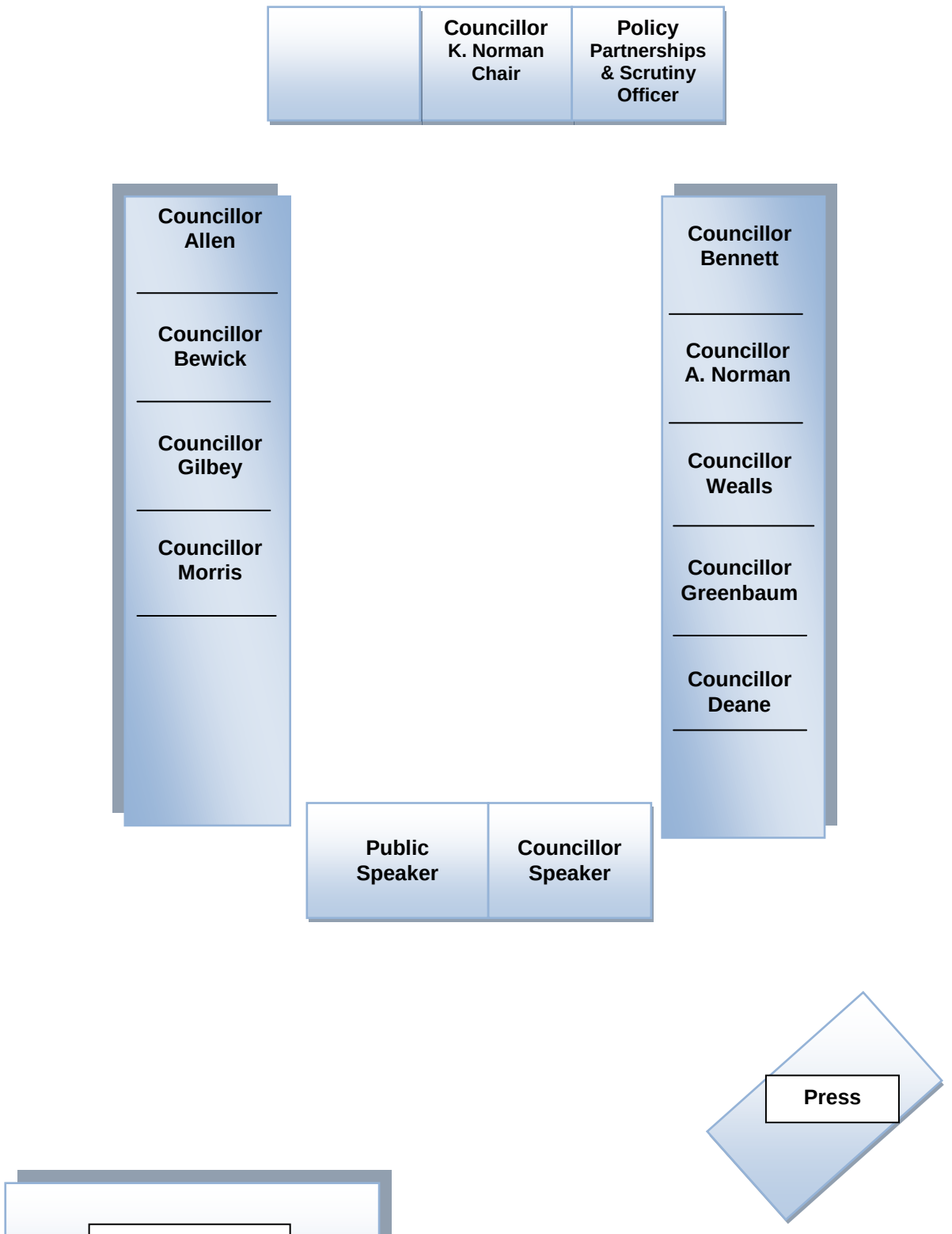
Democratic Services: Health Overview & Scrutiny Committee



AGENDA

PART ONE **Page**

24 APOLOGIES AND DECLARATIONS OF INTEREST

25 MINUTES **1 - 10**

To consider the minutes of the previous Health Overview & Scrutiny Committee meeting held on 06 September 2017 (copy attached).

26 CHAIRS COMMUNICATIONS

27 PUBLIC INVOLVEMENT

To consider the following items raised by members of the public:

(a) **Petitions:** To receive any petitions presented by members of the public to the full Council or to the meeting itself;
(b) **Written Questions:** To receive any questions submitted by the due date of 12noon on the (insert date) 2017.
(c) **Deputations:** To receive any deputations submitted by the due date of 12 noon on the (insert date) 2017.

28 MEMBER INVOLVEMENT

To consider the following matters raised by councillors:

(a) **Petitions:** to receive any petitions submitted to the full Council or at the meeting itself;
(b) **Written Questions:** to consider any written questions;
(c) **Letters:** to consider any letters;
(d) **Notices of Motion:** to consider any Notices of Motion referred from Council or submitted directly to the Committee.

29 MENTAL HEALTH: UPDATE FROM SUSSEX PARTNERSHIP NHS FOUNDATION TRUST (SPFT) **11 - 24**

Samantha Allen, Chief Executive of Sussex Partnership NHS Foundation Trust (SPFT); and Dr Gurprit Singh Pannu, SPFT Consultant Psychiatrist and Clinical & Service Director, Brighton & Hove, will present.

Contact Officer: Giles Rossington Tel: 01273 295514
Ward Affected: All Wards

30 BRIGHTON & HOVE CARING TOGETHER, CCG ALLIANCE AND NHS & SOCIAL CARE INTEGRATION UPDATE **25 - 46**

Presentation from the city council and the CCG on B&H Caring Together,

the CCG Alliance and local health and social care integration (some slides are attached for information)

31 GP SUSTAINABILITY: DECEMBER HOSC UPDATE **47 - 62**

Report from Brighton & Hove CCG on plans to improve the sustainability of city GP services (copy attached)

Contact Officer: *Giles Rossington* *Tel: 01273 295514*
Ward Affected: *All Wards*

32 NHS 111 TENDER FOR NEW CONTRACT **63 - 72**

Report from Coastal West Sussex CCG. Colin Simmons, 111 Programme Director, will present.

Contact Officer: *Giles Rossington* *Tel: 01273 295514*
Ward Affected: *All Wards*

33 HEALTHWATCH ANNUAL REPORT **73 - 106**

David Liley, Chief Executive, Healthwatch Brighton & Hove, will present.

Contact Officer: *Giles Rossington* *Tel: 01273 295514*
Ward Affected: *All Wards*

34 FOR INFORMATION: UPDATE ON HOSC WORKING GROUPS **107 - 128**

Included for information are the minutes of recent HOSC working groups:

- BSUH Quality Improvement Joint Working Group: 30 March 2017 minutes
- BSUH Quality Improvement Joint Working Group: 04 October 2017 minutes
- HOSC STP Working Group: 22 Sep 2017 minutes
- SECAmb Quality Improvement Joint Working Group: 17 Nov 2017 minutes

35 OSC DRAFT WORK PLAN/SCRUTINY UPDATE **129 - 130**

The latest version of the HOSC work programme is attached for information (copy attached).

OVERVIEW & SCRUTINY COMMITTEE

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For further details and general enquiries about this meeting contact Giles Rossington, (01273 295514, email giles.rossington@brighton-hove.gov.uk) or email democratic.services@brighton-hove.gov.uk

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Date of Publication - Tuesday, 28 November 2017

BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00pm 6 SEPTEMBER 2017

COUNCIL CHAMBER, HOVE TOWN HALL, NORTON ROAD, HOVE, BN3 3BQ

MINUTES

Present: Councillor K Norman (Chair)

Also in attendance: Councillors Allen, Greenbaum, Morris, A Norman, Hill, Janio and West

Other Members present: Colin Vincent (Older People's Council), Fran McCabe (Healthwatch), Caroline Ridley (Community & Voluntary Sector)

PART ONE

12 PROCEDURAL BUSINESS

12.1 Apologies were received from Cllr Bewick and from Zac Capewell.

12.2 Cllr Pete West attended as substitute for Cllr Lizzie Deane; Cllr Tony Janio attended as substitute for Cllr Andrew Wealls; Cllr Tracey Hill attended as substitute for Cllr Penny Gilbey.

12.3 There were no declarations of interest.

12.4 It was agreed that the press & public be not excluded from the meeting.

13 MINUTES

13.1 Cllr Allen pointed out that information requested at 2.4 of the minutes (STP expenses to date) had not yet been received. Fran McCabe noted that the HOSC STP working group had also asked for this information, but it had not been forthcoming. The Chair agreed to pursue the matter. [Please note: the information requested has now been received from the CCG and is attached for information at the end of these minutes.]

13.3 RESOLVED – that the minutes of the 28 June 2017 HOSC meeting be approved as an accurate record.

14 CHAIR'S COMMUNICATIONS

14.1 The Chair welcomed everyone to the meeting. The Chair also informed the committee that Item 17: Brighton & Hove Caring Together Update had been deferred until the next meeting at the request of Brighton & Hove Clinical Commissioning Group (CCG).

15 PUBLIC INVOLVEMENT

15.1 There was a public question from Dr Chris Tredgold. Mr Tredgold asked:

"General Practice in Brighton and Hove is becoming unsustainable. 8 practices have closed in the last 2 years. The Ridgeway Surgery in Woodingdean is closing in October. 8 practices are currently not accepting new patients.

Park Crescent surgery is so short staffed that Care UK has been employed to operate a telephone triage system there.

And the STP plans to load more work onto General Practice while GP recruitment falls.

Please can the HOSC say that this situation is not acceptable?"

15.2 The Chair responded:

"Thank you for your question. I'm sure that we are all aware that GP services, both locally and nationally, are under a great deal of pressure and that the situation in Brighton & Hove is very serious.

It certainly isn't the case that nothing is being done here, and later in this meeting, the committee will receive an update on what the NHS in the city is doing to support the sustainability of GP services. Following this presentation, committee members will decide how they want to further pursue the issue of GP sustainability."

15.3 Dr Tredgold then posed a supplementary question, asking the HOSC to agree to ask the CCG to be clear and honest about the further deterioration in local health services (identified by local GPs in a response to a survey) that will occur if more work is transferred from secondary care to General Practice under the Sustainability & Transformation Partnership whilst NHS budgets are being cut.

The Chair responded that the committee would wait and see.

16 MEMBER INVOLVEMENT

16.1 There was none.

17 BRIGHTON & HOVE CARING TOGETHER: UPDATE

17.1 This item was deferred until the next meeting at the request of the CCG.

18 ADULT SOCIAL CARE: FUTURE VISION

18.1 Rob Persey, Executive Director Health & Adult Social Care (HASC), presented on his vision for HASC.

18.2 Mr Persey told members that, on his arrival in 2016, he inherited relatively few issues that caused him serious concern. The most worrying matters were: social care reviews, staff sickness levels, and some issues concerning direct payments (particularly their uptake). Also, the council was and is being stretched by the number of Deprivation of Liberties Safeguarding (DOLS) assessments it is now required to undertake: around 190 per month rather than approximately 130 per annum which had been the figure before the outcome of a court case forced social services departments to change procedures. However, this is a national rather than purely a local problem.

18.3 On a more positive note, Mr Persey inherited a history of positive co-working between social care and the local NHS. This provides a good building-block for further integration. There were also very close working relationships between social care and public health. There has been more work in this direction, and public health is now firmly embedded in everything that social care does.

18.4 Mr Persey also explained his statutory responsibilities as Director of Adult Social Services (DASS); as well as outlining the 3 year directorate plan and HASC's priorities for 2017/18. Health inequalities are a particular priority, as in recent years inequalities have been increasing.

18.5 In response to a question from Colin Vincent on whether a breakdown was available showing how money collected via the social care Council Tax precept has been spent, Mr Persey replied that the precept funding and monies that come via the Better Care Fund (BCF) are ring-fenced to three areas: Adult Social Care (ASC) assessment and delivery; co-working with the NHS on reducing hospital admissions and Delayed Transfers of Care from hospital; and sustaining the ASC provider market. Mr Persey agreed to circulate further information on this.

18.6 Caroline Ridley told the committee that the recently announced tender for supporting Direct Payments is flawed as it demands that potential providers have specific direct experience of this work rather than just being able to demonstrate that they are competent to undertake it. This limits the number of local providers who will be in a position to bid. Mr Persey agreed to look at this issue.

18.7 In answer to a question from Cllr Ann Norman on sickness rates in HASC, Mr Persey told members that social care sickness rates are high everywhere due to the innate stresses of the job. However, BHCC is an outlier in terms of its rates. There are several plans to tackle this. They include running a council-wide wellbeing programme; ensuring staff take proper lunch breaks; encouraging front-line workers to get flu jabs; and the introduction of 'First Care', a new absence reporting system which requires staff to call a helpline rather than their line-manager to report illness. Clinically trained call-handlers are on hand to provide support and advice in addition to registering the absence.

18.8 Cllr Allen made the point that he was eager to see HASC performance reported to HOSC, not dealt with solely at the quarterly joint HOSC/HWB HASC performance workshops. Mr Persey replied that he was happy to bring performance information to HOSC where the data is available (the KPIs for health and social care integration are still being determined). He did not bring performance to this meeting because he had been briefed not to.

However, HASC performance is currently strong. For example, there has been a concerted focus on placements into residential care, where performance has historically been poor. This has been very effective, with the year-end target for reductions already exceeded. Social care reviews remain a real concern, but they are now being processed by priority which should help address the problem.

18.9 Fran McCabe echoed the call for more HASC performance reporting at HOSC, noting that although performance may be reported at other council committees, HOSC co-opted members were unable to scrutinise it there. Ms McCabe also expressed concerns that rising health inequalities might be linked to problems with city GP practices. Mr Persey responded that this was an understandable concern. However, the key factor here was probably the number of GPs working in Brighton & Hove rather than the number of practices, as long as there was a spread across the city. HASC is now working more closely with city GPs: social care has been split into three localities which each align with two of the six city GP clusters.

18.10 In answer to a query from Cllr Janio on the benefits of integration, Mr Persey told members that integration would give the CCG a better understanding of council responsibilities that constitute the broader determinants of health, such as housing and culture. Integration will also help drive a greater focus on prevention. The challenges of integration should not be underestimated, as the council and the NHS are culturally quite different, but this work is very important.

18.11 The Chair thanked Mr Persey for his presentation.

19 GP SUSTAINABILITY

19.1 This item was introduced by Murray King, Interim Associate Director Primary Care, Brighton & Hove CCG. Due to administrative error, the CCG report accompanying this item that should have been tabled at the meeting was not available. There was therefore no report to discuss. The report has subsequently been added to the committee papers on the council's website and circulated to members. Several members noted their dissatisfaction with the absence of a report.

19.2 Mr King told members that there were some local positives: 36 city GP practices are rated 'good' and Brighton & Hove GP Patient Survey results are above average. However, there are also significant problems, particularly in the east of the city where a number of practices are vulnerable.

19.3 Commissioners have developed tools to identify the most vulnerable practices. Four city practices have been identified as being particularly vulnerable, and are receiving additional support. Commissioners are also focusing on single-handed practices due to their inherent vulnerabilities.

19.4 There has also been investment in a telephone service which can augment capacity in practices under pressure. The practices using this service supply a list of their most vulnerable patients who will then *not* be routed to the telephone service. Clinical call-handlers have full access to patient records. In time it is hoped that many call-handlers will be local GPs and practice nurses with a good understanding of the city. The CCG

believes that there is an un-tapped market of local clinicians with the appropriate clinical skills and experience.

19.5 It needs to be recognised, however, that there is a national and indeed an international shortage of GPs and that it is important to think about the skill mix of primary care clinicians – i.e. using physicians' assistants, practice nurses, pharmacists etc. where appropriate and ensuring that GPs only see patients who need to see them.

19.6 Mr King also explained the situation at Ardingly Court, where the practice has effectively decided to split in two. This follows the practice taking on a number of new patients following the recent closure of city GP surgeries run by The Practice Group. The CCG will tender for a new, Whitehawk-based practice, and four of the GPs currently at Ardingly Court will resign in order to bid for the new contract.

19.7 In response to a question from Cllr Morris on practices closing their lists, Mr King told the committee that practices could apply to commissioners to 'cap' (temporarily close) their lists where it was unsafe to register new patients. There are currently five practices with capped lists in the city. This is largely due to practices having to manage the impact of the closure of the Ridgeway surgery and should be a temporary issue. A capped list is not wholly closed; it must still accept some new patients – for example babies born to existing patients on the list.

19.8 The Chair thanked Mr King for his presentation.

20 CLINICALLY EFFECTIVE COMMISSIONING

20.1 This item was introduced by Lola Banjoko, Director of Performance, Planning & Informatics at Brighton & Hove CCG; and by Pippa Ross-Smith, CCG Chief Finance Officer.

20.2 Ms Banjoko told members that the Clinically Effective Commissioning (CEC) initiative is being run across the STP footprint. The focus is on ensuring that planned care decisions reflect current best clinical practice, with unnecessary or low-value interventions identified and eliminated.

20.3 Groups of clinicians from across Sussex and East Surrey will agree on CEC recommendations. However, all decisions about services will be taken by local CCGs, and in theory a CCG could reject CEC recommendations.

20.4 In response to a question from Cllr Greenbaum on referral management, the committee was told that there has been a local system in place for some years to check that GP referrals for treatment are valid and meet the agreed thresholds.

20.5 In answer to a query on CEC public engagement from Fran McCabe, members were informed that there would be engagement on specific service changes, should the changes identified be significant. The timescale for CEC will be determined by the clinicians working on the initiative.

20.6 In response to a question from Cllr Allen as to whether CEC was rationing by another name, members were told that CEC is about ensuring that services are as clinically

effective as possible; it is not about saving money. There are clearly financial challenges that must be addressed, but the system needs to ensure that all activity is clinically justifiable before it can fully tackle financial problems. It is particularly important that everything possible is done to eliminate waste and unnecessary activity so as to minimise the need for changes which might adversely impact upon services.

21 NHS 111 UPDATE

21.1 This item was introduced by Colin Simmons, 111 Programme Director; and Kerry Exley, Coastal CCG.

21.2 Coastal West Sussex CCG is leading the procurement of a new 111 (non-urgent NHS telephone service) contract for Sussex, but all seven Sussex CCGs are responsible for the contract and are actively involved in the project.

21.3 The current contract (with SECAmb) has been extended for 12 months to give sufficient time for a proper re-procurement to be undertaken. This contract is with 17 CCGs across Sussex and Surrey. The new contract will be for five years with an option to extend for a further two years, and will include break clauses. The tender process is expected to begin in January 2018, with a contract award in September 2018 and phased implementation beginning in 2019.

21.4 The Sussex GP Out of Hours (OOH) contract is being re-commissioned together with the 111 contract as it has been recognised that the two services are closely linked, and it is crucial that they are able to work together effectively. This is not always possible currently - for instance, there are IT incompatibilities that mean that patient information can sometimes not be readily accessed or shared. Currently OOH services have some access to records, but 111 has none. Under new arrangements both services should have ready access at least to patient summary care records, and the expectation is that clinicians should be able to access full patient records in read-only mode.

21.5 The new 111 contract will be Sussex-only so as to provide more potential for flexibility should changes to local urgent care systems require a flexing of the contract terms.

21.6 In response to a question from Cllr West on how the new 111 services would better support other NHS services, members were told that a more effective 111 service will relieve pressure on other parts of the NHS by signposting patients to the most suitable service. For example, 111 will have prescribing pharmacists who will be able to issue prescriptions electronically which can be picked up the next day at a local pharmacy. This should reduce pressure on OOH services for repeat prescriptions.

21.7 In answer to a question from Cllr Morris on whether progress would be reported back to the HOSC, Mr Simmons offered to report back both before the tender begins (e.g. December 2017) and also to give an update one year on. Members agreed that this would be helpful.

21.8 In response to a query from Cllr Janio about whether it would be possible to provide a single point of access rather than 111 and 999, members were assured that all calls to 111 are initially assessed to see if they need to be transferred to 999. There is also the facility to transfer less urgent 999 calls to 111.

21.9 In answer to a query on public engagement from Fran McCabe, the committee was informed that it was recognised that good public engagement is key here. A 111 Communications Manager has already been appointed and there will be extensive public and stakeholder engagement as the tender progresses.

21.10 The Chair thanked the presenters.

22 FOR INFORMATION: UPDATE ON THE PROGRESS OF HOSC WORKING GROUPS

23 UPDATED HOSC 2017/18 WORK PROGRAMME

23.1 Fran McCabe suggested that the Healthwatch annual report and the joint Sussex Healthwatch report on Patient Transport Services be included in the committee work programme.

The meeting concluded at 7:05pm

Signed Chair

Dated this day of

Information provided by Brighton & Hove CCG in response to HOSC questions (re: 13.1 in the Minutes of the 06 September 2017 HOSC meeting)

Total expenditure on consultancy by Sussex and East Surrey Sustainability and Transformation Partnership (STP) is as follows:

	2016/17	2017/18*
Total STP Consultancy Spend (inc VAT)	946,059	1,179,079

*To end of September 2017.

Total of above charged to NHS Brighton and Hove CCG is as follows:

	2016/17	2017/18*
NHS Brighton and Hove CCG Share	83,688	129,815

*To end of September 2017

Procurement Route

The three main consulting companies supporting the STP are 2020 Delivery Ltd, Carnall Farrar Ltd and Quo Imus Ltd.

These contracts were procured using framework agreements in compliance with the restricted procedure set out in the Public Contract Regulations 2015.

The two framework agreements used were:

- Lot 1 (Business Services) of the HealthTrust Europe Consultancy and Advisory Services Framework. Contract Notice ref: (2016/S 221-7402825).

- Lot 3.1 (Change Management) of the Crown Commercial Services ConsultancyOne Framework Agreement ref RM1502.

HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 29 Brighton & Hove City Council

Subject:		**Mental Health: Update from Sussex Partnership NHS Foundation Trust (SPFT)**
Date of Meeting:		**06 December 2017**
Report of:		**Executive Lead Officer for Strategy, Governance & Law**
Contact Officer:	**Name:**	**Giles Rossington** **Tel: 01273 295514**
	Email:	**Giles.rossington@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 Sussex Partnership NHS Foundation Trust (SPFT) is the main provider of mental health services across Sussex. The trust's Chief Executive, Samantha Allen, has been invited to present to the HOSC on the challenges and opportunities for local mental health services.

1.2 Information provided by SPFT is included as **Appendix 1** to this report.

2. RECOMMENDATIONS:

2.1 That members note the contents of this report, and the additional information provided by SPFT (**Appendix 1**); and

2.2 Determine whether any of the issues detailed here require additional scrutiny.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 SPFT is the main provider of mental health services across Sussex. In Brighton & Hove, SPFT is responsible for running Mill View hospital, and for a wide range of community based services for children and young people, working age adults, and older people.

3.2 Members may be particularly interested in the following areas of the trust's work:

- The SPFT Clinical Strategy
- The Sustainability & Transformation Partnership (STP) Mental Health Work-stream
- Delayed Transfers of Care (DTOC) from mental health beds
- Child & Adolescent Mental Health Services (CAMHS)
- Dementia services, including the progression of trust plans to provide local single-sex wards for dementia

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 Not applicable: this report is not for decision.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 None to this report.

6. CONCLUSION

6.1 Members are asked to note the information provided by SPFT.

6.2 Members should also consider whether any of the areas of work covered in this report, or any of the plans for service improvement outlined by the trust, require additional scrutiny.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 None to this information report.

Legal Implications:

7.2 There are no legal implications to this report.

Lawyer Consulted: Elizabeth Culbert *Date: 05/09/17*

Equalities Implications:

7.3 None directly. Mental health service users may experience inequalities due to their health problems. Some protected groups (e.g. BMI people, people with disabilities, older people) may also be higher than average users of mental health services. All significant plans for service change consequently require thorough equalities impact assessment, and HOSC members may wish to seek assurances about equalities planning in relation to major service improvement initiatives.

Sustainability Implications:

7.4 None identified.

Any Other Significant Implications:

7.5 None identified.

SUPPORTING DOCUMENTATION

Appendices:

1. Information provided by SPFT

Documents in Members' Rooms
None

Background Documents

1 Mental Health in Sussex & Surrey: Strategic Framework and Delivery Roadmap (STP report) https://www.brightonandhoveccg.nhs.uk/publications/plans-priorities-and-progress/plans/sustainability-and-transformation-partnership (included in October 2017 STP Programme Board papers)
2 Sussex Partnership NHS Foundation Trust: Clinical Strategy

Appendix 1

Sussex Partnership NHS Foundation Trust

Briefing in preparation for Brighton and Hove HOSC meeting

(6 December 2017, 4.00pm, Hove Town Hall)

Content

Appendix 1

1.0 Sustainability and Transformation Partnership Mental Health Workstream

Summary

1.1 Earlier this year, Sussex and East Surrey Sustainability and Transformation Partnership (STP) commissioned a strategic review of mental health services. The work has been overseen by a mental health steering group chaired jointly by Sam Allen Senior Responsible Officer for Mental Health for the STP and Sussex Partnership CEO and Wendy Carberry, Accountable Officer for High Weald Lewes Clinical Commission Group (CCG). This steering group included patient, clinical and partner (including third sector) representation from across the STP.

1.2 Member organisations of the STP are committed to mental health as a priority area; discussions are well underway about how we use the outcome of the review to help improve care and treatment for the service users / patients, families and local communities we serve. The development of our new clinical strategy (see section 2.0), mental health of older people review (see section 3.0) and local transformation plans (including Brighton and Hove Caring Together) are all closely aligned to this work.

Aim of the work

1.3 The overall aim of the work is to help determine how the voluntary sector, local authorities and NHS can work better together to meet the needs of the patients, carers, families and local communities we serve. We are looking at how mental health is funded, planned and provided in our local area. If we get this right, the work will help us develop options about what we could to do improve things for our local population within the resources we have available.

1.4 Most important of all, we want to provide the best possible care and treatment to the people who use mental health services, including those provided by Sussex Partnership. That means getting help to people at the earliest opportunity, providing specialist advice and support to them on all aspects of their life which affect their mental health and wellbeing, and helping people stay well and out of hospital wherever possible. Individual organisations are already doing a lot to make this happen. By combining our expertise and resources, we can build on this, try new things and put ambitious ideas into practice that might not be possible if we worked in isolation.

Why are we doing this now?

1.5 Demand for mental health services is rising - in particular, our area has a high number of people with dementia - and resources are getting tighter. Nationally, there is a drive to encourage health and social care to work more closely together. At the same time – in common with other public services - we're experiencing unprecedented clinical and financial pressure. In short, carrying on as we are now means that patients and services will not be clinically or financially sustainable.

1.6 The need to change the way the health and social care system works is illustrated by the fact that, in Sussex and East Surrey:

- People using mental health services live about 20-25% less than the general population;
- Mental health service users are around 2-4 times more likely to die of cancer, circulatory or respiratory disease than the rest of the population;
- About 20% of all A&E attendances and emergency admission can be attributed to mental health service users – who make up only 7% of the overall population;
- By reducing smoking rates among people with mental health problems to the same level as the general population, over 1,000 hospital admissions a year could be avoided (saving £1.8m);
- New changes to the Mental Health Act require a more responsive service.

Outcome of the review

1.7 The review has led to a case for change within mental health services. This includes how services are commissioned and provided. There are 12 priority areas for attention highlighted as a result of the review which we are now committed as an STP to addressing. An area of focus that is particularly relevant to Brighton and Hove is housing (see section 4).

How clinicians and patients / service users are involved

1.8 One of our principles for carrying out this work is that we wanted it to be shaped from the start by people who work within and use mental health. We have representation from both on our steering group and in other workstreams. These individuals are round the table to give us their expert advice.

1.9 We have also had GP mental health commissioning leads involved: GPs who work within local Clinical Commissioning Groups to determine how resources from national Government are allocated to mental health, and who therefore have a specialist interest in these services. Healthwatch and local authority representatives from across Sussex have contributed; their participation was co-ordinated by Brighton and Hove Healthwatch.

1.10 We also undertook a quick two week survey, advertised online, to gather views from people who have used services and had about 480 responses. The aim of this work was to quickly ‘take the temperature’ on the issues we’re looking at. Further down the line, we may need to do a much bigger piece of work to involve patients, staff and other people who have an interest in the future of mental health.

1.11 One of the principles which guides our work is that we will involve patients, families, staff, partners and the wider public in any decisions about changing the way mental health services are provided.

2.0 Clinical strategy

Summary

2.1 In May 2017 Sussex Partnership published the first draft of its clinical strategy, which has been developed with clinical, patient / service user and carer involvement. Over the past few months we have engaged with stakeholders about the themes and actions presented in the strategy. We will publish a revised version of the strategy in early November 2017, incorporating feedback received. We will work with partners on how we deliver the strategy to help us continue improving care and treatment for the patients, families and local communities we serve.

Context

2.2 Over the last three years we've been trying to change the way we work to promote more positive staff, service user and carer experience. This includes:

- developing values to guide the way we work with each other, people who use our services and who work with us;
- developing an overarching strategy 'Our 2020 Vision' to achieve our vision: outstanding care and treatment you can be confident in;
- overhauling the way our clinical services are managed by creating Care Delivery Services; designed to help us move away from a centralised 'command and control' leadership style towards more local decision making, closer to where patients are treated.

Our clinical strategy builds on all this work. It outlines the type and range of clinical services we want to offer by 2020 to deliver the best possible care to patients.

Our challenge

2.3 We cannot continue offering services the way we do now. The NHS faces a number of challenges including increasing demand, changing health and social care needs, financial pressure and staff recruitment and retention.

2.4 In order to continue providing the best possible care, we need to think and work differently. Across the NHS and social care system, we need to focus more on:

- health promotion and early intervention
- treating people in the community rather than in hospital
- working much more effectively in partnership.

Listening to service users / patients, carers and staff

2.5 We have a lot of feedback from people about what they would like from our services. We have also involved service users and carers in developing the first draft of our strategy, and will involve more as we go along.

2.6 Our staff provide care and treatment with skill and compassion. Their work is highly stressful and demanding. Our clinical strategy focuses on how we can support staff to do the best job they can. We will put teams at the heart of our strategy, because strong teams and teamwork are essential in providing high quality, effective clinical care.

Principles and priorities

2.7 The principles which underpin our clinical strategy are as follows:

- Provide service users and carers with effective, high quality and compassionate care
- Put teams at the heart of our strategy
- Provide care based on clear goals
- Promote partnership with the people who use our services
- Intervene early
- Deliver truly recovery-orientated services
- Offer more integrated services with other partners
- Continue to challenge discrimination and inequality
- Provide care based on reliable, up to date research evidence
- Demonstrate the value and outcome of every penny spent on our clinical care services.

2.8 The priorities outlined in our strategy are as follows:

- Provide better access
- Focus on communities
- Reduce barriers between teams
- Further develop our community services offering
- Provide better mental health care for 14-25 year olds
- Secure funding for and implement 24/7 crisis care
- Improve our use of digital technology
- Use data to make services better
- Develop services that meet people's mental and physical health care needs.

3.0 Review of older people's mental health and dementia services

Summary

3.1 The CEO of Sussex Partnership has commissioned a clinically led review of older people's mental health and dementia services provided by the Trust.

3.2 This review is being led by Professor Sube Banerjee - an international expert in the field who leads our Centre for Dementia Studies with Brighton and Sussex Medical School. He will be working with John Child, who is on secondment with us from his role as Chief Operating Officer at Brighton and Hove Clinical Commissioning Group. The review will be discussed by our Board of Directors in January 2018.

Context

3.3 The population of Sussex has a high number of older people and, therefore, of people with dementia in comparison with other areas of the country. This will grow over the next ten years. It is crucial we take this opportunity to assure the quality of services we provide in this area and ensure they are geared up to meet the future needs of our local population. This will enable us to make a full contribution to any wider proposed changes across Sussex for this frail and vulnerable group of patients.

Aim of the review

3.4 The aim of this work is to:

- review our current services, establish what is working well and where we can improve
- learn from initiatives to improve care for older people with mental disorder and those with dementia
- explore how best to provide high quality services in future.

Why the review is being undertaken now

3.5 Sussex has one of the oldest populations in the UK, with around 20% over 65 years old. This means that we already have a relatively high number of people with dementia (around 20,000) which is set to double in the next thirty years. We need to ensure our services are geared up to meet this demand. This is why we have made a commitment in our clinical strategy (the first draft of which was published May 2017) to undertake the review.

3.6 As described in section 1.0, our STP Sussex and East Surrey has commissioned a wider piece of work looking at how mental health is funded, planned and provided in our local area. The older people's mental health and dementia review will inform this broader piece of work. At the same time, it will draw upon the analysis of performance, quality, finance, prevalence and demographic profiling for dementia and older people's mental health that will be undertaken through the STP work.

3.7 The review will draw on a wide range of sources including learning from serious incidents, safeguarding and national best practice to ensure we have the correct clinical model for

our services. It will also draw on the expertise and experience of people who work within and use our services.

Review process

3.8 A clinical reference group has been established (which includes social care representation) to draw on experts from all professional groups from within the service. Colleagues from across the service will be interviewed over the summer. Engagement events took place in September 2017 involving staff, patients, carers and partners (including local authorities, commissioners and the third sector).

Why is the review only focused on Sussex Partnership?

3.9 We need a rapid, focused piece of work looking at our own services, focussing on the core role of specialist older people's mental health and dementia services. This will inform the broader piece of work within our STP looking at how the voluntary sector, local authorities and NHS can work better together to meet the needs of the patients, carers, families and local communities we serve.

What will happen as a result of the review?

3.10 We haven't embarked upon the review with a fixed view about what we will do at the end of it. The idea if to canvass views from experts within our services, and to look at other evidence, in order to make recommendations on:

- How we develop our clinical model
- Best practice for community and inpatient provision
- Clinical and managerial leadership for our services
- How our services work with research and education.

Appendix 1

4.0 Delayed transfers of care

Summary

4.1 As of 1 November 2017, there are four patients whose discharge from mental health inpatient services in Brighton and Hove is delayed. Managing this issue is particularly challenging when there is limited specialist support available for people with complex needs. The particular challenge in Brighton and Hove is in relation to housing; specifically, a shortage of mental health supported accommodation to support people with combination of psychosis, risk histories, forensic presentation and substance misuse issues.

That said, Sussex Partnership has made progress (working with partners) to reduce delayed discharges from Brighton and Hove services over the last year from 12% to 4.3%; though the issue requires further, sustained attention.

Factors relating to delayed discharges

4.2 Managing this issue is particularly challenging when there is limited specialist support available for people with complex needs. This particularly applies to people with a personality disorder, forensic history and substance misuse problems.

4.3 Local factors include the shortage of nursing and residential accommodation able to accommodate people with functional and organic mental health problems.

4.4 There are a number of patients with learning disabilities at the Selden Centre - our Assessment and Treatment Centre - whose discharge is delayed due to lack of suitable local and national placements, an issue not directly within our control.

4.5 In some areas – particularly Brighton and Hove – we experience a high number of patients admitted with No Fixed Abode which presents significant challenges to access appropriate accommodation and increases length of stay.

Steps being taken to reduce delayed discharges

4.6 Action being taken to reduce delayed discharges includes:

- The STP mental health work stream will develop a set of priorities for mental health care in Sussex including access to acute and urgent care;
- We are working with our Clinical Commissioning Group and Local Authority Partners to identify suitable mental health accommodation plans to support the residential / nursing home sector, the development of care pathways in areas such as residential and community rehabilitation, and the expansion of self-directed support.

Appendix 1

5.0 Care Quality Commission

Summary

5.1 The Care Quality Commission (CQC) is currently undertaking a full, planned inspection of the Trust which will be completed in the week commencing 4 December. We anticipate receipt of their inspection report in early 2018.

Further information

5.2 The inspection currently underway in part of the phase of the new style of 'well-led' inspection introduced by the CQC. Between now and early December they will inspect a range of clinical services across the Trust. The inspections will be unannounced.

5.3 The CQC are also holding focus groups with staff and will undertake a series of indepth interviews with members of the Board, Executive team and other colleagues in the week commencing 4 December 2017. This will result in a reappraisal of our current, overall CQC rating, which we expect to have confirmed in the New Year. The core services inspected will also be rated again; one rating for each core service such as older adult inpatient wards and adult community teams.

5.4 In the initial, informal feedback we have received from the CQC, they have noted our positive response to issues raised during previous inspections such as medicines management, risk assessments, care planning and physical health checks.

Central Sussex
Commissioning Alliance

Central Sussex NHS Commissioning Alliance

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

Goal

- Take control of and lead the system by being stronger commissioners to deliver better outcomes for our population

- Enable the development of new local models of care (e.g. accountable care systems)

The Alliance is needed

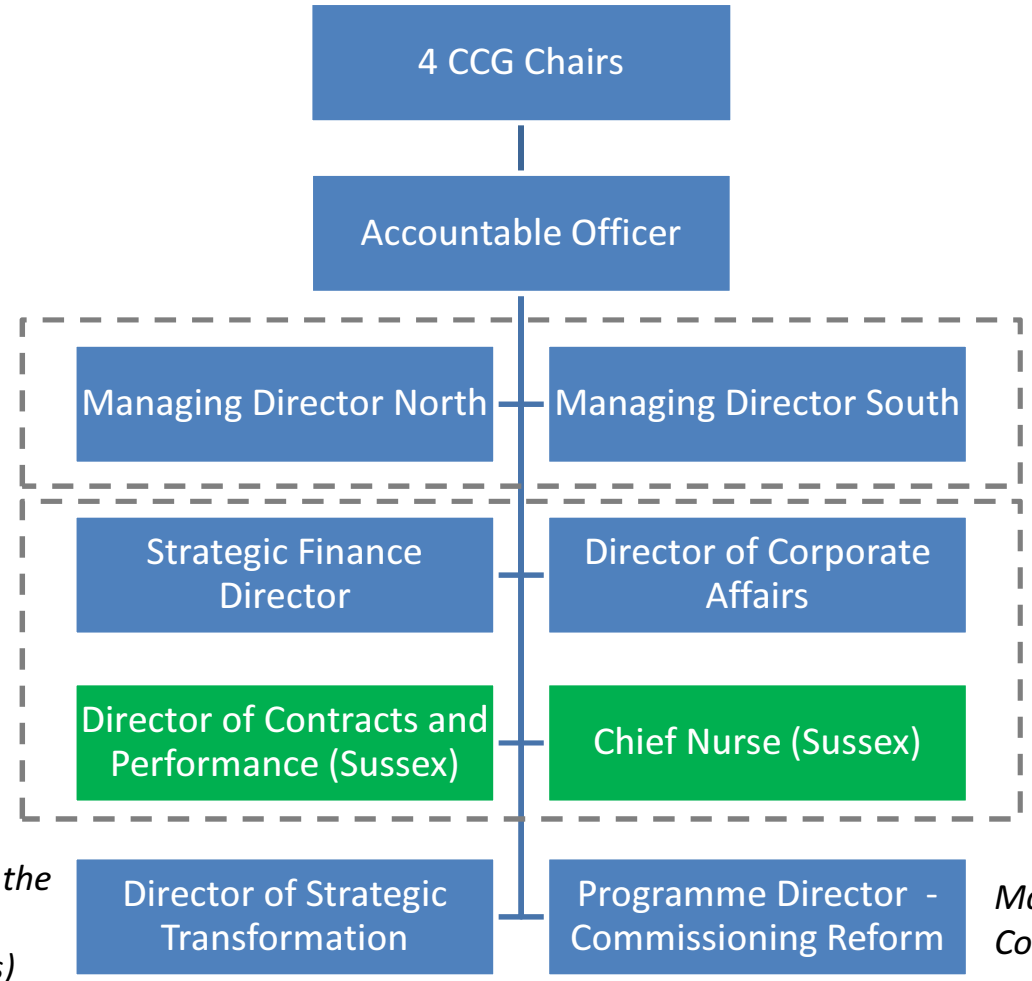
- To get a stronger traction with the providers of healthcare for our population
- To provide clarity for providers through a single commissioning voice
- To free-up local teams to allow them to give more focus to business as usual and integration
- To share and spread clinical service improvements through collaboration (we have more in common than we think)
- To accelerate the pace of delivering transformational change and new local models of care (e.g. accountable care systems)
- To streamline processes and stop duplication across the four CCGs that could be done once
- To better use the limited specialist skills and talent
- To provide more effective organisational development at scale

It is needed now

The system is at a tipping point and many of the problems need to be addressed through stronger collaboration between the CCGs

- There is a deteriorating financial situation that needs to be addressed collectively and consistently through transformation at scale.
- Our relationship with our major providers needs a reset
- We need to have honest conversations with the public about what the NHS is able to continue to provide, and we need to do this in a consistent and joined-up way
- There are workforce gaps that we are struggling to fill with the right talent
- Other systems are coming together (in line with the national direction of travel) and could look more attractive for people to work
- Leadership teams across the CCGs are strongly aligned and motivated to address the challenge

Initial Executive management structure



Local commissioning, delivery & engagement

Managing the areas done together across the Commissioning Alliance

Enabling development of the new models of care (e.g. accountable care systems)

Managing transition to the Commissioning Alliance

Scale of delivery of functions

STP level commissioning

- Quality
- Contracts and Performance
- Specialised commissioning
- Commissioning Support Unit

Done together through the Alliance

- Planning (Annual, operating, finance)
- Assurance (strategy, finance, quality, performance)
- Large scale commissioning
- Strategy coordination
- Back office functions
- Enabling large scale transformation

Place / CCG

- Population based commissioning
- Joint commissioning & integration with LAs
- Primary care commissioning
- QIPP delivery and service transformation
- Clinical engagement & pathway development
- Continuing Healthcare

Staff processes

- No redundancies are expected at this time from the development of the Alliance
- Staff have been informed throughout and are already starting to collaborate between CCGs on specific areas (operational planning, comms)
- Executive team will be appointed during Q3
- Alliance starts in January and staff will then be involved in the design of new structures
- If necessary, formal consultations in Q1 2018/19
- Expected that it may require some changes in management or location

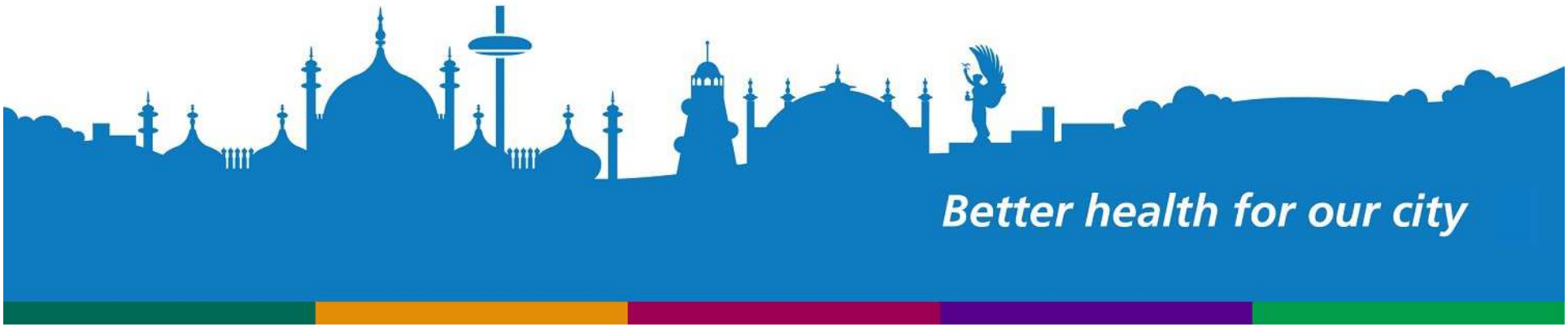
Brighton & Hove City Council

NHS
Brighton and Hove
Clinical Commissioning Group

Caring Together: Update

Dr. David Supple, CCG Clinical Chair

Rob Persey, Executive Director

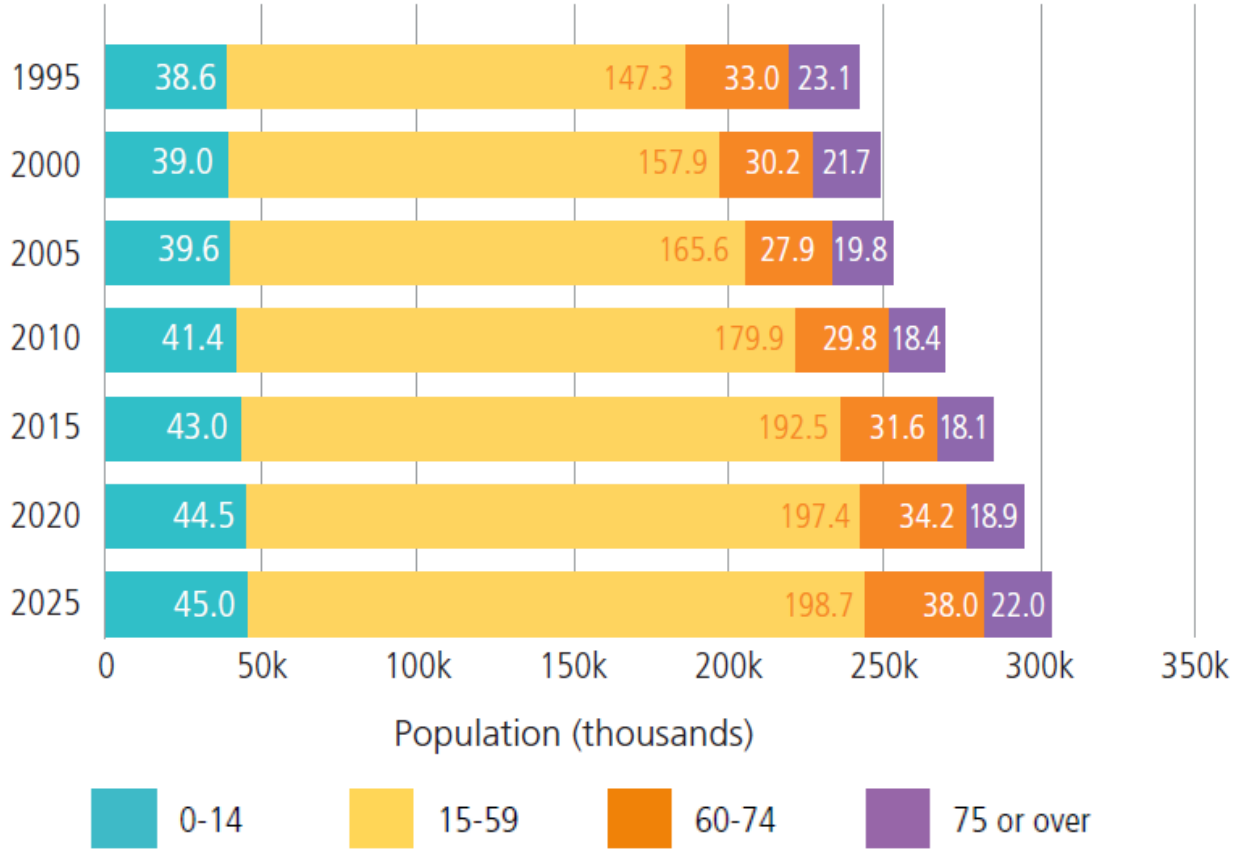


Content

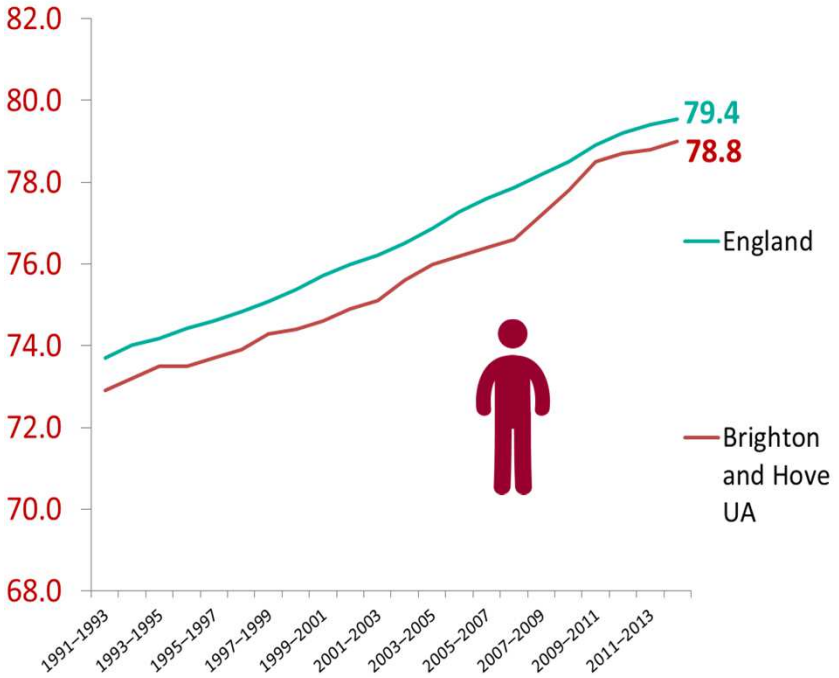
- Joint Overview of Caring Together and Integration progress
- Highlight key health and social care challenges facing our city
- What does this mean in terms of demand
- How are we addressing this and how are we engaging with our residents and other stakeholders
- How are we managing the complex changes

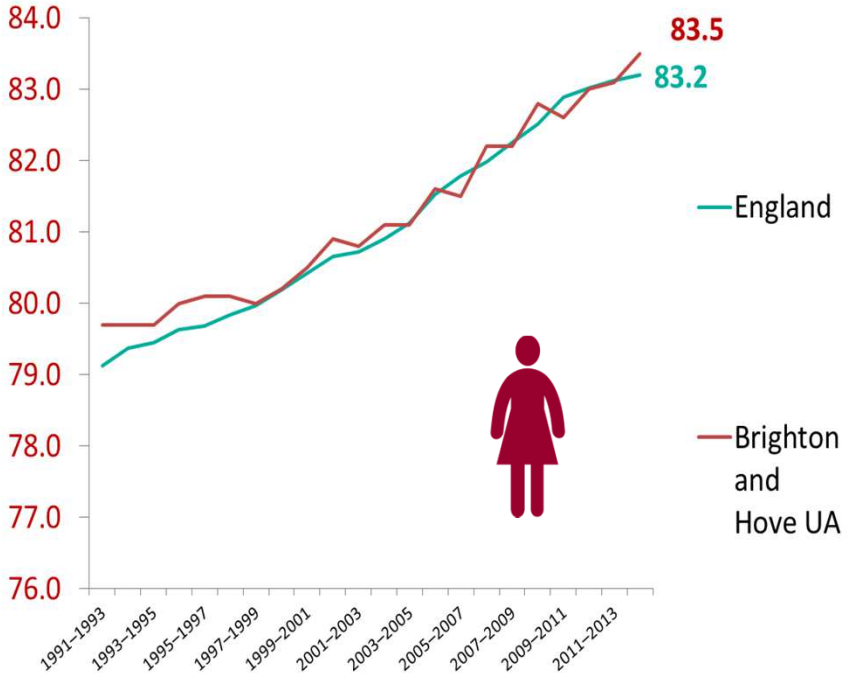
Our population is growing

Figure 1 Population (thousands) by broad age band, Brighton & Hove, 1995 to 2025



Our population is living longer



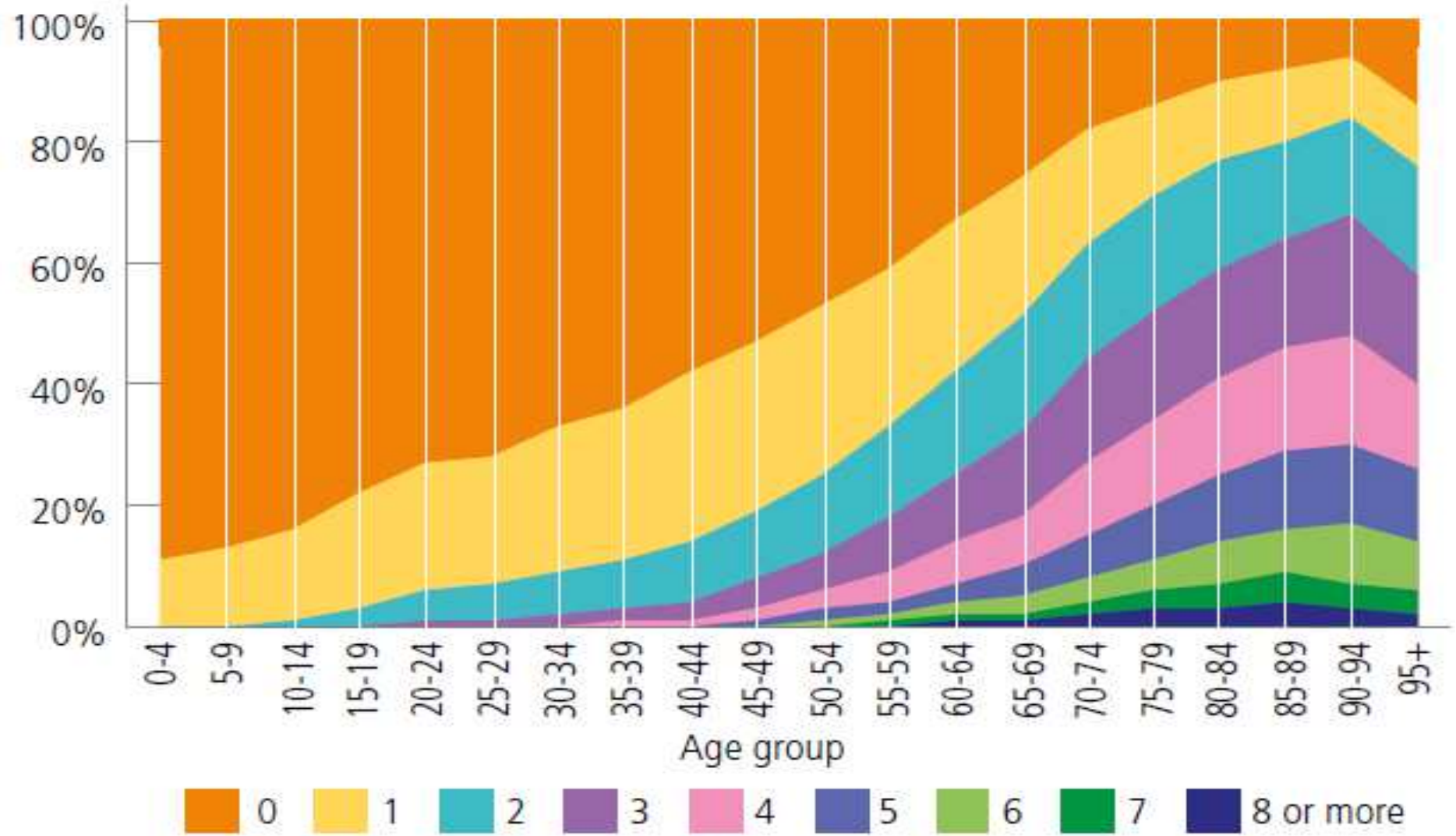


We are living longer but in ill-health - and health inequalities persist

- Between 2001/3 and 2013/15 life expectancy **increased** for males from 75 to 79 years and from 81 to 84 years for females.
- Between 2009/11 and 2013/15 healthy life expectancy **decreased** from 64 to 62 years for males and 64 to 61 for females.
- The healthy life expectancy gap between the most and least affluent local people is 14 years for males and 12.5 years for females.

The challenge of multi-morbidity:

Long term conditions by age Brighton & Hove 2017



Summary

- Demand is increasing
- Complexity is increasing
- Potential for cost to increase is significant
- Integration has the potential to help reduce and better manage demand
- Caring Together is a clinically driven programme to identify improved pathways and models of care
- Considerable future opportunity from further alignment, focussing now on first steps

Caring Together

Current position

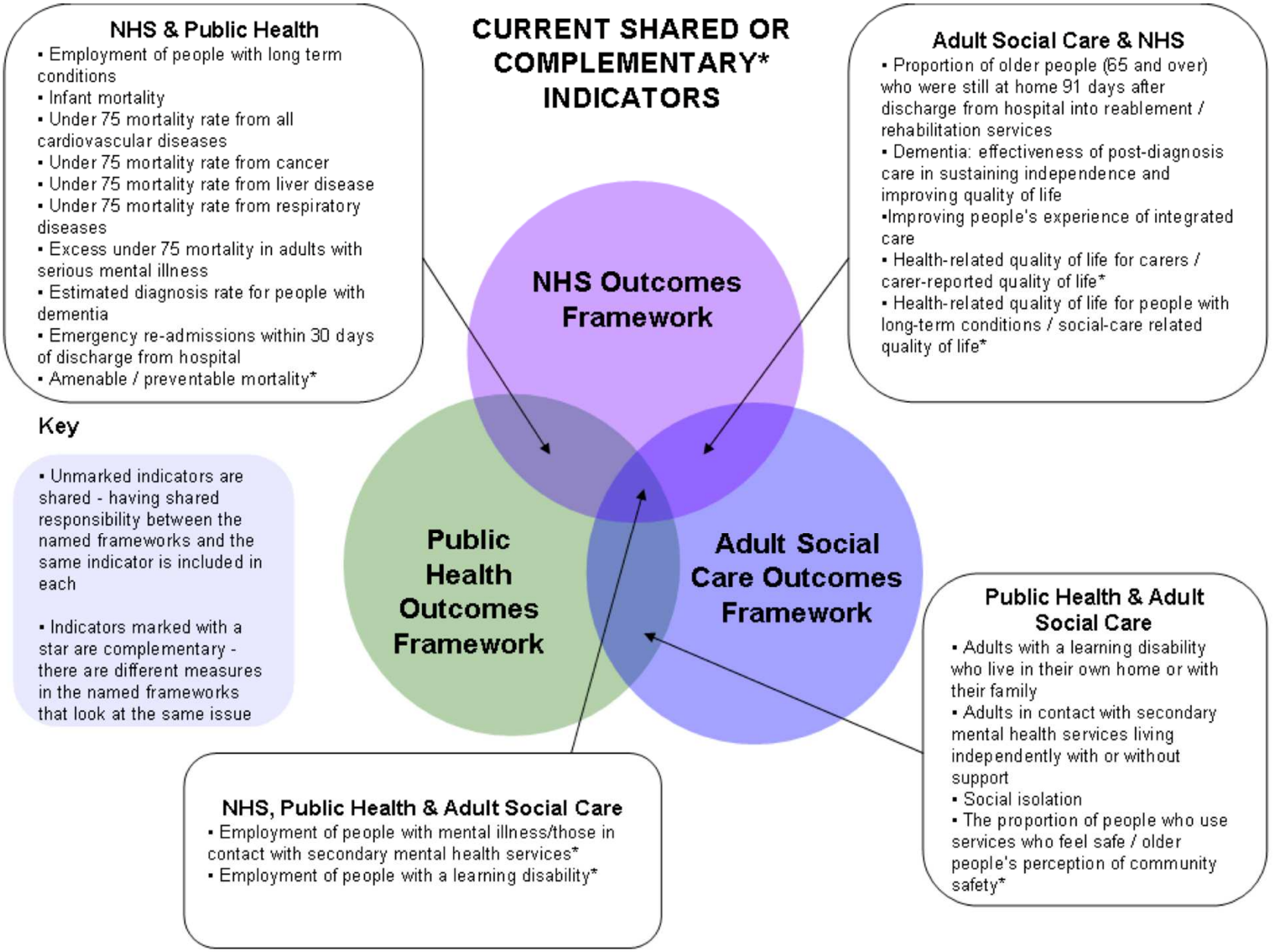
- **The Care Programmes that are currently out for discussion are:**
  1. Preventative Services and Community Care.
  2. Planned Care and Cancer.
  3. Access to Urgent Care and Primary Care.
  4. Mental Health, Learning Disability, Children and Families.
  5. Medicines Optimisation.
  6. Primary Care Development.
- **The objective is to arrive at a system-wide agreement on the outcomes, benefits and timescales of these care programmes by 8 January 2018.**

Big Health & Care Conversation

- Continuing Big Health & Care Conversation communications and engagement during September 2017 and rolling until January 2018
- Significant amounts of engagement taken place, conversations included two open debates about STP and informal ‘drop ins’ for staff
- Big Health & Care Conversation evaluation report will come to the Health & Wellbeing Board in March 2018
- Our engagement will continue in 2018 building on data gained in the first phase

Caring Together / Integration

- Social Care and Health working together more closely
- Whole systems approach to managing demand
- Whole Systems Reporting group -more sophisticated analysis to understand demand across the whole Health and Care System
- Caring Together Outcomes Framework
  - overarching indicator set to track progress towards high level outcomes, evidence effectiveness of new ways of working and highlight areas requiring improvement.
  - Combines existing statutory frameworks and local transformation metrics

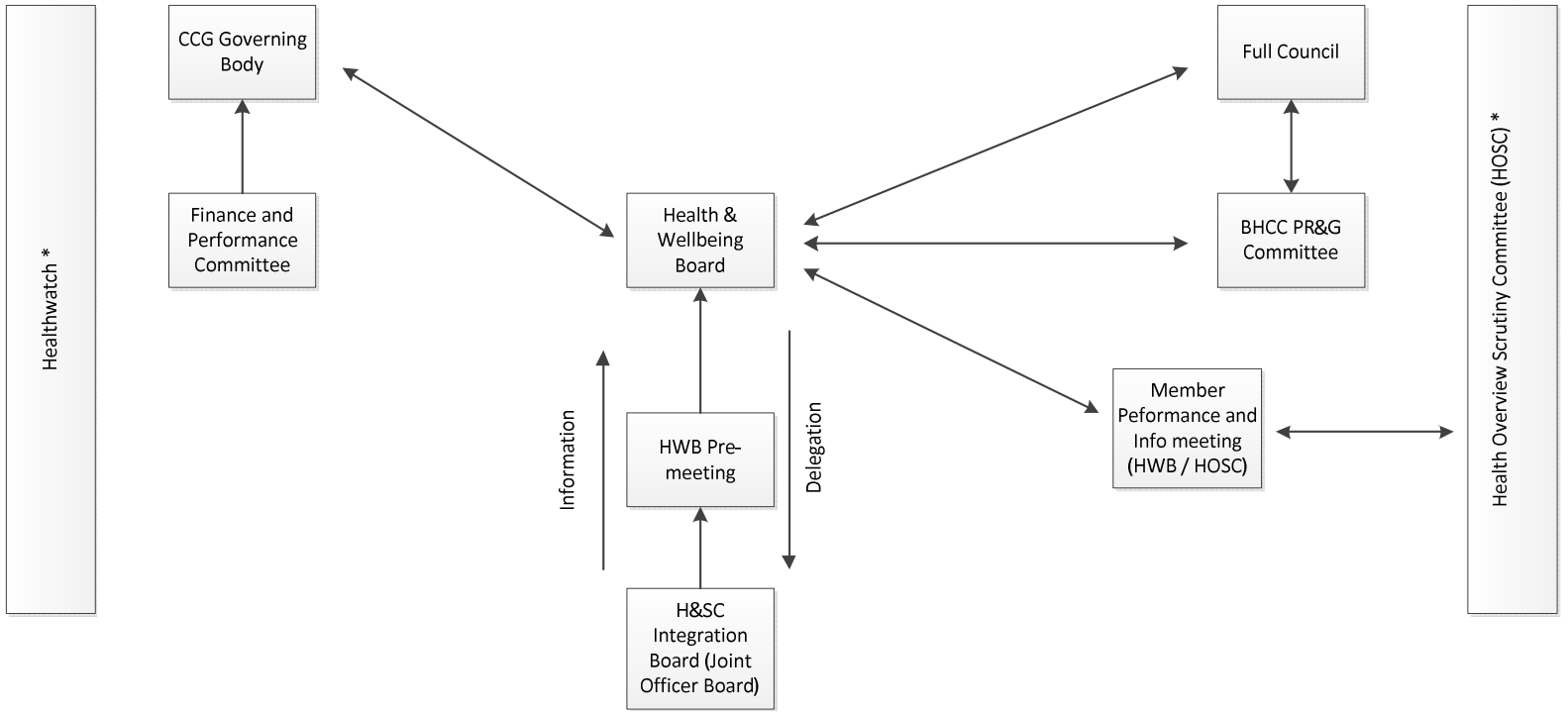

CURRENT SHARED OR COMPLEMENTARY* INDICATORS
NHS & Public Health
• Employment of people with long term conditions
• Infant mortality
• Under 75 mortality rate from all cardiovascular diseases
• Under 75 mortality rate from cancer
• Under 75 mortality rate from liver disease
• Under 75 mortality rate from respiratory diseases
• Excess under 75 mortality in adults with serious mental illness
• Estimated diagnosis rate for people with dementia
• Emergency re-admissions within 30 days of discharge from hospital
• Amenable / preventable mortality*
Adult Social Care & NHS
• Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
• Dementia: effectiveness of post-diagnosis care in sustaining independence and improving quality of life
•Improving people's experience of integrated care
• Health-related quality of life for carers / carer-reported quality of life*
• Health-related quality of life for people with long-term conditions / social-care related quality of life*
NHS Outcomes Framework
Public Health Outcomes Framework
Adult Social Care Outcomes Framework
Key
• Unmarked indicators are shared - having shared responsibility between the named frameworks and the same indicator is included in each
• Indicators marked with a star are complementary - there are different measures in the named frameworks that look at the same issue
Public Health & Adult Social Care
• Adults with a learning disability who live in their own home or with their family
• Adults in contact with secondary mental health services living independently with or without support
• Social isolation
• The proportion of people who use services who feel safe / older people's perception of community safety*
NHS, Public Health & Adult Social Care
• Employment of people with mental illness/those in contact with secondary mental health services*
• Employment of people with a learning disability*

Manging the process

- Integration paper going to CCG GB in November and approved at Brighton & Hove City Council Policy, Resources and Growth Committee 12 October 2017
  Report available here:
  https://present.brighton-hove.gov.uk/Published/C00000912/M00006704/$$ADocPackPublic.pdf
- With recent announcement of establishment of Central Sussex Commissioning Alliance from January 2018 we are actively discussing a complementary relationship with city based integration proposals
- Formally begin shadow year working together from April 2018
- Start to see some changes now e.g. Board papers being more strategically focused
- The shadow year governance structure follows

Governance Structure

Proposed shadow year Governance arrangements commencing April 2018



Hove Caring Together.
* Whole system scrutiny

Questions and discussion

Dr. David Supple

Rob Persey

HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 31 Brighton & Hove City Council

Subject:		**GP Sustainability: December 2017 Update**
Date of Meeting:		**06 December 2017**
Report of:		**Executive Lead, Strategy, Governance & Law**
Contact Officer:	**Name:**	**Giles Rossington** **Tel: 01273 295514**
	Email:	**Giles.rossington@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 Pressures on GP practices have continued to increase over recent years, with a number of Brighton & Hove practices closing in the past two years. The HOSC has been monitoring the situation, and this report is the latest update on GP sustainability.

1.1 This paper provides an update on the situation and members may wish to request a further update at the February 2018 meeting. Information supplied by the CCG is attached as **Appendix 1-5** to this report.

2. RECOMMENDATIONS:

2.1 That members note the information contained in this report and the appendices supplied by the CCG.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 Demand on GP services has been increasing nationally for some years, with problems including: the recruitment and retention of GPs and other practice staff; increasing workload; the suitability of premises; and the sustainability of the current GP partnership model.

3.2 All of these issues have been experienced locally. Brighton & Hove has lost eight GP practices in the past two years, with each closure impacting on surrounding practices.

3.3 City GP services were previously commissioned by NHS England with input from Brighton & Hove CCG, but from April 2017 the CCG has taken on full responsibility for GP services. Additional information, supplied by the CCG, on the current state of GP practices in the city and on the work being undertaken to understand and improve local GP practice sustainability is included as **Appendix 1-5** to this report.

3.4 The appendices deliberately do not provide complete answers or a fully worked up vision and strategy at this stage because the CCG's intention is to co-design these in partnership with member practices, patients/the population and key stakeholders (including the council).

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 None to this report which is for information rather than decision.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 None undertaken in regard to this report for information.

6. CONCLUSION

6.1 Members are asked to note this report and to consider whether this issue requires further scrutiny.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications

7.1 None to this report for information

Legal Implications:

7.2 There are no legal implications to this report.

Lawyer Consulted: Elizabeth Culbert Date: 02/10/2017

Equalities Implications:

7.3 None arising directly from this report for information.

Sustainability Implications:

7.4 None arising directly from this report for information.

Any Other Significant Implications:

7.5 None arising directly from this report for information.

SUPPORTING DOCUMENTATION

Appendices:

1. Outline for a Primary Care Strategy provided by Brighton & Hove CCG
2. National Tends in Primary Care Workload graph (provided by CCG)
3. Comparative Workforce Data graph (provided by CCG)
4. Indicators used to assess practice vulnerability under the QAT
5. Categories under which Practices will be considered for the Practice Support Toolkit

A Strategy for Primary Care – Initial Outline

1. National Context

Primary care is pivotal to any health and care system. Primary care is under significant and sustained pressure across the country and this is reflected in the series of recent national documents and requirements that have been issued over the last few years, the main one of these being the GP Forward View (GPFV), which stresses the need to address the triple challenge of population health, service quality and finance. The GPFV sets out a requirement for CCGs to address:

- service development
- access
- workload
- workforce and
- premises

Dr Arvind Madan, Medical Director of the Department of Health, refers in the GPFV documentation to the need to "reimagine the clinical model, the business model and the career model of General Practice".

2. Local Context

Caring Together is the Brighton and Hove single strategic programme to transform health and social care. Its five Care Programmes and Enabling Programmes set out the framework for this transformational work to be done. A key outcome of this programme will be to shift CCG service delivery (and, therefore, expenditure) away from acute settings into community settings, to improve patient care/experience and enable the CCG to meet its financial targets.

To date, issues concerning primary care development have been included in the Urgent Care/Primary Care Access Care Programme. A new Care Programme specifically for primary care will now be established to ensure that the underlying structural weaknesses in primary care are addressed in the context of Caring Together overall, thus enabling primary care to take a greater role in demand management as a vehicle for the delivery of financial balance.

3. The Current State of Play in Primary Care

There is no "one size fits all" approach to primary care in Brighton and Hove. Some practices are successful, stable, profitable and able to recruit. Generally speaking, these practices:

- have larger populations
- are in less deprived areas
- teach/train
- are innovative in their approach (e.g. to demand and capacity planning)
- use skill mix in new ways
- have strong management
- have a successful business model that brings the necessary funding into the practice

However, there are an increasing number of practices that are to some extent vulnerable and struggling, which tend to be smaller, in more deprived areas, find it hard to teach and train and therefore to recruit. The majority of these are in the east of the city. This has the effect of reducing their ability to innovate, or claim funding for work undertaken with a resulting reduction in morale, service quality and future resilience.
Of the recent practice closures in the City, most have been smaller practices that have become increasingly unviable for either staffing or financial reasons. Their closure could therefore be deemed to have had a positive impact on the quality of service that local patients receive and in terms of achieving a sustainable future model of primary care.

4. Underlying Causes

To penetrate below the surface of the above reveals the following key underlying issues:

4.1 – Workload/Workflow

- There has been a relentless increase in workload over a sustained period (much shifted from acute settings with little or no resource following it); there are very few local data to evidence this but some national data are set out in Appendix 2. Also, the number of patients with complex needs per GP/practice has increased.
- There is also an increasing mismatch between practices' capacity and patient expectation.

4.2 – Workforce

- There are increasing numbers of vacancies in our practices for both GPs and nurses. At the time of writing, our most up to date understanding of the vacancies are as follows:
  - As of 31/10/2017 across Brighton and Hove, there are a total of 11 GP, 3 Practice Nurse and 1 Advanced Nurse Practitioner vacancies advertised online [source: LMC website, BMJ Careers and NHS Jobs]. The data to develop any kind of trend analysis of this are simply not available to us at this stage.
  - According to the workforce Minimum Data Set (wMDS), there has been a decrease in the total number of reported vacancies across NHS England South (South East) since 2015-16. During 2015-16, there were a total number of 264 vacancies, including 116 GP vacancies. This reduced to 248 vacancies overall, with 98 GP vacancies during 2016-17.
  - NHS England South (South East) reports the second highest number of vacancies across England, with NHS London recording the highest number of vacancies. [source: workforce Minimum Dataset, NHS Digital, General Practice Vacancy Tables, 2015-16 and 2016-17].
- Younger GPs are often reluctant to take on partnerships because the commitment and risks involved do not appear to be outweighed by the advantages.
- Older GPs see little hope for the future except retirement, with 55 being the optimum retirement age from a personal financial perspective for most GPs.
- Locums earn more and work less than partners.
- Teaching and training are loss making.
- Pathways from GP and practice nurse training institutions into practices are not well developed.
- There is a lack of data on workforce.

The actions that the CCG are taking to manage these vacancies in the short term are as follows:

- Working with the local universities and the medical school to establish clearer career pathways into Primary Care for GPs, Nurses, Pharmacists and other new roles (i.e. Paramedics, Physiotherapists).

- Brighton and Hove CCG are part of an STP wide bid to attract international doctors to work in Brighton.
- Engaging with the Community Education Provider Network (CEPN), practices, and local GP and Nurse education networks, to create a standardised package of mentorship and preceptorship provided to attract newly qualified GPs and Nurses to general practice.
- Understanding the career aspirations of newly qualified GPs and Nurses to help practices improve their recruitment processes by engaging with those in training.
- Establishing a Locum Nurse and GP bank to help retain clinicians who are looking to retire.
- Supporting practices to introduce new roles into practices and upskill existing staff to manage increasing workload demands, whilst also helping to retain staff (and learning from practices which are already doing this).
- Engaging with local schools and colleges to promote careers in primary care.

4.3 - Finance

- Nationally, practices' profits have been falling since 2006, because costs (e.g. superannuation) have increased and contract values have fallen behind inflation.
- The Global Sum capitation payment for Essential Services was originally intended to cover practices' costs, with Enhanced Services entailing additional work for additional funding. However, the national adjustment formula to payment of the Global Sum does not always reflect the additional workload associated with deprived populations.
- 8-9% of CCGs' funding is spent in primary care, even though undertakes considerable more of the activity.

4.4 - The Overall Model

- The Independent Contractor status model has brought advantages to many for a considerable period – especially the registered list, which creates a strong sense of mutual loyalty between patients and their practice/clinical staff. However, with the changes described above, the model would appear to work for some practices and not always for others.
- Too much variation in service provision is allowed under the same contract – i.e. a practice that invests in staff, training and premises receives the same funding as a practice that does not.
- Stronger practices have little incentive to change their business model, whilst weaker practices are open to change because there appear to be few alternatives.
- This has led to considerable inertia in many cases, with many practices so overwhelmed with work that they are unable to think beyond the day to day and cannot imagine a different future.

5. Opportunities

However, there are significant opportunities to turn this situation around:

- The CCG may be able to find additional funding for primary care out of its current allocation, now that the allocation includes primary care under co-commissioning, (with the caveat that the CCG's overall financial position through QIPP is strong enough to support this). [QIPP: Quality, Innovation, Productivity and Prevention is a national NHS improvement programme that provides additional funding for local areas that are able to make measurable quality improvements.]
- There is additional Access funding due to reach us (£3.34/pt for 170,000 pts in 2018/19, rising to £6/pt for 170,000 pts by 2019/20).

- Co-commissioning offers local flexibility over the use of Quality and Outcomes Framework – QOF - (a national framework for rewarding practices for providing systematic high quality services) and DES (Directed Enhanced Services – nationally mandated services over and above essential primary care services) funding
- A Medical School and Universities are within the City, giving easy access to the organisations that train the next generation of clinical staff.
- The Community Education Provider Network (CEPN) is now established, which provides a forum to bring together those involved in training and education; the CEPN holds budgets for workforce development that the CCG can bid to receive and leads on overseas recruitment.
- New patterns of service delivery are beginning to develop (e.g. Practice Assist).
- Primary care at scale is also emerging (through the relaunched clusters and the nascent Federation).

6. The New Way Forward for Primary Care – Structural Solutions

The situation summarised above is multi-faceted and long standing. The solutions to address this need to be both bold and ambitious on the one hand but also locally-sensitive and carefully planned on the other.

An overall approach for addressing the above structural problems in our practices is set out below in the form of eight key, interdependent interventions. Because of their interdependence, they will need to be quantified and costed in such a way that allows us to assess their impact intelligently, as far as possible.

The eight interventions are consciously not worked up in detail at this early stage but are put forward for discussion, on the understanding that they need:

- The overall support of the membership, patients/the public and other key stakeholders (e.g. Council); and
- Detailed planning before any firm commitments are made.

The next iteration of the strategy document will include an engagement plan, setting out the process and timescales by which we will seek the views of the key stakeholders.
It should be noted that many of the proposals below are already developing and that several practices are well advanced with work in several areas (e.g. workflow, workforce, informatics). We should build on the expertise we have locally available and make it easy for it to be shared easily and consistently.

6.1. - Identify vulnerable practices and establish interventions to bring resilience and stability

The Quality Assessment Tool (QAT) is the tool we use to identify vulnerable practices, along with local intelligence. The indicators used to assess practice vulnerability are set out at Appendix 4.

This will be supported by a Practice Support Toolkit, which will set out the different interventions that the CCG can offer and/or facilitate for vulnerable practices, in order to establish them as strong and viable for the long term future (and avoid them becoming dependent on constant bail outs). The overall categories under which practices will be considered are attached at Appendix 4.

This will be the focus of our initial work on the strategy.

6.2 – Service Model Redesign

Through Caring Together, we need to describe a future that will enhance patient care/experience and of which Practices and their staff want to be a part. This applies both to the new Primary Care Programme and to the other Care Programmes (Mental Health, Urgent Care/Access, Medicines Optimisation, Community/Prevention), which all need to interact in a way that is coherent for patients, providers and commissioners alike - and which need to add up to an overall model for out of hospital care as a whole. A proposed method of doing this will be developed through Caring Together because the ways that other areas of the health and care system work or do not work have a significant impact on the sustainability and resilience of primary care.

Equally, co-designing the new system with patients is important, so that they trust it enough to use it in the way it is designed to be used. Steps for engaging patients/the public are set out below.

Access will be a key element of this work. We should predicate relevant aspects of the service redesign on primary care at scale, with the Federation and clusters as key vehicles for delivery. One possible example could be to differentiate between patients who need to see “A GP” as opposed to those who need the continuity of seeing “My GP”. Services for the latter should be maintained and supported at practice level, whereas front line primary care services for the former could be provided at cluster or even City-wide level, building on any lessons derived from Practice Assist.

6.3 – Workflow/Workload

We need a far better understanding of how work flows through the primary care part of the system. We should therefore undertake a structured and consistent Demand and Capacity analysis (building on existing work in some local practices) to put numbers behind how patients flow through the system and understand the balance of how many patients require contact with “A GP” and how many require contact with “My GP” (or other healthcare professional) – i.e. we are developing population stratification that is professionally relevant and resonant with those who will use it (primary care, community services, social care, mental health, third sector).

On the basis of this analysis, we should then be able to match agreed need with evidence based interventions. Under Caring Together, we envisage significant numbers of patients with self-limiting illness being diverted away from accessing their practice in the traditional way, which will mean that clinical staff will spend their time with their sickest/most needy patients. A key priority for this work will be the need to develop intensive support for practices to manage complex patients – perhaps setting a target maximum no. of complex patients per WTE GP over time – and to shift the balance of the most expert clinical capacity away from 10 minute appointments towards longer appointments.

We should also support all practices to undertake the Productive General Practice and Active Signposting training and embed the “lean” mind-set behind this in all we do (e.g. in monitoring and claims for Locally Commissioned Services - LCS).

6.4 – Create a Step Change in the Contribution that Informatics makes to our practices

We need to ensure that the three components of Informatics (Information Management, Information Governance and Information Technology) are aligned in a whole systems way, which works smoothly for providers. Considerable expertise already exists in our practices that we should celebrate and exploit to the maximum. The suggestions below are merely a starting point for the work that is needed.

The CCG should take and communicate clearly the strategic decision that the Summary Care Record – Additional Information (SCRAI) is the basis for ALL shared record keeping and interoperability work across the entire health system.

We should design templates, claims etc. such that clinicians just have to enter the right clinical code into the computer, with the system automatically generating claims, activity monitoring information etc.

We should develop the systems to generate centrally searches of practices' systems (e.g. to refer patients to existing health promotion services, make formulary changes, launch new pathways, produce patient information leaflets, search for drug interactions etc).

6.5 - Workforce

6.5.1 – Short Term

All Clinical staff will need to work at the "top of their licence" (i.e. the most skilled staff see the most needy patients) with skill mix to support this. (This has been piloted in some local practices and there is considerable local learning to be derived from this.)

We should commence strong engagement with Brighton and Sussex Medical School/the Universities to create pathways into our practices for trainee doctors and nurses (partner pathway, salaried GP pathway, local locum pathway, fellowship pathway etc.).

We should offer to employ retiring GPs and practice nurses in a local "agency" (see section 7 below).

We should undertake (possibly through the Federation) an advertising campaign to attract GPs and practice nurses to Brighton, starting with work with the practices who wish to attract staff to help them understand how to make themselves attractive to the market place they are now in.

6.5.2 – Longer Term

The CCG should work with Health Education, Kent, Surrey and Sussex (HEKSS), the medical school and universities (as well as its own internal training capacity) to ensure that training supports and enables the new ways of working (especially for GPs who will see all the complex patients).

The CCG should use the CEPN to commission the new workforce we need to fill the gaps on a whole systems basis.

We should amalgamate all the money spent on teaching and training placements and commission the new Federation to provide an overall programme of teaching and training placements across the City, with a shared approach to workload/finance and the benefits of growing our own staff.

6.6 – Estates

We have an emerging Estates Strategy. This is now being structured to function on three levels:

- Central Sussex and East Surrey Alliance/Sustainability and Transformation Parntership level, to assess the future state of hospital care and the quantum of care that can be shifted from hospital to community
- Caring Together level, as health and social care learn how to plan premises developments together to support and enable the delivery of Caring Together. (A

multi-agency Caring Together Estates forum has already been established to begin this work, building on the work of the Greater Brighton Operational Estates Forum.)

- Cluster level, as clusters develop their own estates plans, using the existing estate to its maximum potential and sharing facilities where possible – the "Hub and Spoke" approach.

The early work on our Estates strategy – informed by a "Six Facet Survey" earlier this year - has identified possible hub sites at Hove Polyclinic, Preston Barracks/ Moulsecoomb Neighbourhood Hub and Palace Place, using the Caring Together model of integrating out of hospital services (community/mental health/social/third sector care). This will involve a debate over the balance to strike between quality and quantity of premises. This debate will need to be informed by analysis of travel times and will take different forms across the different communities that make up our City.
For existing premises, we should develop an offer to digitise paper notes and store them off site to free up space in practices where space is lacking.

6.7 – Facilitating Primary Care at Scale

In order to address some of the key challenges set out in section 4 above, we need to create/foster/commission an NHS organisation to provide an offer of infrastructure support to those practices who want/need it. (This could enable medium sized practices to continue to exist but be more resilient.) The options offered to practices could include:

- Employ staff/provide back office functions (IT, finance, HR, BI etc.)
- Employ those GPs who wish to be salaried
- Add its Medical Director as a signatory to practices' contracts to provide resilience and easy succession planning
- Hold leases for those practices for whom this is a challenge, in exchange for involvement in the practices' work as providers
- Subsidise/negotiate down indemnity rates by representing large numbers of GPs and providing them with infrastructural backup for their work
- Harmonise pay rates across Out of Hours, 111, Extended Hours Services etc. by coordination and representation of large numbers of clinical staff.

The Federation could be or be a key part of this organisation and it will need to be a key part of any future Accountable Care System.

Cluster development will also facilitate this form of working, with relaunched clusters developing primary care's role as both provider and commissioner over the coming months.

6.8 – A new investment model for Practices in Brighton and Hove

The relationship between the CCG's management team and its member practices needs to be re-set in many ways, with a greater recognition of the interdependence between the provider and commissioner functions that come together in primary care. We should therefore develop a "New Deal" for this, with two components:

Component 1 - Strengthen Core Funding in our Practices

This could include:

- Work on practices' core funding to reflect the additional workload associated with deprivation.
- A streamlined or single payment for QOF and LCSs
- A Care Homes LCS

Component 2 – Strategic Practice Development

In return for the above offers, our practices should commit to an agreed programme of development at both practice and cluster/Federation level. There should be two key elements to this:

6.8.1 - Provider Role Development:

This will ensure practices are all strong and vibrant and could include a commitment to:

- Minimum staffing levels/investment in the business, to ensure that the new investment is focussed on patient care
- Succession planning for key staff and the practice overall,
- Involvement in teaching and training,
- Enhanced reporting of activity and staffing data (see section 6.4 above),
- Data Sharing Agreements/consistent and accurate recording and coding,
- Active participation in cluster/Federation working.

6.8.2 - Commissioner Role Development

This will both feed and feed off practices' role as commissioners through CCG membership and could include a commitment to:

- Take responsibility/ownership of a cluster based budget for the majority of NHS spending;
- Participate in CCG wide and local demand management programmes (including Clinically Effective Commissioning and Peer Review) to support the above;
- Work with the CCG to create savings to be ploughed back into community-based services.

6.8.3 - Schematic Summary

The read across from the challenges identified in section 4 to the interventions in section 6 could be summarised as in the table below:

	QAT/ Toolkit	Service Redesign	Workflow/ Workload	Workforce	Infor matics	Estates	PC at Scale	'New Deal'
Practice Closures	**Y**	**Y**	**Y**	**Y**		**Y**	**Y**	**Y**
Work load	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**
Work force	**Y**	**Y**	**Y**	**Y**			**Y**	**Y**
'Haves' vs 'Have nots'	**Y**	**Y**		**Y**		**Y**	**Y**	**Y**
Overall model		**Y**	**Y**	**Y**		**Y**	**Y**	**Y**
Finance	**Y**		**Y**	**Y**			**Y**	**Y**
Culture		**Y**		**Y**	**Y**	**Y**	**Y**	**Y**

7. Engagement/Governance

As indicated above, there are a large number of "moving parts" in primary care and its interfaces with the rest of the health and care system. We need to balance the following:

- Careful planning, to avoid unintended consequences
- Member ownership and engagement
- Patient/public and other stakeholder engagement
- Conflicts of interest
- The need for a rapid impact in key areas, to prevent some of our current vulnerable practices from becoming crisis practices.

7.1 – Contextualising the Work within Caring Together

Primary Care is now a Care Programme in its own right within Caring Together. As with all Care Programmes, Project Plans are being developed, which will set out the outcomes, processes and success criteria for each of the eight key interventions.

7.2 – Membership Engagement

At the locality meeting on October 17th 2017, the underpinning assessment of primary care and the eight proposed key interventions were tested out with member practices. The overall response was positive, indicating that the eight intervention areas are appropriate and should be developed with the membership and key partners. This will be done through the relaunched clusters. The Organisational Development element of the New Deal (see 6.8.1 above) will also begin to be worked out through the clusters

7.3 – Patient/Public Engagement

Considerable engagement has occurred with Patients/the Public - most recently through the Big Health and Care Conversation – on the subject of primary care. Key themes that have emerged to date include: access, self-care and communication (especially for those with special needs).

A further series of engagement meetings will take place in the coming months, including the creation of a special reference group, constituted via Patient and Public Group chairs, to provide feedback to specific points of the strategy as it develops.

7.4 – Wider Stakeholder Engagement

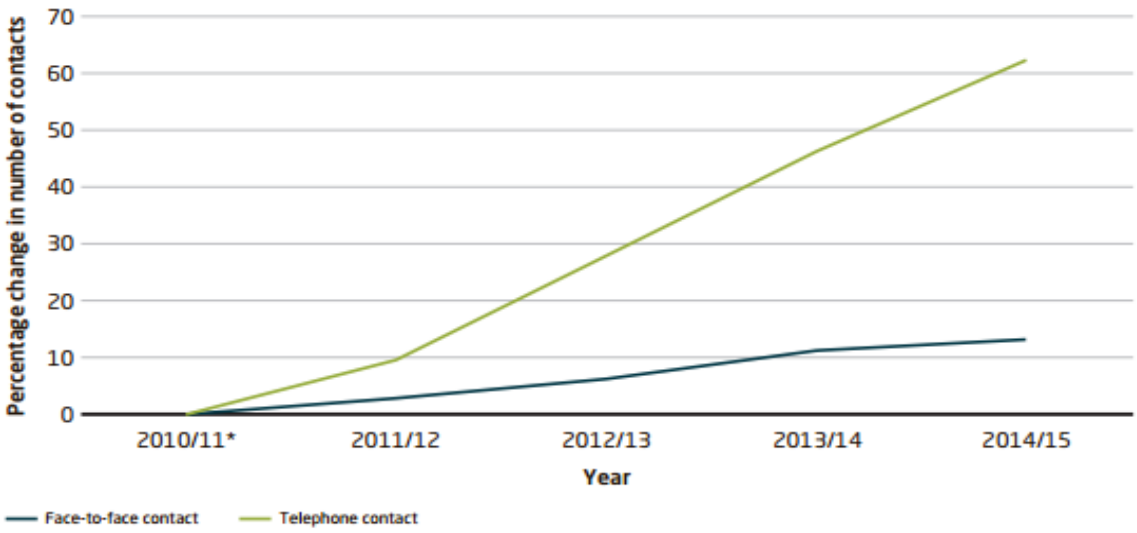
The Caring Together infrastructure provides the ideal opportunity for engagement with key partners – both commissioners and providers. As the Primary Care Programme develops, it will feature in the Care Programme Board, Programme Executive Group and Partnership Board meetings. This will enable key partner organisations in the Council and third sector to provide input and thinking to the strategy.

7.5 - Next Steps

Once the Governing Body's input and support have been secured, an intensive process of planning will begin, with underpinning analysis, to ensure the quickest but best possible delivery of the strategy. Given that the CCG's management team's capacity is already stretched, innovative ways of increasing capacity and/or getting the best from the existing capacity will need to be found for the work to progress at pace. It is hoped that the team will begin to spend less time on firefighting and more on strategy as we bring increasing stability to the system.

Appendix 2 – National Trends in Primary Care Workload

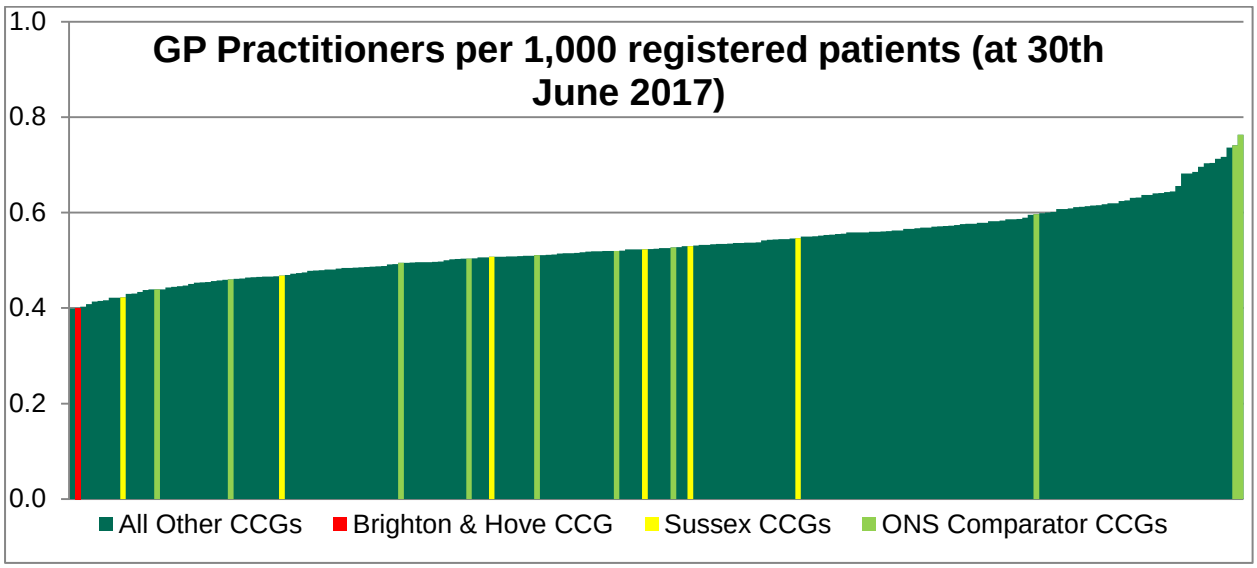
Figure 2 Percentage change in number of contacts with clinical staff by activity type



* Apr/May 2010 contact count estimated based on other years' data

Source: King's Fund analysis of ResearchOne sample data

Appendix 3 – Comparative Workforce Data



Appendix 4 - Indicators used to assess practice vulnerability under the QAT

The data are calculated, where appropriate, using the Carr-Hill weighted capitation data. The indicators include:

Workforce:

- *Clinical Staff per 1,000 patients*
- *Single handed/Two handed or larger*

Quality/Patient Experience:

- *CQC status*
- Friends and Family Test
- GP Patient Survey
- QOF
    - Total achievement
    - Exception reporting

Access:

- List open, closed or capped?
- EHS practice?
- Provides Extended Hours?
- Participates in full range of DESs
- Participates in full range of LCSs
- IC24 usage

Public Health:

- Flu Imms
- Cervical Cytology
- Childhood Imms

Uptake of Acute Services:

- GP referrals to OPD
- A&E usage
- Non-elective admissions
- RMS referrals

Digital Maturity

Estates

Medicines Optimisation

Local Intelligence

These are kept under review.

Italics indicate that this indicator carries a double weighting.

Appendix 5 – Categories under which Practices will be considered for the Practice Support Toolkit

These are as follows:

- System Surveillance
- Early Intervention
- Structured Support
- Rapid Response Intervention
- Crisis Management

The proposed interventions include:

- A visit by a CCG GP, Practice Manager, Practice Nurse and CCG manager to facilitate a diagnostic around a specific area of identified vulnerability
- A visit by a champion of Productive General Practice (PGP) to facilitate a PGP approach to a specific area of identified vulnerability.
- Short term support (such as Practice Assist remote GP appointments to cover a short term clinical staff shortage).
- Short term support using a locum practice manager.
- Short term use of roles to alleviate workload for example an accredited locum Pharmacist or Advanced Nurse Practitioner.
- Reminder to practices of funding that can be claimed, such as funding for GP absence through sickness.
- Free training and coaching from the NHS Leadership Academy[1] for all practice staff to support practice redesign.
- Promotion of Health Champion Training[2].
- Access to Care Navigation training for receptionist staff to direct patients to self-help online tools. In most practices, this has increased job satisfaction for receptionists and released more of the GPs time.
- Promotion of the free confidential NHS GP Health Service[3] to improve access to mental health services for GPs and trainees.
- Advice and guidance on workforce planning issues, for example, help with succession planning and managing upcoming retirements.

[1] NHS Leadership Academy https://www.leadershipacademy.nhs.uk/resources/coaching-register/
[2] Becoming a Health Champion: https://www.healthwatchbrightonandhove.co.uk/news/become-a-ccg-health-champion/

[3]NHS GP Health Service: http://gphealth.nhs.uk/

HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 29 Brighton & Hove City Council

Subject:		**NHS 111 Tender for New Contract**
Date of Meeting:		**06 December 2017**
Report of:		**Executive Lead, Strategy, Governance & Law**
Contact Officer:	**Name:**	**Giles Rossington** **Tel: 01273 295514**
	Email:	**Giles.rossington@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 111 is the NHS telephone service for non-urgent calls. The current 111 contract for Sussex & Surrey ends soon, and a new combined Sussex 111 and GP Out of Hours contract for Sussex will replace it.

1.2 The HOSC received an initial report on this work at its 06 September 2017 meeting. The current report provides an update on progress since September. A further report is planned in around a year's time, once mobilisation of the new contract has been completed.

1.3 Information provided by NHS partners is included as **Appendix 1** to this report.

2. RECOMMENDATIONS:

2.1 That members note the contents of this report.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 NHS 111 is a telephone service that gives advice to patients with non-urgent queries and signposts to other NHS services.

3.2 The current local 111 contract is a joint contract for 17 CCGs in Sussex and Surrey. The provider is South East Coast Ambulance NHS Foundation Trust (SECAmb). This contract has now run its course and it is necessary to re-procure the service. (The current contract has been extended for 12 months while a new contract is agreed.)

3.3 Commissioners have taken the opportunity to re-design the 111 contract to make it more effective. This includes combining it with the GP Out of Hours contract, as there is a considerable symbiosis between the two services. The new contract will be for the seven Sussex CCGs only. A smaller contract will be easier to flex should the local urgent care system change significantly. Coastal West Sussex

CCG is leading on this procurement, although all Sussex CCGs are responsible for and actively involved in the process.

3.4 An update on the progress of the procurement has been provided by Coastal CCG and is included as **Appendix 1** to this report. The current timetable has commissioners beginning the formal tender process in early 2018, with a view to awarding the contract in September 2018 and beginning mobilisation in early 2019.

3.5 It is proposed that the HOSC receives a further update in around one year's time. This is the earliest point at which commissioners are likely to have meaningful data showing how well the new contract is operating.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 Scrutiny of an ongoing procurement process is tricky because commissioners are able to provide little or no information during the actual tender process due to concerns around commercial sensitivity. An approach to scrutiny which includes consultation before the tender formally begins, and then further consultation after the contract, has been mobilised is consequently generally considered to be best practice. Members could seek to request more updates than those proposed, but these would be of limited value.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 None directly relating to this report. Commissioners have committed to engage with the public on the new 111 plans.

6. CONCLUSION

6.1 Members are asked to note this update and the intention to provide a further update report in around a year's time.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 None to this report for information.

Legal Implications:

7.2 There are no legal implications to this report.

Lawyer Consulted: Elizabeth Culbert; Date: 13/09/17

Equalities Implications:

7.3 None identified.

Sustainability Implications:

7.4 None identified.

Any Other Significant Implications:

7.5 None identified.

SUPPORTING DOCUMENTATION

Appendices:

1. Information provided by Coastal CCG.

Background Documents:

1. NHS England Integrated Urgent Care Service Specification (2017) https://www.england.nhs.uk/wp-content/uploads/2014/06/Integrated-Urgent-Care-Service-Specification.pdf

Update on the NHS 111 Integrated Urgent Care Clinical Assessment Centre for Brighton and Hove City Council's - Health Overview and Scrutiny Committee.

December 2017

Existing contract extension 1 April 17 – 31 March 2019

On 5 October 2017, the Care Quality Commission (CQC) published its report on Kent Medway Sussex Surrey (KMSS) NHS 111 service reporting on both SECAmb and Care UK's respective contact centres. The service was assessed as good overall and it identified that the leadership arrangements were outstanding.

As part of the agreement to extend the contract until March 2019, six clinical pilots were identified, with the aim of increasing clinical contact with patients and innovating through proof-of-concept potential future operating models. A Joint Commissioner Provider meeting is held monthly to monitor the development and implementation of these pilots.

The Directory of Services

The Directory of Service (DoS) is a database that holds NHS service information currently utilised by 111 call handlers to direct people to the most appropriate service for their presented symptoms. To allow the call handlers to do this effectively the information held on the system must be accurate and relevant.

Across Sussex we have a DoS lead who is based in the NHS 111 Transformation Team. Each of the seven Sussex CCGs has a DoS Champion who support and update the directory with changes to local services.

There are two programmes of work currently being rollout in the DoS system:

- NHS Urgent Medicine Supply Advanced Service' (NUMSAS) - The NUMSAS provision allows call handlers to direct callers to a pharmacy within their area which can provide them with an emergency supply of repeat prescription-only medication should the caller have insufficient supplies
- Mini DoS (MiDoS) - The MiDoS is a system that will allow health and care professionals to remotely access service information currently available to call handlers on the DoS. Once the system has been established for use by clinicians, a version of the MiDoS will be rolled out for public use. This will be accessible through websites and in the form of an app for smart phones and tablets.

Update on the 111 Transformation Programme:

National Specification:

This August NHS England published the national Integrated Urgent Care specification. This specification has moved from being advisory to mandated. It stipulates that all CCGs are required to commission a service that delivers against the nine key elements of the Integrated Urgent Care (IUC) service:

1. A single call to get an appointment during the out-of-hours period
2. Data can be shared between providers
3. The capacity for NHS 111 and urgent multidisciplinary clinical services needs to be jointly planned
4. The Summary Care Record (SCR) is available in the CAS and elsewhere
5. Care plans and special patient notes are shared
6. Appointments can be made with in-hours GPs
7. There is joint governance across Urgent and Emergency Care
8. Suitable calls are transferred to a Clinical Assessment Service containing GPs and other health care and social care professionals
9. The Workforce Blueprint and guidance are implemented across all providers.

The re-procurement and transformation of the existing NHS 111 service into an Integrated Urgent Care Clinical Assessment Service is pivotal in bring together urgent care services and being able to implement new, improved and sustainable services for our local population across Sussex.

Assurance and Governing Bodies:

Throughout September the team have been attending a range of meetings and boards to engage with stakeholders, provide assurance on the programmes activity and deliverables. There were four decisions that the seven Sussex CCG Governing Bodies were asked to make.

1. **Decision one: Approve and follow the National Integrated Urgent Care Service Specification.**
   [Page 11, NHSE Integrated Urgent Care Service Specification]. This service specification supersedes the previous commissioning standards, moving from an advisory set of recommendations to mandatory requirements, to ensure a consistent service across the country.

   [Page 18, NHSE Integrated Urgent Care Service Specification] GP OOH and 111 services will be combined, and multidisciplinary clinicians added to the integrated working model. In addition, the future NHS111 IUC will book people into urgent face-to-face appointments where needed.

   The National Integrated Urgent Care Specification mandates the need to bring 111 and OOH together to form an Integrated Urgent Care / Clinical Assessment Service. **All seven CCGs approved this decision.**

2. **Decision two: Approve the contract value and length.**
   The contract length should be five years with a possible two year extension. The contract will have the necessary break clauses should they be needed.

   The contract value should cost no more than the current 111 and OOH budgets combined. The Governing Body is asked to approve this indicative value. The final cost of the procurement will be ratified in July / August 2018 on award of contract. **All seven CCGs approved this decision.**

3. **Decision three: Procurement Approach.**
   The procurement will follow the standard PQQ (Pre-Qualification Questionnaire) and ITT (Invitation To Tender) route. **All seven CCGs approved this decision.**

4. **Decision four:** Delegate authority to the Accountable Officers to be able to make minor amendments following the decisions at the CCGs Governing Bodies. As the decisions will need to be passed by seven CCG's, authority is sought to delegate to Accountable Officers of the seven CCG's should minor alterations be needed to the procurement. These will then be communicated back afterwards. **All seven CCGs approved this decision.**

We have provided assurance to the following committees and boards:

- Coastal West Sussex Quality Assurance Committee - **Assured**
  Quality Impact Assessment (QIA) **- Approved**
- Coastal West Sussex Public Engagement Committee - **Assured**
  Equality Impact Assessment (EIA) - **Approved**
- Eastbourne, Hailsham & Seaford and Hastings & Rother Finance and Procurement Committee - **Assured**
- Coastal West Sussex Clinical Innovation and Strategic Committee **– Assured**
- East Sussex County Council's – HOSC**– Assured**
- Brighton and Hove City Council's – HOSC -**– Assured**
- West Sussex County Council's – HASC – **Assured**
- A&E Delivery Boards **- Assured**
- STP Programme Board **- Assured**
- STP Clinical Governance Board **- Assured**
- South East England Regional Healthwatch **- Engaged**
- East Sussex Health and Wellbeing Board - **Assured**

Communications and Engagement Activity August to October:

- **Soft Market Testing Event – 26 July 2017**
  We shared our initial thinking for the pan-Sussex NHS 111 / Clinical Assessment Service with perspective providers and the aim of integrated Urgent Care services across Sussex. The highlighted themes needing more information and detail were:
  - Contract Length:
  - Mobilisation Timeframe:
  - Physical Infrastructure Investment:
  - IUC Workforce

- Indemnity
- Information Governance and Data Sharing:
- Caller Consent

A second soft market testing event is taking place on **Tuesday 14 November**. This event will aim to give detail to prospective bidders.

- **The Sussex wide NHS 111 Public Survey**
  Before any new contract is finalised, we wanted to explore with local people, what their priorities are for this service. To ask questions that will give us a clearer steer about what the service we need to buy for our local population.

  We ran a public survey from 17 July to 20 August 2017. We received **1062** response to the survey in total 650 were completed online and 412 were completed from the local newspaper insert.

  There were some groups that we didn't feel we reached effectively through the survey. But they are users of the NHS 111 service. We have agreed to work together with the three local Healthwatchs across Sussex from October to December to reach:
  - ❑ Parents of children who are both over and under 5yrs old.
  - ❑ Migrant communities, such as Eastern European parents
  - ❑ Ethic Groups, such as the Muslim communities in Crawley
  - ❑ The LGBTQ community

- **Patient Participation Group (PPG) and Public Engagement Events**
  Throughout August and September we attended a range of PPG meetings and public engagement events. This was through the seven Sussex CCG's communications and engagement teams.
- **Staff and Clinical Engagement**
  Throughout July, August and September we have been going out and updating and engaging with CCG staff and our clinical membership on the progress programme. This activity will continue throughout the programme.
- **External Stakeholder Engagement**
  An event on 13 September 2017 brought together a range of NHS and Local Authority and Healthwatch organisations. A lesson learned from previous procurements is the need to have regular wider stakeholder engagement. This event also invited MPs from across Sussex. We have had a request to hold the next event on a Friday so that our local MPs can attend.

The 111 Transformation Team - Contact Information

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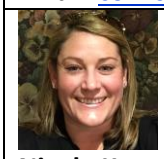
 **Nicola Kemp, Senior Communications & Engagement Manager,** **Sussex 111 Transformation Programme** Tel: 07711920424 Email: nicola.kemp5@nhs.net	 **Dawn Fourniss, 111 Programme Support Officer** **Sussex 111 Transformation Programme** Tel: 07901551957 Email: dawn.fourniss@nhs.net
 **Morven Banks, Senior Commissioning Manager,** **Sussex 111 Contract Team** Tel: 07525 304015 Email: morven.banks1@nhs.net	 **Vinny Hanley, Directory of Services & Project Manager,** **Sussex 111 Contract Team** Tel: 07525906247 Email: vinnyhanley@nhs.net

HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 33 Brighton & Hove City Council

Subject:		**Brighton & Hove Healthwatch Annual Report 2016/17**
Date of Meeting:		**06 December 2017**
Report of:		**Executive Lead, Strategy, Governance & Law**
Contact Officer:	**Name:**	**Michelle Pooley** **Tel: 29-5053**
	Email:	**Michelle.pooley@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 Healthwatch is the local independent consumer champion for health and care.

1.2 Healthwatch is a co-opted member of both the Brighton & Hove HOSC and the Health & Wellbeing Board, and is this year presenting its annual report to the HOSC (**Appendix 1**).

2. RECOMMENDATIONS:

2.1 That members note the Healthwatch annual report (**Appendix 1**).

3. CONTEXT/ BACKGROUND INFORMATION

3.1 The 2012 Health & Social Care Act required each upper-tier local authority in England to commission a local Healthwatch organisation to undertake the statutory responsibility for being the independent consumer champion for health and social care.

3.2 Community Works (then Community and Voluntary Sector Forum) was the successful bidder for the local Healthwatch contract, and Brighton & Hove Healthwatch became operational in April 2013.

3.3 Healthwatch B&H incorporated as an independent Community Interest Company (CIC) organisation with an asset lock on 14 October 2014. This meant that staff moved from Community Works to the new CIC and operated under the new company as of 01 April 2015, with nine active directors.

3.4 In 2015, the organisation restructured as a result of a number of drivers most notably in response to create a fit for purpose organisation capable of delivering its statutory responsibilities and in recognition of the need to improve impact, efficiency and effectiveness in order to be a credible Health and Social Care champion in the city.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 There is no statutory requirement for Healthwatch to present its annual report to the HOSC, but there are obvious benefits in Healthwatch sharing its intelligence with the HOSC.

4.2 The council as part of its statutory responsibility for performance management continues to monitor Healthwatch Brighton & Hove through the Third Sector Investment Programme within a quarterly performance monitoring framework.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 The development of the Annual Report is based on Healthwatch B&H's consistent approach to seeking to hear people's stories about their experiences of health and social care services, using these to develop an effective evidence base. They use their statutory powers to Enter and View any premises so that their authorised representatives can observe matters relating to health and social care services. They also gather information and insight through outreach and by sending trained volunteer representatives to a wide range of public meetings, specialist and strategic committees and decision making forums.

6. CONCLUSION

6.1 The Healthwatch annual report is presented for information.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 None to this report as it is for information.

Legal Implications:

7.2 There are no legal implications to this report

Lawyer Consulted: Elizabeth Culbert Date: 14.09.17

Equalities Implications:

7.3 Healthwatch B&H CIC have updated the actions from the original EIA and have undertaken an Equality Impact Assessment in September 2016 on their Healthwatch activity and the Independent Health Complaints Advocacy Service which is delivered by their partner Brighton & Hove Impetus.

Sustainability Implications:

7.4 None to for this report as it is being presented for information.

Any Other Significant Implications:

7.5 None

SUPPORTING DOCUMENTATION

Appendices:

1. Healthwatch Brighton & Hove Annual Report 2016-17
2. Slides from Healthwatch (noting that some local health services have improved since the period covered by the Annual Report)

healthwatch
Brighton and Hove

Healthwatch Brighton and Hove
Annual Report **2016/17**

Contents

Message from our Chair, Fran McCabe

From its start in 2013, Healthwatch in Brighton and Hove has been challenged by deep seated problems in our health and care system. More people, with increasingly complex needs, are making demands on NHS and care services. Local people expect services to be safe and of good quality. Healthwatch also expect services to provide care that is sensitive to people's individual needs and preferences.

In the last year, our work has continued to be dominated by the NHS agenda, with our local hospital and the ambulance service being put into 'special measures' by the Care Quality Commission [CQC]. The CQC are the official health and care regulators, and work closely nationally and locally with Healthwatch. In addition, the number of GP practices in the City has reduced by about 12% and the Brighton and Hove Clinical Commissioning Group (the CCG is the NHS body that determines what services are available in the city) was identified by NHS England as one of the worst performing CCG's in the Country.

"My Healthwatch Board, all volunteers, have been steadfast through this challenging year and have given up their time liberally. Thanks also to people in the statutory sector, who have opened their doors to us and listened to our challenges."

Healthwatch activities in the City have focused on the Royal Sussex County Hospital [RSCH], which is part of the Brighton and Sussex University Hospitals Trust [BSUH]. The RSCH is a teaching hospital, major trauma centre and includes regional specialist services. Healthwatch has been kept 'on our toes' making sure that the voice of patients and their families has been heard in the NHS response to regulators and inspections.

In the coming year, Healthwatch will continue to be a 'Watchdog' for the NHS but increasingly to also focus on social care, and care in the community. We ended this financial year with a major review of the 'Joint Community Equipment Service' running from January to March 2017. Next year Healthwatch will also do more to ensure that the NHS and care services address equality and diversity issues.

Our volunteers are the backbone of the organisation and I would like to pay tribute to them. Healthwatch has around 40 local people as volunteers. This team are now very experienced in reviewing services. We use trained volunteers to exercise our 'Enter and View' statutory powers. Often we have needed to talk to patients quickly to be able to influence and improve quality and safety improvement plans. Our volunteers have attended meetings and have been our eyes and ears. They have contributed to understanding changes to NHS and care services from the perspective of those most directly affected, namely local people using services on a daily basis. Our support to our volunteers has improved recently and will be a continuing priority next year.

I need also to thank the Healthwatch staff team who have managed this difficult environment. The CEO has only been in post for one year and already we can see his impact and we have to thank him for the development of Young Healthwatch in 2016-17, which we will report on next year.

Regardless of the numerous changes in leadership in the city, recommendations from Healthwatch reports and submissions to decision makers have continued to be implemented. Healthwatch does not, and cannot, claim sole responsibility for all service improvements referred to in this report. Nevertheless, through our powers and position we have provided evidence and arguments ensuring peoples' voices and experiences have been heard and have influenced improvements to services for the citizens of Brighton and Hove and will continue into the coming years.

Message from our Chief Executive, David Liley

I started as Chief Executive for Healthwatch Brighton and Hove in April 2016. My background is in mental health and child protection. I am a registered social worker with senior management experience in the NHS, Social Care and local Healthwatch. It is a privilege to be back working in Brighton and Hove. With all its challenges, this is an exciting, creative and caring place – a great city to live and work and enjoy life. I would like to pay tribute to Nicky Cambridge my predecessor for all the work she did in her time with us.

While this has been a demanding year for Healthwatch Brighton and Hove, it has also been a year of significant success. We have represented local people and challenged decision makers. Healthwatch has made a real impact with tangible service improvements associated with our reports and evidence. Healthwatch has helped local services provide more personal, dignified and safe care.

The Healthwatch staff team has changed in the last year with new posts and new people. For the first time we have a full time professional researcher and two part time project coordinators who will support volunteers in delivering our busy work plan for next year. We have also invested in Young Healthwatch and have a dedicated part time youth worker provided by the YMCA 'Right Here' project.

"Healthwatch in Brighton and Hove have recruited new staff and volunteers. We have delivered a balanced budget, attracted funding in addition to our main contract and retained a working financial reserve."

I believe that our volunteers and staff have made an exceptional contribution to improving local services. In response to staff, volunteer and stakeholder feedback, we have changed the way our volunteers are recruited, trained, briefed and supported. Recently we welcomed 15 new volunteers, seven involved with Young Healthwatch.

During 2016/17 local Healthwatch services were retendered. Healthwatch Brighton and Hove Community Interest Company was retained as Healthwatch providers, and Impetus was retained as providers for the Independent Health Complaints Advocacy service. Both contracts have been extended by two years.

The year at a glance

Practice visits and engagement leading to service improvement

We undertook **67** visits to health and social care services to talk to people about their experiences and make observations about practice.

67
visits

We reached **580** users of the Adult Social Care Equipment and Adaptations service to hear their views.

27 Enter and View visits to Royal Sussex County Hospital.

27 visits to users of Equipment and Adaptations service in their home.

13 Patient-Led Assessments of the Care Environment (PLACE) in Brighton hospitals.

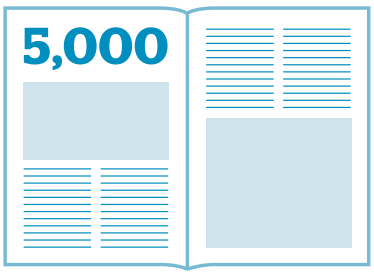
101
recommendations to services were made as a result of these visits which led to **46** actions to improve practice. An estimated **3,700** patients benefitted from these changes.

Communicating the voice of the patient through media

We issued **21** press releases raising the voice of the patient on critical issues.

41

We did **41** interviews for local radio, newspapers and television.



We produced **6** editions of our Healthwatch magazine; **940** paper copies and **500** digital copies of each edition were sent to subscribers, reaching an estimated audience of **5,000** people across Brighton and Hove.

Our website had over
20,000
hits

1,611

521

We attracted **1,611** Twitter and **521** Facebook followers, and our Facebook posts reached over **57,000** people.

Using volunteers to maximise value

Volunteers contributed an average of **180** hours on improving health and social care services..

Volunteers contributed work worth **£26,000** for the **67** site visits.

26,000

Who we are

Healthwatch is the official consumer champion for Health and Social Care Services.

Our vision

We want better health and care services, with consumers' expectations and preferences at the heart of how those services are provided, commissioned, designed, managed and funded. We are working towards a society where all health and social care needs are heard, understood and met.

Achieving this vision will mean that:

- the people who use services shape their delivery;
- people can influence the services they receive in a personal and individual way;
- people hold services to account.

Our priorities

- to help increase consumer confidence in local services by ensuring that decision makers 'keep their promises';
- to promote the involvement of consumers in decisions about health and care;
- provide evidence of consumer experiences of health and care services using our 'enter and view';
- statutory powers and other accredited methods;
- to help decision makers by providing timely evidence and information on topical health and care issues from the service user and public perspective.

We achieve this by

- listening to people, especially the most vulnerable, to understand their experiences and what matters most to them;
- influencing those who have the power to change services;
- informing and empowering people to get the most from their health and social care services;
- working with the Healthwatch national network to champion service improvement and empower local people.

We know that you want services that work for you, your friends and family. That's why we want you to share your experiences of using health and care services with us – both good and bad. We use your voice to encourage those who run services to act on what matters to you.

BRIGHTON PULSE

www.brightonpulse.org

Be a 5 minute volunteer for the NHS!
Visit Brighton Pulse online and tell us your experiences of Health and Social Care services. You can make a difference!

Healthwatch Brighton and Hove – not for profit

We are a Community Interest Company (CIC) set up by and run by local people. Healthwatch is not for profit, any funds we receive or earn are spent helping local people. We have a small paid staff team of four people. Impetus provides our sister service, the Independent Health Complaints Advocacy Service (IHCAS), and Young Healthwatch is provided in partnership with the YMCA. They are also not for profit organisations.

Healthwatch Brighton and Hove CIC has been established for 3 years. Our funding is provided by Brighton and Hove City Council but we are entirely independent from NHS or local council control.

Our Healthwatch Team 2016/17 (below, clockwise from top left): David Liley, Dr Roland Marden, Steve Turner, Magda Pasiut.

Run by local people for local people

Healthwatch Brighton and Hove has 40 trained and supported volunteers who visit services and ask people about their experiences and how they could be improved.

Healthwatch volunteers attend decision making committees and discussion forums to represent patients and people who use social care services. We sit on the Health and Wellbeing Board, the City Council Health Overview Scrutiny Committee, Adult Safeguarding and the Child Safeguarding Engagement Sub Committee. Healthwatch Co Chairs the Royal Sussex County Hospital (RSCH) Patient Experience Panel.

Our volunteers and staff attend approximately 25 standing committees and decision making forums. Those include 'Brighton and Hove Caring Together' and the Sustainability and Transformation Partnership (STP) Board, which leads the STP. Healthwatch has two roles in this STP process:

1. The first is influencing future investment, and the integration of health and care services; GP services and Primary Care; A&E and Urgent Care; Planned Care and Cancer Services, and 'Better Care' in the community and out of hospital care.
2. The second is to provide independent assurance to the public that engagement and consultation is being carried out in line with accepted best practice. We ensure that the people who use services are involved when they are changed, and that the impact of changes on equality and diversity issues is properly considered.

Your views on health and care

Listening to local people's views – improving services

Healthwatch listens to people's views in a number of ways:

- Our volunteers go to hospital wards, outpatient clinics and GP surgeries and talk directly to people using those services.
- Brighton Pulse is Healthwatch's online feedback centre gathering patient views on services.
- We use questionnaires, postal surveys and social media to contact people.
- We regularly ask the views of voluntary and community groups who represent the diversity of our City.
- We listen to all age groups. In the last year we established Young Healthwatch and recommended improvements in services used predominantly by older and frail people.
- Healthwatch has supported Advocacy for the Trans Community.
- We have represented people living in Brighton and Hove and people who travel here for Hospital and outpatient treatments.
- We carry out monthly environment reviews at the RSCH and some other NHS facilities – this has led to direct and immediate improvements to some patient areas.
- Healthwatch provide a peer review of hospital complaints, checking how complaints have been handled and suggesting ways that could be improved. We have a team of volunteers dedicated specifically to that work.
- Next year we plan to extend complaints peer review to Mental Health Services. In partnership with local Healthwatch in East and in West Sussex, that will cover the whole county.

"Healthwatch spoke up for us and made people listen. Patient transport has improved since then."

Vicki, who uses Patient Transport Services for dialysis treatments

What we've learnt from visiting services

Healthwatch reviews usually start when an issue is brought to our attention. Some examples in the last year:

- Local people contacted Brighton Pulse and the Healthwatch Information line about difficulties getting outpatient appointments at the RSCH, and a poor physical environment in some clinics. A year later the booking system was more reliable and administration time was cut from one week to one day. Missed appointments dropped from 10% to 6.6% – below the national average of 8.3%.
- Healthwatch recently raised concerns about privacy and the physical environment at a sexual health clinic in the city. A team of managers and nurses were there the next morning starting an improvement programme.
- From past experience and working closely with the Care Quality Commission (CQC) regulators, we knew that the local A&E Department needed to be improved. Our recommendations made in the A&E report of May 2016 were implemented leading to a redesign of A&E in layout and changing the service delivery model.
- People using the local renal dialysis service drew our attention to failures in patient transport services. Our report published in November 2016 influenced a change of providers and the model for delivering this service.
- Brighton and Hove City Council social care officers asked us to review the Equipment and Adaptations service requesting an independent view of consumer experiences. Our report of March 2017 found high service user satisfaction rates and made recommendations for improving the service and making it more efficient.

In 2016/17 Healthwatch Brighton and Hove had 11 authorised representative volunteers who carried out statutory 'Enter and View' activities on our behalf:

Tony Benton
Mike Doodson
Nick Goslett
Vanessa Greenaway
Carol King
Frances McCabe
Sylvia New
Sophie Reilly
Sue Seymour
Maureen Smalldridge
Roger Squier
Paul Wilson

"Healthwatch has played an important role in being a critical friend to the CCG and has helped us embed the voice of patients in the work we do."

Adam Doyle, Chief Accountable Officer of NHS Brighton and Hove CCG

Helping you find the answers

How we have helped the community access the care they need

- The Healthwatch Brighton and Hove website keeps local people up to date with changes in the NHS and in adult social care.
- We use email, our information line and social media to help individuals, families and carers to access local services and to take more control of their own health and care.
- The Independent Health Complaints Advocacy Service (IHCAS), provided for us by Impetus, helps people resolve problems and complaints with NHS services.
- At times of uncertainty Healthwatch is frequently used by local newspapers, radio and TV to provide the voice of patients and to advise local people about accessing services.

"My GP surgery is closing, I don't know what to do, how will I get my prescription renewed?"

Betty, Whitehawk resident

Betty heard Healthwatch being interviewed on the radio and wanted more advice. Betty does not use the internet, so we advised her over the phone and made sure her grandson was able to go to our web page and get the full details of how to re-register with a new GP. Healthwatch had agreed this advice with the NHS locally and NHS England and we had prepared frequently asked questions that were used by partner organisations to advise local people.

Advocacy support from IHCAS

A woman with serious physical and mental health needs experienced delay and then cancellation of brain surgery at RSCH as staff were unable to locate the patient's notes. An IHCAS advocate made two home visits and liaised with PALS for a resolution meeting with the ward manager and matron of neuro surgery. The meeting provided clarity on her concerns and reassurance that changes had been made to avoid this occurring again. Changes included improved storage facilities on the ward, greater awareness of the tracking system for notes and a new staff position to assist with information sharing with patients. The patient reported that it felt "nice to meet face to face and know that staff took my concerns seriously."

Families and carers

Reena emailed the Healthwatch Office because she was concerned about aspects of the treatment her grandmother was having in a local hospital. Reena lived in London and was not able to visit her grandmother in Brighton very often. The doctors and nurses always seemed so busy and she could not seem to get a straight answer to any queries over the phone. We were able to put her in touch with the Hospital PALS service. They arranged for Reena to have time with a doctor and nurse. They also arranged to have an interpreter visit as her Grandmother is more comfortable using another language.

Making a difference together

Consumer experiences are helping influence change

Healthwatch gathers evidence and produces reports to influence decision makers. These include Brighton and Hove City Council who provide and purchase social care services for adults, families and children and the Brighton and Hove Clinical Commissioning Group (CCG). The CCG, part of the NHS, is led by local doctors and is responsible for purchasing healthcare for local people.

"Social Care, Safeguarding and Public Health have all benefitted from Healthwatch evidence-based reports in the last year. These reports are an important source of independent evidence gathered from patients and service users and can be used to support continuous service improvement."

Rob Persey, Executive Director for Health and Social Care, Brighton and Hove City Council

Healthwatch undertook a review of the Equipment and Adaptations service gathering the views of 580 users and interviewing 27 in their homes. The report highlighted ways in which the needs of users could be better met.

Healthwatch visited the main Outpatients Department at the RSCH and seven specialist clinics: the Cancer Centre, ENT including audiology, Eye Hospital, Fracture Clinic, Gynaecology, Physiotherapy, and Rheumatology. We interviewed 117 people attending these clinics.

Healthwatch also presents reports to the Hospital, Community, Mental Health and Ambulance Trusts that provide health services.

- A new waiting area provided at Royal Sussex County Hospital A&E department.
- People waiting on trolleys now have active and positive nursing.
- Waiting times from arrival at hospital to being allocated a bed decreased.
- Dozens of our suggestions for improvements at the RSCH are being implemented in patient areas including: improved information provided to patients, provision of better signage, better access to hand sanitisers, more consistent practices about use of hand sanitisers, decluttered waiting areas, improved quality of seating.
- All Healthwatch recommendations were welcomed and accepted by the CCG and the hospital. Our recommendations were included in the safety and quality improvement plans for the hospital.

Healthwatch provides evidence to the Care Quality Commission (CQC). The CQC regulates quality and safety in Hospitals, Community Clinics, GP surgeries, Care and Nursing Homes and other Adult Social Care services. Healthwatch worked closely with the CQC when both the BSUH Hospital Trust and SECAmb, the Ambulance Trust went into special measures. Changes recommended by Healthwatch have been implemented.

Working with other organisations

Healthwatch works best in partnership with other organisations. We rely on a network of community and voluntary organisations to help us identify emerging issues.

This year we brought change through partnership:

- Healthwatch provided evidence to the CQC about deficits in the RSCH A&E department and other hospital services.
- When the Brighton and Sussex University Hospitals Trust were placed in 'special measures' Healthwatch immediately offered a package of support to the Trust. Our contribution to improving safety and the Trust recovery plans was praised by the Chair and Chief Executive of BSUH.
- Healthwatch drew the attention of the CQC to the failure of our patient transport services and they followed up with an inspection visit, creating further pressure for more reliable and personalised services.
- Working with clinicians and managers at the Royal Sussex County Hospital, Healthwatch set up monthly consumer reviews of the physical environment. We also provided independent consumer feedback to the RSCH on how they managed patient complaints.
- Healthwatch Brighton and Hove has worked Sussex-wide with Healthwatch in East and West Sussex and also with colleagues in Surrey and Kent to support the South East Coast Ambulance Trust (SECAmb). We helped SECAmb interview for a new Chief Executive, arranged for local people to visit the Ambulance Control Centre and HQ. We also provided advice to the Trust on their recovery plans as they were placed in 'special measures' following an adverse CQC report.
- We have worked with Healthwatch England on preparing to engage local people in the NHS Sustainability and Transformation Programme (STP).
- At the 2016 Healthwatch England National Conference we received two special commendation awards. The first was for promoting equality and diversity recognising local work with the Trans community. The second was for our collaboration with the CQC regulators, which was shared with Healthwatch colleagues across the South East Region.

How we've worked with our community

We helped local people have a direct say in how services were commissioned, provided and managed:

- Healthwatch representatives on the Health and Wellbeing Board and the Health Overview and Scrutiny Committee spoke up about GP closures and the concerns of local people about accessing GP's at high pressure times e.g. Bank Holidays.
- Healthwatch provided authorised training and supported consumer representatives on decision-making forums covering: Adult and Child Safeguarding Primary Care; Community-based Health and Social Care; Acute NHS services; Cancer services, and Mental Health services.
- Healthwatch co-Chaired the redesign of the BSUH Patient Experience Panel (PEP). Separate PEP's were created for the RSCH and the Princess Royal Hospital (Haywards Heath), with our colleagues in Healthwatch East and West Sussex becoming more directly involved; and new members were recruited for the RSCH PEP that better reflected the diversity of the local community.
- The vast majority of Healthwatch Representatives are volunteers and we estimate they have contributed 7,500 volunteer hours over the last year.

It starts with you

#ItStartsWithYou – Improving services starts with individuals.

Eye Hospital

- Fran, one of our Healthwatch Volunteers, visited the local Eye Hospital and was deeply disappointed to see it had very poor décor, inadequate seating and lacking in basic facilities.
- Healthwatch took up these issues with the Hospital Trust top managers and Chief Nurse and raised the issue at the Health and Wellbeing Board and other meetings.
- As a result the Eye Hospital had a £3m redevelopment – it has taken three years but Healthwatch was determined to see these improvements delivered.
- The Eye Hospital improvements included the expansion of two outpatient areas and eight new clinical spaces to ensure that patients are seen in an appropriate setting sooner, reducing waiting times and improving the patient experience. There are also two new dedicated waiting rooms, one for adults and one specifically tailored for children.

> "I was shocked to see the state of the Eye Hospital and it has taken three years of constant prompting and pressing for improvements."
>
> Fran, Healthwatch Brighton and Hove Volunteer

Child safeguarding

- Two years ago Healthwatch raised a child protection issue with BSUH which has now been fully investigated, an independent enquiry took place and the matter has been resolved.

The work of Fran and other Healthwatch volunteers alongside staff at the hospital made these improvements happen.

> "We have seen a total transformation of this clinical area, it is now better for patients, parents and the clinicians and staff who work here."
>
> Peter, Healthwatch Brighton and Hove Volunteer

YMCA 'Right Here' project

- Thanks to Jacob and the YMCA 'Right Here' project, GP services for young people will be improving in Brighton and Hove. Jacob is a participation coordinator with 'Right Here' and enables young volunteers to identify how services could be improved for young people.
- As part of the Healthwatch Community Information Network (SPOKES) Jacob and others at the YMCA prepared a report for us on how GP services could better address the needs of young people.
- He and others visited GP surgeries for observational visits and interviewed young people. They have recommended changes including: better information about emotional support and access to psychological services; respect for the privacy for young people when they want to discuss confidential personal issues.
- The YMCA 'Right Here' project are now working with one GP surgery to make it a beacon practice for young people.

Healthwatch has 13 authorised representatives (staff and volunteers) who attended decision-making forums and spoke up for patients and care service users:

Tony Barton
Denis Bartup
John Davies
Bob Deschene
Karin Janson
David Liley
Frances McCabe
Neil McIntosh
Dr Roland Marden
Barbara Marshall
Hilary Martin
Sylvia New
Sophie Reilly

"Healthwatch volunteers are constantly challenging us to improve our services and physical environment, to improve the patient experience. They bring clear evidence and a reasoned argument."

Caroline Davies, Deputy Chief Nurse, Patient Experience, BSUH

Meetings attended regularly in the last year include:
A&E delivery board
Adult Safeguarding Board
BSUH Board meeting
BSUH Quality Improvement Experience
C&YP Emotional Health & Mental Wellbeing Steering Group
Cancer Action Group
Care Governance Board
CCG Engagement Organisations Network
City Needs Assessment Steering Group
Commissioning Short Term Services Board (CSTSB)
Community Governance meetings (SPFT)
CQC Quarterly meeting
Health & Wellbeing Board
Healthwatch Regional Network Meetings
Martlets Palliative Care Partnership Governing Group
Maternity Services Liasion Committee
BHCC Chief Officers Health and Care meeting
Overview and Scrutiny Committee
Palliative & End of Life Governing Group (PEGG)
Palliative Care and End of Life Steering Group
Brighton and Hove Caring Together + STP Board
Patient Experience SPFT
Patient Experience Panel BSUH
Patient Participation Group Network
Primary Care Commissioning Committee
Quality Surveillance Group
Safeguarding Adults Board
Safeguarding Adults Board Case Review subgroup
SCT Board meetings
SECAmb Board
South East Coast Clinical Network (SECCN)
Sussex Cancer Partnership
Sussex Healthwatch Liaison meetings (SPFT)
Safeguarding Children Engagement sub group
Central Sussex and East Surrey Alliance Board (CSESA) STP

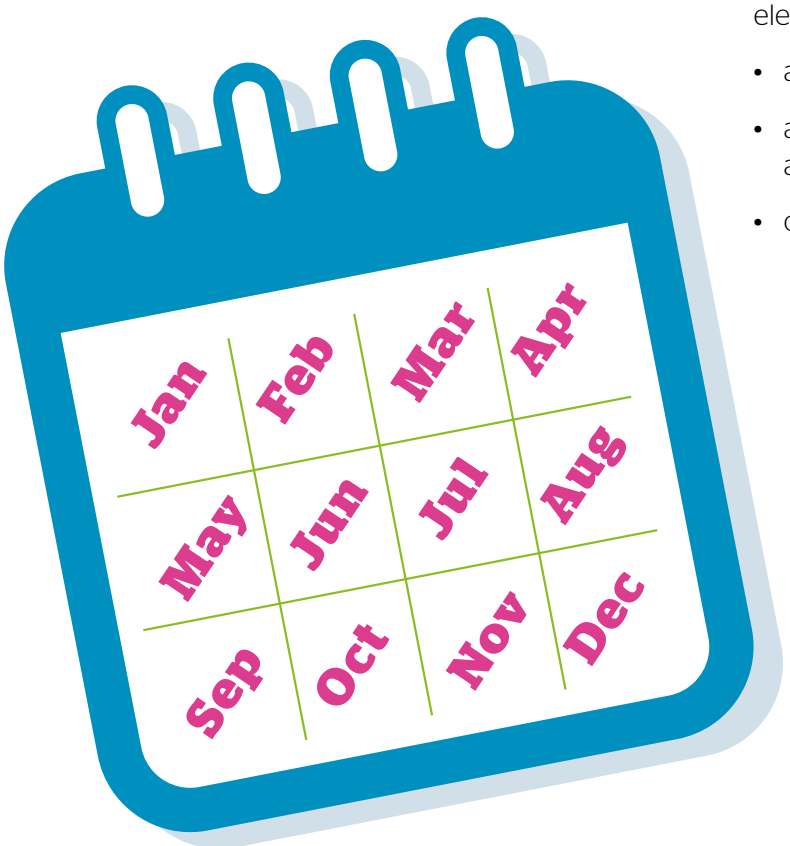
Our plans for next year

What next?

In the next year, Healthwatch plans to maintain and improve our 'Watchdog' role representing patients, and social care consumers. Our priority will be to support and provide assurance to 'The Big Health and Care Conversation' and local integration and improvement plans expressed in the Brighton and Hove 'Caring Together' programme.

Local services face challenges to improve quality and safety, make the best of their resources and maintain a trained and stable workforce. Healthwatch want consumer views to directly impact how those services are planned, managed and delivered.

Healthwatch working in collaboration with voluntary and community organisations will involve the voice of patients and the public in improvement plans for health and care services in the city.



In the first part of 2017/18, Healthwatch will be returning to the issue of Patient Transport Services. From April 2017 the new service provider South Central Ambulance Service will be in place. Healthwatch Brighton and Hove along with Healthwatch East Sussex and Healthwatch West Sussex have been commissioned to gather patient views on how the new arrangements are addressing consumer needs and expectations. Last year we interviewed 60 PTS service users. In the next year we plan to increase this to 100 people in Brighton and Hove with a target overall of 300 people interviewed across Sussex.

Over the summer and into the autumn 2017 we will be doing a major review of GP services. We know that GP services in the city have been hard-pressed in the last year with GP practice closures resulting in people needing to change their GP.

Healthwatch will be reviewing people's personal experiences of their GP surgery. This will have three elements:

- a patient survey;
- a practice survey completed by the GP surgery and its local PPG (Patient Participation Group);
- observation visits to every GP surgery in the city.

Listening is part of the 'conversation'

Healthwatch will be asking people directly on the street about the health and social care issues that affect them. We will gather consumer views, particularly those of young people, about services and provide that evidence to decision makers.

Healthwatch will maintain and build on our Community Information Network – voluntary and Community organisations that provide us with grassroots evidence about emerging health and social care issues. We also want to create a Sussex wide Healthwatch 'Voice' in partnership with Healthwatch East and West Sussex.

6 Our people

Decision-making

We want decisions about local Healthwatch activity to be accountable, open and transparent.

Members of the public attend Healthwatch Board meetings. We report each year to the Health and Wellbeing Board on activities, priorities and decision-making. We submit our annual report to Healthwatch England and we ask partner organisations to give us their views on how well we are doing through our annual Stakeholders survey.

Last year we held a 360 review involving the public, partner organisations, our Board, volunteers and staff. In the coming year we are considering how best to repeat that process and we may seek a peer review with another local Healthwatch serving a similar population.

How we involve the public and volunteers

Healthwatch wants to involve the public and volunteers in:

- Board meetings – we publish the date, time and venue of our Board meetings on our website. The minutes of our meetings and all our reports are also available online.
- We frequently issue press notices and appear in local media to ensure the Healthwatch consumer perspective is prominent on emerging and topical issues of public concern.
- Healthwatch Brighton and Hove maintains a Facebook page and Twitter presence encouraging feedback from the public on issues affecting them and also feedback about how we operate.
- In the next year we want to improve the way local people can influence decisions about our plans and future activities.

Healthwatch has been in existence for only four years but it is establishing itself as a respected voice for consumers of health and social care. Increasingly people come to us to represent their views.

"Healthwatch is an active partner at the city's Health and Wellbeing Board. The voice of service users across our health and care services are crucial to develop and build stronger, more resilient services for the future."

Daniel Yates, Labour Councillor for Moulsecoomb and Bevendean, Chair, Brighton & Hove Health and Wellbeing Board

Our finances

Income

Funding received from local authority to deliver local Healthwatch statutory activities	£199,000.00
Additional income	£11,249.99
Total income	**£210,249.99**

Expenditure

Office costs	£25,312.37
Staffing costs	£154,640.65
Direct delivery costs	£29,566.01
Total expenditure	**£209,519.03**
Balance brought forward	£730.96

Contact us

Healthwatch Brighton and Hove, Community Interest Company (CIC) will be making this annual report publicly available by publishing it on our website and sharing it with Healthwatch England, CQC, NHS England, Clinical Commissioning Group/s, Overview and Scrutiny Committee/s, and our local authority.

We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

If you require this report in an alternative format please contact us at the address below.

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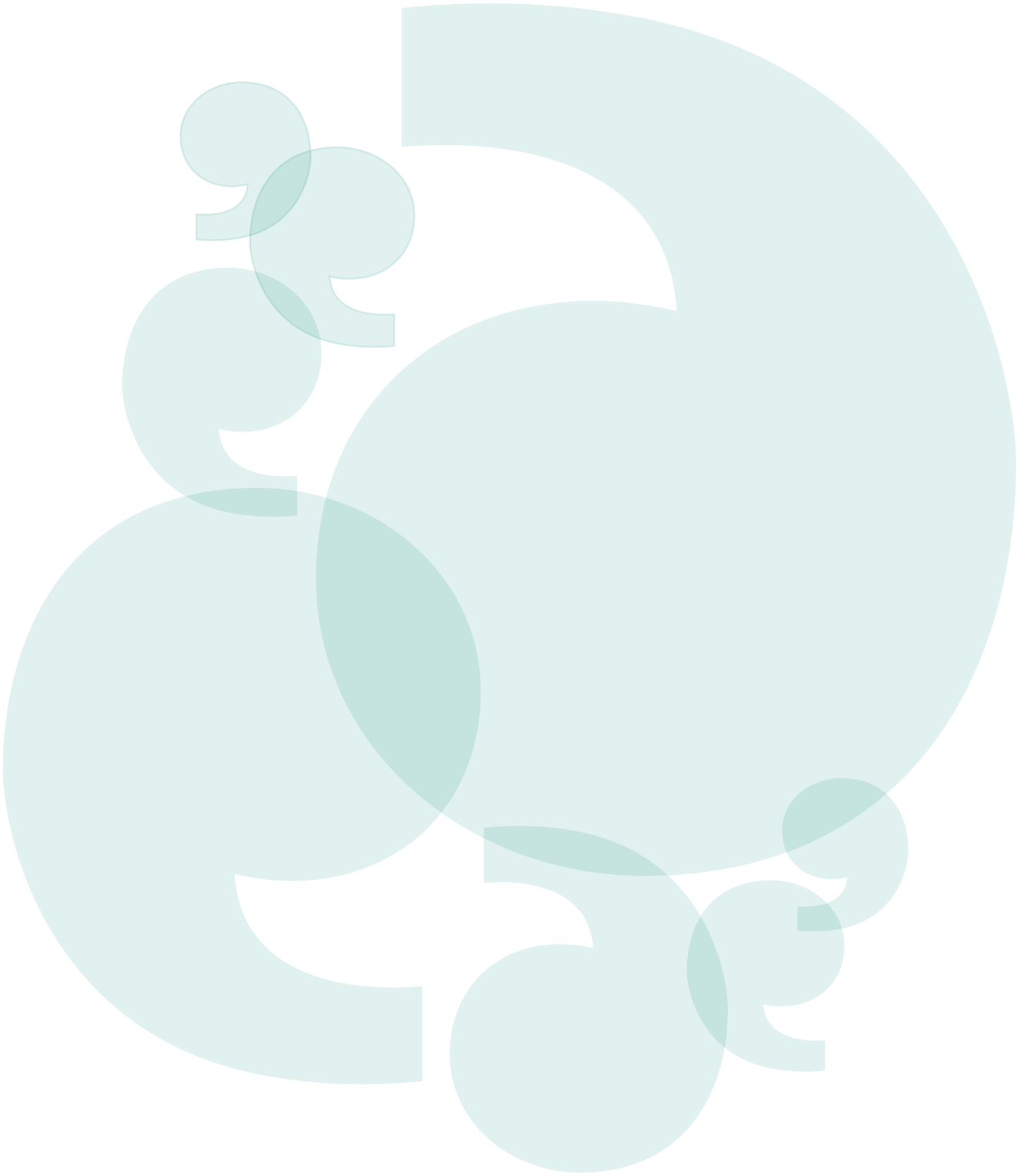
Brighton and Hove



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Healthwatch Brighton and Hove Annual Report 2016/17

The Official consumer champion for health and care

Update since June 2017

- 2016 was a very challenging year for the NHS and for care services in Brighton and Hove
- Since last year our NHS Clinical Commissioning Group is now rated as good
- GP practices in the City are out of 'special measures'
- The Royal Sussex County Hospital has improved in safety and quality on the last inspection
- Patient Transport Services are now much more reliable and with higher approval ratings

Item 34(a)

Joint Sussex HOSC Working Group: Brighton and Sussex University Hospitals NHS Trust (BSUH) Quality Improvement

Thursday 30 March 2017

Attendees (HOSCs):
Cllr Dee Simson, Chair (BH HOSC), Cllr Kevin Allen (BH HOSC), Cllr Lizzie Deane (BH HOSC), Cllr Colin Belsey (ES HOSC), Cllr Ruth O'Keeffe (ES HOSC), Cllr Edward Belsey (WS HASC), Cllr Bryan Turner (WS HASC)

Attendees (BSUH):
Lois Howell, Director of Clinical Governance
Pat Keeling, Consultant (supporting BSUH with outpatient performance)

1. Apologies

1.1 Cllr Johanna Howell (ES HOSC), Cllr Dr James Walsh (WS HASC) and Dominic Ford (BSUH).

2. Notes of the last meeting 14.2.17

2.1 In regard 2.2, bullet point 1 Mr Turner wished he had challenged Mr McEwan's comments regarding 'Adult Social Care (ASC) funding cuts causing exit lock from A&E' and that Mr McEwan was unable to provide evidence to substantiate that statement.

3. Outpatients

3.1 Pat Keeling gave a presentation on outpatient performance at BSUH (see separate slides). Since the CQC inspection BSUH had been working to improve certain aspects of the patient journey through outpatients, members were updated on the progress that had been made.

3.2 **GP referral management** – backlog in the numbers of referrals had averaged around 2,000-3,000 per week during the first half of 2016, additional staff had removed the backlog and following the implementation of a digital link in September 2016 numbers had fallen below 1,000 per week. The digital link at reduced referral management from 8 days to 1 day and had been great for staff morale. The next stage was to move to an e-referral system and process within 24 hours.

3.3 **Consultant Triage Times** - in relation to some unacceptable referral triage times, work was underway looking into nuances with particular consultants. The target was to move to referrals being triaged within 48 hours.

3.4 **Patient 'Did Not Attend' (DNA) rates -** DNAs were down to 6.6% which was better than the national average and the trust was trying to get everything right first time. Appointment letters had been sent asking patients to ring to book an appointment and then patients couldn't get through. Patients were now being telephone and given a choice with appointments. Two way

texting had begun on 6 March which was beginning to have an impact and was good for offering appointments too. It was planned that digital barcoded letters would be offered, which was saving some trusts approximately £1.5m a year. Continuous improvement was expected but at a lesser rate than had been experienced so far.

3.5 **30 Minute Wait Time –** 26.51% of patients were waiting longer than 30 minutes wait to see a consultant and again there was a need to get things right first time. Individual audits would take place as the year progressed on routine OD appointments. It was asked if digitalisation gave a truer picture of how long patients were waiting. Members were informed that a patient admin system was due to be introduced in October which would track patients across the hospital on a particular day. It was asked if this work would assist the CQC when they revisiting the hospital. Members were informed that previous figures could not be repeated and that the Trust was doing a deep dive with a number of variables being look at, in addition to working with the outpatient nurse forum. A lot of money was being lost for patients who did not attend approximately £160 per patient. It was hoped that by using two way texting this would allow patients to be slotted in. Members highlighted the need to use publicity to make the public aware.

3.6 **Clinics which over run** – Members noted that Rheumatology was high in percentage terms compared to others. The issues had been identified as reception staff leaving after contracted which contributed to a loss of effective follow on appointments. This would continue to be monitored.

3.7 **Reduced number of missing follow up appointments** - There had been an issue of forms not being processed at the end of clinics with receptionists not picking up or consultants filling them in. Work had been done with consultants the numbers were coming down. The new module which was being launched in October was anticipated to help but the CQC expected no missing forms when they re-inspected the Trust. There was a sustained improvement across the Trust.

3.8 Members were pleased that things were going in the right direction and supported the planned digitalisation. It was asked if the current team were able to take this work forward. An officer had been brought in who would identify and map processes which could then be digitalised. In turn information management strategies would be looked at to strategically align with all Trust strategies. However, there were constraints with Wi-Fi access in some buildings and that infrastructure would not be put into buildings which would be redeveloped. Although, it was commented that it was important to get digital systems in place regardless of buildings. Two way texting was hoped to be in all departments by the end of April and that a procurement/business case would be needed before letters could be digitalised. Members were informed that it was not possible to estimate the savings that would be gained by digitalisation although savings would be made through two way texting for all outpatients and looking at diagnostics. Digitalised forms for inpatient booking and theatres from October may be more of a challenge for some clinicians.

3.9 Other digital pathways included a digital fracture clinic where clinicians use Skype to talk to patients; integrated discharge team to follow-up digital approaches; digital signatures for consultants in order to catch up on admin. Infrastructure was a big theme both buildings and digital.

4. Quality and Safety Improvement Plan (QSIP)

4.1 Lois Howell presented an update (papers attached). There was an emphasis to remind staff of the improvement that had been made. Work was continuing with staff and wards, with mock inspections undertaken. These inspections had been with supported from NHSI, WSHT, SECAmb, Sussex Police, CCGs, Healthwatch and BSUH staff. There was a focus on what must do's/should do's.

4.2 Members noted for the following points from Ms Howell's presentation:

- There had been considerable improvement in the four hour access targets and ambulance handover times – for the week ending 8 January the four hour target was 74.3% although only 20% of ambulance turnovers were within 15 minutes
- For the week ending 26 March the four hour target was 86.5% with increased attendance, which was much better performance. 45% within 15 minutes, 86% delayed more than 30 minutes, 8% more than an hour which was to do with space in hospital, although delayed transfers of care have reduced
- 94% occupancy rate in March – aiming for 85% - good patient flow was key
- The national target for 18 week waiting time is 92% in February BSUH was at 82.1%, an improvement. The Trust is now 136 out of 154 in this regard nationally.
- Cancer performance target of 31 days, the Trust was 62 day below national standard. The Trust was treating people in backlog and expected to be compliant in April.
- There was a focus on people and to talk positively on what has been done.
- Routine and continual improvement regarding the one patient experience panel working with Healthwatch. People were being invited to apply to be on the panel with training provided.
- It was asked if what was being done was sustainable going into next winter. Members were informed that there would be pressures but there was potential to have 40 beds at Newhaven and look at movement between PRH & RSC recommissioning 75 extra short stay beds so patients would not need to go to wards.
- An infusion suite was being created at PRH so that patients did not need to be in a hospital bed when received treatment.
- Regarding Hospital at Home, members were informed that the Community Trust was struggling to appoint to those roles and that through turnover there had been a net loss. However, there had been some successful recruitment days.
- Part of the problem at PRH was affordable accommodation for staff, with more available in Brighton. There was a small supply of suitable accommodation Haywards Heath.
- Cleaning had been outsourced but was to be brought back in-house as the standard wasn't good enough.

- Over the past 18 months extra recruitment had been an issue so the Trust was embarking on an apprentice scheme, NVQ etc and enhancing the NHS Band 4 role.
- It was asked if anything could be done regarding the loss of a nursery bursary. Help was need for affordable and suitable accommodation and help with travel to Haywards Heath. The take-up for nurse's houses had not been great as they were one step up from university accommodation.

5. Update on management arrangement with Western Sussex Hospitals NHS Foundation Trust

5.1 Members received an update on management arrangements at the Trust and were provided with staff briefings which had just been issued (attached). NHS Trusts were legally obliged to have a Chief Executive, Head of Finance, Chief Nurse and Medical Directors. The management team at WSHT would divide roles between the two Trusts. Evelyn Barker had a one year contract currently with BSUH.

6. Quality Account 2016/17

6.1 Lois Howell provided members with the main headlines from the Trusts previous Quality Account and the nine targets for coming year (presentation attached). There had been mixed performance regarding the Trusts previous years Quality Account. The Medical Examiner has tasked all Trusts to review deaths in hospitals in order to learn effectively. An engaged workforce would continue to be an area of focus for the coming year.

6.2 Members noted that the target within the Enhanced Recovery Programme for Orthopaedics had not been met and in terms of reducing hospital required infections the Trust had not achieved targets regarding C-difficile and MRSA.

6.3 Focus for the coming year was:
- Three Patient Experience Projects – Patient Experience Panels/Booking Hub/Mouth care matters
- Three Patient Safety Projects – Safety Huddles/Improving care for the deteriorating patient – Sepsis and Acute Kidney Injury (AKI)
- Three Clinical Effectiveness Projects – Urgent Care Centre/Ward supplies system/Fractured neck of femur surgical pathway

6.4 Through the discussion members were informed that regarding 'Mouth care matters' there was an aspiration to eliminate rather than reduce numbers of lost and broken dentures. Work would be done in the run up to surgery to ensure that patients had not had a change in condition over the 18 week referral to treatment target.

6.5 It was agreed that individual HOSCs would contact the Trust to respond to the Quality Account consultation.

7. Date of next meeting

7.1 It was agreed the next meeting should be held in July to focus on a 3Ts update and CQC re-inspection update. Members also asked to use this opportunity to meet new directors.

Item 34(b)

Joint Sussex HOSC Working Group: BSUH Quality Improvement

Wednesday 04 October 2017 Meeting Note

HOSC attendees:
Cllr Ken Norman, Chair (BH HOSC); Cllr Colin Belsey (ES HOSC), Cllr Ruth O'Keeffe (ES HOSC); Mrs Anne Jones (WS HASC), Dr James Walsh (WS HASC), Mr Bryan Turner (WS HASC)

BSUH attendees:
Nicola Ranger, Chief Nurse; Pete Landstrom, Chief Delivery & Strategy Officer

1. Apologies

1.1 Apologies were received from Cllrs Kevin Allen, Louisa Greenbaum and Johanna Howell.

2. Notes of the last meeting

2.1 A meeting note from the 30.03.17 meeting was agreed.

Ms Ranger and Mr Landstrom gave three presentations: on the recent CQC inspection (3); on trust quality improvement plans (4); and on specific plans to make improvements in A&E (5).

3. Recent CQC inspection report results and next steps

3.1 Nicola Ranger told the group that the recent CQC inspection report had seen an improved rating for the trust: from *Inadequate* to *Requires Improvement*. The CQC made some positive comments on improvements within the Trust.

3.2 The CQC believes that BSUH is beginning to address its corporate culture issues. It is important to note that the CQC did not inspect against the *Well-led* domain in 2017, as the trust leadership team had only recently been appointed at the time of the inspection. Because of this the BSUH *Well-led* domain still shows as *Inadequate* (the 2016 inspection rating) and the trust remains in *Special Measures*.

3.3 The 2017 inspection has seen significant improvement in the *Caring* domain, with all BSUH services now either good or outstanding in terms of *Caring*.

3.4 Some key services have also seen performance improve substantially – e.g. maternity, urgent care and diagnostic imaging.

3.5 Current areas of concern include the *Safety* domain and the Critical Care service where the CQC picked up on significant culture issues caused by the move of neurological services from Hurstwood Park to the RSCH site. However, whilst the cultural problems highlighted by the CQC are serious, it is important to recognise that the inadequate score for *Safety* against this service does not mean that Critical Care services at BSUH are unsafe: clinical outcomes (e.g. mortality and morbidity rates) are in fact very good when bench-marked against comparators.

3.6 In answer to a question from Cllr O'Keeffe about the degree of improvement, Mr Landstrom told members that turning around BSUH is a long-term task. Whilst the direction of travel is positive, people need to concentrate as much on the plans for improvement as on what has happened to date.

3.7 In response to a question from Dr Walsh on the Critical Care department, Mr Landstrom told the group that the CQC had identified issues with a very long back-log of incidents and a lack of evidence to demonstrate that the service had learnt from previous incidents. Culture problems connected with the single-siting of trauma were also evident. Ms Ranger added that the CQC had also focused on trust failures in identifying when patients required Critical Care services.

3.8 In answer to a question from Mrs Jones on ambulance performance, Mr Landstrom explained that some aspects of this were covered in the CQC inspection report: for example ambulance to hospital handover times. However, the bulk of ambulance services are inspected separately (i.e. as part of SECAmb's CQC regime).

3.9 In terms of financial pressures, BSUH is currently on track to deliver on its planned year-end financial position (a deficit of £60M). This is good news as it means that the trust does not have to borrow at very high interest rates, as it would be forced to do if it was significantly off-track. It is however recognised that this is a very large deficit.

3.10 The trust has also recently agreed cost improvement plans; established a leadership development programme; had significant Emergency Department (ED) investment approved.

3.11 BSUH has recently introduced a Single Oversight Committee where the trust engages with all its regulators. The aim of this is to reduce the amount of duplication and for the Trust to work to one improvement plan.

4. BSUH Quality Improvement

4.1 Improving staff culture is a key priority for the trust, and the corporate centre can assist by establishing some guiding principles. Cultural change will take time and it is important to maintain focus: having an action plan in place does not mean that culture will improve without consistent reinforcement of

messages over time. It also needs to be recognised that this is a long-standing problem and several past attempts to improve organisational culture have failed.

4.2 The trust recognises that patient views are an important driver of improvement and will make efforts to reach out to a wide range of patients. Western has done some excellent work around using some very challenging patient views to improve services, and this will inform the work at BSUH.

4.3 The trust has adopted a new approach to quality improvement planning. Some of its planning will be focused on the CQC's demands for improvement. These can be generally very transactional in nature. Separately, BSUH has identified five 'breakthrough objectives' for change and has developed these into a set of clear and measurable priorities.

4.4 Firstly, there will be more focus on the care of deteriorating patients. The trust does well in terms of most measures of clinical safety: mortality and morbidity rates are relatively low as are statistical measures of avoidable harm suffered by patients whilst in hospital (e.g. pressure sores and falls). However, the trust has studied all Serious Incidents that have taken place over the past 18 months, and has found evidence that BSUH is sometimes challenged in terms of quickly identifying and responding to deterioration. This may partly because staff have become habituated to dealing with increased acuity of patients in recent years and have consequently become slower than they should be in reacting to worsening conditions. The trust also needs to look at the current administrative demands placed on front-line staff. For example, nurses need to fill in more than 40 assessments for every admission. If this can be managed-down into something more reasonable then staff should have more time to interact with patients and be better placed to spot deterioration.

4.5 The second breakthrough objective is to improve staff attitudes to patients. Whilst it is doubtless the case that the great majority of staff consistently display an excellent attitude, some staff attitude is not where we would want it to be. The aim is therefore to reduce complaints about staff.

4.6 The third priority is to improve staff perceptions of the trust. Staff survey results also show that staff are sceptical that patient care is the top priority for BSUH (52% believe it is, compared to a national average of 74% and a score for Western of 86%).

4.7 The fourth priority will be to ensure that there are no Referral To Treatment (RTT) waits over more than 52 weeks. The national RTT target is 18 weeks, but BSUH has no chance of hitting this target in the short term.

4.9 The final priority is to decrease the number of non-admitted A&E patients who are not treated within 4 hours (i.e. patients who will not ultimately require admission as in-patients). The aim is to decrease the number of 4 hour breaches by 75%.

4.10 There are deliberately few breakthrough objectives. This is to allow proper focus on the five targets that have been identified and to ensure that there are in fact delivered.

4.11 As well as the five targets detailed above and the CQC must and should-dos, the trust has a number of strategic priorities. These include continuing to improve quality (with a particular focus on the Emergency Department and on the Intensive Care Unit); refreshing the clinical strategy (lots of successful work has already taken place in terms of developing the Major Trauma Unit); transforming organisational culture; and enhancing leadership (including additional investment in HR capacity and in clinical leadership just below board level).

4.12 The trust will also undertake 'deep-dives' to better understand some key areas of work. These are: fire regulation compliance, patient flow, people & culture, new governance structure, critical care – culture and deteriorating patient, and infection control.

4.13 Workforce remains a major challenge for the trust, as it is for the NHS across the South East of England. BSUH is keen to look at developing nursing apprenticeships so as to provide a route into nursing for people who might otherwise have been discouraged by the abolition of bursaries.

5. A&E Improvement Plan

5.1 BSUH has four distinct A&E access Points: at the RSCH, at Princess Royal (PRH), at the children's hospital (RACH), and at the Sussex Eye Hospital. Performance across all sites varies, but RSCH typically experiences the greatest pressures.

5.2 A&E attendances are actually fairly static, bucking the national trend where they have been rising. This suggests that local diversion measures have been relatively effective.

5.3 While the national target for A&E is that 95% of patients should be seen within four hours, the trust is setting itself an initial target of 90%. This is realistically achievable. Moreover, evidence suggests that an A&E department operating at 90% will generally be functioning well. The target is already being applied.

5.4 In seeking to understand A&E performance, the trust has split attendees into two categories: admitted and non-admitted (i.e. will the patient eventually be admitted to the hospital for treatment or not).

5.5 In terms of non-admitted patients, key to improving performance will be to ensure that the RSCH Urgent Care Centre (UCC) is working effectively, that those patients who will be treated directly by A&E staff are managed efficiently, and that the PRH A&E is re-developed to provide a dedicated area for 'minors' (currently minor and major patients are seen in the same area).

5.6 In terms of admitted patients, the key issue is Delayed Transfers of Care (DTOCs). This has been a long-term problem, particularly at RSCH and is the challenge of the health and care system rather than any single organisation. There are some internal improvements that should help things: for example, improving the number of a.m. discharges. Currently very few patients are discharged in the morning, even though a.m. discharges have a much more positive impact for flow through the hospital than p.m. ones. This is partly about getting patients and their families used to the idea that they should expect and arrange for a morning discharge. It is partly about the hospital getting its procedures right too: e.g. ensuring that medications are available on discharge and not several hours later.

5.7 Although the 90% target is challenging it is achievable: it amounts to around 10 fewer breaches per day at RSCH.

5.8 Key actions for A&E include:

- Re-design of the UCC and changes to how triage is delivered.
- The RSCH PAT area is very effective, but there is a need to protect staffing as the PAT area is currently suspended when the ED is very busy, which is counterproductive.
- Changes to diagnostics: e.g. blood tests tend currently to be bundled together which means that the results of relatively quick-to-process tests are delayed while other tests are completed. Splitting the tests will mean that some results are available more swiftly.
- Up to 20% of blood tests are cannot be used as the blood has haemolysed by the time the test is taken. This can be avoided by using different procedures.
- The creation of a dedicated treatment area at PRH for minors.
- A dedicated A&E consultant will now be employed at PRH until 10pm.

5.9 There was discussion of what can be done about people presenting inappropriately at A&E. Ms Ranger told members that it was important to address the issue of people who made frequent unnecessary presentations. Mr Landstrom added that RSCH already has excellent links with mental health, rough sleeper and drugs & alcohol services which helps to manage this cohort of attendees. However, the high prevalence of mental health problems in Brighton & Hove means that the issue is persistent.

5.10 In response to a question from Mrs Jones about links with Out Of Hours (OOH) services, Mr Landstrom told the group that GPs are already embedded in RSCH A&E and there are plans to do the same at PRH.

5.11 In answer to a query from Cllr Belsey about the possible introduction of a ‘breakfast room’ for patients being discharged, members were told that this has just been agreed and will be introduced soon along with a revamp of the RSCH discharge lounge.

5.12 There are also significant physical improvements planned to the ED at RSCH. These include adding 30+ new beds, building two new short-term stay wards and reconfiguration of A&E once the extra beds are available.

5.13 The Chair thanked Ms Ranger and Mr Landstrom for their time. Members agreed that they were considerably assured by what they had heard. They particularly welcomed the decision to focus on a few key targets.

7. Date and focus of next meeting

7.1 It was agreed that another meeting should be booked for early 2018. Support officers will liaise with BSUH to identify a date that makes sense in terms of the trust's reporting commitments. The next meeting will provide an update on progress against the targets detailed above as well as information about the deep-dives that will have taken place.

Item 34(c)

BRIGHTON & HOVE CITY COUNCIL

HOSC WORKING GROUP: SUSTAINABILITY & TRANSFORMATION PARTNERSHIP (STP)

11.00am 22 SEPTEMBER 2017

COUNCIL CHAMBER, BRIGHTON TOWN HALL

MINUTES

Present: Councillor Allen (Chair), Councillor Wealls, Fran McCabe (Healthwatch), Colin Vincent (Older People's Council)

PART ONE

13 DECLARATIONS OF INTEREST

13.1 There were none.

14 CHAIR'S COMMUNICATIONS

14.1 There were none.

15 MINUTES OF THE PREVIOUS MEETING

15.1 The minutes of the previous meeting were agreed.

16 PUBLIC INVOLVEMENT

16.1 **Madeleine Dickens** raised a number of points about the STP process, including:

- The STP currently has no Chair. There is a concern that a replacement Chair will be imposed from above rather than chosen locally.

- There has been no information on acute care changes to date, other than the 'merger' of Brighton & Sussex University Hospitals Trust (BSUH) and Western Sussex Hospitals NHS Foundation Trust (Western). However, it is evident that some acute reconfiguration must be being considered given the size of the savings required, and rumours of planned changes are circulating (e.g. that the Sussex Eye Hospital will be moved to Worthing). It is important that the public is informed of plans at an early stage and not presented with a *fait accompli*. HOSC should press for this information.

- There has been little or no information about the planned Multi-Disciplinary Community Provider (MCP) model. Again, in the absence of fact rumours are circulating – for

example that independent sector providers may be being considered to run some of the MCPs.

- The Naylor Review states that STPs should partly be funded by the disposal of spare NHS estates. However, other than plans to re-purpose parts of the Brighton General Hospital (BGH) site, there has been no information about any disposal of local NHS assets. There was mention of asset disposal at a recent Greater Brighton Economic Board (GBEB) meeting, but the substantive discussion was not in public. It is concerning that information on this is not in the public domain. In terms of the BGH site, it is also unclear where NHS services currently using the site (i.e. East Brighton Community Mental Health services) will go should the site be used for other purposes.

16.2 Fran McCabe agreed that the lack of public information on the STP was worrying and that clarity was urgently needed – for example in terms of any plans to move services from the Royal Sussex County Hospital (RSCH) site.

16.3 Cllr Wealls queried what the role of the working group was here: there seems to be little value in the group taking up matters which may just be speculation.

16.4 **John Kapp** raised concerns about which body is responsible for the city NHS commissioning budget, arguing that the Health & Social Care Act (2012) ascribes ultimate responsibility for this budget to the Health & Wellbeing Board rather than the CCG. Mr Kapp also argued that transforming mental health services should be a key part of the STP plans.

16.5 The Chair thanked Mr Kapp for his submission but noted that it was not a matter that the working group could take up.

17 BRIGHTON & HOVE GP SURVEY

17.1 This item was introduced by two retired city GPs, Judith Aston and Jane Roderic-Evans.

17.2 A survey of city GPs was undertaken earlier in the year, in May, in which 56 GPs replied out of 125 contacted. Over 50% GPs surveyed expressed dissatisfaction with the STP process to date. This has been followed by further questioning of GPs in six local practices. GPs in these practices continue to report feeling uninvolved in the STP; believing it remains a top-down process; one worried that GP provision will increasingly become a telephone triage service. The CCG has not responded adequately to the findings of the local GP survey.

17.3 The local healthcare system is under increasing and unsustainable pressure. For example, Brighton & Hove CCG wrote to GP Practices on18th September urging them not to refer patients to RSCH A&E unless absolutely necessary due to the severe bed pressures being experienced at the hospital (and the winter has not yet begun). GPs are already working beyond their safe capacity, and unlike acute services, do not have the option of limiting increases in their workload.

17.4 The STP will only increase pressure on GPs, particularly in terms of plans to move activity from acute to community settings. Without significant additional investment in

GP services, the system will be in danger of collapse with an adverse impact on patient care including increased mortality. UK mortality rates are already rising according to the Journal of the Royal Society of Medicine: we are one of the few developed countries to see such a rise in recent years.

17.5 Brighton & Hove already has below average GPs per 1000 people). Eight city practices have closed in the past two years, and more may shut in the near future. Closure creates a domino effect, with adjacent surgeries having to take on many more patients which impacts on their own sustainability. The CCG has not been adequately supporting surgeries to cope with this additional demand.

17.6 Six city practices currently have closed lists. Many city GPs are near retirement age (17.80 FTE aged 55+ years) and many more are considering early retirement.

17.7 Local STP plans include saving considerable sums (£40M) via peer review of GP referrals. Experience of previous referral management systems (e.g. the one run by BICS) suggests that this will not be a clinically worthwhile activity and will only save money in the short term by delaying necessary treatments, with possible negative impacts on patients in the longer term.

17.8 Other possible changes to save money will not only have a detrimental impact on patients, but could actually increase healthcare costs in the longer term. For example, not providing hearing aids for people suffering moderate hearing loss might save money in the short term, but hearing loss is strongly correlated with the earlier onset of dementia; any savings may be swallowed by the costs associated with increased numbers of dementia sufferers.

17.9 Plans to scale-up the delivery of GP services may deliver efficiency savings, but they threaten continuity of care. There is strong evidence, particularly with frail and elderly patients, that continuity of care delivers better outcomes. Moving to larger hubs, and relying more on apps and telephone consultation threatens to worsen outcomes.

17.10 The STP focuses on reducing pressure on hospitals, but reducing pressure on GP services should be just a high a priority. CCGs has the option to resist STP plans, as Hackney CCG has done; there is no legal requirement to implement them.

17.11 Cllr Wealls noted that it was important to be cautious with statistics: whilst it is true that UK mortality rates have risen in the past 2-3 years, death rates went up in a number of developed countries in 2015, including France, Germany and Italy.

17.12 In response to a question from the Chair on how CCGs had engaged with GPs on the STP, members were told that this was mainly via CCG locality meetings. However, only one person from each practice attends these meetings, so information is not broadly disseminated.

17.13 In answer to a question from Colin Vincent about the role played by GP professional bodies, the working group was informed that neither the British Medical Association (BMA) nor the Royal College of General Practitioners (RCGP) have lobbied effectively with regard to STPs.

17.14 Fran McCabe noted that she was concerned by what she had heard. In particular, whilst moving activity from acute to community settings could have benefits, it is important that it is properly funded, and that there is the primary care capacity to deal with increased demand. Any significant activity shifts should include full Equality Impact Assessments (EIAs).

17.15 Cllr Wealls reminded the working group that it should remain focused on matters that the HOSC could conceivably influence.

17.16 In response to a query from the Chair as to whether the GP partnership model was no longer appropriate, members were told that this was not the problem: the issues are of under-funding and excess demand.

17.17 The Chair thanked Dr Aston and Dr Roderic-Evans for their contributions.

18 BRIGHTON CITIZENS' HEALTH SURVEY

18.1 This item was introduced by Carl Walker.

18.2 There have now been two Citizens' Health surveys (completed by 1000 and by 700 respondents respectively). It should be stressed that this is a novel approach to garnering public views and is not a typical 'survey' – for example, it asks questions on complex areas that respondents do not necessarily have a definite opinion on.

18.3 Respondents to the surveys overwhelmingly want to be consulted about plans to make cuts to NHS services. A significant majority are also opposed to major structural change of the NHS. Although the surveys predate the STP, there is evidence that members of the public and clinicians hold similar views about the STP process (this includes recently published research by the BMA and by the King's Fund).

18.4 There are a number of specific concerns about the STP:

- Governance – this is currently very unclear, particularly in terms of where accountability lies as the STP currently has no statutory form.

- Finance – the £900M local gap by 2021 is very concerning, as are intimations that this gap may be reduced by 'rationing' access to procedures such as tonsillectomy, knee arthroscopy, cataract removal and IVF; to technological aids such as hearing aids; or by requiring obese people and smokers to make lifestyle changes before getting an operation.

- Secrecy – the development of STPs has been done secretly, with local authorities discouraged from publishing the initial STP submissions.

- The Big Conversation – this has been billed as meaningful engagement, but there has been no detail of the changes planned. A number of people who have been involved in the Big Conversation have reported being frustrated by it.

18.5 Mr Walker proposed the following actions:

- That the HOSC should undertake an independent examination of the STP, including looking specifically at governance arrangements; and
- That there should be a health and care impact assessment of all the STP plans (Mr Walker noted that when this was done for plans to change the West Sussex Musculoskeletal Services model, the plans were subsequently withdrawn).

18.6 Fran McCabe agreed that it was important that a health and care impact assessment and an EIA were undertaken before major changes take place. She also agreed that to date the focus of STP engagement had been on broad principles, and it is worrying that more detail has not been forthcoming.

18.7 Colin Vincent agreed, noting that the Big Conversation events he had attended had been devoid of detail about service changes. Given this, it is unsurprising that many people have assumed the worst about the STP plans.

18.8 Cllr Wealls noted that the city council is not able to undertake the assessments suggested, but that the HOSC could choose to recommend to the CCG that it undertakes the assessments. HOSC could also find out what the CCG's triggers for undertaking impact assessments are.

18.9 There was discussion with the speakers and members of the public. The following points were raised:

- The STP is already being implemented via local place-based plans. Where are the impact assessments for these plans?
- HOSC and Healthwatch Brighton & Hove should jointly recommend that the CCG impact assesses all STP plans for service change.
- There has been no public feedback on the Big Conversation events to date – some feedback would be welcomed.
- Some people are unhappy with the STP focus on footprint-wide savings plans and want local engagement to focus on local savings requirements.
- When the public is fully involved in planning service change, health outcomes are improved.

18.10 The Chair thanked everyone for contributing.

Item 34(d)

A meeting of the South East Coast Ambulance Service (SECAmb) NHS Foundation Trust – Regional HOSCs Sub-Group held at SECAmb Headquarters, Crawley on Tuesday 17 October 2017

Present: Mr Bryan Turner (Chairman, West Sussex HASC); Cllr Ken Norman (Chairman, Brighton & Hove HOSC); Cllr Ann Norman (Member, Brighton & Hove HOSC); Cllr Mike Angell (Vice-Chair, Kent HOSC); Cllr David Mansfield (Member, Surrey Wellbeing and Health Scrutiny Board)

In Attendance: Daren Mochrie (Chief Executive, SECAmb); Jon Amos (Acting Executive Director of Strategy and Business Development, SECAmb); Mark Whitbread (Consultant Paramedic, SECAmb); Claire Lee (Officer, East Sussex HOSC); Andrew Baird (Officer, Surrey WHSB); Nuala Friedman (Officer, Brighton & Hove); Lizzy Adam (Officer, Kent HOSC) and Helena Cox (Officer, West Sussex HASC)

Apologies: Cllr Colin Belsey (Chair, East Sussex HOSC); Cllr Ruth O'Keefe (Vice-Chair, East Sussex HOSC); Cllr Sue Chandler (Chair, Kent HOSC); Cllr Wendy Purdy (Chair, Medway HOSC); Cllr David Royle (Chair, Medway Children's OSC); Dr James Walsh (Vice-Chairman, West Sussex HASC); Giles Rossington (Officer, Brighton & Hove HOSC) and Jon Pitt (Officer, Medway HOSC)

CQC re-inspection report key findings and Trust response

1. Daren Mochrie, highlighted to members the key themes from the recent Care Quality Commission (CQC) re-inspection report and feedback from the Quality Summit, which was held on 5 October. The Trust was disappointed with the overall rating but was pleased with the pockets of good and outstanding practise, particularly in relation to 111.

2. Two 'Notice of Proposal' had been issued to the Trust in relation to Medicines Management and 999 call recording, which had since been withdrawn due to significant improvements since the notice had been issued. In relation to 999 recording, there were issues with the telephony platform and this was on the Trusts risk register. Improvements had been made and the issues were now a small number. A paper would be presented to the Trust Board to seek approval to replace the telephony platform to resolve issues of technically finding calls and the static on the line. The Trust had brought in a member of staff to help with the issues and Mr Mochrie was confident that the Trust would have a grip on this. The replacement platform would be funded from money received as the Trust was in special measures. BT was also recording the line to trace any fall out calls. It was asked what the target would be in relation to numbers of calls recorded/completed. This would be between 95-100%.

3. The Trust had 17 'must-do's' set by the CQC. Eleven task and finish group (these built on the success of the medicines management task and finish group chaired by Mr Mochrie) had been set up and were chaired by a member of the executive leadership team, to monitor a comprehensive action plan and ensure rigour and grip in terms of improvement. Mr Mochrie's presentation focused on an example of some of the 'must-do's', which included:

- **Incident Reporting** – There was a need to improve incident reporting and reduce the current backlog. It was asked how many serious incidents the Trust reported each month, to which members were told that there was about 400 incidents a month which were reported but around one a week was then considered to be a serious incident, so approximately 50 per year. Members were told of the good relationship which the Trust had with other blue light colleagues, although a vitally important relationship for the Trust was with other health colleagues in relation to serious incidents. Mr Mochrie expressed his wish to make the organisation more of a 'learning organisation', minimising mistakes and learning from those that did occur.
- **Safeguarding** – Members were informed that the Trust had not necessarily had the right resource in the key areas but there were some improvements and plans in place for all staff to complete level 3 safeguarding training.
- **Staffing in EOC** – Staffing in the control centre on 999 call handling was a challenge since we had moved to the new EOC. There is a robust plan in place to recruit new staff and plans to recruit a more multidisciplinary clinical workforce. Since the move to the new EOC we have implemented seamlessly a new command and control system. On 22 November, the national Emergency Response Programme (ERP) would be implemented at the Trust.
- **Improved ACQI – Heart Attack** – A strategy would be implemented across the Trust in relation to improving clinical outcomes for, in this example, heart attack patients. A new health informatics system would be in place by March 2018 which would provide more meaningful data and audit. Members were informed that the Trust had 70 Critical Care Consultant Paramedics who were targeted to patients who were really sick, with a critical care hub within the control centre. Members were informed that Mark Whitbread, a consultant paramedic, had been employed by the Trust to drive the strategy, embed it within the organisation and engage with staff.
- **Staff Engagement** – The Trust planned to design solutions from the bottom up and had held a number of local staff engagement sessions across the Trust. It was early days but there were signs of improvement, with a 200% increase in the response rate for the staff Friends and Family test. Feedback from the unions was also improving. Work would continue and the importance of the leadership team leading by example was emphasised.

4. Mr Mochrie emphasised that much more pace was needed on what was required to be done and the year would focus efforts on areas within the overall Trust strategy and the various different work streams to take the organisation forward. The Trust's project management office was wrapping around the task and finish groups to ensure evidence of improvement .

5. In terms of the Quality Summit and discussions with partners, Mr Mochrie highlighted the importance of handover delays at emergency departments across the Trust area and that this was something that needed to be addressed as a whole system and would have a significant impact on the performance of the Trust and patients. Members agreed that they would like to receive monthly performance/handover delay statistics to identify hotspot areas, which would allow HOSCs to ask the question of local health partners if required. Regarding the cleaning of vehicles once a patient had been handed to an acute trust, members were informed that it would be for the paramedics to decide whether they would need to visit a make ready system or not to be prepared for the next job.

6. SECAmb had not previously had a surge management plan, unlike the acute trusts and other ambulance trusts such as London, so was working with partners to put a surge plan in place before the winter. To address demand and handover delays system solutions were required in the community as well as emergency departments as it was not a good use of paramedic time to be spending hours on scene trying to secure additional pathways or looking after patients in emergency departments awaiting handover. In terms of handover delays, it was asked where the area sat nationally. Members were informed that there were hospitals in the patch which were in the top 10 hospitals nationally for delays. Mr Mochrie explained that there was work underway with commissioners in regard to demand and capacity modelling to ascertain whether it had the right baseline funding to meet demand or whether additional investment in SECAmb was required. Mr Mochrie's view is that by investing in the right ambulance model it could take pressure off other parts of the system. For example if SECAmb transported 10% less patients to attending emergency departments this would have a significant benefit to the whole system but this model needed funded. Between now and January, the Trust would work with commissioners and an external company – Operational Research in Health (ORH) to undertake a demand and capacity review and there needed to be a conservation with all stakeholders on any potential models which would be planned for January 2018 onwards.

7. An enquiry was made as to what staff turnover levels were at the Trust. Members were informed that the turnover of advanced paramedics was high as they could receive higher paid rates working at acute trusts or in Primary care. This is why this needs included in the demand capacity modelling. It was also asked what impact there had been on the ambulance service in regard to Friday/Saturday call outs for issues related to the use of alcohol. Members were informed that with better data collection the Trust would be able to understand this more but like most ambulance Trusts alcohol related calls were significant during these times. There were additional issues regarding fallers, in that there were not 24/7 fall prevention team support so an ambulance was called to lift patients, so more work was needed with local authorities and Careline and nursing homes to try and address the problem. Members agreed that receipt of SECAmb on data regarding call outs to care homes/falls/alcohol/mental health would be incredibly useful and give councillors the opportunity to take issues forward. Mr Amos highlighted that the data was available at a high level and could be shared in order for the importance to be highlighted.

Professor Lewis report - key findings and Trust response

8. Mr Mochrie informed members that the Professor Lewis had identified issues of a culture of bullying and harassment at the Trust, which was disappointing but the Trust was taking appropriate action including individual investigations to address this. The Trust Board had agreed that the report should be made publically available as they did not wish to hide the findings contained in the report and want to encourage and open and honest culture. The Board would receive a further report at the end of the month regarding the strategy moving forward and continued efforts to strengthen staff engagement. An additional member of staff with an OD/cultural background had been employed to drive this work forward.

Quality Improvement Plan (QIP)

9. Mr Amos informed members that a revised QIP was to be presented to the Trust Board next week, with measures which could be tracked on a weekly/monthly basis and was much more focused on key performance indicators. There were challenges of balancing finances, quality and performance and the focus on a demand and capacity review would assist this. It was agreed that the revised QIP would be presented to members at the next meeting of the sub group.

10. Members were informed that the Trust had not formally been notified whether NHSI would keep the Trust in special measures but believed this would not be reviewed until the Trusts re-inspection next year.

Performance and Clinical Outcomes

11. Members noted that a paper regarding performance and clinical outcomes was not attached so would be circulated separately. Challenges of staff turnover in the control room were discussed, these was due to multifactorial factors and were typical of overall system pressures regarding workforce. The impact of control room relocation to Crawley was starting be seen regarding control room turnover although all call centres tended to have a high turnover of staff. A lot was being done regarding recruitment processes. All control centre staff were being trained on the national ambulance response programme. The impact of the temporary relocation of services from Kent & Canterbury Hospital was raised. Mr Amos informed Members that the Trust was working with East Kent CCGs who had agreed short-term funding to resource additional journeys; as a result, there had been no real impact on the Trust's performance. Focused work with NHS Improvement was being undertaken to reduce handover delays particularly at the Ashford site.

12. In terms of headlines, the capacity to answer calls in the control room was a core focus and the impact on Red 1/Red 2 response times, as was patient safety and wait times. The Trust was looking at those patients in the 'tail end' who wait longer than 8 or 9 minutes. From 22 November the national ambulance response programme would be adopted by the Trust and Red 1 and Red 2 calls would disappear and be replaced by new clinically led targets.

13. There was a new online system for appraisals and e-learning for staff across the Trust which allowed staff to access these when they are out and about. It was early days but there had been uplift in the numbers of staff completing training and feedback had been positive. Regarding quality, historical backlogs were being cleared with extra staff being brought in to help. Financially the Trust was to achieve £15m of efficiencies this year which was on track but there were pressures in other areas.

Ambulance Response Programme (ARP)

14. Mr Amos presented members with details of the new national Ambulance Response Programme (ARP). Currently the Trust had 60 seconds to answer a call and deploy a resource at which time the clock starts for an 8 minute response. There are a large number of patients within that cohort and doesn't differentiate well, with multiple resources being sent to one patient in order to hit targets. There approximately 750,000 duplicate calls a year. The ARP wad developed working with patients groups and changes the order in which questions are asked, using technology to identify the location of the caller. The time allowed prior to resource despatch has been extended to 4 minutes for calls other than cardiac

arrest to ensure the right resource goes to the right patient. The national review saw no patient harm as a result of the changes and positive feedback had been received from staff, patients and stakeholders.

15. The four new categories were detailed as follows, with a response by an ambulance in the first instance, expected for the first two:

Category	Target Time	Example	Target
Category 1	7 minutes	Cardiac, life threatening	50% within target time
Category 2	18 minutes	Stroke, critical burns	50% within target time
Category 3	120 minutes	Late stages of labour, non-severe burns, diabetes	90% within target time
Category 4	180 minutes	D&V, infections	90% within target time

16. The longer terms challenges emerging from the ARP were that there would need to be a change to the mix of vehicles needed, as SECAmb had a large number of cars at the moment. Ambulance Trusts would be monitored and the first set of data which would show the impact on SECAmb would be available in January. Local issues in East Sussex regarding maternity provision were raised due to the target time of 120 minutes to reach women in the later stages of labour and that work would be needed to communicate rationale to the public. Uninjured falls were cited as a hidden group as patients could wait 3-5 hours for assistance. Staff in the control room will continually monitor and re-prioritise if necessary. It was asked how categories related to the out of hours service, the benefit of a new platform would make it easier to refer category 4 calls to the out of hours service with an automated referral system. It was agreed that the presentation slides would be shared with members after the meeting.

Surge Management Plan

17. Mr Amos informed members that discussions were currently ongoing with partners regarding a surge management plan for the Trust to ensure that there could be prioritisation and balance of risk. It was planned to share details with the sub group at the next meeting.

Cardiac survival to discharge data

18. Mark Whitbread, Consultant Paramedic, informed members that he had been employed by the Trust to ascertain how outcomes for those patients treated for cardiac arrest can be improved and shared data regarding analysis of cardiac arrest data over April – June 2017. Mr Whitbread explained the use of 'utstein' figures when considering cardiac arrest data so that figures across the country could be compared like for like. The higher survival rate figures relating to the Isle of Wight needed the caveat of the small numbers the data was based on. Data was being reviewed by the Trust Board on a monthly basis. However, the Trust was struggling to receive outcome data from some acute trusts across SECAmb's area, especially St Peters, Chertsey, although there was no mandate for trusts to share this data. Six to twelve months of data was needed to breakdown to understand the geography and be under constant review.

19. The current cardiac arrest data for SECAmb in 2016/17 was 22.2%, the Trust wished to raise this to between 30-40%, going above 40% would be extremely challenging. A rise of 1 or 2% was also quite hard.

20. Mr Whitbread had presented the Trust Board with a number of recommendations based on his work so far. One of these was related to public education and promote resuscitation and access to defibrillators. Calls are to be triaged correctly so that a response is despatched quickly and can reach a specialist centre when required. Members noted that there was only one specialist centre in Kent, with other options based at Brighton and St Georges, London. The recommendations were short, medium and long term. Members were informed that the Fire Brigade Union had called on their members to reject a proposal to be able to co-respond with the ambulance service.

21. Members discussed the location of defibrillators and agreed to speak to their local communities to ensure that defibrillator cabinets are not locked and available to be used quickly when needed.

Date of Next Meeting

22. It was agreed that the next meeting of the sub group would be held in late January/early February 2018. Claire Lee would liaise with the Trust on possible dates.

Members of the sub group were given a tour of the control room followed the conclusion of the meeting.

V7 Suggested HOSC 2017/2018 Work Programme

HOSC Working Groups – Updates to be given at each meeting (if relevant):

- **BSUH Quality Improvement** (joint with East Sussex HOSC and West Sussex HASC)
- **SECAmb Quality Improvement** (joint with East Sussex, West Sussex, Surrey, Kent and Medway HOSCs).
- **Sustainability & Transformation Partnership (STP)**

HOSC Network Groups – no updates at committee

- **Southeast Coast HOSC Chairs' Network** (Brighton & Hove, Kent, Medway, East Sussex, West Sussex, Surrey) – meets 2-3 times a year with regional NHS leaders to discuss strategic issues
- **SPFT** (Brighton & Hove, East Sussex, West Sussex) – meets 2-3 times a year with SPFT executive board to discuss trust strategic issues, quality reports etc.

28 February 2018

Item and title	To invite
Chairs communications	
B&H Caring Together - STP update	Standing item CCG, ASC
Outpatients (if not a major part of CQC inspection report)	BSUH & CCG
Access to information about city health and care services	CCG and ASC
Update on HOSC Working Groups	Standing Item: HOSC Members
Patient Transport Services: Update	CCG (and High Weald Lewes Havens CCG)

PTS: Healthwatch report on patient experiences of new PTS provider	David Liley, Healthwatch CE

- Additional Item (date to be agreed with CCG): Clinically Effective Commissioning: Update