BRIGHTON & HOVE CITY COUNCIL
HOSC WORKING GROUP: SUSTAINABILITY & TRANSFORMATION PLAN (STP)

21 JUNE 2017, 12PM-2PM

COUNCIL CHAMBER, BIGHTON TOWN HALL
MINUTES

Members Present

Cllr Kevin Allen (Chair)
Cllr Louisa Greenbaum
Fran McCabe (Healthwatch)
Colin Vincent (Older People's Council)

Others

Mike Jennings, Deputy Chief Executive & Director of Finance and Estates, Sussex Community NHS Foundation Trust
Evelyn Barker, Managing Director, Brighton & Sussex University Hospitals
Karen Amsden (BHCC)

Apologies

Cllr Nick Taylor
Caroline Ridley

6 PUBLIC INVOLVEMENT:

Mr Ken Kirk was asked to come forward and read out his question

"You may have seen this article in the Health Service Journal.

https://www.hsj.co.uk/home/daily-insight/daily-insight-nhs-managers-told-to-think-the-unthinkable/7018489.article

You will notice that it applies to our area, Surrey and Sussex. It seems that all our fears about government plans to inflict massive cuts on our health services are coming true. Up to now campaigners' insistence that massive cuts are planned have been denied but now the truth is out. Can you now confirm …

1. *the fact that cuts are coming to our local health services, and*
2. *which health services are under consideration."*

The Chair of the Working Party read out the following response from the CCG:

'A number of organisations across our STP have been financially challenged for some time and have, individually, been trying to find ways to address the situation, which they have found difficult. We also know that we have systems and processes

in place currently across the STP that are not as efficient as they could be for our patients and this is something we have to look at improving locally and across the STP area.

We now have an opportunity to collectively look closer at how we can get more value for money across Sussex and East Surrey by putting processes and systems in place that are more efficient and effective. This will help to ensure our patients are getting the best possible services with the funding that is available

The CCG will consult the public on any proposed significant changes to services. A comprehensive engagement plan is being developed and the next public engagement event is planned for 4 July.'

Mr Kirk added that his research had found that community care was cheaper than hospital care. His concern was that these ideas were never evidence based and focussed on reducing spend on health care, even though we already spend far less than other EU country. He felt that the STP was about cutting costs for central government.

Cllr Louisa Greenbaum (LG) asked Ken Kirk which area he felt faced the greatest threat. He replied that it was not known due to the lack of public information. He was concerned that centralisation of services could increase travel times and patient inconvenience. Colin Vincent (CV) asked for the link given in the question be recirculated and Mr Kirk agreed to forward this alongside additional evidence.

7 DECLARATIONS OF INTEREST

None

8 CHAIRS COMMUNICATIONS

Cllr Kevin Allen (KA) explained that this is the second meeting of the working party for the **SUSTAINABILITY & TRANSFORMATION PARTNERSHIP (**STP) adding that for the next meeting a group of GPs will be invited.

He also gave details of the **"Big Health and Care Conversation"** being launched on 4 July 2017 at Brighton Dome. The event had been organised by Brighton and Hove NHS Clinical Commissioning Group (CCG) with the input of Brighton & Hove City Council (Health & Adult Social Care), Brighton & Hove Healthwatch and Community Works. The aim is to discuss the future of local health and care in Brighton and Hove with key partners, patients, carers and the public. It is also an opportunity to hear about latest STP developments and to discuss your views with us ; and will be the start of an ongoing dialogue with local people on the STP.
KA encourage people to join the conversation to ensure that people's views and experiences are heard, acted on, and help to shape the way health and care are planned and delivered now and in the future.

Spaces for the event are limited, and must be booked in advance using Eventbright on the link below.

https://www.eventbrite.co.uk/e/brighton-and-hove-big-health-conversation-general-public-tickets-35002241647

9. MINUTES OF THE PREVIOUS MEETING

The minutes were agreed.

Actions arising: Karen Amsden agreed to follow up the responses from the questions raised in the last meeting in March.

It was also agreed that Adam Doyle should be invited back as soon as possible to update members on, how the partnership is developing.

10 EVIDENCE FROM EVELYN BARKER, MANAGING DIRECTOR, BRIGHTON & SUSSEX UNIVERSITY HOSPITALS (BSUH)

Evelyn Barker (EB) began by saying that she had been part of the Executive Team of BSUH since January and explained about the current difficulties surrounding the Trust, since it had been placed in financial and quality Special Measures. The focus of her involvement in the STP was in a review of acute services, due to concerns of the impact of winter on these services.

This Acute Service Review ran from January to March 2017, and was undertaken by external company – Carnall Farrar - along East Sussex and East Surrey NHS Trusts. Its aim is to assess capacity across Sussex and East Surrey, with a particular focus on BSUH's capacity to deliver planned District and Specialist work. The report came out in April.

The headlines for BSUH are that there is an immediate capacity shortfall of 78 beds at the County site rising to 115 beds prior to the opening of the 3T's (assuming a 90% bed occupancy). There are a number of additional beds on the County site but these are sometimes deemed not satisfactory as they are not placed in suitable areas, ideally not be used for patient care. For example, beds in the Barry Building have been closed for safety and quality reasons.

There is potential for capacity gaps to emerge at all local hospitals over this period, and a range of different scenarios have been modelled to address this shortfall as there will be a pressure on bed capacity until the first phase of 3Ts is completed in 2019. The charts provided show 4 potential scenarios for the five years from 2017/18, but they are just about to receive £30m to improve the emergency floor, which will include 70 beds. The first beds will be available in 2018 and before that there will be an increase in ambulatory space.

The hospital will face pressure on this site for the next 3 years. As consequence, alternatives are being looked at and actions taken to address the shortfall. Hospital at Home is a system that allows patient to be cared for at home with support, and currently 16 patients are treated a day this way. In Newhaven an additional 30 beds have been created with effective pathways for patients as a stepdown (currently

housing 24 patients).A focus on streamlining care to acutely unwell patients, improving primary care and to ensuring that a flow through and out of the hospital is maintained.

The CCG 'place-based' plans seek to reduce demand for Acute capacity through improved prevention and community provision.
EB then went on to discuss the Major Trauma Centre (MTC) Review and explained that this is being undertaken by NHS England, in conjunction with the STP and the Trust. This is a comprehensive review of the Trust's Major Trauma Centre services, against the national standards. It is a huge national issue for NHS, however we are making good progress and good position. The review included input from all teams, not just the A&E team.

The report strongly supported the continuation of MTC services at Brighton but highlighted a number of areas requiring improvement. The Trust has already addressed a range of these and is putting in place an action plan to ensure that all issues are resolved. This includes improving infrastructure and trauma management, such as the new helipad area to improve the delivery of patients by this means.

Questions:

Councillor Kevin Allen (KA) asked that given how challenging the conditions were in the hospital during the heatwave, what plans are in place to alleviate discomfort for patients and staff?

EB explained that a Heatwave Policy had been implemented, staff were allowed to wear lightweight scrubs, both patients and staff were also being given plenty of fluids, air-conditioning systems and fans have also been installed.

KA said that while this sounds very positive in context of the STP, how will this get rid of the deficit, an issue raised by as Adam Doyle at the last meeting.. If that's the frame work how are you going to do more for a lot less?

EB explained that the Trust was in special financial measures and had submitted a detailed financial plan, which would provide them more time to address the situation. There was an agreed £13m deficit at the end of month 2 and they were on course to meet their £80million trajectory. They checked all 12 directorates to check that they are fully funded for posts and can now work with framework agreed with NHSI.

Frances McCabe (FMcB) commented that this specifically sounds like an investment programme and how does this stack up if the aim is to reduce the deficit gap? How will the deficit be reduced, even with efficiencies? Will there be additional pots of money coming in?

EB replied that the cost improvement plan was to achieve 3% efficiency savings this year, which was on track. The additional beds will not fall into this financial year. She also explained that right now there are vacancies across the NHS, so are in the midst of a huge recruitment campaign, encouraging flexible work patterns, and avoiding using agency staff – it is important to get the quality right, patients first.

FMcB asked whether there were plans to reduce services in some areas? If local services are to provide tertiary and trauma services, where is the cost going to fall – is there capacity in other places?

EB confirmed that they are not closing networked arrangements with other hospital trusts. Instead there will be sharing of expertise, realigning services and swopping general medical beds. For example the centralisation of Stroke services onto a single site was to ensure the right infrastructure. They were now working with SASH to carry out programmes such as amalgamating pathology, to a single site at the Princess Royal. But there were no plans to close any services.

FMcB said that while she could understand the sharing of expertise like stroke services and back office operations but, queried whether it saves money or improved the service for patients? E.g. can it mean a longer wait for test results?

EB explained that the amalgamation of Pathology services for example is about efficiencies and consolidations, as well as achieving savings. Using a purpose built lab and better technology (e.g. greater digitalisation) would provide a better service.

KA sought reassurance that our local hospital would remain open. Then Colin Vincent (CV) asked about the effect of STP on older people, was interested in the Hospital at Home service and whether it was able to tackle delayed discharges?

EB agreed that delayed discharge was a big issue in B&H, and across the county. The figure for the city was 10% early in the year which was not good enough, as patients become more compromised and more likely to get infections. Additional work has been carried out, including Hospital at Home and buying spot packages of care. This had led to a significant reduction in delayed discharges to 4% (although the goal was 3.5%).

CV asked for confirmation if funding is still available to improve delayed discharges?

EB agreed that funding was still a challenge, but imminently there would be a plan going to the A&E delivery board on this issues and it was expected that there would be more money into social care.

CV referred to the CQC inspection where some of the key concerns about A&E situation had included examples such as people lying in makeshift beds in corridors or lying in own urine. The Chief Inspector of Hospitals identified it as being an issue of space. Is this difficulty likely to be addressed soon?

EB explained that as a result of people being found in corridors in 2016, four additional assessment cubicles have been introduced which has improved things, and helped ambulance crews. While the issue has not gone away completely, robust processes are in place to maintain patient dignity and privacy. There has been 3% month on month improvements, as well as a 40-50% reduction in those waiting over 12 hours.

CV asked if the RACK UP Service (a multi-purpose assessment place for older people) would be maintained in the 3Ts programme?

EB confirmed that frailty assessment clinics were in the place based plans and it was essential to have consultants who were expert in the care of the frail elderly in the hospital.

Councillor Louisa Greenbaum (LG) asked whether the ICT system would see streamlining and efficiencies? Will there be a unified ICT system for whole SPT area?

EB agreed that an ICT strategy was needed. The patient administration system would be retendered next year and might include linking this to GPs. There was not good connectivity currently, especially sharing results with GPs. LG would like to find out more about the Digital Working Group

FMcB asked for clarification on the other partners in the STP and how engaged are they with Caring Better Together? What were the governance arrangements for the hospital Board, and was anyone on the Board specifically involved in Caring Together and the whole STP?

EB confirmed that all healthcare providers were taking part in the STP process, which was attracting genuine support and engagement. Questions about the STP were better directed to Adam Doyle as the Chief Accountable Officer for the CCG. She then explained that 3 original Executive Directors of BSUH remained on the Board alongside 3 non-Executive Directors and Chair from the Western Board.

11 EVIDENCE FROM MIKE JENNINGS, DEPUTY CHIEF EXECUTIVE & DIRECTOR OF FINANCE AND ESTATES, SUSSEX COMMUNITY NHS FOUNDATION TRUST (SCFT)

Mike Jennings (MJ) began by explaining that he was the Deputy CE at SCFT which runs community services across 3 of the 4 (except East Sussex) place based plans of the SPT. Community Services sit beyond primary care, working between GP Services and the hospitals. They also include children's services, such as the Healthy Child Programme. SCFT were the biggest community provider within the STP and were involved in Caring Together within Brighton and Hove, which has the aim of making care more resilient. The Trust was developing services that can work with Primary and Acute Services and acknowledge that sometimes there can be better and cheaper care in people's homes.

Examples include Hospital at Home, and responsive services, where GPs can refer patients who are becoming less well, to be visited by community nurses to help them avoid going into hospital whilst also offering help when patients are discharged from hospital to provide support at home. The Trust also runs community beds, such as rehabilitation beds, but this is not within the city. A significant focus of work in the STP is to increase the amount of care being offered to people in their home. SCFT were working with the CCG and BSUH to look at how to ensure safe and patient-focussed care within financial resources.

Questions:

FMcB asked when will there be information about how the model for community care will work? Would it be revolutionary and have sufficient funds to enable people with a high level of need to avoid hospitals? (Giving the example in New Zealand of a model of palliative end of life care). Did you have sufficient staff of the calibre to deliver such services and leadership stability? Were there sufficient financial resources to take on such staff?

MJ replied that whilst no final model has been produced yet, options are being generated for appraisal. The key issues to be addressed were quality of care, the availability of workforce and affordability. The evidence for change was being generated by the Carnell Farrar review. After the generating options stage is completed in July this year, this would then be followed by a feasibility study and if necessary public consultation, with an aim to be choosing options by the end of the financial year.

He agreed that work force is a challenge – there were capacity issues in some services due to vacancy rates not related to restriction on funding. This does lead to the use of agency staff to cover these vacancies although this can be expensive and delivers less effective results. SCFT were launching a recruitment campaign which aimed to highlight the offer of training, support and mentoring, along with rotation of roles to gain experience. They will also aim to bring in more newly qualified staff.

The Trust ended the last financial year with a surplus of £103K. However they are expected to achieve a surplus of over £2.9m by the end of this financial year, to enable them to invest sufficiently in buildings and equipment.

KA praised the valuable and sometimes unglamorous work of the Trust then asked how the Trust fitted into the STP process?

MJ replied that within the city, GP practices were combining to work collaboratively to plan delivery on a wider scale. This worked in an area with a population of circa 50,000. This joined up working would help keep GP practices sustainable and keep decision making about patient care, which suits the best needs of the people, within that particular area. SCFT were working with this strategy, described as Communities of Practice within SCFTs Clinical Care Strategy.

KA asked about the level of staff engagement and awareness of these changes?
MJ thought that a high percentage of staff had heard about the STP, there was low awareness of MCP and other contractual forms but a high awareness of Communities of Practice.

CV expressed his concern that although the STP featured in both presentations general public know very little about the process, and raised concerns that it appears to be so far advanced without more information disseminated. He felt that the Working Group was also behind the game and was surprised that the plan had been approved.

MJ explained that some plans within the STP had existed prior to the STP process such as the Communities of Practice and the Pathology Hub mentioned in the

previous presentation. The STP makes it easier to work together, but it is not well advanced and much is in the planning stage. However, it is acknowledged that there is a need for further engagement,

CV asked whether the funding was to come directly from NHS, or the Better Care Fund?

MJ explained that it is a complicated funding process, including the CCG contracting for some services, some directly commissioned by the NHS England, and some commissioned by local authority Children's services and Better Care.. For example the West Sussex proactive care teams, which identifies people who are vulnerable to greater health needs, which does get funds from Better Care.

FMcB asked whether the STP process will make these services more sustainable, or will some parts of services be siphoned off to other organisations?

MJ said that the NHS will always look at where services should sit, but the STP will be focussed on solutions. One of the goals will be to increase community solutions, which will give SCFT a stronger voice. However, if a good quality patient outcome could be delivered by another organisation, this work could go to another organisation. The aim is to reduce barriers to deliver the right type of care.

KA expressed concern that the Trust would be fishing in same pool for recruiting nurses, and asked if the cost of housing affected the Trust's ability to recruit?

MJ agreed that in Brighton & Hove rental costs and the cost of housing across the STP impacted the number of trained nurses across area, as did wages. They are working together across the STP to establish joint solutions,

12 AOB

FMcB asked that in the minutes we try not to use jargon, be more user friendly.

LG asked about the Terms of Reference – some issues are regional level. Karen Amsden gave a response on the TOR.