Brighton & Hove City Council

Title:	**Health Overview & Scrutiny Committee**
Date:	**7 December 2016**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall, Norton Road, Hove, BN3 4AH**
Members:	**Councillors:** Simson (Chair), Allen, Bennett, Cattell, Deane, Knight, O'Quinn, Peltzer Dunn, Taylor **Co-opted Members:** Zac Capewell (Youth Council), Fran McCabe (Healthwatch), Caroline Ridley (Community & Voluntary Sector representative), Colin Vincent (Older People's Council)
Contact:	**Giles Rossington** Senior Scrutiny Officer 01273 295514 Giles.rossington@brighton-hove.gov.uk

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AGENDA

Part One **Page**

36 Apologies and Declarations of Interest

37 Minutes **1 - 10**

To consider the minutes of the meeting held on 19 October 2016 (copy attached)

38 Chairs Communications

39 Public Involvement

40 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.

41 Sustainability & Transformation PLan (STP): Special Item **11 - 82**

Contact Officer: *Giles Rossington, Senior Scrutiny Officer* *Tel: 01273 295514*

Ward Affected: *All Wards*

42 BSUH: New Working Arrangements with Western Sussex Hospitals NHS Foundation Trust **83 - 86**

Contact Officer: *Giles Rossington, Senior Scrutiny Officer* *Tel: 01273 295514*

Ward Affected: *All Wards*

43 3Ts Update **87 - 90**

Contact Officer: *Giles Rossington, Senior Scrutiny Officer* *Tel: 01273 295514*

Ward Affected: *All Wards*

44 Tier 4 Residential Detox: Update **91 - 96**

Contact Officer: *Kathy Caley* *Tel: 01273 296557*

Ward Affected: *All Wards*

45 Brighton & Hove Healthwatch Annual Report 2016/17 **97 - 132**

Contact Officer: *Giles Rossington, Senior Scrutiny Officer* *Tel: 01273 295514*

Ward Affected: *All Wards*

46 HOSC Draft Work Plan/Scrutiny Update **133 - 136**

The latest version of the HOSC 2016/17 work plan is included for information (copy attached)

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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)

Date of Publication November 29th 2016

BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00pm 19 OCTOBER 2016

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

MINUTES

Present: Councillor Simson (Chair)

Also in attendance: Councillor Allen, Bennett, Cattell, Deane, Marsh, Peltzer Dunn, O'Quinn, Taylor and Mac Cafferty

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

PART ONE

27 APOLOGIES AND DECLARATIONS OF INTEREST

(a) Declarations of Substitutes

27.1 Councillor Mac Cafferty was present in substitution for Councillor Knight.

27.2 The Youth Council sent apologies.

(b) Declarations of Interest

27.3 There were no declarations of interest.

(c) Exclusion of Press and Public

27.4 In accordance with Section 100A of the Local Government Act 1972 ("the Act"), the Committee considered whether the public should be excluded from the meeting during consideration of any item of business on the grounds that it is likely in view of the business to be transacted or the nature of the proceedings, that if members of the public were present during it, there would be disclosure to them of confidential information as defined in Section 100A (3) of the Act.

27.5 **RESOLVED** - That the public abe not excluded from any item of business on the agenda.

28 MINUTES

28.1 The minutes of the committee meetings of 20 July 2016 and 05 October 2016 were agreed as an accurate record.

29 CHAIRS COMMUNICATIONS

29.1 The Chair gave the following communication:

"I would like to welcome everyone to the HOSC meeting.

There are a number of members of the public here, which is good to see. Clearly there are issues on today's agenda which people feel passionate about. Please do note that you are here as observers, not as participants in the meeting. The council has a number of ways for people to ask questions or present petitions to committee meetings – and we have members of the public here today with a deputation. However, we cannot have the meeting disrupted by people shouting out from the public gallery, and I'm sure everyone here today will respect this.

Today we will be looking at the Sussex-wide review of stroke services, where it is proposed that services for the Brighton & Sussex University Hospitals Trust (BSUH) 'footprint' should be single-sited at the Royal Sussex County Hospital. We will also be looking at the recent CQC inspection report of South East Coast Ambulance NHS Foundation Trust (SECAmb); and at the latest developments in Sussex Patient Transport Services.

In terms of today's agenda, I'd like you to note that there is an addendum to the papers. This contains draft minutes for both the 20 July HOSC meeting and the special meeting on 05 October. It also contains the revised text of a deputation to HOSC on Sustainability & Transformation Plans.

In addition, I'm like to change the order of items a little and take Item 34 (PTS) before Item 33 (SECAmb). This is at the request of the SECAmb Acting Chief Executive, Geraint Davies, who is on his way from another meeting in Surrey.

Before we start the meeting, I'd also like to mention two other things. Firstly, you may have seen media coverage of the publication of the Sussex Partnership Trust (SPFT) Thematic Homicide Review. The review makes worrying reading and we plan to explore its implications with SPFT at the next meeting between their executive leadership team and Sussex HOSC Chairs. This issue may also be considered by the HOSC later in the year.

Secondly, you also may have seen that BSUH, our hospital trust, has been placed in Financial Special Measures by NHS Improvement – the trust was already in Special Measures for quality. We're in the process of setting up the joint HOSC working group to look at quality improvement plans, and we'll seek to include these financial issues in the scope of this work."

30 PUBLIC INVOLVEMENT

30.1 A deputation on Sustainability & Transformation Plans (STP) was presented by Mr Ken Kirk and Ms Madeleine Dickens. A similar deputation was presented to the July 2016

meeting of Full Council and was referred on to the HOSC. Given the time that had elapsed between the July Full Council meeting and the HOSC meeting, and given recent developments in the STP process, Mr Kirk and Ms Dickens were invited to revise their deputation and to re-present it.

30.2 The Chair responded to the deputation requests for action:

In view of emerging information about wholly new NHS governance structures Councillors communicate their disquiet about the proposed STP arrangements to the STP Board and request the attendance of the Board Chair at a specially convened HOSC meeting.

HOSCs' main statutory duty is to scrutinise NHS plans to make major changes or improvements to health services for local people, checking that they are not detrimental and that there is proper engagement and consultation with stakeholders and the public. The HOSC will certainly want to examine, at as early a date as possible, any STP plans to make substantial changes to local services. It is not possible to say precisely what the HOSC would do with these plans, since we do not yet know what they might contain, but should they involve large-scale service changes then the HOSC is likely to want to gather evidence about them and potentially to make recommendations to Full Council or to other bodies.

Our understanding is that the 'checkpoint update' submitted on June 30 did not include detailed plans for service change. It consisted, rather, of high-level diagnostics of the quality, care and resource gaps facing the STP footprint, and outline proposals for better regional co-working. As such, this submission is not strictly relevant to the HOSC; the HOSC's role is to respond to detailed proposals, not to engage with planning work in progress.

We acknowledge that there is public concern about the STP process. The council is involved in STP planning: HWB Chairs from across the STP footprint are part of the Central Sussex & East Surrey Alliance Programme Board, and council officers sit on various STP sub-groups. The Health & Wellbeing Board has already received a presentation from the Chair of the STP Board, and an STP update is a standing item on HWB agendas. At a regional level, HOSC Chairs are beginning to work together with the STP Board to plan the scrutiny of the detailed STP proposals when these become available.

We believe that these actions are appropriate at the current time, although we will continue to review this as the STP process evolves.

> **The full council recommended that the HWB call public consultation meetings on STP at the earliest opportunity. It has since become clear that councillors and officers will participate in the proposed new STP governance structures. The lack of any public consultation or engagement in decisions of this magnitude flies in the face of democratic and legal (see Gunning) principle. Urgent action should be taken to redress this.**

The city council and the CCG are committed to engaging with local people. We are still some way from being in a position to *consult* with residents about the STP, because consultation requires there to be concrete proposals to consult on.

It is important to recognise that there has been a commitment to date to ensure the STP plan will incorporate existing local initiatives. The local initiative for better integration of local health and social care services, Brighton & Hove Caring Together, will provide the foundation for local STP planning and in many ways is formalising how we already work together and intend to develop our provision over the next 4-5 years. The council and the CCG have already begun engaging on B&H Caring Together, with more events planned in the next few weeks.

A recommendation be made back to full council to propose a delay in acceptance of the STPlan pending much fuller objective consideration of its consequences.

We do not currently know what the detailed contents of the local STP will be. We do know that the city faces serious problems with health and care services which urgently need addressing. We also know that solutions for many of these problems will not solely be found in Brighton & Hove: for example, a significant proportion of patient-flow into the Royal Sussex County Hospital comes from outside the city. In addition many residents already use services outside the city. We are also committed to the continuing integration of local health and social care services.

The STP offers opportunities to step up our work on integration and to develop the kind of regional co-working relationships which are key to improving services at our hospital trust and elsewhere. It is not recommended that members seek to delay these developments when we don't yet know what the full implications of the STP are.

The most effective means of soliciting the opinion of city residents on the tendering out of local NHS services should be identified along the lines of the University of Brighton Citizens' Health services survey examining attitudes to privatisation.

It is clearly the case that a number of local people are unhappy with the prospect of services currently provided by NHS organisations being delivered by independent sector organisations following the re-tender of contracts. However, it is important to understand that NHS and local authority commissioners have to act in ways which accord with procurement law and best practice.

30.3 Cllr Mac Cafferty proposed an amendment to the recommendation: that, in addition to noting the deputation, the HOSC should agree to hold a special committee meeting to scrutinise STP plans to date. This amendment was seconded by Cllr Allen and agreed by the committee. The Chair confirmed to Mr Kirk that the special meeting will be held in public.

31 MEMBER INVOLVEMENT

31.1 There were no issues referred by members.

32 REGIONAL REVIEW OF STROKE SERVICES: UPDATE

32.1 This item was introduced by Caroline Huff (CF), Clinical Programme Director, Central Sussex & East Surrey Alliance; and by Dr Nicky Gainsborough (NG), Consultant in Stroke, Brighton & Sussex University Hospitals Trust.

32.2 In response to a question from Cllr O'Quinn about the risk of longer blue-light journey times for Mid Sussex residents should stroke services be single-sited at the Royal Sussex County Hospital (RSCH), NG told members that the advantages of single-siting outweigh any disadvantages of increased journey times. In response to a query from Cllr Deane, NG confirmed that this is likely to be true even if road works or congestion lead to longer than anticipated journeys to RSCH.

32.3 In reply to a question from Fran McCabe (Healthwatch representative) on whether current quality could be maintained with a single-site service, NG told the committee that there has been a divert to RSCH in place since February this year, so effectively stroke treatment has been single-sited for a number of months, and has been offering a superb service, despite all the estates challenges at RSCH. As a consequence of the divert, 10-14 beds have been freed at the Princess Royal Hospital (PRH). Patient satisfaction with the service remains very high (consistently at 98% for the NHS Friends & Family survey), even amongst those who have to travel further, because patients recognise that quality of service is more important than travel times. Although travel is an issue, there are good transport links to RSCH from Mid-Sussex, including the 40x bus service linking PRH and RSCH.

32.4 In response to a question from Cllr Taylor on performance as measured in terms of patient outcomes, NG told members that outcomes have improved recently. It should also be noted that outcomes are identical across the catchment: patients who have to travel longer to access services at RSCH are not disadvantaged by this. Further improvements in outcomes are expected when the team is fully staffed and able to offer a full seven day service.

32.5 In answer to a question from Colin Vincent (Older People's Council representative) on whether Mid Sussex patients could initially be seen and assessed at PRH, with those needing more specialist treatment then being referred on to RSCH, NG told the committee that this had been considered, but that it was quicker to process all patients at RSCH.

32.6 In response to a question from Cllr Mac Cafferty on the impact on stroke services of initiatives like 3Ts and of system pressures, NG told members that her team are ferocious in protecting their patients' interests and generally manage to do so successfully. However, delays in getting timely social care assessments and placements do represent a challenge.

32.7 RESOLVED - That the evidence provided detailing the benefits and risks of the Central Sussex Stroke Programme Board's recommendation to centralise Hyper Acute Stroke

services and Acute Stroke services at the Royal Sussex County Hospital (RSCH), Brighton (**Appendix 1**) be noted; and

That members agree that the HOSC should continue to receive updates on the progress of the stroke review, but that no further formal consultation with the HOSC is required.

33 SOUTH EAST COAST AMBULANCE NHS FOUNDATION TRUST: CQC INSPECTION REPORT

33.1 This item was introduced by Geraint Davies (GD), Acting Chief Executive, South East Coast Ambulance NHS Foundation Trust (SECAmb).

33.2 In response to a question from Caroline Ridley (Community Sector representative) on the CQC's finding that some SECAmb staff did not fully understand their job roles, GD told members that SECAmb acknowledged this problem. The trust is taking a number of steps to address this: for example, by ensuring that managers are no longer required to crew ambulances at times of very high demand – allowing them to concentrate on their managerial role. The trust is also introducing a better escalation process for staff concerns; has introduced a new system of appraisal that focuses on quality; and regular 'temperature check' meetings with front-line staff.

33.3 In answer to a query from Cllr Marsh on when permanent board appointments would be made, GD told the committee that a substantive Chief Executive was currently being recruited. Once in place, the Chief Executive would lead the process of recruiting a Chair.

33.4 In response to a question from Cllr Taylor on whether trust leaders had been aware how serious some of the problems facing the trust were, GD told members that although it was known that the trust was facing significant challenges, the full extent of these was not necessarily known as there was significant staff under-reporting of issues. The trust had not been fully aware of governance shortcomings until the Deloitte report on the Red 3 scheme was released earlier in 2016.

33.5 In response to a question from Cllr Allen about safeguarding, GD informed the committee that SECAmb took the CQC's findings on safeguarding very seriously, and had already instituted changes – for example in how the trust Board deals with safeguarding alerts. However, some of the poor safeguarding performance identified by the CQC was not in fact due to under-reporting of safeguarding concerns, but the use of terminology in staff reporting that the CQC did not recognise as relating to safeguarding.

33.6 In answer to a question from Cllr Allen about how much ambulance capacity was being lost due to handover delays at hospital, GD told members that delays amounted to 3% of total ambulance capacity. This is unacceptable, but is a system problem not just a problem for hospital trusts.

33.7 In response to a question from Cllr O'Quinn on ambulance crew mix, GD told members that the trust endeavours to buddy new staff with experienced people. However, it is important to understand that all the paramedics employed by SECAmb are fully trained graduates, many of whom will have done their training with SECAmb.

33.8 GD told the committee that the trust is experiencing significant problems with staff retention. Part of the problem is that ambulance paramedics are being actively recruited into primary and secondary healthcare, often at much better pay than the ambulance service can offer.

33.9 Cllr Peltzer Dunn thanked GD for attending the meeting, noting that it was refreshing to get such a candid and open response to service failure.

33.10 The Chair suggested that the HOSC should see the SECAmb action plan in response to the CQC's finding as soon as it became available. This was agreed by members.

33.10 Cllr Peltzer Dunn proposed an amendment to the report recommendations: to insert at point 2.3 the following: "that there be regular reports back to the HOSC for information and/or decision. No formal powers shall be delegated to the working group." The amendment was seconded by Cllr Bennett and agreed by HOSC members.

33.11 **RESOLVED -** That the report be noted; that HOSC members agree that scrutiny of the implementation of SECAMb quality improvement measures in response to the CQC report findings be undertaken by an informal joint working group representing all the interested HOSCs in the SECAmb 'region'; and that there be regular reports back to the HOSC for information and/or decision. No formal powers shall be delegated to the working group.

34 PATIENT TRANSPORT SERVICES (PTS): UPDATE

34.1 This item was introduced by John Child (JC), Chief Operating Officer, Brighton & Hove CCG; Alan Beasley (AB), Chief Finance Officer, High Weald Lewes Havens CCG; and Ian Thomson (IT), Business Unit Manager (Sussex), Coperforma.

34.2 In response to a question from Cllr Allen on TIAA being unable to interview all the staff they wished to in preparing their independent report on Patient Transport Services (PTS) contract mobilisation, AB told members that at the time of TIAA's investigation some staff were unavailable because they were no longer employed by Coperforma. IT added that he had been in place in May; TIAA had not attempted to contact the previous incumbent.

34.3 In answer to a query from Cllr Allen on why CCGs had paid for external legal advice on this issue, AB told the committee that CCGs did not have the requisite specialist legal expertise in-house.

34.4 In response to Cllr Taylor's request to see performance data broken down to locality level, AB told members that the contract was not established with this granularity of data in mind. However, data by locality has now been requested and should be imminently available. IT added that he has taken personal charge of the Brighton & Hove locality. He meets regularly with staff at the royal Sussex County Hospital (RSCH), particularly with renal department nurses, to ensure that all PTS journeys are booked correctly. IT is developing contingency plans for when the 3Ts building work impacts on parking at RSCH.

34.5 In answer to a question from Cllr O'Quinn on the employment by CCGs of a PTS expert, AB confirmed that someone has been in post since August 30. IT added that this arrangement is working well for Coperforma: the new staff member has an in-depth practical knowledge of PTS and provides an effective means of liaison between Coperforma and commissioners.

34.6 In response to a query from Cllr Mac Cafferty on how the learning from the TIAA mobilisation report can be entrenched into future CCG procurement, AB told members that the learning from the TIAA report has been shared amongst all Sussex CCGs and also with specialist procurement support organisations. Procurement of the PRS contract was not supported by the regional Commissioning Support Unit (CSU), although it is unlikely that CSU involvement would have resulted in a different outcome. The TIAA report has been shared with the CSU.

34.7 Fran McCabe told members that HW has been surveying patients since the beginning of the current PTS contract. User satisfaction has gradually improved, but is still nowhere near the 80% quoted by the CCGs. Patients remain very worried about the future of the service. Users would also like to see some continuity of care – i.e. being regularly assigned the same driver. Whilst some aspects of the PTS service are doubtless complex because it is hard to estimate how long appointments may take, treatment times for other services (e.g. renal dialysis) are much more predictable, and it should be relatively straightforward to run a decent PTS for these patients.

34.8 Cllr Cattell commented that she was sceptical of the user satisfaction being claimed by the CCGs and would like to see the survey proforma being used. To be trusted it may be necessary that the wording of any survey be agreed with an independent body such as Healthwatch. It is shocking that TIAA was unable to access all the information it required to undertake its independent investigation.

34.9 Cllr Peltzer Dunn proposed an amendment to the report recommendation, suggesting that an additional resolution be inserted at 2.2: "that bi-annual updates, to include comparative patient satisfaction data, be brought to the HOSC." The amendment was seconded by Cllr Allen and agreed by members.

34.10 RESOLVED – that the report be noted; and that bi-annual updates, to include comparative patient satisfaction data, be brought to the HOSC.

35 HOSC DRAFT WORK PLAN/SCRUTINY UPDATE

35.1 Items to be added to the work plan following this meeting are:

- a Patient Transport Services update in six months' time
- the SECAmb action plan in response to CQC inspection recommendations
- a special meeting to discuss Sustainability & Transformation Plans (STP).

35.2 Fran McCabe (Healthwatch representative) suggested that NHS Referral to Treatment times be added to the HOSC work programme.

25.3 Cllr Taylor suggested that cancer indicators (cancer mortality, waiting times for treatment and waiting times for/take-up of screening programmes be added to the HOSC work programme.

25.4 Cllr Allen suggested, and members agreed, that the incoming Executive Director of Health & Care should be invited to the next HOSC meeting to introduce himself and to answer questions about ASC performance.

The meeting concluded at Time Not Specified

Signed Chair

Dated this day of

HEALTH OVERVIEW & SCRUTINYCOMMITTEE	Agenda Item 41 Brighton & Hove City Council

Subject:		**Sustainability & Transformation Plan (STP): Special Item**		
Date of Meeting:		**07 December 2017**		
Report of:		**Executive Lead, Strategy, Governance & Law**		
Contact Officer:	**Name:**	**Giles Rossington**	**Tel:**	**29-1038**
	Email:	**Giles.rossington**		
Ward(s) affected:		**All**		

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 There is a current national initiative to redesign NHS and social care services in order to improve quality, enhance sustainability and meet financial challenges. Sustainability & Transformation Plans (STPs) form an integral part of this work.

1.2 The Sussex & East Surrey STP submission is included as **Appendix 1** to this report. The Central Sussex & East Surrey Alliance (CSESA) Place-Based Plan is included as **Appendix 2**. NHS officers engaged with STP planning will be available to answer questions at the 07 December committee meeting.

2. RECOMMENDATIONS:

2.1 That members note this report for information.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 In 2014 national NHS organisations published the NHS Five Year Forward View, setting out a new vision for the future of NHS services. https://www.england.nhs.uk/ourwork/futurenhs/

3.2 In December 2015, annual NHS planning guidance was published, introducing a requirement for local health and care commissioners and providers to come together in sub-regional 'footprints' to develop Sustainability & Transformation Plans (STPs) in order to implement the Five Year Forward View. https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

3.3 STPs must include plans to:

- Bring the NHS back into financial balance by 2022
- Improve the sustainability and quality of GP services

- Meet all national NHS access standards (i.e. the four hour A&E wait and ambulance response targets)
- Meet national NHS standards for Referral to Treatment (the 18 week target)
- Deliver the 62 day cancer waiting standard and improve one year cancer survival rates
- Meet new mental health access standards and dementia diagnosis targets
- Deliver action plans to improve services for people with Learning Disabilities
- Deliver and implement affordable plans to improve quality in NHS provider organisations, particularly those in Special Measures.

3.4 Footprints were left to local determination rather than centrally prescribed. Footprints are intended to make as much sense as possible in terms of CCG catchments, local authority boundaries and hospital patient flow. Locally, upper-tier councils, CCGs and NHS providers agreed to work on a footprint encompassing all of Sussex plus East Surrey CCG area.

3.5 Footprint areas were required to submit initial high-level thinking in June 2016, and then to make more detailed submissions in October 2016. NHSE initially embargoed the publication of these submissions, but more recently have approved the publication of the October submission. The Sussex & East Surrey STP submission was published on November 25th 2016, and is included as **Appendix 1** to this report. It is also available on the Brighton & Hove CCG website: http://www.brightonandhoveccg.nhs.uk/your-services/sustainability-and-transformation-plan

3.6 Feeding into the STP plan are three locality 'place-based plans'. The localities are:

- Hastings & Rother and Eastbourne and Seaford & Hailsham CCG areas (East Sussex Better Together)
- Coastal West Sussex CCG area (Coastal Together)
- Brighton & Hove; Horsham & Mid Sussex; High Weald Lewes Havens; Crawley and East Surrey CCG areas (Central Sussex & East Surrey Alliance: CSESA).

3.7 The CSESA plan is included as **Appendix 2** to this report. The place-based plans are less high-level than the STP, but still relatively strategic documents. More detailed local plans will sit underneath these. The local integration plan for the city is Brighton & Hove Caring Together.

3.8 It is important to note that, whilst the STP is a new initiative, much of the locality activity that informs the sub-regional plan represents work that is already being undertaken, particularly in terms of joint commissioning and service integration.

3.9 NHS bodies are legally obliged to consult the HOSCs of all areas impacted when planning to make 'substantial variations' to NHS services. 'Substantial Variation' here refers to detailed intentions for service change rather than strategic plans like the STP/place-based plan, so the time for formal HOSC involvement will be when and if the STP enters into detailed planning for specific and significant service changes. Given the scale of the overall STP footprint and of the CSESA locality, it is likely that this HOSC involvement will be via some form of Joint

HOSC (JHOSC) representing all the relevant upper-tier local authority areas. However, HOSCs also have general powers to hold local NHS bodies to account for strategic as well as operational planning, and may choose to scrutinise the STP plans at an earlier stage.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 Not applicable to this report for information.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 None to this report.

6. CONCLUSION

6.1 Members are asked to note the STP initiative and the now published STP and CSESA plans.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 None to this report which is for information

Legal Implications:

7.2 None to this report which is for information

Equalities Implications:

7.3 None to this report which is for information

Sustainability Implications:

7.4 None to this report which is for information

Any Other Significant Implications:

7.5 None to this report which is for information

SUPPORTING DOCUMENTATION

Appendices:

1. Sussex & East Surrey Sustainability & Transformation Plan (STP) submission

2. Central Sussex & East Surrey Alliance (CSESA) Place-Based Plan

Sussex and East Surrey Sustainability & Transformation Plan

15

WORK IN PROGRESS

Name of footprint and no: Sussex and East Surrey (33)

Region: NHSE South

Nominated lead of the footprint including organisation/function: Michael Wilson, Chief Executive, Surrey and Sussex Healthcare NHS Trust

Contact details (email): *Michael.Wilson@sash.nhs.uk*

22nd November 2016

Our "plan on a page"

WORK IN PROGRESS

Sussex & East Surrey Sustainability & Transformation Plan

Context and challenges: We are a large and diverse region, with 23 organisations serving 1.7m people. We have significant challenges with waiting times and cancer outcomes, alongside a relatively older population. We have established three "Place-Based" areas (Delivery plans in Appendix B), each defined around local communities, empowered to co-design person-centred services, led by GPs with support from a wide range of professionals. Our challenge is to improve the health of our communities, make it quicker and easier to access services, to deliver improvements identified by regulators and find a way to do so within a tighter budget than we have faced in many years.

Benefits:

Years 1-2	Years 3-4	Year 5
Quality: Waiting time targets met or exceeded, All trusts exit special measures, all GPs working in a new way, e.g. in a locality and delivering person-centred frailty models. GP appointments available more readily for all communities.	**Quality:** Each Place to have at least one walk-in primary urgent care with max 30 min wait. Hospital performance in top quartile for all measures. All services to have full mind and body integration/approach	**Quality**: patients report having full ownership of care and wellbeing for all LTCs and frailty
Performance: Delivery of agreed trajectories in year 1. Further improvement in performance in year 2.	**Performance**: Minimum constitutional targets met and improved outcomes where performance is poor e.g. lung cancer, EIP and IAPT Access delivered,	**Performance:** Prevention goals achieved, ~20% reduction in bed days per 1,000 population
Finance: Overall position improved by £147m	**Finance**: Further efficiencies of £279m delivered	**Finance:** overall position £60m deficit

Priorities:

Years 1-2: Addressing the quality and performance gap

Place based transformation:
Accountable Care: ESBT/Coastal new models in place by Year 2 with pooled budgets Y1 in ESBT. CSESA significant progress towards MCP and collaborative commissioning
Primary care: Make GP services easier to access and work better for patients, and integrate multidisciplinary teams.
Frailty (primary care): led by primary care, develop services for older people that respond to their complex needs;
New primary and community urgent care models: networked with acute hospitals, aiming to make better use of resources

Whole system: acute recovery plan (Appendix C):
Capacity review: making the best use of existing beds
Community beds: new community beds (primary care and community led in partnership with BSUH and ESHT)
Elective redesign: share resources to improve efficiency
Discharge delays: reduce blockages in the care system to free up capacity to care for those who need it most
Networked hospital care: working together on cancer, stroke, pathology and imaging, and to deliver seven day services

Years 3-4: Accelerating transformation

Place based transformation:
Accountable Care: place-based decision making and financial incentives implemented, e.g. capitated budgets
Innovation across all LTC pathways, primary care and mental health: each place empowered to drive local transformation building on best practice sharing
Workforce transformation: training for new roles and workforce productivity plans implemented and contracts to underpin community based models and deliver a motivated and engaged workforce
Mind and body care: all models to have full "holistic" approach

Provider sustainability:
Elective centre: Build on initial partnerships to deliver transformed model across whole STP footprint
Networks for DGH services: mapped patient pathways to underpin new model of acute collaboration through acute networks
Specialised integration: ensure delivery of transformational schemes to underpin future configuration around Brighton

Year 5: Embed transformation

Transformed Place based care:
Continue to transform and integrate care, led by GPs and integrated mind and body teams, with further local innovation and tailoring to deliver the needs of local populations to remain independent and healthy

Completion of:
Deliver future Brighton hospital: MTC and teaching hospital
Deliver on patient pathway integration and implications for acute sites

Supported by: Estates | Digital | Workforce | Comms & Engagement

Executive summary

WORK IN PROGRESS

This document summarises our work in progress plans to improve the quality of care patients receive, make it easier to see a GP or to use specialist services and to deliver services within the money available. It builds upon our submission of 30th June 2016, and should be seen as work in progress to guide delivery of change. We will need to co-create the detail of solutions with local communities and we will significantly expand our engagement activities to achieve this.

We are committed to working as an STP footprint as we believe this is the only way to achieve change at scale and specifically to achieve acute networking and pathways, support our tertiary services and facilitate transformation in partnership with organisations that span the whole footprint (mental health and community).

Our STP footprint shares the challenges and opportunities of the rest of the country in delivering the triple aim of STPs, with particular challenges locally due to our population demographics, performance of some providers and CCGs and our overall outcomes particularly in Cancer.

Our aspirations for longer term transformation and delivery of the 5YFV, including GP and Mental Health 5YFV will be driven by our three “places” – with each aiming for an accountable care model, and an agreed focus on three areas for next year as an STP (in addition to local priorities): frailty, urgent care and primary care transformation. We have significantly progressed our governance as an STP to enable this local work to flourish, and there has been significant movement in the development of localities or care practice groups of GPs in each of our areas. (Appendix B for delivery plans)

The added value of working as an STP across the three places is the ability to share learning and speed up transformation and to make clear links between the granular person centred care plans and our commitment to furthering acute networking for secondary services as a whole STP.

We acknowledge that despite this good progress we have some particularly acute challenges that require focus in the short term to deliver system sustainability this winter:

- Operational performance challenges in A&E and RTT, and for Cancer
- Significant financial challenges at a number of trusts and commissioners; most notably BSUH, but also ESHT, SECAmb and two CCGs

We believe that the largest opportunity to solve these issues and prepare for winter is to maximise the number of acute beds, particularly across BSUH sites, where approx. 86 have been lost in the past year, and at ESHT where there is a projected shortfall of 66 beds between the two sites. (Appendix C for recovery plans)

Our STP has brought organisations together to develop a shared plan to solve the bed shortage. These resilience plans are founded upon a mix of: opening additional capacity at RSC site through internal reconfiguration and optimisation of space, opening additional community beds at existing sites, and working in partnership with social care to deliver nursing solutions to decompress acute sites. These are in addition to whole system daily capacity management “operations rooms” that have been established by ESBT and are being designed rapidly for Brighton and catchment.

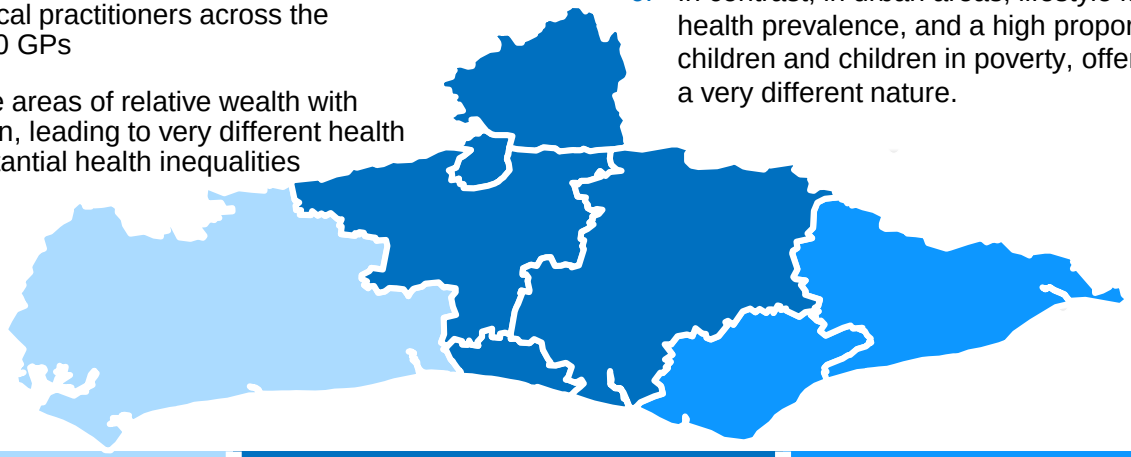
We have a history of working in acute networks e.g. vascular/stroke services and our aspiration is to build on this to design a networked future for secondary care. The detailed work for this winter has also rapidly progressed a number of medium term actions for years 2 and 3, that will link with this networking including elective care factory, balancing capacity for both daycase and elective work across sites and driving economies of scale.

We remain committed to delivering the efficiency improvements set out by the centre. However we have found that the scale of our starting performance and finance challenge raises concerns around material safety issues in relation to winter capacity. Therefore we will not be able to submit a plan that balances and meets CCG business rules in all years. We have not made this trade off lightly and are keen to discuss and test our assumptions with you, as well as to continue to work to find solutions to further close the gap.

WORK IN PROGRESS

Our sustainability and transformation footprint

1. Our footprint is home to 1.7 million people providing health and social care at a cost of £4bn
2. 23 partner organisations are involved across all health and social care sectors
3. There are over 37,000 medical practitioners across the footprint including over 1,000 GPs
4. The footprint combines large areas of relative wealth with pockets of severe deprivation, leading to very different health challenges, along with substantial health inequalities
5. We have a larger than average elderly and ageing population, which when combined with the rural areas and variable transport links makes supporting this complex and vulnerable cohort a significant challenge.
6. In contrast, in urban areas, lifestyle factors and mental health prevalence, and a high proportion of looked after children and children in poverty, offer equal challenges of a very different nature.



Coastal Care

Coastal West Sussex CCG
Sussex Community NHS Foundation Trust **(SCFT)**
Sussex Partnership NHS Foundation Trust **(SPFT)**
West Sussex County Council
Western Sussex Hospitals NHS Foundation Trust **(WSHFT)**
South East Coast Ambulance Service **(SECAmb)**
GP Providers
IC24

Central Sussex & East Surrey Alliance (CSESA)

East Surrey CCG
Crawley CCG
Horsham & Mid Sussex CCG
Brighton & Hove CCG
High Weald Lewes Havens CCG
Queen Victoria Hospital NHS Foundation Trust **(QVH)**
Surrey & Sussex Healthcare NHS Trust **(SaSH)**
Surrey & Borders Partnership NHS Foundation Trust **(SaBP)**
Brighton & Sussex University Hospitals NHS Trust **(BSUH)**
Sussex Community NHS Foundation Trust
Sussex Partnership NHS Foundation Trust
Brighton & Hove City Council
West Sussex County Council
East Sussex County Council
Surrey County Council
First Community Health & Care
SECAmb
GP Providers
IC24

ESBT

Eastbourne, Hailsham and Seaford CCG
Hastings and Rother CCG
East Sussex Healthcare NHS Trust **(ESHT)**
East Sussex County Council
Sussex Partnership NHS Foundation Trust
SECAmb
GP Providers
IC24

Our vision for Sussex and East Surrey

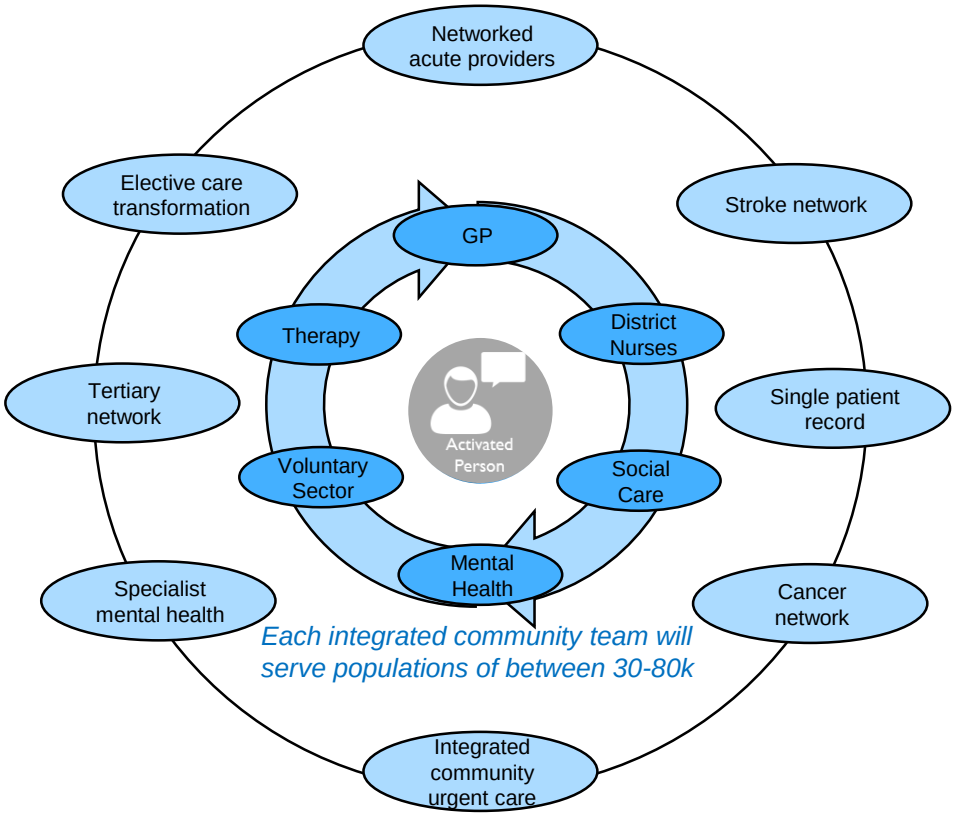
WORK IN PROGRESS

Key principles

1. Full engagement of local populations to support us in delivering the best outcomes with available resources
2. Led by place-based integrated care in our 3 “places” to be responsive to the range of needs of our population
3. Focused on prevention and proactive care through multidisciplinary locality teams supported by a shift in investment towards Primary Care and Community
4. Supported by a provider sector that collaborates to network services, share workforce, and balance capacity across the system
5. Move at pace, and support local organisations to go as fast as they can, recognising different starting points of each of the 3 Places

Our Ambition

- Our ambition is to improve population health and wellbeing by working together as an STP footprint
- Prevention and self-care is central to all of our plans to prevent illness and enable people to live well
- The care you receive will be integrated and all of the people and organisations involved will be centred around you and in communication with each other
- Where care is more specialist – this care will be provided through acute clinical networks to ensure that you receive the highest quality care that meets your needs
- We are committed to having one shared patient record – this means that you will not have to repeat your patient history each time you meet someone new



Each integrated community team will serve populations of between 30-80k

Hospital and specialist mental health services will be arranged over appropriate populations, i.e. 1m to 2m

How has the footprint responded to feedback received on the June 30th submission

WORK IN PROGRESS

	Feedback received from NHSE/NHSI in July 2016	Actions implemented since June 30th
Leadership and Governance	▪ Governance and behaviours should facilitate stronger collective leadership ▪ Streamline governance and ensure appropriate decision making can occur at pace ▪ Move quickly to address leadership issues where possible ▪ Describe and resource additional programme support arrangements and establish at pace ▪ Work closely with Kent on cross-border issues	▪ Single system leadership (SPoLs) now in place across our three "Places" ▪ Programme Board Executive created to drive STP-wide progress with agreed behaviours and principles as contained in Appendix A of this document ▪ Workstreams reviewed and enhanced to focus on delivery with Chairs in post to drive change ▪ Programme resource planning – programme director interviews held and offer made ▪ Engagement with Kent STP leaders to align plans
Transformation of local care through "Places"	▪ Provide clearer plans on how the STP will move forward to address the quality gap ▪ Clarity on how place-based plans are being developed in light of the STP ▪ Clarify engagement with local authorities in Estates discussions ▪ Ensure delivery of Primary Care five year forward view is embedded in places ▪ Stronger plans for Mental Health, drawing on the Five Year Forward View	▪ Place based delivery plans accelerated (note differing starting points) – clarity on vision, governance, resourcing, clinical models, contracting and finance, and enabling streams. ▪ Local transformation teams now present in all three places ▪ Clear future state identified for each place, with plans to deliver in Years 1&2, two accountable care models and one commissioner collaborative with an MCP ▪ Further testing of basis (including evidence base) for plans ▪ A Mental Health review panel (across the three places) has reviewed each of the place-based plans to ensure that the main priorities of the MH5YFV are in place ▪ Significant engagement of primary care colleagues in development of all place-based plans
Provider collaboration and transformation	▪ Identification of more radical solutions to close the finance gap ▪ Further develop the options for sustainable acute and specialised services ▪ Ensure compelling case for 3Ts model is developed and is consistent with the STP plans	▪ Agreement to build on existing acute networks to identify future models for networked DGH provision, building on pathways of care that integrate with place-based plans ▪ NHSE led work to assess requirements and sustainability of MTC at BSUH to report December 2016 ▪ Strategy for sustainable elective care in development, building on analysis and ensuring delivery of RTT

Overview of the challenge we face

WORK IN PROGRESS

- Patients are receiving varied care across the footprint, this combined with poor health outcomes for some means that people are suffering unnecessarily. Coupled with poor patient experience and poor health for some, the financial burden across the footprint is growing. Consequently all stakeholders need to work together to successfully improve care for all in Sussex and East Surrey.

Health & Wellbeing Gap

- The STP footprint has a growing and ageing population, with an increasing number of people suffering from long term conditions (LTCs) and in particular a significant older population living with multiple LTCs. Health is poor in some areas of the footprint, notably in in coastal towns, where pockets of deprivation across the STP lead to significantly poorer health outcomes and fewer disability free years of life lived.
- Specifically, we have gaps across the footprint relating to:
  - Smoking: above average smoking rates amongst 15 year-olds, and some localities with high adult smoking rates
  - Cancer: we perform poorly on 1-year cancer survival, driven in particular by lung cancer
  - Obesity: we have above average rates of adult obesity
  - Mental health: above-average rates of hospitalisation for self-harm

Care & Quality Gap

- We have significant problems in primary care – specifically to patients unable to book appointments within a reasonable time period, old buildings that are not fit for purpose and high vacancy openings that GP surgeries are struggling to fill.
- Within our hospitals:
  - ESHT, BSUH and SECAmb are in special measures
  - Referral to Treatment times, cancer waits and A&E 4-hour performance continue to decline, and are getting worse
  - High vacancies are resulting in very high levels of bank and agency use which is adding further pressure on finances
- Care & Quality problems also exist in other sectors, with variable performance in mental health care, issues in recruitment within social care, and capacity issues where care homes have closed.
- Care and quality issues relating to specific physical and mental health conditions include:
  1. Cancer: early diagnosis rates and poor patient experience
  2. Stroke outcomes: particularly rehabilitation and social support
  3. Mental health detection, access and outcomes
  4. Management of long term conditions (e.g., respiratory): prevention and support
  5. Support to the frail and elderly: End-of-life care, organisational and funding structures
  6. Maternity and children's services: perinatal services, complex families and poverty

Finance & Efficiency Gap

- Total allocated funds for CCGs, primary care, social care and specialised commissioning was £4bn in 16/17.
- In 15/16, the financial gap STP-wide was £127m.
- The ‘do nothing’ financial gap by 2020-21 is predicted to be £864m.
- ESHT and BSUH are in financial special measures.
- STP-wide efficiencies and new models of care must make better use of the £4bn to address this growing financial challenge.
- In November 2016, all organisations within this footprint will reforecast their financial position. This will also give a clearer indication of the system as a whole and will enable STP financial planning from a stable foundation

Transforming care through our 3 localities

Our STP is comprised of 3 'places' responsible for locally driven community and integrated care with the aim of improving health outcomes for our communities and reducing avoidable illness and health and care expenditure.

Each place is building a model that best responds to both the local health needs and context of the health and care organisations in the region, however many commonalities exist between them. Each place will oversee radical clinical transformation of LTCs, frailty, mental health, community, social care, general practice and urgent services to transform outcomes and quality.

Coastal Care

Model: Accountable care model with one capitated budget

Ambition: to take our good care and make it excellent, working together as partners to improve the health and wellbeing of the population, to improve outcomes for individuals and to deliver better value for money.

Strategic objectives:

- Enhance primary and community care and focus on population wellbeing and early intervention to reduce demand for hospital services
- Successful integration of teams and providers

Initial priorities:

- Develop Local Clinical Networks
- Tackle the challenge of the ageing population
- Redesign urgent care services
- Implement new pathways for planned care
- Carry out targeted service improvements for children to enhance physical and mental wellbeing

Predicted benefits:

- Enhanced primary care
- Sustainable community, mental health and social care provision
- Improved access to specialist expertise
- Communities engaged and developed
- Reduce spend on traditional hospital care by £44m by 20/21 (8%)

Central Sussex & East Surrey Alliance (CSESA)

Model: Multispecialty community provider (MCP)

Vision: To develop pro-active, community-centric and more integrated health system, led by primary care that promotes wellbeing, self care and care closer to home.

Strategic objectives:

- Care designed for the needs of local populations
- Successful integration of providers
- Sustainability of primary care, acute care, community and mental health care

Initial priorities:

- Improve prevention and self care
- Better access to urgent care
- Continuity of care for patients with LTCs
- Coordinated care for frail and complex patients
- System-wide higher quality and performance

Predicted benefits:

- Reduction in emergency and planned admissions
- More episodes of care in the community
- Increased quality of care and patient satisfaction
- Stable, sustainable workforce
- Sustainable primary and acute providers along with sustainable community, mental health and social care provision
- Reduce spend on traditional hospital care by £80m by 20/21 (12%)

East Sussex Better Together (ESBT)

Model: Accountable Care model with capitated funding and pooled budgets

Vision: Develop a fully integrated health and social care system, ensuring every patient enjoys proactive, joined-up care and is able to live fully within the community.

Strategic objectives:

- Improve health outcomes of the population
- Enhance the quality and experience of people's care
- Reduce the per-capita cost of care

Initial priorities:

- Pooled budget Year 1, full ACM in Year 2
- Develop new Integrated Locality Teams
- Provide streamlined points of access for health and social care services
- Develop new models for GP-led urgent and emergency care
- Increase efforts to prevent illness and to promote healthy living and wellbeing

Predicted benefits:

- Improved community health and wellbeing
- Better user experience of services
- Cost of care is sustainable and affordable
- Staff able to make the most of their dedication, skills and professionalism
- Reduce spend on traditional hospital care by £44m by 20/21 (14%)

WORK IN PROGRESS

STP-wide place-based priorities (Years 1-2)

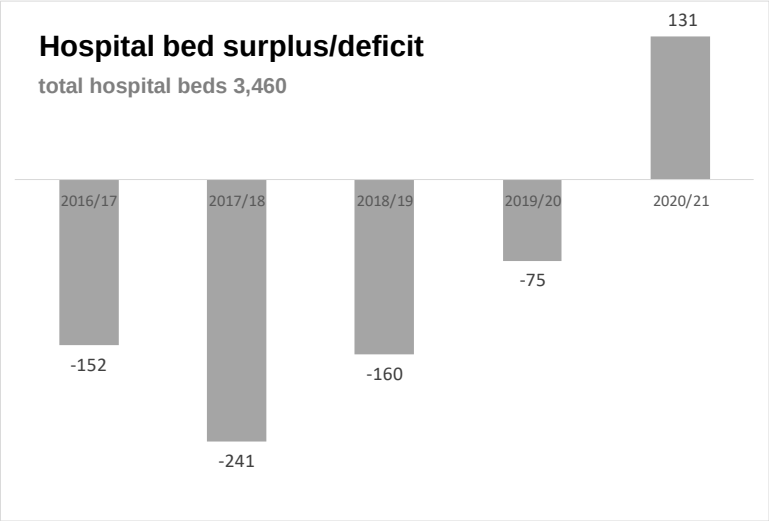
Since June, this STP has sought to collaborate in a way that has not existed before now. Our leaders recognise we can do more for our communities, faster, if we work on the following priorities collaboratively across the three places. Whilst the models will differ according to local context, there are strong commonalities in approach.

	Urgent & Emergency Care	Frailty	Primary Care
SRO	Marianne Griffiths	Keith Hinkley	Geraldine Hoban
Case for change	Currently the STP footprint is experiencing a high number of avoidable A&E attends in part due to inconsistent opening hours across each of the three places. Links to GP services also require strengthening to deliver a 'joined-up' system.	Our STP footprint has an older than average population, and, in common with the rest of the country, services are currently fragmented and do not support people to live independently.	A lack of historic investment and significant shortages of GPs across the footprint has resulted in multiple list closures and the population struggling to access primary care in places.
Vision	For all Urgent & Emergency Care Centres to be networked and linked with an ED, and embedded in a primary care community of practice, to enable a highly responsive service and for patients to be cared for as close to home as possible.	People living with frailty to be treated proactively in a coordinated and well managed way. Patients receive care that better reflects the complexity of their needs, closer to home and in the community as much as possible.	Strengthened GP services, through locality teams (or communities of practice), that coordinate care of patients – improving access, outcomes and delivering greater value to communities from available funding.
Benefits	▪ Improved A&E performance – key underpinning action to achieve target trajectories ▪ Better support for people and their families to self-care or care for their dependents ▪ Availability of the right advice in the right place, first time; ▪ Responsive, urgent physical and mental health services outside of hospital at any time of day, every day of the week	▪ People supported to live independently for as long as possible ▪ Reduction in unplanned, avoidable admissions and reduced length of stay in acute hospital resulting in reductions (up to) 18% in total bed use within an acute care setting ▪ Substantial reduction in outpatient appointments in acute settings ▪ Patients dying in their place of choice	▪ Underpins our transformation model and is core to future delivery of integrated care ▪ Individuals supported to manage their own conditions and stay well as much as possible ▪ Improved system performance, across A&E, RTT and financial efficiency
Year 1 Priority	▪ Define operating model for UCCs, including an STP wide service specification ▪ Review current services and work with providers on rapid action plan to improve, or identify need for retendering ▪ Oversee implementation of plan to agreed timescales (within year 1/2)	▪ Implementation at pace in ESBT and learning to be shared, including proactive care, integrated locality teams and personal resilience schemes ▪ Agree STP-wide principles for implementation ▪ Coordinate with hospices, third sector and voluntary organisations	▪ Complete design of primary care models to deliver the GP 5YFV and ten high impact changes ▪ Ensure implementation trajectory to enable pace of plans – i.e. new models implemented for all practices no later than 2017/18

WORK IN PROGRESS

Our STP plan for this winter

WORK IN PROGRESS



Our challenge

We have an immediate capacity shortfall (of around 3% of hospital beds) that we think will continue, and peak, next year, before our "person-centred" models begin to change the number of hospital beds needed.

There are three hospitals that will face particular pressure, Brighton (Royal Sussex County site), Eastbourne, and Hastings.

We have worked together as an STP to explore opportunities to make best use of space at existing hospitals. We have worked in partnership with social care and community providers, and have found alternative beds where patients no longer need medical care but aren't yet ready to return home.

Our solutions

We have developed an immediate action plan, summarised below, and are continuing to develop further opportunities as an STP, both to mitigate any under-delivery and to prepare for next winter.

Immediate actions:

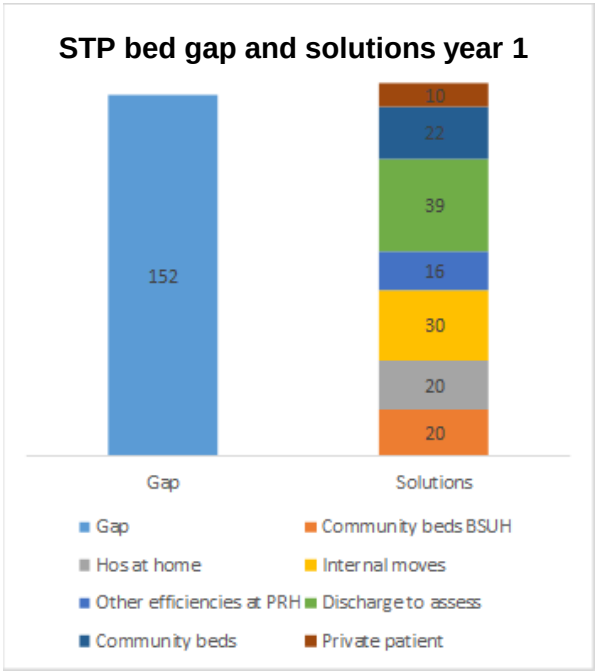
At RSC in Brighton: 20 beds at a community site: with a nursing model and active management of capacity for rapid discharge, 20 beds through "Hospital at Home" expansion: focussing on improving quality of care for this cohort of patients, rather than making them wait in acute beds for rehab, and 30 beds through internal movement of services and better use of existing estate

For Eastbourne and Hastings: 39 community beds through the "discharge to assess" programme where patients do not need to stay in hospital but don't yet have the support to live at home, 22 additional beds opened in existing community hospitals that were closed over the summer, and10 beds internal movement of services and better use of existing estate

Subsequent actions requiring further planning:

The STP will monitor fortnightly and accelerate any plans if additional risks come to light or there is any unexpected surge in demand.

The additional actions being explored include: Identification of a small number of tertiary services that could be temporarily diverted to relieve pressure, new models at the front door, conversion of non-clinical space, extension of use of community beds and building temporary beds.



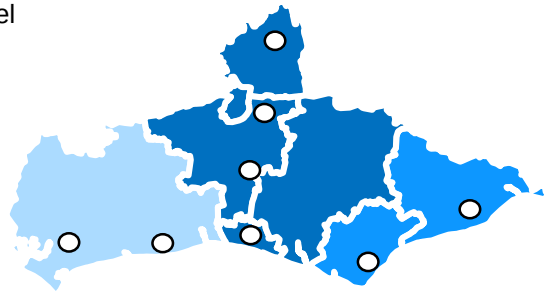
*After adjustments for unmet demand, target occupancy and winter surge capacity.
Sources: Modelling by 2020 Delivery, based on BSUH 3Ts model and EY Benchmarking 2015. Beds from national sitrep data; growth and impacts of place-based care and prevention from STP financial model

Long term provider sustainability (2-5 year plan)

WORK IN PROGRESS

Acute sector sustainability challenge

- Within our STP we have a history of collaboration and successful networking around a range of specialist and tertiary services, including vascular, stroke, cancer and others.
- We recognise that our place-based, integrated plans will mean that patients will less frequently need to travel to hospital for care, and are built upon an increase in primary care and community care capacity.
- Opportunities through improved digital technology will allow further networking of services, with doctors in one hospital able to provide support and input to the team caring for a patient in another part of the patch, however there will remain a mis-match in available capacity and local demand between our sites,
- We also have a significant financial sustainability challenge in our acute sector, which may increase if services change but the model of provision and care pathways do not evolve at sufficient pace.
- We are now considering how we work together as an STP to support individual organisations around DGH services that we believe will become unsustainable over time. This work is about extending and furthering the existing networks and collaboration across the patch.
- We recognise that this discussion also needs to link with the outcomes of the NHS England led work assessing the requirements and sustainability for an MTC at RSC in Brighton, alongside teaching and tertiary services



Our acute sustainability solutions

Short Term → **Medium Term**

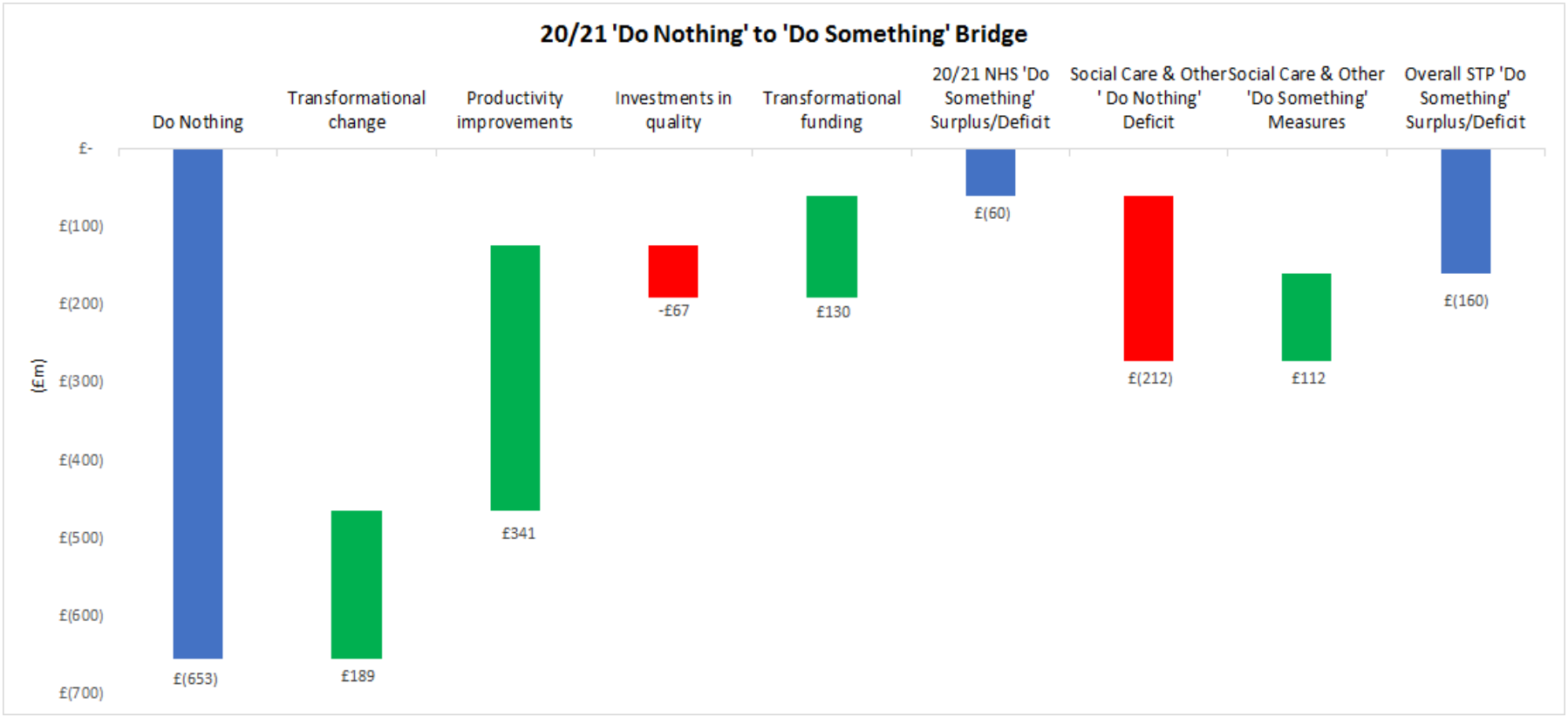
Elective care collaboration: partnership discussions are underway between hospitals
Specialised transformation: work closely with Specialised Commissioning on transformational QIPP schemes in addition to successful completion of MTC review at BSUH
Efficiency: pathology and imaging collaboration
Networks: working together to design how we will work as an STP on networked DGH services
Alignment with person-centred care: networking with local urgent care centres
for quality of care

Elective factory: further develop scope to reduce waiting times and increase efficiency
Alignment with ACO Models: our providers participate in our ACOs in different ways, but we intend to maximise access and use of services at all sites including for integrated care models
Complete the detailed design and implications of our future networked model to deliver sustainability as an STP

Brighton hospital re-development underway: working through networks with other providers and with underpinning specialised services model to support complete
Patient pathways for all sites mapped and delivered: through networks across sites and providers
Whole system performance transformed: aiming for top quartile nationally

Financial position by 2020/21

WORK IN PROGRESS



- Our financial plan includes £530m of net savings across the NHS resulting in a residual deficit of £60m
- An additional £112m of social care efficiencies have been identified. We continue to work with colleagues in LAs to understand and develop a response to financial pressures they face and how we ensure our plans effectively mitigate this too
- Our plan includes £140m of recurrent investment in quality by 20/21 to deliver the service improvements outlined in the NHS Five Year Forward View (£73m is in the “Do Nothing” position and £67m is shown above)
- In addition to a £450m transformation of the Royal Sussex County Hospital site, we are planning a number of strategic capital projects to develop the estate and digital infrastructure that our transformative new models of care need to thrive (see appendix D3)

Integrating mental health with physical health across our footprint

Our June submission highlighted the case for change across the footprint and since then we have created a Mental Health Review team to ensure each place-based plan delivers the MH5YFV . In managing the challenges of the years ahead, the **integration of mental and physical health** is at the core of our wider strategic thinking, enabling opportunities to co-design and improve access to care and treatment that is holistic, timely, of a high quality and delivered in an appropriate non stigmatising setting. The footprint is committed to ensuring that the investment identified for mental health is spent on addressing the priorities identified in the MH5YFV & Transforming Care for People with Learning Disabilities and where there are gaps in service provision and variation in practice and outcomes across Sussex and East Surrey.

Priority	Our future vision/what is going to be different?	Actions to be implemented
1. Specialist Services	Developing new models of care and integrated pathways which focus on early intervention and prevention to avoid Tier 4 inpatient admissions, support early discharge, treatment and repatriation as close to home as possible.	▪ To work with NHSE to establish Specialist Commissioning arrangements for: CAMHS Tier 4, Eating Disorders, Personality Disorders forensics & people with learning difficulties and expand perinatal mental health services ▪ To develop new evidence based pathways and models of care that support admission avoidance and reduced lengths of stay.
2. Integration of Mental Health with Physical Health	Co-designed networked operating model developed with each place based plan & local populations that connects across the wider health and social care system, embedding the principles of integrated mental & physical wellbeing and providing a seamless interface with primary, acute and out of hospital care services and a 'no wrong door approach.'.	▪ Explore New Care Models that support the integration of mental, physical and social care across the system. ▪ Co-design a connected networked model for mental health that provides a seamless interface for people of all ages and levels of ability, exploring options for integration, single point of access, co-location, estates optimisation, common & shared governance, & outcomes. ▪ Implementing Making Every Contact Count Training across the whole workforce
3. Gaps in Primary Care Provision	Improved access and availability of mental health knowledge and expertise in primary care to include early diagnosis and treatment of people with dementia & long term conditions and improved access to holistic care for people with mental health and / or a learning disability	▪ To explore evidence based approaches that support good physical & mental health and wellbeing in primary care including: increased access to IAPT across long term conditions & integrated with physical healthcare; increase in dementia diagnosis rates. ▪ Establish primary care pilots during 17/18 e.g. to co-locate integrated mental health within GP services & expand Sussex Youth service model (i-Rock) ▪ Build on Dementia Crisis team in Coastal W. Sussex and Golden Ticket in High Weald Lewes & Havens and rolling this scheme out wider across the footprint by 17/18. ▪ Build on learning of Technology integrated Health Management (Dementia) Innovation Test Bed.
4. Citizen Led Prevention and self management	We will create resilient communities and engage citizens in activities that improve awareness & understanding of the psychological determinants of ill health including factors that underpin poor lifestyle choices.	▪ Develop in-reach emotional wellbeing support to the PHSE syllabus in schools by exploring and providing actual & virtual initiatives ▪ Implementing MECC across the whole health & social care workforce ▪ Expand Recovery College & Social Prescribing models.
5. Managing Crisis Well	People experiencing mental health crises will have rapid access to a range of well coordinated community care options and high quality inpatient provision, supported by an effective Crisis Care Concordat, that will impact on the wider system by reducing pressure on acute services, reducing non elective admissions, attendances at A&E and lengths of stay and provide opportunities for estates optimisation.	In 17/18 commit to develop and invest in a range of approaches to address gaps in quality & service provision: ▪ Expand evidence based Psychiatric Liaison model ▪ Expand model of Crisis Response & Home Treatment 24/7 ▪ Implement Single Point of Access for Urgent and Crisis Care ▪ Expand out of hospital networks of support e.g. Safe Haven model & Street Triage ▪ Review quality and capacity for acute inpatient and intensive care services
6. Increase Digital maturity & Shared Digital Record	There will be full interoperability of healthcare records across the health & care system that supports people in telling their story only once. We will have developed a digitally competent workforce.	▪ Implement integrated care records through the Digital Road Map. ▪ Identify training and development needs of the workforce to embrace new healthcare technologies that create efficiencies and improve quality of care.

WORK IN PROGRESS

Digital transformation plan

WORK IN PROGRESS

Digital is a key enabler of our STP. In learning from the past we are proposing a multi track approach to Digital development that we believe will deliver the best outcome for the Citizen and the Health and Care professional. In parallel we are responding to feedback from NHSE on the detailed elements of our Local Digital Roadmap. With significant central finance available to support Digital Transformation we will build detailed plans to maximise benefit to citizens and staff.

Strategic approach

Digital Solutions that most benefit from scale in terms of procurement, cost, and integration capability, are implemented at STP level, not separately within each Place.

Integrate the Digital Team with the priority care pathways to support digitisation of both the professional and citizen journey

As the Place based models mature we will develop solutions by place that can best meet the business requirements. These developments will be subject to STP Digital Goverance to ensure we balance speed with efficiency

Proactively engage with Health & Care professionals.

We will explore the value of using resources more effectively at a Place and STP level to deliver the most financial and service benefit.

Priorities

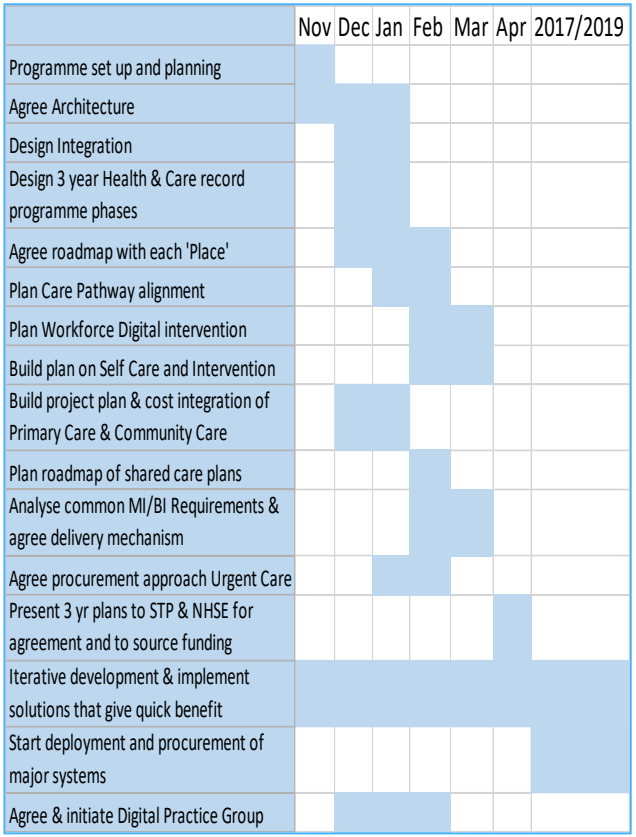
STP Wide

- Shared Digital Care Record (Physical & Mental Health, Community & Social Care).
- Urgent Care technology as part of the 111 procurement.
- Shared Infrastructure.
- Importing learning from other footprints E.g. Digitisation of Cancer Pathways.
- Supporting Workforce work stream in secondary care resource optimisation
- Health & Social Care Practice Group

Place Based

- Consolidation of Primary Care Systems and integration with Community Care Systems.
- Shared Health & Social Care, Care Plans.
- Development of operational technology to run the Place based systems . Analytics to enable Place based performance measurement.
- Prevention and self care technology
- E Consultations
- Interactions between Secondary & Primary Care

Programme Plan

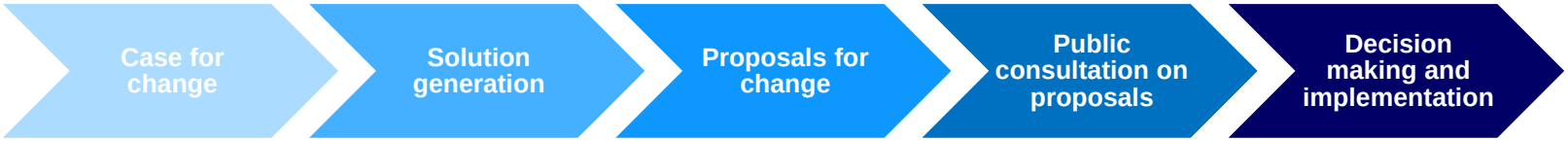


Continuing to engage our population: our patients, the public, our workforce, and our culture

WORK IN PROGRESS

- We believe passionately that public/patient engagement is not just a duty; but the pre-requisite for effective service improvement; from collectively identifying problems and designing solutions to influencing delivery and review.
- Our communications and stakeholder engagement plan is a working document that is being crafted and updated to fully exploit all existing communication channels to promote and continue an ongoing conversation with everybody who uses our services; including those people who live outside of our area.
  - It will focus on a wide range of channels to encourage wide community engagement; including digital; face to face and printed materials.
- Our primary aim is to design people-centred methods of engagement to match the needs of individual groups in the area and to ensure that we draw in views from people whose voices are seldom heard and those representing people with protected characteristics.
- In addition to the broad engagement activities we acknowledge that a number of our organisations have significant cultural issues, in some instances signalled by the CQC, and forming part of regulatory action. We will roll out an STP wide change management and performance improvement approach built on Virginia Mason principles, and catalysed by our two providers who have participated in the national pilot scheme.

Stages for STP Engagement



- We are working closely with our colleagues in health and social care, and via Healthwatch, to ensure that our plans are built on insights and conversations around patient experience and service needs and expectations.
- The heart of our approach will be centred on continuous dialogue; however we will closely monitor all emerging plans and seek legal input, and test with our overview and scrutiny committee, to ensure that we fully comply with legal guidance on more formal consultations.
- We will adopt a fully transparent and open approach to our community re all changes; not just to ensure that we adhere to the checks and balances in the system but because we truly believe this process provides us all with a unique opportunity to design a strong, effective health service that will meet both our needs and those of the generations to come.
- Everybody with an interest in our health service will be invited to join our conversation.
- We will continually update people on progress of our Comms and Engagement plan and there will be a clear audit trail of the activity that has taken place; including questions raised and responses to them.

What support do we need to ensure that we are able to deliver?

WORK IN PROGRESS

Financial

- Support transition funding to manage capacity and activity during build of 3Ts project, for BSUH and other sites in the STP
- To secure both support and agreed funding on the 16/17 BSUH and ESHT winter recovery capital ask as signalled in both organisations' recovery plans and their respective summaries contained in Appendix C of this document
- We recognise the tight position on national NHS funding. We have a number of challenged organisations in our STP. As part of the support that we require from the Centre we would propose that careful consideration is given to the overall control totals that are set in the first two years of our plan. Our goal is to achieve financial sustainability over the five year period, but given the heavy deficit position which is our starting position we will find it very difficult to achieve current control totals in the first two years.
- Guidance on how delivery of large scale transformation and long terms savings should be balanced against very challenging short term financial targets, surrounding both revenue and capital
- We would like to register the need for appropriate funding for investment in integrated care record systems for which plans will be forthcoming by the end of the calendar year

System Leadership

- Support in delivering commissioning reform as signalled in our place-based plans
- Support the STP to have the authority to deliver sustainability and improvement actions as a whole system

System Recovery

- Assistance in balancing the need of specialised commissioning with local delivery of safe care and constitutional standards, particularly in relation to the immediate challenges at BSUH and the long term vision for that site

Appendices

Glossary: Acronyms used

Acronym	Meaning
ACO	Accountable care organisation
CIP	Cost improvement programme
CSESA	Central Sussex & East Surrey Alliance
ESBT	East Sussex Better Together
MECC	Making Every Contact Count
MCPs	Multi-speciality community provider
MTC	Major trauma centre
PACS	Primary and acute care system
RSC	Royal Sussex County (Hospital site in central Brighton)
RTT	Referral to Treatment
SPoLs	Single Points of Leadership (one for each Place)
UCC	Urgent Care Centre

Contents of appendices

a) Governance

b) Place-based delivery plans – CSESA, Coastal, ESBT plans **(in separate document)**

c) Acute recovery plans **(Detailed plans contained in separate document)** –
   i. Summary BSUH Winter Sustainability Plans
   ii. Summary ESHT Winter Sustainability Plans

d) Finance

e) Workforce

f) Specialised Commissioning

g) Achieving savings through environmental sustainability

h) Summary of cancer and stroke improvement priorities

Appendix A.1: STP Governance

WORK IN PROGRESS

Programme groups

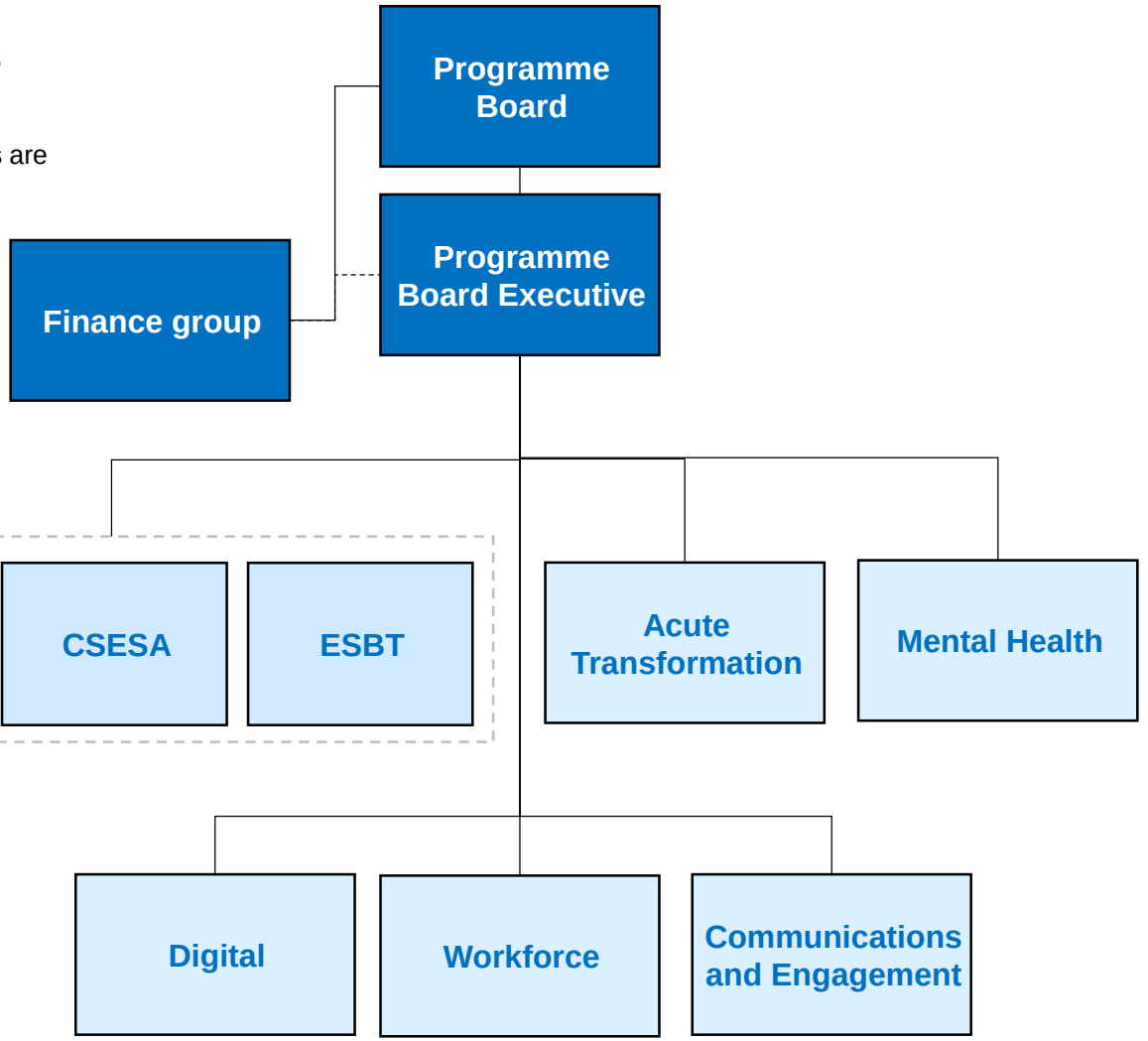
- Programme board has representation from all 23 STP organisations
- The Programme Board Executive is led by the leaders of our three places to ensure local needs are at the heart of our planning
- The Finance workstream is a "sub-group" of the programme board, with representation from all organisations, to provide robust information for planning

Core workstreams

- Each place is responsible for patient-centred care models
- Collaboration between streams are facilitated by the Programme Board and Executive

Enabling workstreams

- Membership include three places, acute, mental health, plus other "experts", e.g. HEE in workforce
- Each group have built on existing networks, e.g. communications and engagement working through the existing acute communications group



Appendix A.2:
STP Executive Group – Purpose and Principles/Behaviours

WORK IN PROGRESS

An Executive Group has been established to drive delivery of the STP.

Purpose of the STP Executive Group:

The purpose of the Sussex and East Surrey STP Executive Group is to oversee and drive the implementation of pan-STP decisions on behalf of the population served by the 23 member organisations. In addition, the group facilitates place-based progress/accelerate to achieve overall transformation of the STP footprint/5YFV triple aims.

The following principles/behaviours will apply to the model:

1. All organisations are signed up to the STP, its targets and delivery plan.
2. The **Executive Group** will deal only with those issues which are best considered on a pan-STP basis.
3. **Place-based "single points of leadership" (SPOLs)** will deal with their local place-based issues through their local governance.
4. Each member organisation retains its own Governance authority and accountability to its Board of Directors in line with current organisational form.
5. The **Executive Group** facilitate collaboration and cooperation across its membership in the interests of the population served. Where individual Boards do not agree with proposed plans, it is the responsibility of the **place-based SPOLs** to resolve locally or identify a range of options for negotiation at Programme Board.
6. Place-based responsibilities are the role of the SPOLs. Local governance should approve SPOLs to act on behalf of their Place at Executive Group.
7. Boards of all members will be responsible for agreeing recommendations and no-gos in order to support the single system leader in their decision making .
8. Decisions will not be taken that totally destabilise one partner.
9. No single organisation will halt the progress agreed by all the other place-based or STP partners.

Membership of the STP Executive Group:

Chair – Michael Wilson, *Chief Executive, Surrey & Sussex Healthcare NHS Trust*
SRO – Wendy Carberry, *Chief Officer, High Weald Lewes Havens CCG*
Coastal Care SPoL - Marianne Griffiths, *Chief Executive, Western Sussex Hospitals NHS Foundation Trust*
CSESA SPoL - Geraldine Hoban, *Accountable Officer, Horsham & Mid Sussex CCG*
ESBT SPoL - Keith Hinkley, *Director of Adult Social Care & Health, East Sussex County Council*
Siobhan Melia, *Chief Executive, Sussex Community NHS Foundation Trust*
Colm Donaghy, *Chief Executive, Sussex Partnership NHS Foundation Trust*
Dr Minesh Patel, *Chair, Horsham & Mid Sussex CCG*
Steve Emerton, *Director of Delivery, NHS England Specialised Commissioning STP South East*

Appendix B: Place-Based Delivery Plans

WORK IN PROGRESS

Please note: the Place-based Delivery Plans are contained in a separate document.

WORK IN PROGRESS

Appendix C.1: Winter sustainability plans

Please note: Winter sustainability delivery plans are contained in a separate document.

Appendix C.2:
BSUH acute winter sustainability plan 2016

WORK IN PROGRESS

Total gap at RSC site in Brighton is 66 beds. The current actions to solve this issue are:

Solution description	Beds saved*	Milestones for implementation	Risks/Implications	STP assessment of delivery risk and key mitigations
Agreement across STP has been reached that additional capacity is needed – community beds	20 (17)	10/16 - Lease agreement & pathways 11/16 – staffing complete	• Staffing • Impact of step-down beds on acute beds (not 1:1 due to ALOS)	The model will only work if sufficient focus is maintained on keeping length of stay down by getting people discharged promptly. This may need additional focus, e.g. through daily monitoring/escalation in partnership with LAs
Hospital at home	20 (15)	17/10/16 – expand capacity to 8 patients 11/16 – expand to 20 patients	• Staffing for expansion, particularly if any acceleration is required	The workforce to deliver this model overlaps with that for a number of other schemes and so will need STP-wide coordination
Moves off-site (primarily to PRH site)	4 (4) 4 (4) 8 (6) 10 (8) 2 (2) 2 (2)	Balcombe wards – 11/16 Sussex rehab beds – review staffing 10/16 Use of Allbourne – TBC Oncology SOTC bays Spinal Infusions at HWP	• Staffing • 30 day consultation for Oncology and Spinal	Risks are primarily in deliverability and thus felt to be manageable
Total solutions	**70 (58)**			
Total indicative cost^	**£1m**	^ BSUH received support from NHSE/I on 19th October 2016 for this winter recovery plan		

The STP is supportive of BSUH's plan to develop a number of additional potential solutions that will be worked up in parallel to mitigate for any slippage. These actions include: identification of a small number of tertiary services that could be temporarily diverted to relieve pressure, Hospital at Home at front door, conversion of non-clinical space, extension of use of community beds and building temporary beds. The combined scale of these actions before risk adjusting is of the order of an additional 60+ beds.
The STP will monitor fortnightly and accelerate any plans if additional risks come to light or there is any unexpected surge in demand.

* Risk adjusted number
Source: BSUH plan

WORK IN PROGRESS

Appendix C.3:
ESHT acute winter sustainability plan 2016

Total gap at ESHT is 66 beds: the current actions to resolve this are:

Solution description	Impact – on beds	Milestones for implementation	Risks/Implications	STP assessment of delivery risk
Hastings site				
Discharge to assess nursing home beds	19	Already commissioned with CCG and agreement with SC. Staffing will be covered by nursing home	• Impact of step-down beds on acute beds (not 1:1 due to ALOS) • Mitigation in ESBT "operations room"	The model will only work if sufficient focus is maintained on keeping length of stay down by getting people discharged promptly
Rye Memorial hospital	5	Beds owned by trust, staffing planning taking place 13/10	• Impact of step-down beds on acute beds (not 1:1 due to ALOS)	Risks are primarily in deliverability and thus felt to be manageable
Eastbourne site				
Discharge to assess nursing home beds	20	SC working with CCG 13/10 – beds already identified	• Impact of step-down beds on acute beds (not 1:1 due to ALOS)	The model will only work if sufficient focus is maintained on keeping length of stay down by getting people discharged promptly
Private unit beds	10	Agreement in place for beds	• Staffing – recruitment required	Requires coordinated recruitment approach
Seaford 2 beds	17	Beds owned by trust, staffing planning taking place 13/10		Risks are primarily in deliverability and thus felt to be manageable
Total solutions	**73**			
Total indicative costs	**£2.89m**			

Source: ESHT plan

WORK IN PROGRESS

Appendix D.1:
Financial challenge in intervening years

	2016/17 FOT	2017/18	2018/19	2019/20	2020/21
Do Nothing NHS Position	**£ (47,639)**	**£ (310,599)**	**£ (421,720)**	**£ (541,690)**	**£ (653,490)**
Investing for Quality‡					
Seven Day Services		£ -	£ -	£ (3,811)	£ (38,114)
Cancer Taskforce		£ (5,820)	£ (7,060)	£ (8,403)	£ (9,573)
National Maternity Review		£ -	£ (4,570)	£ (4,573)	£ (4,576)
Digital Roadmaps		£ (3,600)	£ (7,200)	£ (10,800)	£ (14,400)
Sub-total		**£ (9,420)**	**£ (18,830)**	**£ (27,587)**	**£ (66,663)**
Place-based care†					
Community – based investment		**£ (13,553)**	**£ (21,838)**	**£ (30,204)**	**£ (38,394)**
Acute Savings		£ 51,733	£ 96,434	£ 135,314	£ 171,021
Sub-total		**£ 38,180**	**£ 74,596**	**£ 105,110**	**£ 132,628**
Further Efficiencies					
Prevention		£ 6,946	£ 14,029	£ 21,243	£ 28,670
Provider Productivity		£ 64,769	£ 132,078	£ 202,242	£ 276,215
Medicines Management		£ 8,685	£ 17,736	£ 27,151	£ 36,945
Specialised Commissioning		£ 14,651	£ 26,756	£ 40,275	£ 55,734
Sub-total		**£ 95,052**	**£ 190,599**	**£ 290,911**	**£ 397,563**
CCG Surplus replenishment*		**£ (24,733)**	**£ -**	**£ -**	**£ -**
Transformational Funding		**£ 49,176**	**£ 49,176**	**£ -**	**£ 130,000**
Do Something NHS Position	**£ (47,639)**	**£ (162,343)**	**£ (126,179)**	**£ (173,257)**	**£ (59,962)**

- Despite our plans achieving significant progress by 20/21, there exists a stark financial challenge across years 2- 4 of the STP, driven by a starting deficit, increasing demand pressures and a time requirements associated with mobilising new place-based models of care
- As a result, our plan does not meet control totals for 17/18 and 18/19, but we remain committed to identifying further opportunities to improve our position and reduce the gap
- ‡Additional investments to deliver the GP Forward view (£51m by 20/21), and Mental Health Taskforce and CAMHS (£18m by 20/21) are included in the Do Nothing baseline
- †The level and phasing of place-based savings is different across the 3 places, as outlined in appendix D.2
- *The current conservative assumption a £25m non-recurrent requirement to replenish all CCG surpluses in 20/21

WORK IN PROGRESS

Appendix D.2: Capital expenditure projects by Place and category

- Each place is planning investments in it's communities to ensure the impacts on acute demand growth and population health are delivered
- Acknowledging the shortage of centrally-held capital, we are planning an innovative and diverse range of capital sources

Place	STP-wide solutions	Enabling out of hospital care	System Resilience	IM&T	TOTAL
CSESA	-	£175m	£70m	£32m	£277m
Coastal	£17m	£67.5m	£20m	£10m	£114.5m
ESBT	-	£50m	£35m	£15m	£100m
TOTAL	**£17m**	**£292.5m**	**£125m**	**£57m**	**£491.5m**

Source: Place based capital plans

Appendix D.3: Potential capital sources by project category

WORK IN PROGRESS

Category	Project	Value £m	Source	
System resilience	BGH Reconfiguration	20	PDC and DH loans	Required to ensure quality of service and outcomes are protected
	East Sussex BT alignment of acute	35		
	Western Ward Block	20		
	Pathology network	15		
	Rapid diagnostic centres	30		
	A&E reconfiguration Royal Sussex	5		
	Reconfiguration of PRH	TBC		
	TOTAL	**125**		
Enabling out of hospital care	Crawley, Horsham and Mid-Sussex Community Hubs	165	Commercial capital partnerships & commercial loans	Required to underpin new person-centred, integrated models that deliver care in community settings, reduce acute demand and improve population health
	Southlands Ambulatory hub	20		
	Littlehampton Community Hub	12.5		
	Worthing Civic Quarter Community Hub	16		
	Shoreham Community Hub	12		
	Bognor Community Hub	2		
	Durrington Community Hub	5		
	East Sussex Community Hubs	10		
	Preston Barracks community hub	TBC		
	ESBT Community hubs	50		
	TOTAL	**292.5**		
STP-wide	LDR capital projects	**57**	LDR bids	Key STP strategic enablers
	Western Radiotherapy unit	**17**	Commercial capital partnerships & commercial loans	
Total		**491.5**		

Source: Place based capital plans

WORK IN PROGRESS

Appendix E.1:
Strategic Workforce Plan

- The Sussex and East Surrey Sustainability and Transformation plan has developed a workforce strategy to deliver the transformation required to serve the needs of our population.
- The challenge for the workforce programme is to address the immediate problems and support the plans for winter pressures, whilst developing the strategic solutions for a sustainable future.
- The STP has set up a Local Workforce Action Board to lead and implement the workforce strategy to support the STP. The Board is Co-Chaired by Richard Tyler CEO of Queen Victoria NHS FT and Philippa Spicer the HEE Local Director and its membership includes representation from the new 'Places' together with clinical leadership and commissioning
- HEE is providing programme management, and resource to ensure that the actions, particularly the priorities, will be implemented. An allocation of £1.3m has been identified to support the implementation of the LWAB action plan. These funds are being are being distributed to meet the needs of the priority task and finish groups. A further allocation of £460k has been funded through the Community Education Provider Networks (CEPNs) within the STP footprint.
- N.B. The Acute recovery plans are dependent on workforce being able to support the plans that have been put together to ensure Acute sustainability through 16/17. Without a coordinated focus from both the workforce subgroup and the organisations involved, the plans are at risk. All providers are relying on the same pool of staff and so this will require coordination. That said, plans are in place with specific providers such as 130 nurses in pipeline at one provider and international recruitment being reinstated due to the success of the previous scheme.

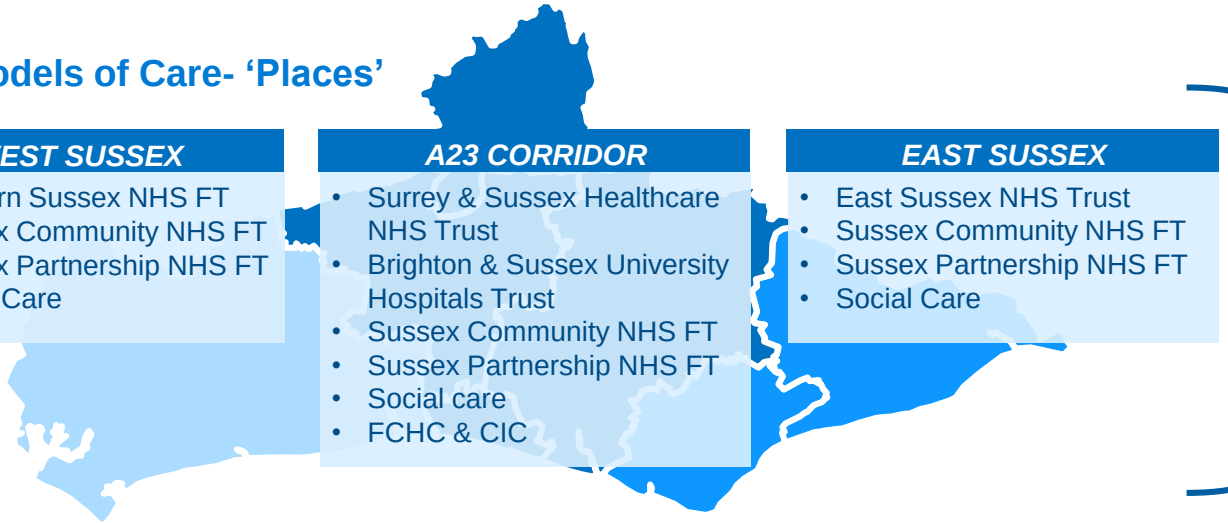
The LWAB has held several stakeholder events to develop an action plan to meet the requirements of the STP. Meetings on the 25th July and 30th September have helped to shape this work, building on existing work, identified challenges and key priority areas that have been highlighted through stakeholder engagement sessions, which have included all organisations, both health, social care, PVI, Education and Trade Unions. The plan has pulled together the actions from the June 2016 STP Submission and is grouped under five key areas within the 5YFV:

Workforce Action Plan / 5YFV	Priorities 2016/17
Prevention	MECC – Joint Programme with Public Health April 2016 – March 2017
New Models of Care	▪ Implementation of the WRaPT Workforce Repository/Planning Tool. – East Sussex Better ▪ Together and Brighton Hospital at Home. Proposal and resource agreed by STP. Mobilisation meeting on X date
System Wide – Effective & Efficient	▪ Temporary Staffing – Agency Programme in place, implementation by March 2017 ▪ Locum Spend – Trend mapping underway to report to STP December 2016 ▪ Shared Functions – Skills Passport – programme agreed
Integration	▪ Proposals from 30th September stakeholder event being developed for implementation, e.g. Shared Therapy teams to support re-enablement and Cross care pathway role
Recruitment and Retention	▪ Retention programmes: newly qualified – e.g. common preceptorship programme ▪ Mature workforce – Health and Well-being proposals. Paramedics retention ▪ Recruitment – Pre- Employment Coordinators. Prince's Trust programmes, Health and social care careers events etc.

Appendix E.2:
Strategic Workforce Programme

WORK IN PROGRESS

New Models of Care- 'Places'



WEST SUSSEX
- Western Sussex NHS FT
- Sussex Community NHS FT
- Sussex Partnership NHS FT
- Social Care

A23 CORRIDOR
- Surrey & Sussex Healthcare NHS Trust
- Brighton & Sussex University Hospitals Trust
- Sussex Community NHS FT
- Sussex Partnership NHS FT
- Social care
- FCHC & CIC

EAST SUSSEX
- East Sussex NHS Trust
- Sussex Community NHS FT
- Sussex Partnership NHS FT
- Social Care

LWAB IMPLEMENTATION PLAN BUDGET OF £1.8M provided by HEE

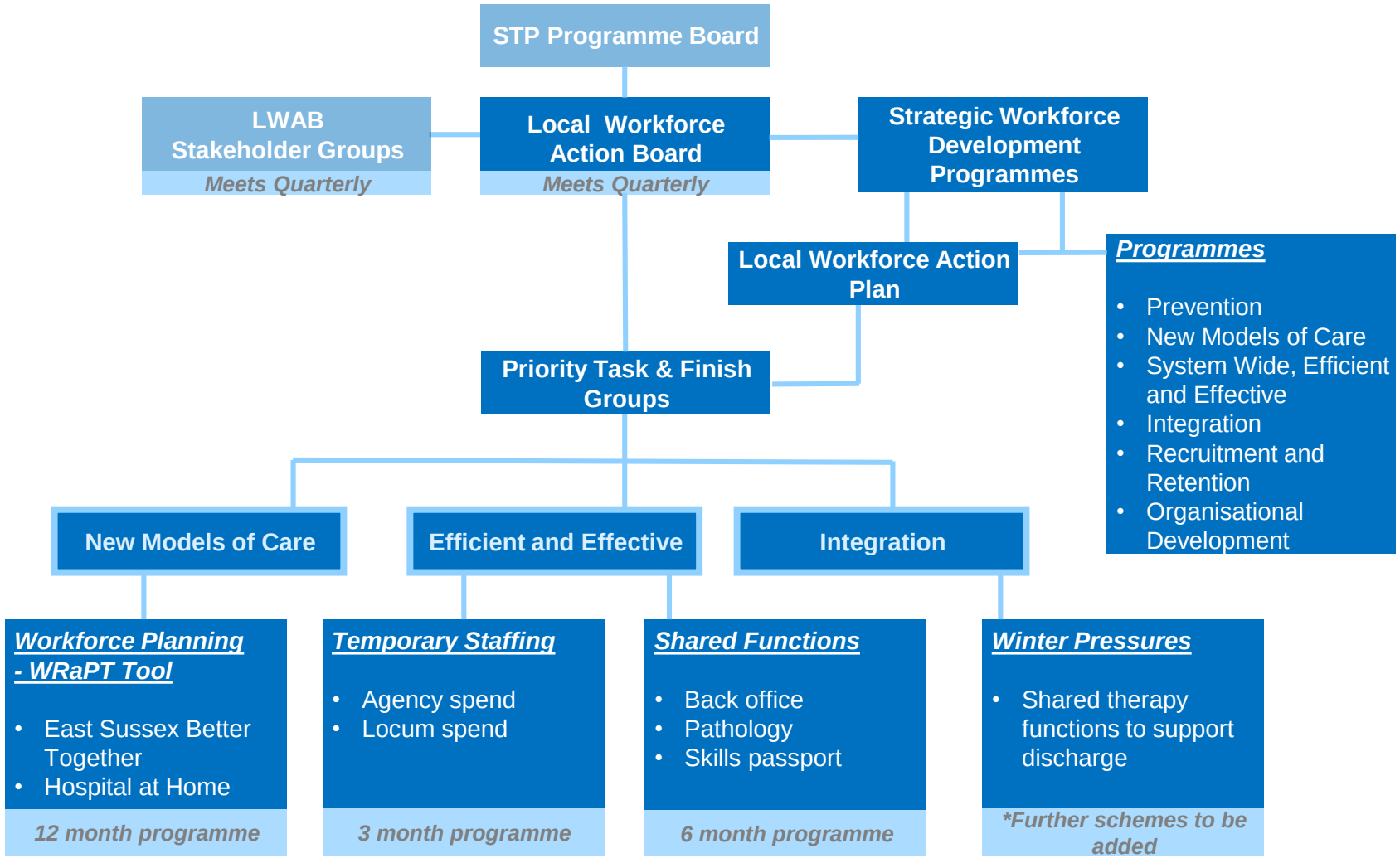
PRIORITY PROGRAMMES	**Temporary Staffing- agency and locums**		**Skills Passport**			**Winter Pressures- Shared Workforce (e.g. therapists)**		
PROGRAMMES OF WORK	Prevention	New Models of Care 'Places' WRaPT/OD	System Wide- Efficient & Effective			Recruitment & Retention		Integration
DRIVERS	Shift to Primary & Community settings	Finance/ Pay Bill	Performance & Quality	Acute Pressures	Community Pressures	Mental Health Pressures	Primary Care Pressures	Social Care Pressures

The Workforce Action Plan is based on the need to transform the workforce for new ways of working in the future, whilst managing the immediate challenges of the workforce shortages and increased demand on services.

Diagram 1 shows the three 'places' within which the new models of care are being developed and which the workforce will need to work within. Diagram 2 shows the drivers for change and the programmes being undertaken

Appendix E.3:
Local Workforce Action Board – Governance

WORK IN PROGRESS



Appendix F.1:
Specialised Commissioning QIPP Schemes for 17/18

WORK IN PROGRESS

Transformational Schemes

Theme	Potential Transformational Schemes
Right Care	▪ Cardiology (links to pathway work below) ▪ Right care to look at work for Spec comm re MH, Neonatal and Cardiac ▪ Assessing timescales for outputs from " Getting it Right First Time" programme which may have implications for specialised services
New Models of Care	▪ Complex Cardiology pathway ▪ Cancer pathways (Inc. chemotherapy regimens) ▪ Neonatal – increasing proportion of term admissions ▪ Mental Health national 'New Models of Care- 2 pilots. Scope to roll out similar approach for CAMHS with SE as priority ▪ Assess scope for savings from current work on Vascular networks and Spinal pathways
Urgent & Emergency Care	▪ Enhanced supportive care – to reduce emergency cancer admissions
Self Care	▪ Opportunities re some neurological pathways
Prevention	▪ Secondary prevention re cardiology interventions (business case for project in preparation) ▪ Cancer ▪ Renal
CHC/Long term conditions	▪ Neuro- Rehabilitation pathways (to review scope for roll out of actions in SW)
Other productivity	▪ See Transactional schemes (on following slide) ▪ Ensuring effective planned care pathways (Inpt/ day case/ Daycase/ opt procedures
Cross Cutting Themes	▪ Critical Care – both transactional and transformational element s, focus on reducing length of stay ▪ Enhanced Supportive care (Inc. opportunities beyond cancer services) ▪ Peri-operative medicine Inc. Enhanced recovery and shared decision making with patients ▪ Repatriation – joint work with London to avoid unplanned changes of pathway but ensure appropriate, agreed pathway changes where appropriate.

Appendix F.2:
Specialised Commissioning QIPP Schemes for 17/18

WORK IN PROGRESS

Transactional Schemes

Theme	Potential Transformational Schemes
Medicines Optimisation* *Mix of full and part year effect	▪ Switch to generics and biosimilars – specific drugs to be identified together with phasing – and optimisation through ensuring more rapid take up ▪ Antifungal Stewardship – reviewing variation ▪ Starting and stopping criteria for MS drugs ▪ Intravenous immunoglobulin- best practice and reviewing database information which suggests variation in volumes being prescribed ▪ Effective prescribing of Antiretroviral Medicines – national tender ▪ Extension of SACT dose banding for chemotherapy and reducing chemotherapy wastage ▪ Home Parenteral Nutrition – recent national tender – reduction in associated costs ▪ Immunosuppressant repatriation (from CCG to NHS England for certain solid tumours) ▪ Optimising procurement opportunities ▪ Rationalise provision of aseptic units ▪ Review of outsourced pharmacies and in share arrangements ▪ Ensuring all PAS rebates secured ▪ Addressing variation in prescribing rates (links to population based prescribing work) ▪ Ensuring compliance with NICE pathways through individual patient tracking for certain high cost drugs
Reduced prostate fractionation	▪ Fye of scheme commencing Autumn 2017
Outpatients	▪ Mix of transformational and transactional elements- encouraging shift to non-face to face or lower costs appointments
Review of shared care pathways	▪ Mix of transformational and transactional elements- encouraging shift to non-face to face or lower costs appointments
Roll out of National Devices Procurement Scheme	
Continuation of CUR CQUIN	▪ To identify benefits of implementation
Price Benchmarking	
Neonatal	▪ ATAIN to follow clinical protocols to ensure consistent thresholds for referral to SCBU

Appendix G:
Achieving savings through environmental sustainability

CARE WITHOUT CARBON

A coordinated approach to carbon management within the STP

1. Context

Sussex Community NHS Foundation Trust (SCFT) has pioneered an innovative and award-winning approach to delivering sustainable, low-carbon healthcare called ***Care Without Carbon*** (CWC)**.** The CWC model successfully delivers value to the NHS by pursuing three complementary objectives:

1. **Carbon reduction** (measured in tonnes CO_2) – a measure of reduced environmental impact incorporating energy and water efficiency, waste management and travel and transport among other areas
2. **Cost improvement** – a reduction in CO_2 will almost always deliver a cost saving, for example through energy efficiency or travel avoidance
3. **Enhanced staff wellbeing** – a key focus for Lord Carter, CWC incorporates a strong staff engagement and organisational development element, aimed at encouraging behaviours that deliver not only cost and carbon savings but also help to support workforce wellbeing

The team behind CWC has developed a comprehensive approach to measuring and reporting on these outputs – most recently this has involved work with the New Economics Foundation to develop new metrics for measuring workplace wellbeing. Carbon management plans based on the CWC model are being developed for all the major provider organisations within the STP footprint and each has made commitments and plans to reduce emissions in line with NHS targets.

2. An SDMP (carbon management programme) for the STP

The STP's collective carbon footprint is estimated at 100,000 tonnes CO_2e per annum. This is primarily driven by energy consumption across the estate but it is also estimated the system produces over 10,000 tonnes of physical waste with staff driving over 20 million business miles each year. The cost of these impact s is estimated at £32M per annum and so carbon reduction presents a significant and tangible opportunity for cash-releasing savings.

Whilst individual Trusts have made commitments to reduce carbon, the STP offers an opportunity to deliver faster and more significant progress by taking a coordinated approach and achieving economies of scale in a number of key areas. As a key operational element of the STP, **a single, overarching carbon management plan will be produced** based on the CWC model, which will harmonise baselines, reporting and action planning on carbon reduction across services delivered in the STP. The plan will necessarily be closely aligned with the STP Estates Strategy and the CCGs' Local Estates Strategies and will be developed and implemented in parallel.

3. Implementation Plan

The CWC team at Sussex Community NHS Foundation Trust will lead on this work stream. Year 1 implementation plan tasks:

1. Review and merge organisational plans, creating overarching plan aligned with Estates Strategy, including harmonised baseline and targets
2. Establish five key sustainability work streams:
   - *i.* ***Utilities***: Options for driving energy & water efficiency across estate (including water industry deregulation options) and scope centralised Energy Bureau function. Investigate opportunity to create single investment vehicle to achieve cost and carbon savings across estate.
   - *ii.* ***Waste & Resources***: Assess potential for harmonised waste policy, targets and operational procedures, collective contract tendering and centralised Waste Bureau service to manage service
   - *iii.* ***Staff Travel:*** Scope opportunity for single Travel Transformation Plan to reduce staff travel time, cost and carbon across system and centralised Travel Bureau function to implement project work and support staff
   - *iv.* ***Commercial Transport*****:** Assess potential for consolidation of commercial courier services delivered by and provided to all STP organisations.
   - *v.* ***Culture****:* Assess opportunity to roll out successful staff engagement programme developed by SCFT to reduce costs, save carbon and improve workplace wellbeing
3. Assess additional resources and skills required to deliver work stream and create business case to secure necessary funding.

WORK IN PROGRESS

Appendix H.1:
Summary of cancer performance improvement priorities

Key drivers for change:

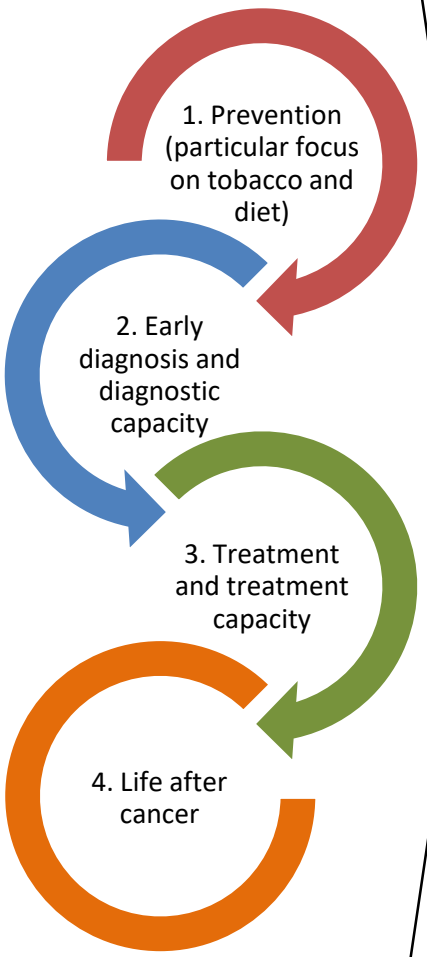
Performance:

- Poor historic one year survival rates, driven, for example, by lung cancer survival rates
- Poor historic rates of early diagnosis in particular tumour sites
- Trusts are struggling to deliver consistently on cancer waiting targets (in particular 62-day target)
- Below average patient experience of cancer services

Drivers of performance:

- High smoking prevalence in parts of the STP footprint (e.g., Brighton, Crawley, Hastings), high rates of obesity in some areas
- Growth in demand (especially for diagnostics), insufficient capacity in imaging, endoscopy, radiotherapy

Scope of end-to-end improvement initiatives:



Examples of specific improvements (detail to be developed Jul – Sept):

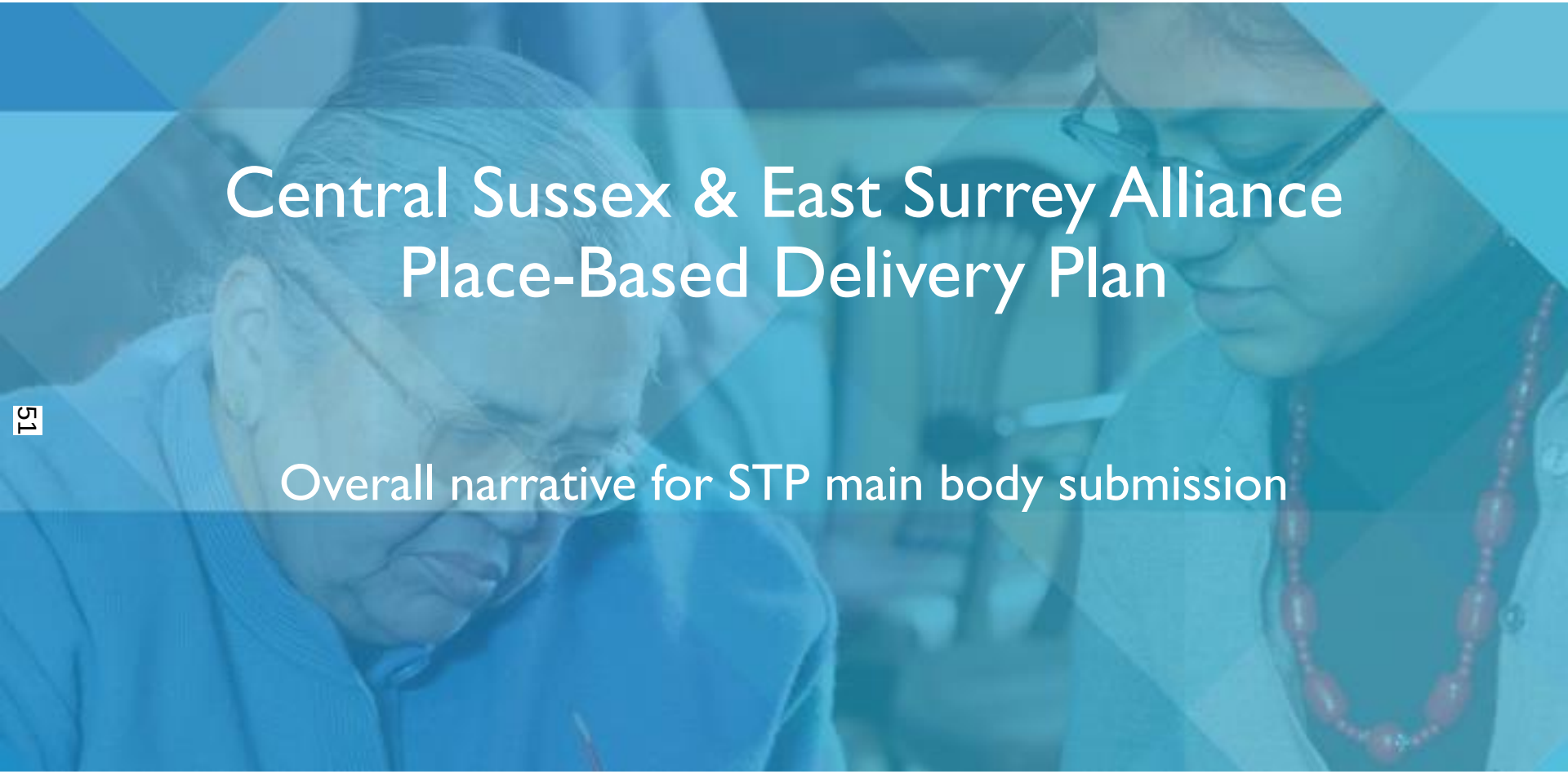
1. Development of "Rapid Access Diagnostic Centres" and pathways for symptomatic patients, ring-fenced from acute diagnostics, addressing shortfall of imaging and endoscopy capacity
2. Our "transforming care through our four localities" workstream includes a locally-driven focus on prevention and self-care in each locality, focused on tobacco, diet and exercise
3. Improving patient awareness of symptoms of potential cancers
4. Improving uptake on screening and vaccination, including:
    - HPV and cervical screening
    - Bowel screening (F.I.T. and bowel scope)
5. Exploring trial of GP direct referral for low-dose CT for patients at highest risk of lung cancer
6. Development of radiotherapy capacity (e.g., Eastbourne) and redevelopment of cancer centre as part of the 3Ts development at Brighton

WORK IN PROGRESS

Appendix H.2:
Summary of stroke performance improvement priorities

Area	Current performance of stroke services	Priorities for stroke improvements
Primary prevention of stroke	• Smoking prevalence high in parts of the STP footprint (e.g., Brighton, Crawley, Hastings) • Obesity prevalence is high in some of the same areas	• Implement the preventative activities related to tobacco, diet and exercise, that have been highlighted in the STP. This implementation to be driven via local place-based integrated care
Secondary prevention of stroke	• Detection and management of atrial fibrillation (AF) is critical to preventing strokes – performance across the STP area is currently mixed both as regards detection and management of AF • Detection and management of hypertension is important in preventing strokes – performance is poor in several CCGs	• Primary care-led implementation of actions to improve the detection and appropriate management of AF, including supporting patients to make an informed choice about which anti-coagulation is best for them, including considering of NOACs. • Improve the detection and management of hypertension
Treatment of TIAs and Acute Stroke	• Configuration of hyper-acute and acute stroke services not complete across: (1) Brighton/ Haywards Heath; (2) Worthing/ Chichester • Performance on "early assessment by specialist physician" is highly variable across CCGs	• Determine preferred configuration of hyper-acute and acute stroke services for each of (1) Brighton/ Haywards Heath; and (2) Worthing/ Chichester. The CCG Governing Bodies and HOSCs/HASC will then decide whether to implement a formal public consultation on these configurations, and, if appropriate, implement.
Rehabilitation and life after stroke	• Relatively poor performance on returning patients to their usual place of residence following stroke (4 CCGs statistically worse than peers) • Relatively poor compliance on physiotherapy and occupational therapy compliance vs targets	• For A23S and Coastal Care, Sussex Community Foundation Trust is meeting with each of the Acute Trusts and the CCGs to improve gaps in Early Supported Discharge and Community Neuro Rehabilitation.

WORK IN PROGRESS



Central Sussex & East Surrey Alliance Place-Based Delivery Plan

Overall narrative for STP main body submission

Central Sussex & East Surrey Alliance

Contents

Central Sussex & East Surrey Alliance

Executive summary

Case for change

- Continuing to **operate as we currently are is not an option**. The **funding and capacity gap** if we do nothing will become insurmountable.
- **Case mix and complexity will increase**, driving the demand for beds higher than just the total population growth. But the **acute sector is already straining to provide capacity**.
- The population is **growing**, and **growing older,** and the overall health of the population is deteriorating
- **Care quality issues** need to be addressed & **social factors** are having a direct impact on health
- Patients are not always receiving the **levels of care** that they want
- Central Sussex and East Surrey Alliance is the **right place** to deliver the future **health and wellbeing needs of its population** but the local health and social care **system is under pressure**.
- **Workforce issues**, organisations in special measures and a lack of **organisation and data integration** complicate the picture
- There are **significant organisational and infrastructure challenges** which the place-based plan needs to address

Vision & priorities

- A **less reactive**, less **hospital bed-based** system which promotes **well being**, **self care** and care at **home**. A system which places **integration** at its centre, providing care and services closer to home. **Led by primary care**, building on good work in progress, promoting **collaboration** across health and social care.

Strategic Objectives	Care designed for the local populations, including families, children & carers	Meaningful integration of providers	Sustainability of primary care	Sustainability of acute care
Priorities	Prevention and education	LTCs and EOLC managed in the community	Coordinated care for frail & complex patients	Better access to Urgent Care	Cancer, RTT and A&E targets

MCP is the right model

- The components needed to meet our strategic objectives and deliver our priorities are a **close match with the components of an MCP**
- **Primary care** services are already **moving in the MCP direction**
- **Primary care are best placed to lead** the system

The **key outcomes** are:
- Accessibility
- Continuity
- Coordination
- Workforce
- Sustainability
- Quality

The **key components** are:
- Data-driven care model
- Organisational consolidation
- Devolved finance & contracting
- MPC integrator
- Balanced workforce
- Patient at the centre

Key **needs**:
- Bottom-up integration
- Workforce without borders
- GPs are core to the model
- Full data integration

- We have strong foundations for an MCP model and we will drive delivery from care hubs
- We plan to determine the number of MCPs by 09/17, complete public consultation by 03/18 and settle on the legal construction approach by 09/18

Delivery structure

Delivery Streams	Prevention and self care	Continuity for patients with LTCs	Coordination of frail and complex patients	Improved access to urgent care
Enablers	OD & Leadership	Change Management	Workforce	IM&T	Estates

What it will take to execute

Investment in primary care is absolutely essential to the success of changing the system. Our GPs will provide **clinical leadership**, and they are at the heart of **care hubs – our engines for delivery**.

We need to address **challenges** in all areas in order to be able to deliver this whole-system change

Clinical leadership	Workforce	Change Management	Programme delivery
Technology	Estates	Investment	Contracting

Finances

Nine levers are being used to drive our model for acute savings and community re-provision

Frailty	A multidisciplinary, ambulatory approach	Non Elective admission	Ambulatory care	Long Term Conditions	Increasing patient self management
Elective Reduction	Cascade of electives to day cases to out patient to community	A&E	Improved access to urgent care	Complex Patients	Care coordination and multi-disciplinary teams
Step Down Care	Alternative setting	Outpatient Appointments	Extended primary care	PBR Excluded Drugs	Medicine Management of non PBR drugs

Our approach will reduce the projected deficit in 20/21 from £91m to £31m

See slide 17

Timeline

Next 6 months	Year 2	Year3	Year 4	Year 5
Strategy	*Co-design*	*Deployment & Shadow contract*	*Stabilisation & new contract*	
Service Scope defined (01/01) ◆ CSESA Strategy ◆	#MCPs defined ◆ Public consultation complete ◆	5 year MCP and acute contracts in place ◆ Delegated budgets agreed ◆	◆ MCPs live	
Programme team in place ◆ CSESA 4 year plan ◆	**Gateway #2a**: Capabilities & contract set up (shadow) Shadow delegated budgets agreed ◆	**Gateway #2b**: Capabilities & contract set up (full MCP) **Gateway #3**: Is it safe to commence?		
Gateway* **#1**: Case for Change				

Vanguard ready

We will be formally registering an **expression of interest** in joining the next wave of **Vanguard** projects.

We have:

- A credible **vision**
- A defined **care model**
- Clear **timelines**
- **Work in progress**
- Good understanding of our **financial case**

Case for change: the challenges that we face

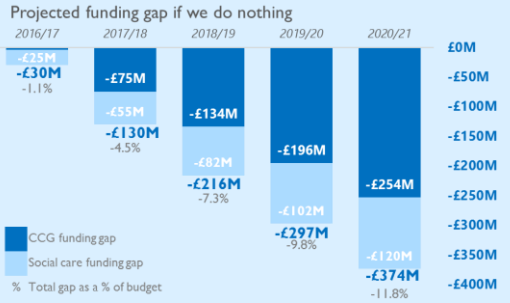
The national and local health and funding issues that must be addressed

Primary care has been underfunded for a long time

- The share of NHS funding for GPs has been cut with respect to acute over the past 10 years. As a direct result, primary care – and its workforce – are under enormous pressure.

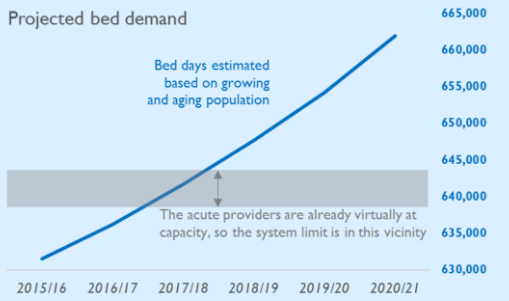
Continuing to operate as we currently are is not an option

- Over the next 5 years, the population is due to grow by an average of 0.9% per annum
- CCG spend is forecast to increase by an average 4.5% per annum, and provider spend by 5.7%.
- This increase in expenditure is forecast to result in a £5m health budget deficit in 2016 and a £254m deficit in 2020



Note: data shows position as estimated in July

- Case mix and complexity will increase, driving the demand for beds higher than just the total population growth. But the acute sector is already straining to provide capacity.



The population is growing, and growing older

- Life expectancy continues to rise. The number of people over 85 will have doubled in Surrey by 2030. In Sussex, the number of people aged 90+ is expected to increase by 50% by 2022 and over 300% by 2037. In more deprived areas this rate of increase is slower, meaning that inequality, as expressed in terms of life expectancy has, and will, continue to increase.
- As the population ages, more people will be living longer with a long-term condition or disability and many people will be living with multiple long term conditions. Many long-term conditions are strongly associated with age, but lifestyle risk factors are important, and some long term conditions are preventable. The number of people with conditions such as diabetes, coronary heart disease and chronic obstructive pulmonary disease is expected to increase over the next five to ten years. A greater number of frail patients will result in a proportional increase in of end-of-life care beds.
- Approximately 6% of the adult population in West Sussex has a diagnosis of diabetes. This is projected to increase ahead of overall population increase. Most diabetes is preventable and the risk factors understood; excess weight, smoking, poor diet, low levels of physical activity.
- It is estimated that 15%-30% of dementia is linked to cardiovascular problems. Therefore current public health interventions aimed at increasing healthy lifestyles may reduce the incidence of dementia.

The overall health of children and working age adults is deteriorating

- We have above average-smoking rates for 15 year olds and some localities have high adult smoking rate. 18% of the population in East Sussex smoke and in Brighton & Hove the prevalence of smoking is 21%; both are higher than the national figure of 17%. One in four adults drink more than the recommended daily drinking guidelines.
- There are above average levels of obesity and self harm rates of hospitalisation.

Cancer and stroke need a particular focus

- Mortality from all cancers in people under 75 years of age is significantly higher in Brighton & Hove than England and the South East, and screening uptake rates generally lower. 25% of patients in Brighton and Hove are diagnosed through emergency routes, above the national average of 20%.
- In line with national findings, we can do much to improve our levels of cancer care to an acceptable standard. Britain has the worst cancer survival rate in Western Europe.
- With 1 in 2 people born after 1960 destined to develop cancer in their lifetimes, this is a wide-ranging issue. Cancer treatment is evolving quickly but it still very costly so early diagnosis will be key.
- 1 in 5 women and 1 in 6 men over 75 will have a stroke. Our ageing population means that the volumes of strokes will continue to increase.

Patients are not always receiving the levels of care that they want

- Patient expectations continue to increase. People expect to be seen and treated more quickly and at a time and place more convenient for them.
- In Crawley, patient satisfaction rates for care inside hospital and in the community are in the lowest quartiles of performance as measured nationally. Ambition is to drive quality of these experiences up towards the national average.
- A lack of coordination across the system contributes to the poor patient experience.

Care quality issues need to be addressed

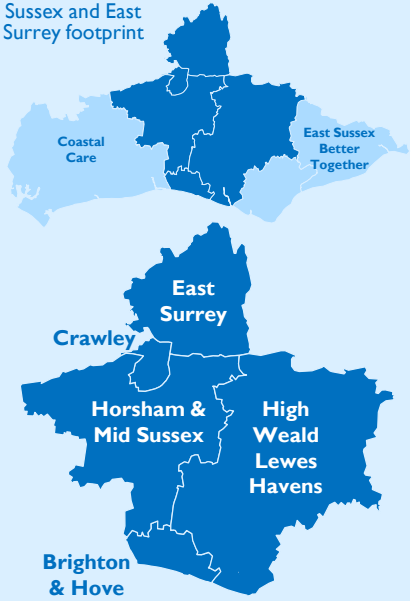
- Cancer and direct diagnostics are insufficient to meet NICE guidelines NG12
- Several other major areas of care have been identified as requiring improvement:
  - mental health detection, access and outcomes
  - LTCM prevention and support
  - support to frail and complex patients
  - maternity and children's services.

Social factors are having a direct impact on health

- Social care is also under pressure: funding levels are declining and this is a significant driver behind deteriorating health issues.
- Homelessness has increased, including rough sleeping, presenting significant risks to individuals' health and wellbeing, as well as challenges for health and social care services. For example in Brighton & Hove street services worked with 775 people during 2014/15; in November 2015, a snapshot of a single night estimated there were 78 people sleeping rough.

Case for change: understanding the CSESA place today

We have the right assets in good locations but there are a number of system challenges



1.2M	people
£1.6bn	annual healthcare spend
117	general practices
5	CCGs
4	local authorities
7	district councils
3	acute trusts
5	acute hospitals
3	hospices
5	community hospitals
2	community health trusts
2	mental health trusts
1	ambulance trust

CSESA was formed as a place-based area in August 2016

CSESA is the right place to deliver a future health and wellbeing service

- Primary care is already starting to come together at scale through in each CCG:
  - East Surrey: 4 Primary Care Networks have been established and the GP Federation selected as most capable provider of enhanced primary care services
  - Crawley: the 2 Communities of Practice are working together on introducing social prescribing
  - HMS: 4 Communities of Practice including a PCH Vanguard in East Grinstead. Exploring early shadow capitated budgets.
  - HWLH: 4 Communities of Practice pilot – Connecting 4 You
  - B&H: 6 clusters delivering services as Brighton & Hove Caring Together
- The three acute trusts are building a network where they are able to plan and deliver higher quality, sustainable services at scale. BSUH and QVH are drafting an MoU to cover short term elective capacity and strategic relationship.
- Transport links support the flow of patients up and down the corridor, provided by the A23 and M23 alongside a good rail infrastructure between London and Brighton.
- There is a wide range of inequality and diversity when looking across the footprint as a whole. There are deprived and highly affluent areas. There is also a mix of urban and rural geography. A larger place covering all of these aspects allows services to be commissioned and provided at a scale; services which are more wide-reaching and capable of delivering better outcomes for patients. Where there are currently a few people in need, a more sustainable service can be provided across a greater population.
- The wider place allows for increased partnership working, better utilisation of assets and new ways of defining and using budgets to commission services. Collaboration around the infrastructure and shared sites for health services will provide greater access to a wider range of services.
- By planning for services at this scale, we believe it will be possible to return the system back into financial balance. Capitated budgets and programme level budgeting will be possible through pooling resources. Designing services at a scale of 1.2M people with delivery localism will make it easier to invest in primary care.

But the local health and social care system is under pressure. There are significant challenges which the place-based plan must address.

- The historical under-investment in primary care has left it in a precarious state. All of the issues recognised in the GP Five year Forward View are manifested in our place.
- Recruitment and retention of clinicians is challenging: GP lists are closed and practices are closing (seven recently in Brighton) as the aging GP & nurse population retires. 17% of GPs and 39% of practice nurses are forecast to retire in the next 5 years, with no identified source of replacement.
- In our hospitals, patients are waiting too long for planned care services and are not being seen quickly enough when they attend A&E. Mandatory performance indicators such as RTT and the 4 hour A&E department standard are not being consistently met.
- As the BSUH 3Ts development progresses and decants further capacity, the broader STP will demonstrate how we will provide additional capacity in the short and long term.
- The August CQC inspection rated Brighton & Sussex University Hospitals Trust overall as Inadequate. The CQC noted that patients were not receiving the quality of care that they are entitled to expect, or within the timescales required.
- South East Coast Ambulance Trust is rated Inadequate by the CQC and has been placed into special measures.
- NHS Brighton and Hove CCG and East Surrey CCG are both rated as Inadequate. East Surrey is in special measures for its finances.
- It is not possible to access and share patient data between clinicians across organisational boundaries and patients are unable to access information about their conditions.
- There is a diverse legacy of primary and community estate with premises owned variously by GP partners, County Councils, NHS Property Services, and third party landlords including private finance initiatives.
- Whilst there is some opportunity for rationalisation and/or disposal of estate, this is outweighed by the need for substantial investment, both to address the significant local housing planned for the subsequent population growth, and to enable the shift of care from acute to primary and community settings. The development of the Royal Sussex County Hospital is a start, but will need to be accompanied by robust planning to absorb additional care, closer to home.
- Silo workforces, bound by organisational structure, result in multiple hand-offs and lack of understanding of the range of services available to patients.
- Time pressure for staff training or development and demand on services outweighing staffing levels means that stress levels are at an all-time high for many staff.
- GPs are taking on different roles as care hubs evolve and there will be a significant level of training and education required.
- In the current configuration, it is natural for organisations to compete rather than collaborate for the best interests of the patients and the system.
- The 'normal' NHS pace of change is very slow and needs to embrace digital working.

Our vision for CSESA

We will invest to develop a system of healthcare that is less reactive and less hospital bed-based. It will deliver a great start in life and continue to promote people's wellbeing, their ability to stay healthy, to self care and be cared for at home. We will bring together a system which places integration at its centre, providing more care and services closer to patients' homes and places of need. Led by primary care, we will build on the good work already in progress, promoting collaboration between all organisations working across health and social care.

Our strategic objectives

Care designed for the needs of local populations

- Uses detailed, integrated health and social care datasets based on combined GP lists to determine the changing needs of local people – as an ongoing evaluation, not a snapshot
- Applies risk stratification using real-time data and Rightcare methodology to drive proactive interventions to keep people healthy
- Identifies demographic subsets based on factors such as isolation, dependency, and deprivation to determine additional or focused services
- Applies the pay-it-forward principle to developing systems of care for children and families – especially complex ones
- Identifies and supports carers, to protect the pivotal role they play
- Maintains equality of service access and is developed in partnership with the population
- Supports patient choice to ensure dignity and quality of life
- Enables the system-wide carbon management approach

Meaningful integration of providers

- Delivers real organisational and operational integration between primary and community services
- Enables effective integration of mental health, adults and children's social care and acute services into a team around the patient
- Weaves social care tightly with healthcare to address the needs of the whole person and family
- Builds working at scale and removes existing organisation boundaries
- Formalises significant third sector support
- Uses single data systems for a seamless patient experience and real-time handovers
- Links people to a range of support services via social prescribing

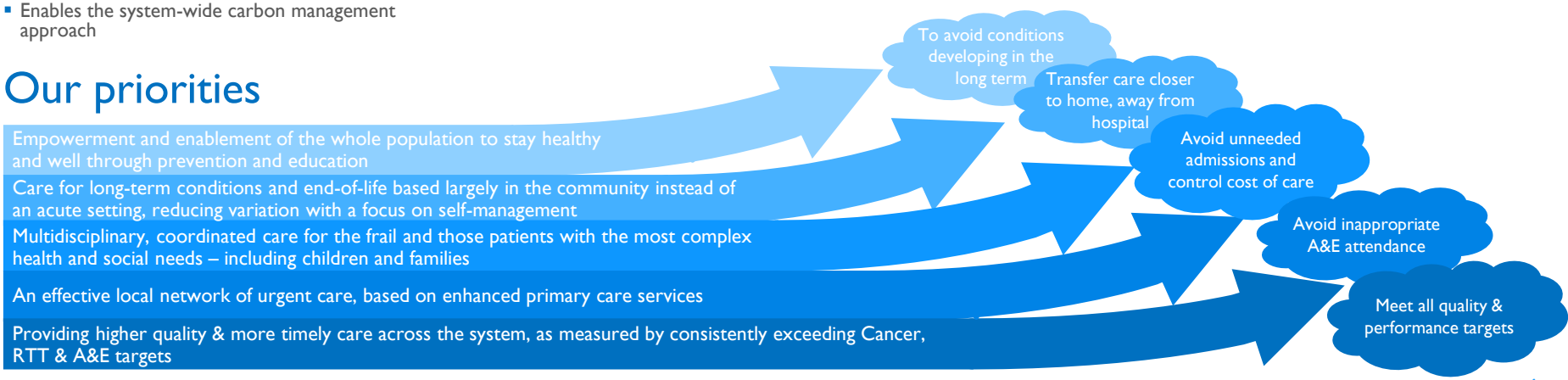
Sustainability of primary care

- Reduces people's dependence on the system and its services
- Empowers and supports front-line primary care to take a system leadership role
- Builds broader, resilient general practice at the heart of the MCP model
- Releases GP capacity through an increased use of skill mix
- Enables GPs to focus on complex patients and planned care
- Increases capacity and capabilities in primary care to enable delivery of services currently in acute – including direct cancer diagnosis and some levels of speciality current in secondary

Sustainability of acute care

- Enables acute providers to meet and exceed the constitutional quality & performance thresholds
- Transfers significant levels of activity from acute to community setting
- Reduces total healthcare spend to enable long-term sustainability
- Reduces pressure on the acute system to allow focus on specialist acute care
- Provides care closer to home and minimises the need for admissions
- Dovetails primary & community care closely with acute capability and capacity to balance supply with demand

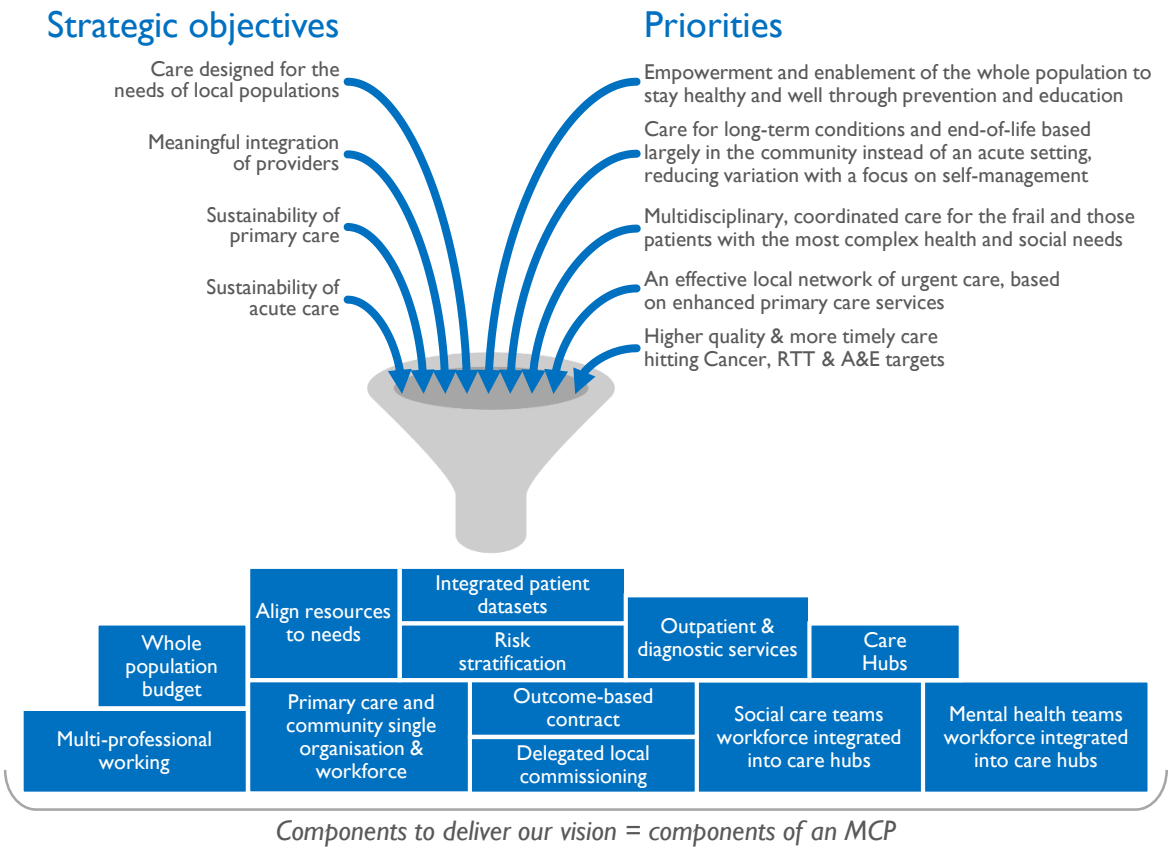
Our priorities



Why an MCP is the right model for accountable care

The current system cannot deliver the change required. There are three reasons why a multispecialty community provider (MCP) model is the best solution to both meet the local healthcare needs of our diverse population needs, and to render the system sustainable.

1 We have a shared vision which closely aligns to the MCP model and whose objectives and priorities can be met with the components of an MCP



Components to deliver our vision = components of an MCP

2 We are already building strong foundations for the MCP model

- The Brighton & Hove Caring together project already has services being delivered in integrated 'clusters'
- In Horsham and Mid-Sussex, East Grinstead have set up the Primary Care Home model with vanguard funding, and are planning to expand.
- High Weald Lewes Havens are fully co-commissioned; Brighton and Hove have recently voted to transfer to co-commissioning; Horsham and Mid Sussex are voting in October and Crawley are in discussions with GPs.
- In East Surrey, all practices are members of a Federation which has just been awarded most capable provider status for all enhanced primary care services, as a precursor to the CCG replacing individual practice LCS contracts with an umbrella contract with the Federation.

3 We have strong leadership from our primary care clinicians

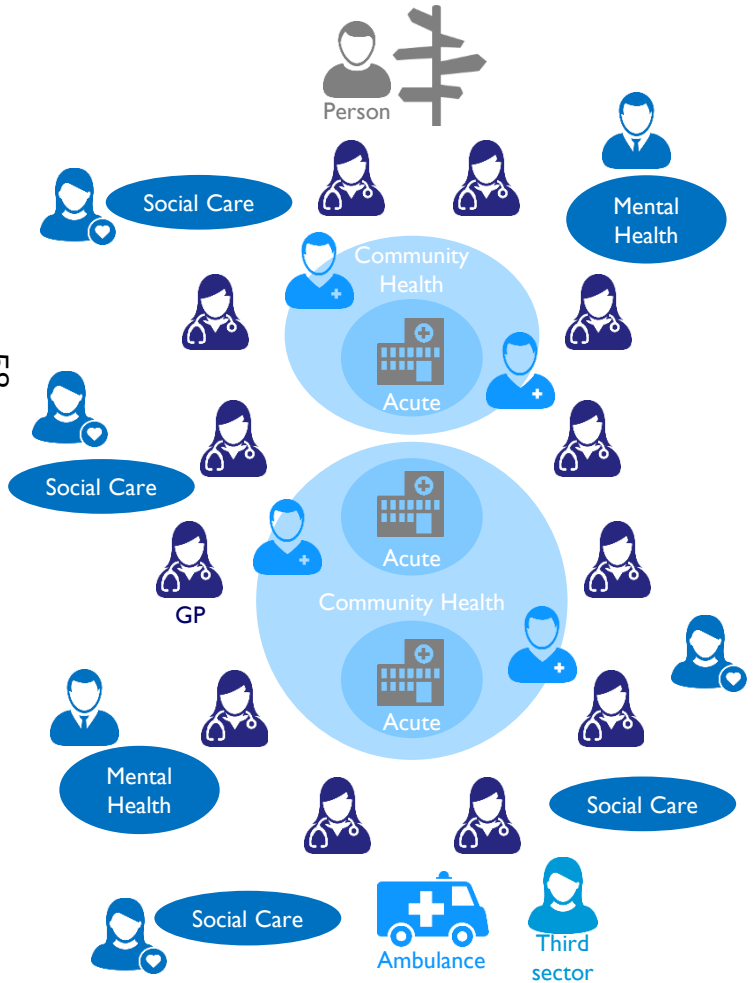
- There is very strong support from GPs across the CSESA place.
- GPs are the driving force behind change and will be providing the clinical leadership to drive the pulling of activity from the acute setting.
- Two-thirds of the workload on the system is as a result of LTCs which by their nature should be driven as a population-focused service. Primary care is best placed to coordinate that.
- We need to give the acute trusts the space to develop sustainable and networked models of care that integrate with the MCP model.

What will be different in an MCP

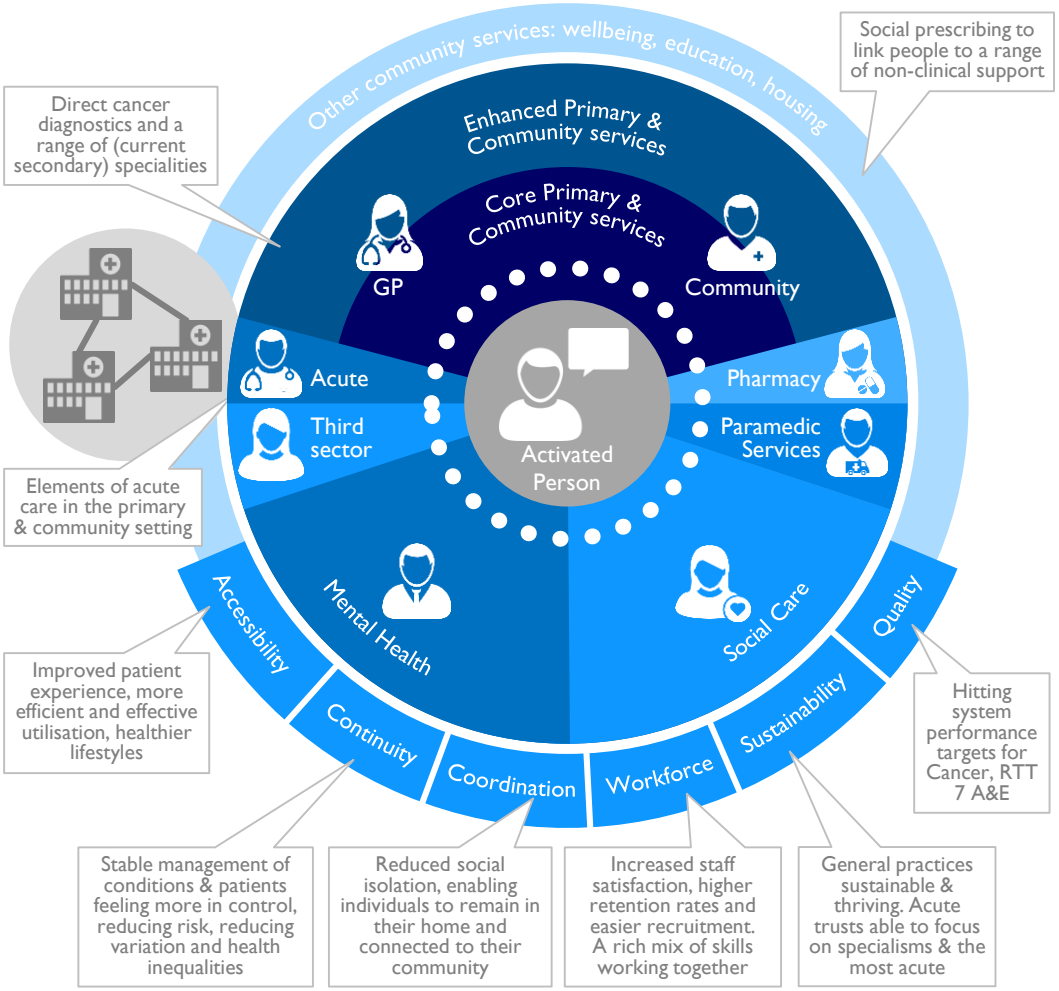
The MCP model arranges care around the person and integrates out-of-hospital services

This is today

The patient experience is very much one of disjointed organisations, with little sense of a joined-up service



This is our future



What the MCP will look like

The key differences in how an MCP will work

Organisational consolidation

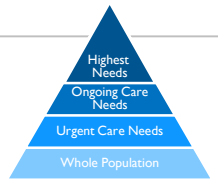
- Integrated primary and community care via networks of general practices. This may mean federations or super practices joining organisations with community providers – or it may mean a prime/subcontractor model
- Organised into 20 care hubs of 30-50k, with a minimum total population of 100k
- Mix of informal alliances, federations, or super-partnerships – working as partners, subcontractors or employees – according to the choice of local general practices
- Closely aligned mental health care and social care, with a consistent MDT structure
- Clinically-led local care hubs
- Collaborative, shared leadership and management across the MCP
- Designed-in connection to and use of the voluntary sector
- Shared estates & back office functions
- Community diagnostics and outpatient services

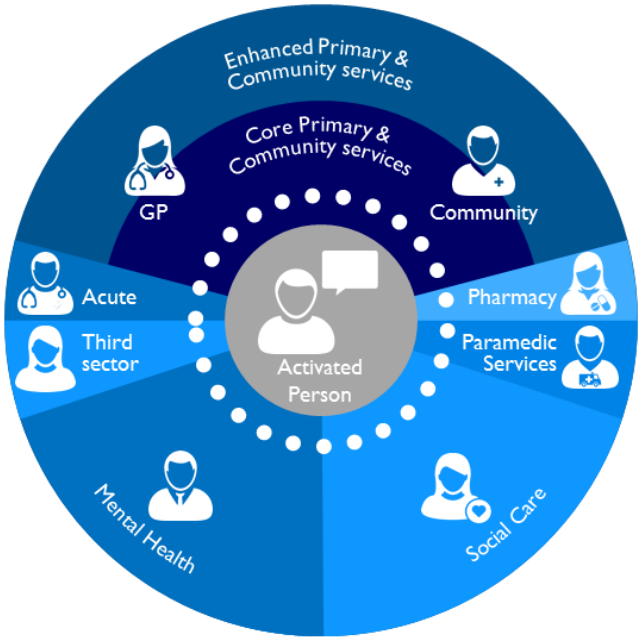
MCP Integrator

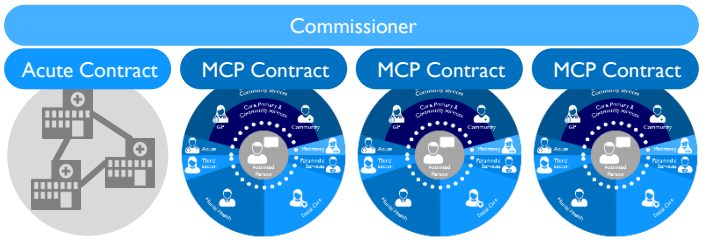
- The model will include a provider-based function to oversee all in-MCP services and respond to commissioner, effectively running delegated commissioning and taking make-or-buy decisions
- Uses dynamic analytics so that continuous data is available info to clinicians, organisations, system and used to adjust services
- Coordinates delivery, defines performance agreements, manages payments, organises networks and membership, trains practice staff

Data driven care model

- Clear and deep understanding of the population needs with risk stratification
- Prevention and care designed for segmented population
- Analytical, predictive models to target variation
- Single technology stack and integrated digital care record across primary, community, social care and acute







3 MCPs shown not indicative of anticipated number

Patient at the centre

- Better patient experience, with the patient's and population's needs determining the services and delivery in a location closer to home
- Activates patients, carers and families
- Uses digital technology to transform contact, diagnosis and treatment
- Supports the patient choice agenda, whilst working in partnership with patients and their families about the most appropriate place of care

Balanced workforce

- Locality managers
- Single workforce with a richer skill mix (GPs, nurses, paramedics, pharmacists, consultants, social prescribers, etc.)
- Redesigned jobs and workforce mobility within and MCP
- Close working with acute, even employing consultants

Devolved finance & contracting

- Broader and larger in scope, joint outcome-based contracts between the CCGs and the MCP, with separate contracts for acute
- Holding single whole-population capitated budgets, with a new performance framework. Discussions are already underway for early shadow budgets.
- Collaborative commissioning and co-design
- Greater responsibility for performance monitoring & management
- Flexibility to manage whole resource pool according to budget

We have strong foundations from which to grow our MCP

We will focus on building the care hub locality services first

- Although CSESA is a relatively new group covering a large and very diverse area, there is a great deal of work to transform services already underway and much good practice to leverage. Social care and mental health are already integrated to varying extents and we are in the process of aligning contracts.
- The parallels and cooperation across CCGs and providers are what has brought us together as a place footprint and is why leaders are aligned on an MCP model as the right answer. This will incorporate the 20 existing care hubs and will be arranged around a robustly networked acute service.
- We want to drive delivery from the care hubs upwards. We are already having conversations about how some of them could be given early delegated budgets to provide services at this local scale.
- There are three key milestones:

Determine number of MCPs
We will perform additional population modelling and compare the options for MCP configuration

Sep 2017

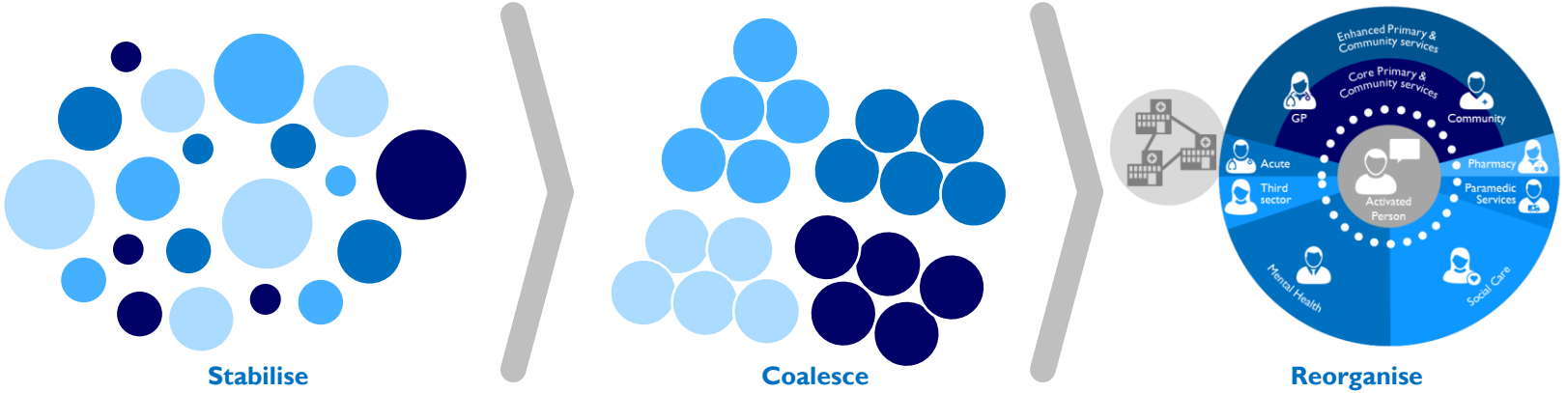
Hold Public Consultation
Gather patient and public feedback on the rationale for, approach to, construction of and number of MCPs

March 2018
Dates TBC subject to purdah

Decide the legal form that each MCP will take
In partnership with providers, establish whether a virtual, partially integrated or fully integrated model works best in each MCP. There is appetite for full integration.

Sep 2018

- We will build MCPs from the ground upwards, starting with establishing sustainable care hubs:



Stabilise
We will focus our immediate effort on laying the firm foundations: establishing strong, sustainable care hubs that deliver services at local scale.

Coalesce
As communities develop and stabilise, we will determine how they informally come together into large groups – taking into account national evidence and learning.

Reorganise
The groups will pivot into a formal MCP structure(s) with transfer of workforce into new organisations

How our organisational capability will mature

Comparing where we are now with our ambition highlights the change that is needed

The WISH maturity model sets out 5 capability 'ladders'

- This is a framework for maturity progression for population-based accountable care
- It is a robust framework for planning out the changes that are required to move from our current set of capabilities to those needed to operate our MCP model
- Each step up each of the 5 ladders will mean a significant change to organisation, leadership, ways of working for all staff, use of technology and estates

The LGA and NHS Confederation Integration self-assessment tool will be used to help plan these changes

- This tool will be used to assess the readiness of the leadership, system and programme team for setting out on and managing the complex programme of change

Where we want to be

Where we are now

	i Population	ii Outcomes	iii Metrics and learning	iv Payments and incentives	v Co-ordinated delivery
5	**Intersections accounted for** (ie, co-morbidities)	Outcomes that **matter to people**; prioritized based on **individual goals**	Aggregated longitudinal data made **public** in cross-provider **consistent** format	**Full capitation** with guard rails on quality; differential payments for outcomes	Clinical and data **integration of provider network**; patients **co-design** care
4	**At-risk** individuals identified, using all available sources	Focus on **prevention** and **wellness**; goals adjusted based on patient **risk** level	Results shared with people in **usable** form; monitoring **built into** clinical work flow	Upside and **downside** shared savings; strong professional competition	Patients **empowered** to self-care; **care plan** and **managed transitions**
3	**Registry** of population **integrated** with EHR	**Comparable** with other providers and aligned with global **best practice**	**Real-time** and **summary** learning; results **shared** with payer and clinicians	**Upside-only** shared savings and risk for whole health; bonuses to staff	**Clinicians empowered** to adjust interventions to improve outcomes
2	**Defined** population (eg, morbidity, age, geography, payer)	Incorporation of **patient experience** into targets	**Leading clinical indicators** with **evidence link** to outcomes	**Bundled payments** with quality controls for episodes of care	Multi-disciplinary **meetings**; all team members used to **maximum potential**
1	**Holistic view** of existing funding and providers	**Basic clinical outcomes** decided at local level	**Admin-based** measures; **limited** transparency; summary evaluation only	**Pay-for-performance** bonuses **on top of** fee-for-service or block payments	**Basic electronic data-sharing** across providers
0	No identified population	No target outcomes	No metrics nor learning	Payments for activity only	Uncoordinated provision of elements of care

WISH
مؤتمر القمة العالمي للابتكار في الرعاية الصحية
World Innovation Summit for Health

The clinical approach within the MCP model

We have 4 clinical priorities

	Whole Population	Urgent care needs	Ongoing Care needs	Highest needs
Link to the wider System	Significantly increased prevention initiatives | Integration with public health | Social prescribing and signposting to social and third sector services | Tailored health coaching to encourage self-care	Networked UTC/WIC/MIUs | Broadening direct patient access to services | Diagnostic centres to provide quicker and easier access	Consultants providing advice / support working in the community to the same outcome basis as general practice | Increasing shared decision making in elective pathways | More EOLC at home/in community integrated to hospice care	Geriatricians supporting MDT-led frailty pathway | Community beds model reviewed and services optimised with emphasis on care at home but providing short term specialist support | Responsive services teams & specialist nurses supporting patients needing urgent care in their own homes, preventing admissions and immediate discharge
Locality	Targeted health education based on population data	Locality wide improvements to on the day access towards 7/7 working | Better utilisation of existing walk-in facilities	Connecting to other public services and the voluntary sector | Access to extended care hub team | LTC management through wider skill mix based around practices	Lead GP co-ordinating locality approach | Care hubs as locus of coordination | Practice collaboration in areas such as a visiting service | Integrated health & social care packages | Greater mental health involvement in MDTs
Practice	Increased focus on routine and complex patients (due to urgent on-the-day demand moving to single locality solution)	Different skill mix to enable easier access | digital access to primary care and online diversion to self-care | Load balancing supply across locality	Named primary point of contact. Increased skill mix in practice (nurse practitioners, paramedics, physician assistants etc.)	Locality care coordinators to manage the day-to-day provision of care and act as single point of contact for patients
GP	Increased role in leadership of designing and delivering local services | Increased flexibility to shift between: focussing on routine and complex patients | Providing on-the-day urgent access for locality | Roving GP for home visits		Focused attention on better outcomes/management of LTCs such as respiratory conditions & diabetes (LCS)	Lead professional as co-ordinator of care (not always GP) | Focused attention on better management of complex high cost patients (LCS)
Person	Prevention & self-care	Accessibility	Continuity	Coordination
Examples of services/ projects already in place or in progress, and ready to scale	Care hubs: East Surrey GP Federation Networks | Crawley Communities of Practice | HMS Primary Care Home vanguard | HWLH Connecting 4 You | Brighton and Hove Caring Together Social prescribing | Health coaching and patient activation | Smoking cessation | Homeless GP practice | LCS funding weighted by population need | Care without Carbon	Commitment to place-wide diagnostic centre | Paramedic practitioner Whitstable model | Roving GP | Rapid response community services and tech-enabled care link | A&E GP front door services |Trials of digital consultation channels | Pharmacy moving into community locations | 24-hour single point of access for Mental Health | Safe havens and street triage	MSK pathway | Cardiology triage and ambulatory ECG | Acute referral management | Community geriatrician | Perinatal mental health | Integrated children's mental health | CAHMS transformation plan | Golden ticket dementia service | Community transport | Enhanced nursing home care | Care homes prescribing | End of life care strategy | Tier 2&3 diabetes community service	Complex patients care coordination at practice level | Care-hub MDTs for most complex patients | Lead professional

We will deliver the clinical changes by driving delivery at a local, care hub level within an outcomes-based framework, with consistency, support and enablers managed at a programme level. The clinical work will fit into one of four delivery streams:

Delivery Streams	1. Prevention and self care	2. Improved access to urgent care	3. Continuity for patients with LTCs	4. Coordination of frail and complex patients
Enablers	OD & Leadership	Change Management	Workforce	IM&T	Estates

How our place-based plan will support sustainability of acute care

There is whole-system support for the BSUH recovery plan and building a sustainable acute network

The acute system is **under pressure across our STP**. It is particularly fragile at BSUH, . We recognise the need for **investment** in the BSUH **3Ts** programme and the **Urgent Care Centre expansion** this winter. We also recognise that there is an immediate need to invest in **more beds** as a short term measure but we aim for the place-based system to relieve significant pressure from acute starting next year. We must secure improvements in **patient flows** though the acute sector, which includes plans to **support our ambulance trust** in increasing their performance – for example, working on ambulance handover delays at A&E.

Our model will significantly increase the episodes of care in the out-of-hospital setting, in order to **decrease the demand** on all acute hospitals. Even where resilience is currently good, our plan will ensure that the increasing need and complexity bought by a changing demographic profile will be met while, only increasing activity in secondary care where this is clinically appropriate. We will be looking beyond the health system to **local authorities** and the **third sector** to bring support to a **highly integrated** system.

Our MCP model will have bring **three key benefits** in controlling demand for acute services. It will: **avoid unnecessary attendance**; or **admission**; and **accelerate discharge**

Benefit	Whole Population	Urgent care needs	Ongoing Care needs	Highest needs
Avoid attendance	▪ Increased prevention and self-care will enable people to have increasing disability free life years and, where needed, to access care early, thereby decreasing care need and cost. This is a longer term impact. ▪ Social prescribing will provide people with more rounded health and wellbeing support and will give people a wide range of options so that hospital is not the default solution.	▪ A more integrated approach to urgent care, with improved access to GPs and other local clinicians through the Clinical Navigation Hubs will avoid unnecessary use of A&E ▪ Increased community diagnostics will reduce demand on acute trust diagnostic services currently under enormous pressure such as digestive diseases. It will also detect issues earlier, reducing the amount of acute care needed to treat patients ▪ Paramedic Practitioner Whitstable model seeing patients at home will decrease conveyances ▪ Mental health safe havens will decrease the use of A&E for episodes of crisis ▪ GP on A&E front door	▪ Significant shift of LTC care into the community with specialist support. Working with NHS England in the commissioning and delivery of whole pathways involving specialist services ▪ Elective care system with shared decision making interventions focussed on outcomes ▪ A more resilient range of elective care providers ▪ Reduced barriers between primary and secondary professionals (such as Consultant Connect) ▪ Day case procedures provided by MCP ▪ EOLC with a focus on care in the place of choice will reduce need for patients to come to hospital and support rapid discharge ▪ Enhanced nursing home care will reduce reliance on 999	▪ Community-led MDTs will incorporate consultant input to decrease travel to hospital ▪ Care coordination will ensure timely and joined-up care packages at home, and provide patients with a single point of access ▪ Increasing 'Discharge to Assess' to reduce deterioration and frailty in the acute environment
Avoid admission	▪ Follows from avoided attendance above, but will be a limited impact in the short term	▪ Better integration of community health, social care and mental health led by primary care will make it easier to be able to send patients home with appropriate follow-up care	▪ Increased focus on supported self-management will reduce episodes of crisis that might have needed bed-based care	▪ Proactive integrated care will reduce episodes of crisis avoiding unnecessary bed-based care ▪ Responsive services and specialist nurses will increase treatment at home, avoiding unnecessary short stays
Accelerate discharge	▪ Not applicable		▪ Better integration will make it easier to be able to send patients home with appropriate follow-up care	▪ The integrated MDT and MCP organisation will be a single team helping patients home

Our model includes significant use of acute consultants in a community setting and therefore in time we would expect initiatives such as Hospital at Home to embed as an integral part of the MCP delivery team, led by primary care with support from acute. We will also reduce pressure on the acute day-case units by providing procedures in the MCP. In the short term, key quick wins include increased community diagnostics and more integrated MDT teams for the most complex patients at risk of admission. Both of these will help relieve pressure from the acute setting quickly.

Timescales

	Year 1 – 2016/17 (next 6 months)	Year 2 – 2017/18	Year 3 – 2018/19	Year 4 – 2019/20	Year 5 – 2020/21
	Strategy	**Co-design**	**Deployment & Shadow contract**	**Stabilisation & new contract**	
Clinical Approach	▪ Use risk-stratification models to identify the priority service needs for 20 care hubs ▪ Determine clinical scope, priority workstreams & resource requirements ▪ Draft logic models (1 per care hub)	▪ Redesign priority pathway redesign (in 4 delivery streams) ▪ Perform full service mapping ▪ Construct business cases for Year 3 shadow running	▪ Deploy 'new' MCP services and localised delivery ▪ Complete full MCP business case(s)	▪ Stabilise MCP-based delivery ▪ Improve and extend services	
Modelling	▪ Iterate financial model & assumptions ▪ Procure & mobilise actuarial modelling ▪ Define capitated budget & delegation framework ▪ Estimate population-based budgets	▪ Build and iterate detailed actuarial model ▪ Calculate delegated budgets at granularity required in each locality	▪ Refine model using evidence from live services ▪ Readjust delegated budgets	▪ Continue to drive benefits	
Procurement & Contracting	▪ Agree contracting approach & principles ▪ Design risk/gain approach ▪ Define procurement strategy	▪ Review national MCP contract ▪ Create outcomes framework for future contracting, including metrics ▪ Create procurement plan	▪ Create 5 year MCP contract ▪ Transition delegated quality monitoring and performance to MCPs (skills, tools, people) ▪ Monitor shadow metrics	▪ Report on benefits realisation at place, MCP and care hub level ▪ MCPs monitor quality and manage performance across care hubs	
Commission reform	▪ Agree approach to leadership, management & ways of working, virtual teams ▪ Specify commissioner OD requirements ▪ Estimate resources to create, run and assure new model	▪ Design & plan commissioner changes ▪ Deploy new commissioner leadership & management structure	▪ Mobilise and transition delegated commissioning functions in MCPs: due diligence, delegation framework, op models ▪ Define future organisation form of CCGs	▪ MCPs running delegated budgets, make or buy decisions ▪ CCGs transition to new organisational form	
Organisational form	▪ Compare MCP configurations (number of MCPs) ▪ Create MCP business plan framework	▪ Complete assessment of org options ▪ Determine no. of MCPs ▪ Define transitional MCP governance ▪ Create business plan per MCP	▪ Define per-locality, multi-speed approach to new orgs	▪ Formalise new orgs	
Workforce	▪ Complete ongoing workforce analysis ▪ Create training, recruitment & retention plan ▪ Specify MCP & care hub OD requirements ▪ Design skills development programme ▪ Design MCP leadership academy	▪ Launch skills development curriculum ▪ Launch academy	▪ Embed 'one team' and 'no borders' cultural change ▪ Increase skills mix through training and recruitment		
Engagement	▪ Create internal comms & engagement plan ▪ Start internal comms & engagement ▪ Create public engagement plan ▪ Start public engagement	▪ Design public consultation ▪ Execute & analyse public consultation (subject to purdah) ▪ Continue workforce comms & engagement	▪ Continue public comms & engagement	▪ Launch event. Ongoing public comms	
Programme & PMO	▪ Agree place-based programme plan for Year 2+3 in detail ▪ Mobilise programme team ▪ Define & mobilise programme transformation governance	▪ Support local delivery to programme plan ▪ Link with overall STP enabler workstreams ▪ Assure delivery of above to plan ▪ Manage risks, issues, programme budget, stakeholder engagement, programme governance			
Milestones	Service Scope defined (01/01) ◆ CSESA Strategy ◆ Programme team in place ◆ CSESA 4 year plan ◆ **Gateway* #1**: Case for Change	#MCPs defined ◆ Public consultation complete ◆ Shadow delegated budgets agreed ◆ **Gateway #2a**: Capabilities & contract set up (shadow)	5 year MCP and acute contracts in place ◆ Delegated budgets agreed ◆ **Gateway #2b**: Capabilities & contract set up (full MCP)	◆ MCPs live **Gateway #3**: Is it safe to commence?	* *Gateways based on proposed Dudley CCG approach*

What it will take to execute

Significant investment, time and thought will be needed to bring about this change

Investment in primary care is absolutely essential to the success of changing the system. Our GPs will provide clinical leadership, and they are at the heart of care hubs – our engines for delivery.

Investment

- **Investment** in all of the items listed here is needed, starting with **primary care**
- A **ring-fenced, pooled budget** used to fund all the above activity and the associated costs of delivery
- Tight, **centralised financial management** of budgets

Contracting

- An **outcomes framework** aligned with the national MCP contract and an agreement on **a risk/gain share** approach
- An framework for establishing **delegated budgets** to support shadow contracting, with a view to identifying early pilot delegated budgets e.g. in PCH vanguard

Leadership Development

- **Clinical leaders championing the change**, and working directly with peers to drive engagement across primary, community, secondary, tertiary, mental health, nursing, hospice, ambulance, pharmacy and other experts
- **Co-production** of service redesign engaging both workforce and patients – a coal-face integrated approach to implementing change, enabled by senior management delegation of local decision making
- Creating the **right forums and environment** to accelerate clinical dialogue at all levels – from care hubs through MCP up to governance forums – to **cut across organisational boundaries** and foster true joint working
- Continuous **clinical and patient/carer input** into service design
- **Leadership academy** to be ready in next academic year

Workforce

- Initial informal agreement to **pool workforce** where practical, via loans or secondments. Requires a **willingness to work across organisational boundaries**. **Workforce planning** needs to be performed across the **whole system**.
- Rapidly developed **training curriculum** to support Collaborative Care and Support Planning and enable us to grow the right type of resources. **Education** to upskill existing resources. This is needed to underpin both clinician and patient activation.
- **Place-wide contracts** for resource types across a variety of roles (e.g. paramedic practitioners, advance nurse practitioners)

Technology

- A fully developed **roadmap of delivery** for an **integrated digital care record**, including interim improvements to enable care hubs to operate at local scale
- **Clinical and patient/carer input** into solution design and testing
- Properly resourced **implementation team**

Estates

- **Pooling of estates** resources across the place into a single asset register, aligned with One Public Estate and combined ETTF bids
- Creation of additional space; repair, repurposing or disposal of existing space
- Use of estates for building **housing for key workers**
- **Consolidation** of estates management functions

Change Management

- A **dedicated function** for enabling the workforce, patients and public to absorb the changes
- An agreed change model for the **whole health and care system**
- A detailed and robust **comms and engagement** plan, backed up by the resources to execute it
- A new **operating and governance model**

Programme delivery

- A **single programme** plan run by a senior programme director, backed up by a team of clinical and commissioner experts, seconded subject matter experts and a lean PMO function
- Leveraging of **local care hub leadership** to deliver services within the programme timescale. Learning from local **vanguard PCH** projects.
- **Sponsorship** at the highest level and recognition that this is the single highest priority

Assumptions driving our financial model

There are a number of different levers that could be pulled in the acute setting to close the forecast financial deficit. The finance subgroup will model the impact of these levers to propose an optimal model that is both deliverable and maximises the potential savings.

Lever	Definition	Reduction assumption (worst case)	Max. saving	% saving	Cost of alternative…	…based on
Frailty	Any non elective admission for a patient over 75, with LOS <7 days	The SASH frailty business case assumes a Frailty Centre to provide a multidisciplinary approach to reducing frailty admissions; this could be implemented across all sites.	£21.2m	40%	£884 per avoided spell	Cost per patient in SASH Pendleton Assessment Unit (PAU) business case
Elective Reduction	Any elective, day case or outpatient activity	Based on the High Weald MSK approach, some electives will move to day case cost, day cases to out patient cost and out patient to community.	£296.4m	15%	£981 per avoided elective £450 per avoided day case £40 per avoided outpatient appt.	£981: average day case cost across the 5 CCGs. £450: average outpatient plus two follow-up appointments across the 5 CCGs £40: combined experience of the 5 CCG Directors of Finance.
Step Down Care	Excess bed days consumed by patients over 75	Excess bed days could be replaced in an alternative setting	£8.1m	50%	£200 per bed day saved	Real costs of a recent project in Brighton & Hove
Non Elective admission	Non elective stays of 0-1 days, excl. maternity	Many of these short stays could be avoided at using ambulatory care at a cost of £320	£17.4m	30%	£320 per avoided spell	Sample tariff from another acute trust
A&E	All Type 1 A&E activity, excl. UCC	These could be delivered in a UTC setting	£14.6m	30%	£90 per avoided attendance	Apportioned cost per patient of the existing block contract for the 24/7 UTC in Crawley
First Outpatient Appts.	All first OP appointments	Encouraging GPs to review whether appointment is necessary, potentially using peer review	£47.4m	5%	£60 per avoided appointment	Combined experience of the 5 CCG Directors of Finance
Long Term Conditions	*As per CCG Docobo risk stratification definition*	Enabling and supporting patients to self manage their long term conditions, thereby avoiding the patient getting critical enough to need hospital treatment	£1.2m	30%	£455 per avoided admission	Horsham and Mid Sussex tailored healthcare approach pilot
Complex Patients	*As per CCG Docobo risk stratification definition*	Care coordination and multi-disciplinary teams based in the community	£17.3m	30%	£719 per avoided admission	Annual running costs of admission avoidance schemes per admission avoided
PBR Excluded Drugs	All spend associated with PBR-X drugs	Medicine Management at pharmacy undertaking more drug reviews on non PBR drugs	£56.1m	20%	£0	Change in process using existing Medicines Management resources and tools

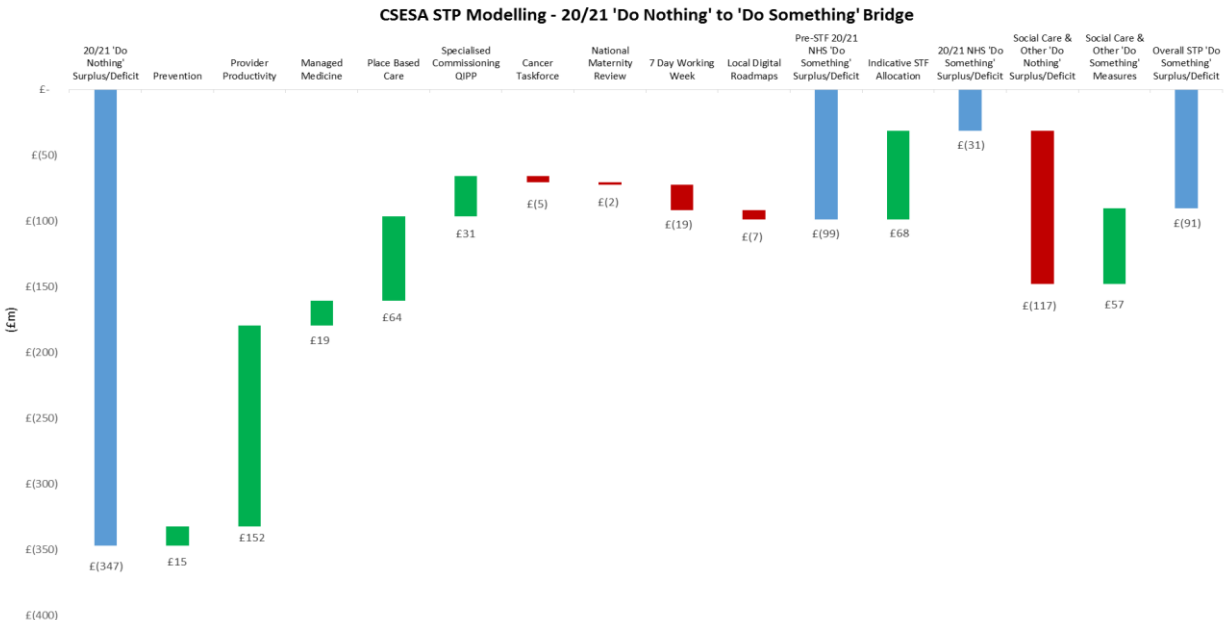
The model then de-duplicates savings by applying business logic to historical per-person data. It also assumes a benefits lag. After these adjustments the expected annual saving is:

Total annual saving expected at the end of year 5	£92m

← Indicative estimate that that there are sufficient savings available

Finance projection

By 2021 we expect to have addressed the financial gap – and improved quality and performance



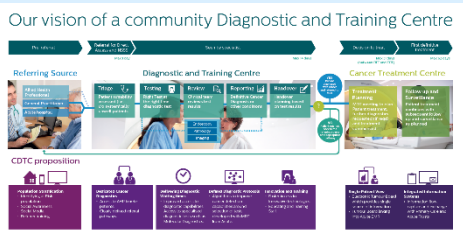
By Year 5 we will have reduced the healthcare deficit to £31m

- The current level of modelling performed indicates that there is sufficient total benefit (within the nine levers identified in our assumptions) to reduce the acute costs by 25% while being re-provided in the community at 70%; or cheaper. This is equivalent to a net saving of 7.5%.
- At this stage, the model does not take into account the one-off or ongoing investments in primary care that will be needed to enable this change to happen.
- We will undertake a more detailed modelling exercise between now and the end of March 2017. This will be done in parallel with a programme planning exercise so that firm dates can be put against benefits and costs.
- This doesn't take into account the quality and performance improvements that we expect the new model of care to bring, or the sustainable system that it will create.

- Further detailed modelling can examine whether increasing capacity out of hospital will lead to a direct corresponding reduction in bed capacity in acute. There are two reasons why this may not be the case:
  1. The immediate impact of reducing demand will be to enable the hospitals to remain safe at all times, even through winter resilience pressures
  2. A secondary impact will be to create the headroom for hospitals to absorb the additional – appropriate – demand that will occur with the demographic changes in the population, without having to open additional wards

We are assuming it will be possible for early wins to bring benefit in Year 2

- Our current model assumes a linear ramp-up of benefits over four years, starting in Year 2. This means that we expect 25% of benefits to have kicked in by March 2018. The model does not at this point specify the projects that will deliver this 25% of benefits in year 2.
- By the end of this financial year we will have drafted tailored logic models for each of the 20 care hubs in the CSESA place. These will help us to identify where to target early wins in each locality and across the place. However, there are projects that we aim to see delivering substantial benefits by the end of Year 2, for instance:
  1. We are currently exploring how to stand up one or more community diagnostic and training centres. These would supply X-ray, CT, MRI, ultrasound, bone scan and barium swallow services and address both the immediate shortfall in equipment and staffing capacity as well as the projected demand. This will significantly improve early diagnosis rates and RTT for cancer and other acute, chronic and long term conditions, which in turn will improve patient outcomes.



  2. Risk stratification will identify interventions needed for the top 2-5% of patients with long term conditions. Locality MDTs, widespread care coordination and efforts to increase patient activation can be put in place quickly to reduce the spend on the most costly percentiles whilst improving the quality of their care.

Governance

An adjusted governance model will be needed to oversee this period of transformation

- To launch the **integrated system** that our vision sets out, correct **governance is essential** to have decisions made by the groups with the appropriate legal authority to do so.
- Decisions need to be **binding**, made at the **right level** and the **right pace**. This will require clear roles and responsibilities, with engagement from the right stakeholders in the right forums at the right time.
- Moving to a single health and social care governance model across 5 CCGs and 4 local authorities will be a **complex task** and will take time to negotiate. This design and deployment work will be undertaken by the Change workstream of the programme and therefore an end-state solution is not set out here.
- In this submission, we define instead a proposed model of **governance** to **oversee the programme** and the **transition** to a new model. This is based on a set of **guiding principles**

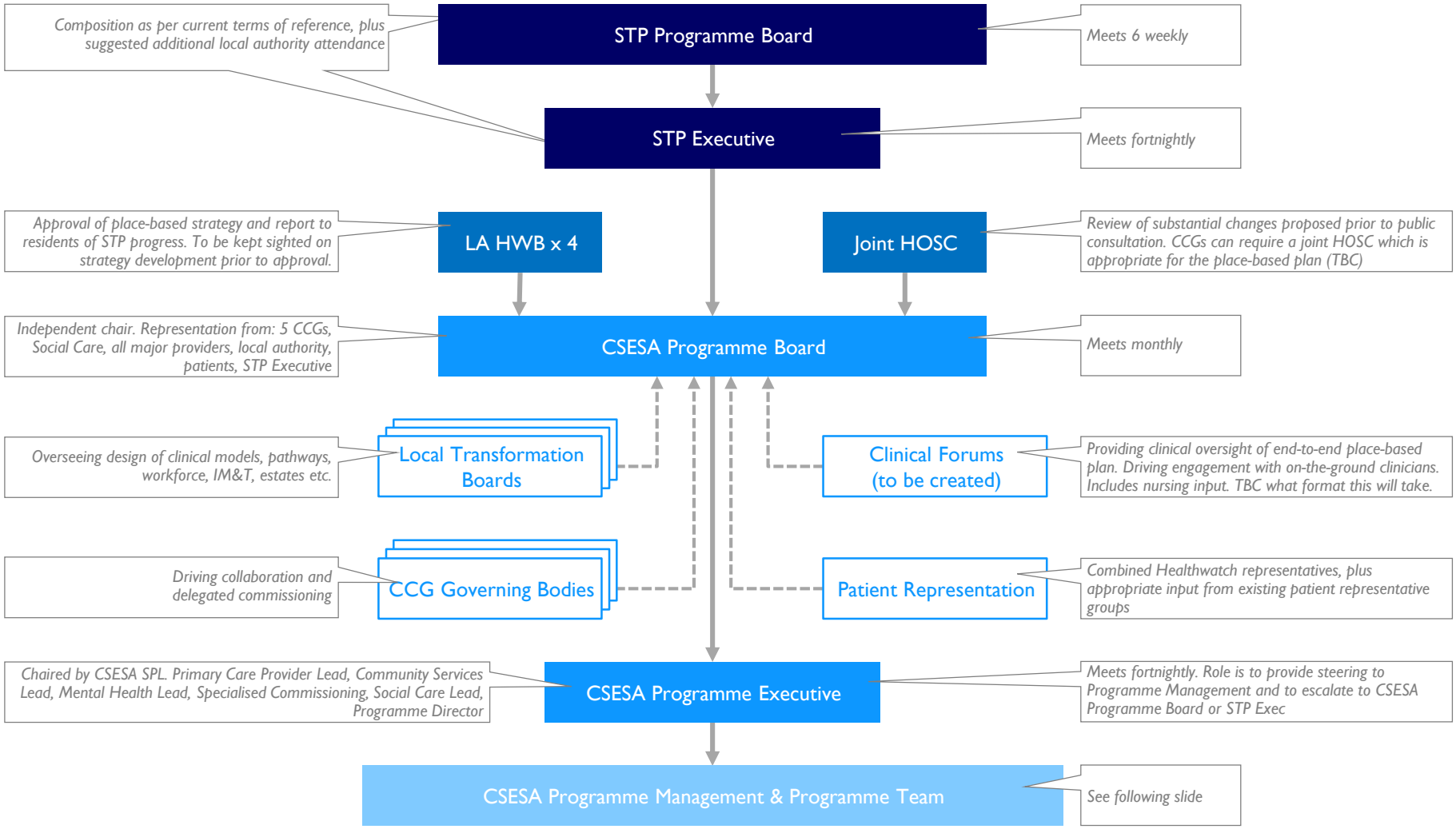
- Note that A common case for change, a common set of principles, a common MCP approach and common governance will not necessarily result in a singular outcome in terms of organisational form or local delivery model

Principles of Governance

- ✓ *Shared leadership*
- ✓ *Parity between board members*
- ✓ *Representation of all major providers*
- ✓ *Shared ownership of the board and accountability to communities*
- ✓ *Openness, transparency, inclusiveness*
- ✓ *Joined up governance to avoid repetition*
- ✓ *Programme board independent chair*
- ✓ *Democratic representation to provide public accountability*
- ✓ *The public will be engaged throughout and consulted appropriately*
- ✓ *Place-based programme aligns strategic direction across 'place'*
- ✓ *Seeks integration, sharing and efficiencies across place-based themes*
- ✓ *Works with the leadership of the other two places to align across borders and avoid repetition or competition*
- ✓ *Delivers consistent messages to STP Programme Board & individual organisations sovereign governance arrangements*
- ✓ *Delivers place-based messages alongside local strategy to the 4 HWB's to enable an aligned strategic view across the whole of the local health and care economy*
- ✓ *Local HOSCs continue to review proposals for substantial change in context of place based plans*
- ✓ *Single financial statements*
- ✓ *Single published view of estates*

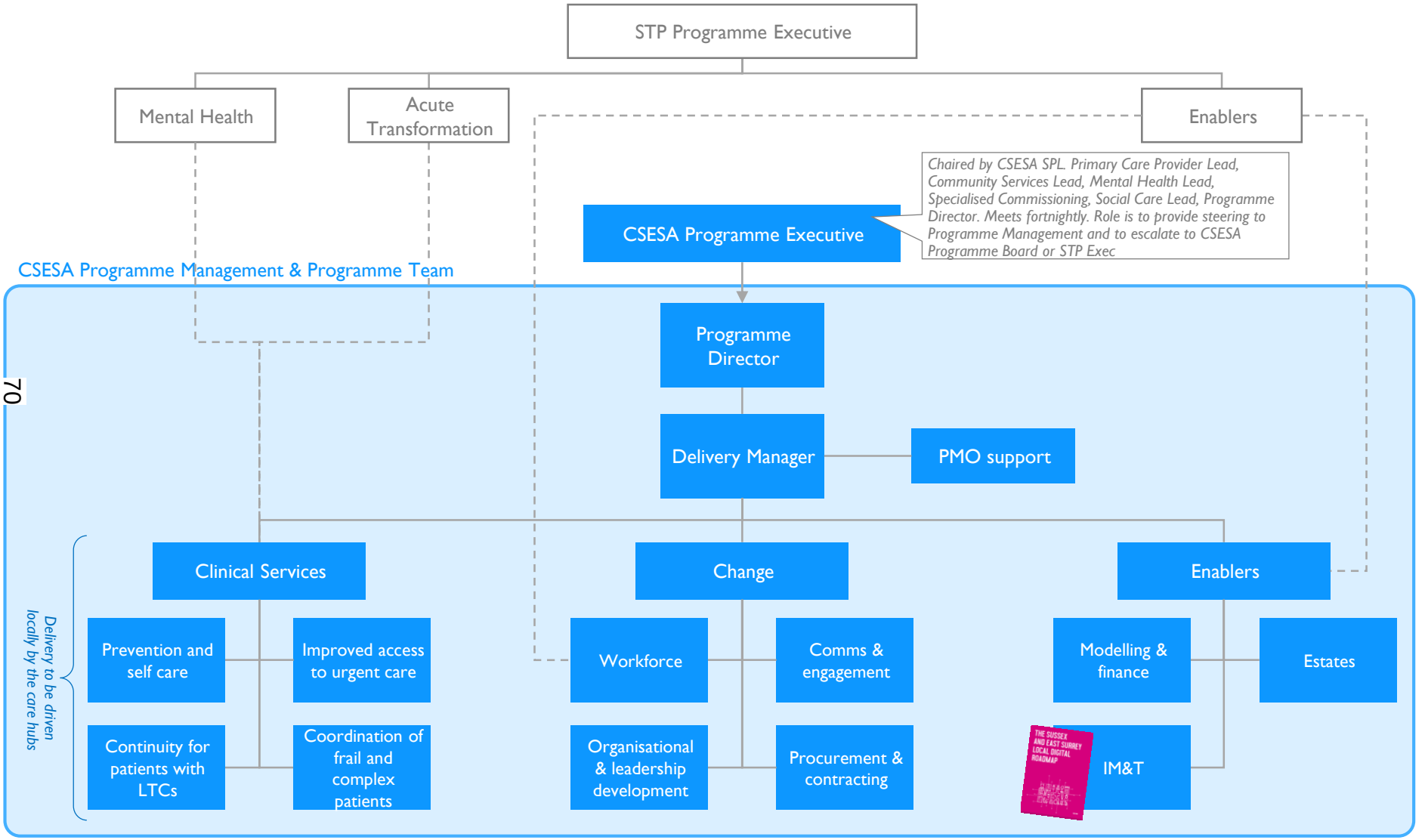
Programme and transition governance model

The **governance** here is that needed to oversee the **journey**, not the end state



Delivery programme structure

A robust, dedicated **programme team** to **deliver** the plan



In conclusion

The Central Sussex and East Surrey Alliance has a strongly held vision in common and we are already moving in the same direction

- We will transform our model of care: from one that is reactive, often crisis-triggered and heavily acute-focused – to one that promotes wellbeing, provides early detection and diagnosis and empowers people to manage their health more effectively within their communities. Primary care will lead the delivery of an effective and sustainable new care model. Practices will work in a more co-ordinated way with each other around natural geographies, embracing a wider skill mix. They will integrate with community health, mental health, social care and voluntary services.
- Each of the five CCGs have already established their respective care hubs. All 20 care hubs are in the process of integrating care around their local populations. We are also beginning to evidence the impact of more proactive, community-based care on utilisation of acute care - albeit in a narrow cohort of patients or geographical patch. Working together across the CSESA footprint, we will drive a level of efficiency, scale and pace for our clinical redesign programmes and organisational development. As we move to our MCP model we will consolidate pathways into and out of our acute providers more effectively. We will also have greater impact by working together on key enablers such as workforce requirements, interoperable digital care records and estates.
- We have set out an ambitious programme to realise fully operational, legal MCP entities by 2020. This will be underpinned by robust benefits realisation of the new care models, delegated population based budgets and reform of the commissioner landscape.
- We will now actively engage more fully with patients, clinicians, our public and key stakeholders, and in particular our local authority colleagues.
- We have a credible vision, a defined care model, clear timelines, demonstrable work in progress and a good understanding of our financial case. This puts us in a strong position to register an expression of interest for the next wave of vanguard funding.

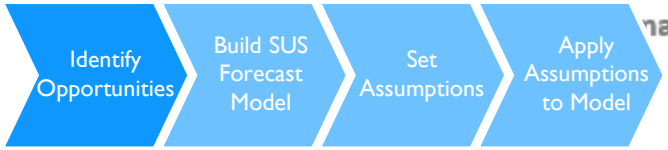
Appendix A

Financial Modelling

Modelling Approach

Identify Opportunities	We have identified a number of activity groups that could potentially be moved out from the Acute setting. Each of the activity groups have been linked to discrete episodes with SUS data to enable us to understand the scope in terms of spells, bed days and tariff.
Build SUS Forecast Model	We have developed a sophisticated model that extrapolates historical SUS data into the future, using granular population growth data and historical trends.
Set Assumptions	Against each opportunity, we have identified the size of the opportunity, the extent to which Acute activity could be reduced and what it would cost to either reduce or re-provision the activity in a community / primary care setting.
Apply Assumptions to Model	The "before" and "after" SUS forecasts are compared to understand the impact of the opportunities in terms of bed days, spells and total spend.

We have identified 9 opportunity areas



Lever	Definition
Frailty	Any non elective admission for a patient over 75, with LOS <7 days
Elective Reduction	Any elective, day case or outpatient activity
Step Down Care	Excess bed days consumed by patients over 75

Lever	Definition
Non Elective admission	Non elective stays of 0-1 days, excl. maternity
A&E	All Type 1 A&E activity, excl. UCC
First Outpatient Appts.	All first OP appointments

Lever	Definition
Long Term Conditions	As per CCG Docobo risk stratification definition
Complex Patients	As per CCG Docobo risk stratification definition
PBR Excluded Drugs	All spend associated with PBR-X drugs

We have built a sophisticated model

Identify Opportunities → Build SUS Forecast Model → Set Assumptions → Apply Assumptions to Model

Our model extrapolates out episode-level SUS data out to 2020

Demographic Growth and Demographic Change

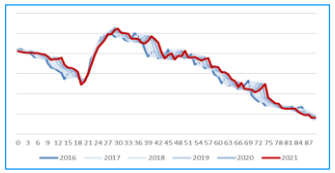
- Using granular ONS population data, we have extrapolated out episode-level FY2015/16 SUS data out to FY2020/21. This equates to 4,000,000 rows of data in the model, and is built on MS SQL-Server.
  - For example, if a CCG has an aging population, then the demand for services that the elderly will consume will grow at a faster rate than other services.
  - Similarly, as the elderly tend to have longer lengths of stay, the bed day demand will also increase.

Non Demographic Growth

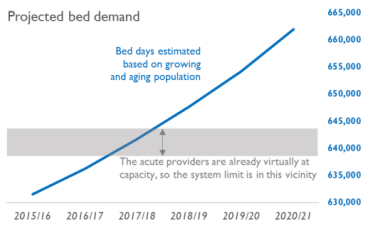
- Patient's expectations are increasing, as are advances in medical treatment. This has lead to longer term trends in activity that are, in many cases, over and above the demographic change.
- We have applied 3-year growth trends at POD / CCG level to the data.

Activity x Population Growth by Year and age band x 3yr historical Trend = Future Demand

Age	Gender	Specialty	HRG	Cost
0	M	560	PA57Z	£1,088
37	F	560	PB03Z	£981
68	M	560	PB03Z	£1,088
52	M	501	NZ08C	£1,088



CCG	POD	3 Yr. Trend
09D	A&E	2.05%
09D	DC	0.67%
09D	EL	2.90%
09D	NEL	-1.21%
09D	NELNE	-1.21%
09D	NELSD	-1.21%
09D	NELST	-1.21%
09D	OP	3.60%



We set the levels for our assumptions

The Directors of Finance for the 5 CCGs agreed the levels of saving and the cost of the alternative

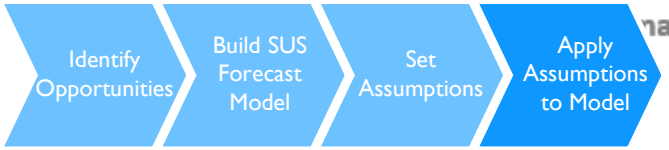
Lever	Definition	Reduction assumption (worst case)	Max. saving	% saving	Cost of alternative…	…based on
Frailty	Any non elective admission for a patient over 75, with LOS <7 days	The SASH frailty business case assumes a Frailty Centre to provide a multidisciplinary approach to reducing frailty admissions; this could be implemented across all sites.	£21.2m	40%	£884 per avoided spell	Cost per patient in SASH Pendleton Assessment Unit (PAU) business case
Elective Reduction	Any elective, day case or outpatient activity	Based on the High Weald MSK approach, some electives will move to day case cost, day cases to out patient cost and out patient to community.	£296.4m	15%	£981 per avoided elective £450 per avoided day case £40 per avoided outpatient appt.	£981: average day case cost across the 5 CCGs. £450: average outpatient plus two follow-up appointments across the 5 CCGs £40: combined experience of the 5 CCG Directors of Finance.
Step Down Care	Excess bed days consumed by patients over 75	Excess bed days could be replaced in an alternative setting	£8.1m	50%	£200 per bed day saved	Real costs of a recent project in Brighton & Hove
Non Elective admission	Non elective stays of 0-1 days, excl. maternity	Many of these short stays could be avoided at using ambulatory care at a cost of £320	£17.4m	30%	£320 per avoided spell	Sample tariff from another acute trust
A&E	All Type 1 A&E activity, excl. UCC	These could be delivered in a UTC setting	£14.6m	30%	£90 per avoided attendance	Apportioned cost per patient of the existing block contract for the 24/7 UTC in Crawley
First Outpatient Appts.	All first OP appointments	Encouraging GPs to review whether appointment is necessary, potentially using peer review	£47.4m	5%	£60 per avoided appointment	Combined experience of the 5 CCG Directors of Finance
Long Term Conditions	*As per CCG Docobo risk stratification definition*	Enabling and supporting patients to self manage their long term conditions, thereby avoiding the patient getting critical enough to need hospital treatment	£1.2m	30%	£455 per avoided admission	Horsham and Mid Sussex tailored healthcare approach pilot
Complex Patients	*As per CCG Docobo risk stratification definition*	Care coordination and multi-disciplinary teams based in the community	£17.3m	30%	£719 per avoided admission	Annual running costs of admission avoidance schemes per admission avoided
PBR Excluded Drugs	All spend associated with PBR-X drugs	Medicine Management at pharmacy undertaking more drug reviews on non PBR drugs	£56.1m	20%	£0	Change in process using existing Medicines Management resources and tools

The model then de-duplicates savings by applying business logic to historical per-person data. It also assumes a benefits lag. After these adjustments the expected annual saving is:

Total annual saving expected at the end of year 5	£92m

← Indicative estimate that that there are sufficient savings available

The model enables users to test the impact of different assumptions



- The front end of the model is built in Excel (see following slide) and takes a summary feed from the SUS Forecast model.
- The summary feed totals activity and cost by a variety of dimensions including CCG, POD, Site, Year, and, importantly, allocates flags against the each row according to which opportunities the data applies to.
- Within the Excel model, we can assign multiple opportunities to each episode.
  - For example, a 75 year old non elective admission could be subject to multiple opportunities, but in reality that episode can only be saved once.
  - The model ensures that double counting is minimised by applying business logic to each episode; this ensures that for opportunities are that mutually exclusive, only the opportunity that has the greatest impact is applied.
- The CCGs and Providers can then apply different assumptions to the model, and instantly see the impact. These assumptions are:
  - Year-by-year scale to which Acute activity can be reduced by each opportunity
  - Unit cost of re-provisioning or avoiding Acute activity
- As the model is built up from granular data, it is possible to view the impact of the opportunities by multiple dimensions:
  - CCG, Site / Trust, POD etc…

A quick overview of the Excel model

1 Do Nothing view, aligned with 2020Delivery financial model

2 Opportunities, and extent to which activity could be reduced

Do Nothing

	In Patient, Out Patient and A&E	*Baseline*	*Do Nothing*	-->	-->	-->
	CCG	**2016**	**2017**	**2018**	**2019**	**2020**
	NHS BRIGHTON & HOVE CCG	£ 120.8m	£ 122.3m	£ 123.6m	£ 124.9m	£ 127.5m
	NHS CRAWLEY CCG	£ 66.4m	£ 67.4m	£ 68.4m	£ 69.4m	£ 71.2m
	NHS EAST SURREY CCG	£ 96.0m	£ 96.1m	£ 96.1m	£ 96.2m	£ 97.3m
	NHS HORSHAM AND MID SUSSEX CC	£ 112.3m	£ 115.7m	£ 118.8m	£ 122.1m	£ 126.6m
	NHS HIGH WEALD LEWES HAVENS CC	£ 81.4m	£ 82.8m	£ 84.1m	£ 85.3m	£ 87.4m
	NON PBR DRUGS (CCG)	£ 19.2m	£ 20.1m	£ 21.0m	£ 22.0m	£ 23.2m
	OTHER ACUTE ACTIVITY	£ 53.4m	£ 59.8m	£ 67.2m	£ 74.2m	£ 81.2m
	ACUTE - NON NHS	£ 66.0m	£ 67.8m	£ 69.6m	£ 71.4m	£ 73.8m
SUS	SPECIALIST	£ 59.1m	£ 62.6m	£ 66.0m	£ 69.6m	£ 73.6m
Non SUS	SPECIALIST (Non SUS)	£ 165.3m	£ 178.1m	£ 192.4m	£ 207.7m	£ 225.8m
	NON PBR DRUGS (SpecComm)	£ 37.0m	£ 40.2m	£ 42.1m	£ 44.1m	£ 46.2m
	TOTAL	**£ 876.8m**	**£ 913.0m**	**£ 949.2m**	**£ 987.0m**	**£ 1,033.8m**

	Levers	**Spend (2016)**			**2017**	**2018**	**2019**	**2020**
2	Frailty	£ 19.3m	40%	*Patient is over 75, LOS < 7, NEL*	10%	20%	30%	40%
3	Elective Reduction	£ 296.3m	10%	*PCD is EL, DC or Out Patient*	3%	5%	8%	10%
4	Step Down Care	£ 8.1m	50%	*Age > = 75, Excess Bed Days*	13%	25%	38%	50%
5	Non Elective Admission	£ 19.7m	30%	*NEL, LOS <= 1*	8%	15%	23%	30%
6	A&E	£ 26.2m	30%	*HRG in VB07Z, VB08Z, VB09Z, VB11Z; no*	8%	15%	23%	30%
7	First Outpatient Appointments	£ 47.4m	5%	*First OP*	1%	3%	4%	5%
8	Long Term Conditions	£ 2.9m	50%	*HRG in Diabetes, Pulmonary, Arthritis or A*	13%	25%	38%	50%
9	Complex Patients	£ 35.6m	30%	*Previous CCG analysis (see tab)*	8%	15%	23%	30%
10	PBR Excluded Drugs (CCG)	£ 19.2m	20%		5%	10%	15%	20%
11	PBR Excluded Drugs (SpecComm)	£ 37.0m	20%		5%	10%	15%	20%

3 Ramp-up profile of opportunities

Do Something - based on Levers

	In Patient, Out Patient and A&E	*Baseline*	*Do Something*	-->	-->	-->
	CCG	**2016**	**2017**	**2018**	**2019**	**2020**
	NHS BRIGHTON & HOVE CCG	£ 120.8m	£ 119.0m	£ 116.9m	£ 114.7m	£ 113.5m
	NHS CRAWLEY CCG	£ 66.4m	£ 65.5m	£ 64.4m	£ 63.2m	£ 62.7m
	NHS EAST SURREY CCG	£ 96.0m	£ 93.4m	£ 90.6m	£ 87.8m	£ 85.9m
	NHS HORSHAM AND MID SUSSEX CC	£ 112.3m	£ 112.5m	£ 112.2m	£ 111.9m	£ 112.6m
	NHS HIGH WEALD LEWES HAVENS CC	£ 81.4m	£ 80.5m	£ 79.3m	£ 78.1m	£ 77.6m
	NON PBR DRUGS (CCG)	£ 19.2m	£ 19.1m	£ 18.9m	£ 18.7m	£ 18.6m
	OTHER ACUTE ACTIVITY	£ 53.4m	£ 59.8m	£ 67.2m	£ 74.2m	£ 81.2m
	ACUTE - NON NHS	£ 66.0m	£ 67.8m	£ 69.6m	£ 71.4m	£ 73.8m
SUS	SPECIALIST	£ 59.1m	£ 61.3m	£ 63.4m	£ 65.5m	£ 67.9m
Non SUS	SPECIALIST (Non SUS)	£ 165.3m	£ 178.1m	£ 192.4m	£ 207.7m	£ 225.8m
	NON PBR DRUGS (SpecComm)	£ 37.0m	£ 38.2m	£ 37.9m	£ 37.5m	£ 36.9m
	[Complex Patients]	£ - m	-£ 2.7m	-£ 5.6m	-£ 8.7m	-£ 11.9m
	TOTAL	**£ 876.8m**	**£ 892.5m**	**£ 907.2m**	**£ 922.2m**	**£ 944.6m**
	Acute Savings	**£ - m**	**-£ 20.5m**	**-£ 42.1m**	**-£ 64.8m**	**-£ 89.2m**

4 View of Acute spend once opportunities have been implemented

Assuming no savings
Assuming no savings
Assuming no savings
Complex patients are calculated separately, in lieu of Docabo data to merge with SUS

5 Cost of reducing / re-provisioning each opportunity

Prevention / Reprovisioning Costs

	Lever	**2016**	**2017**	**2018**	**2019**	**2020**
	Frailty	£ - m	£ 0.7m	£ 1.4m	£ 2.2m	£ 2.9m
EL	Elective Reduction	£ - m	£ 0.6m	£ 1.2m	£ 1.9m	£ 2.6m
DC	Elective Reduction	£ - m	£ 1.1m	£ 2.2m	£ 3.4m	£ 4.5m
OP	Elective Reduction	£ - m	£ 1.1m	£ 2.3m	£ 3.5m	£ 4.9m
	Step Down Care	£ - m	£ 0.7m	£ 1.3m	£ 2.0m	£ 2.7m
	Non Elective Admission	£ - m	£ 0.5m	£ 0.9m	£ 1.4m	£ 1.9m
	A&E	£ - m	£ 2.0m	£ 4.0m	£ 6.2m	£ 8.4m
	First Outpatient Appointments	£ - m	£ - m	£ - m	£ - m	£ - m
	Long Term Conditions	£ - m	£ 0.0m	£ 0.1m	£ 0.1m	£ 0.2m
	Complex Patients	£ - m	£ 0.7m	£ 1.5m	£ 2.3m	£ 3.2m
	PBR Excluded Drugs (CCG)	£ - m	£ - m	£ - m	£ - m	£ - m
	PBR Excluded Drugs (SpecComm)	£ - m	£ - m	£ - m	£ - m	£ - m
	TOTAL	**£ - m**	**£ 7.4m**	**£ 15.0m**	**£ 23.0m**	**£ 31.2m**
	Net Savings	**£ - m**	**-£ 13.2m**	**-£ 27.1m**	**-£ 41.9m**	**-£ 58.0m**
			Net Total (across all years)			**-£ 140.2m**

	Levers		**Unit Cost**	**Units**	
	Frailty		£ 884	*per admission reduced*	*Based on SASH bus case*
	Elective Reduction	EL	£ 981	*per elective reduced*	*Avg cost of Day Case*
	"	DC	£ 450	*per day case reduced*	*Avg cost of OP1 + 2xOP2*
	"	OP	£ 40	*per out patient appointment saved*	*Estimate*
	Step Down Care		£ 150	*per excess bed day saved*	*Estimate*
	Non Elective Admission		£ 320	*per admission reduced*	*Based on OP1 cost*
	A&E		£ 90	*per attendance saved*	*Based on Crawley average*
	First Outpatient Appointments		£ 40	*per attendance saved*	*Estimate*
	Long Term Conditions		£ 204	*per admission reduced*	*Self care*
	Complex Patients		£ 884	*per admission reduced*	*Specialist unit*
	PBR Excluded Drugs (CCG)		£ -	*per £ saved*	*Estimate*
	PBR Excluded Drugs (SpecComm)		£ -	*per £ saved*	*Estimate*

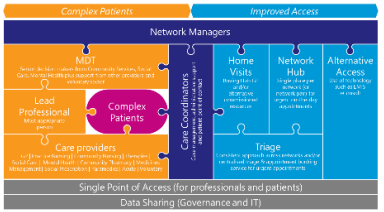
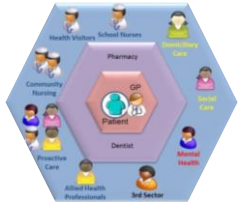
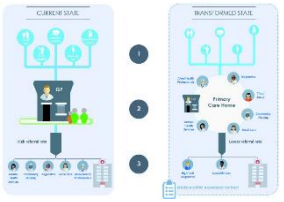
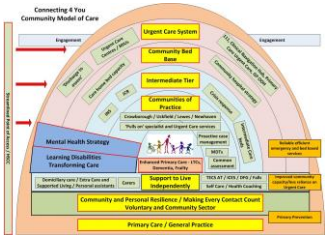
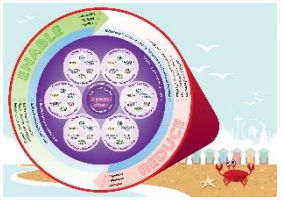
6 Net impact to financial position

Appendix B

Existing primary care development projects

How each CCG is currently developing primary care

All 5 CCGs are already taking steps to integrate primary care at scale

CCG	# Care Hubs / practices	Development Project Name	Current status summary	Model
East Surrey	4 Networks / 18 general practices	Primary Care Networks	There is a GP Federation – Alliance for Better Care Ltd – representing all practices which has worked with the CCG and other partners to co-develop new models of care that can be used to both drive the establishment of the networks and improve access to urgent care and the coordination of the most complex patients, including integrated models with social care, mental health and community services. The CCG has awarded a preferred provider contract to the federation for enhanced primary services, and is now determining how best to invest in the new model.	
Crawley	2 Communities of Practice / 12 general practices	Communities of Practice	In 2016/17 the CCGs are jointly developing enhanced primary healthcare teams, bringing together community nursing teams and multi-disciplinary proactive care teams into one integrated team based around communities of practice in the communities. Care will be designed around complex patients supported by the enhanced multidisciplinary teams and focused on early intervention, living well at home and avoiding unnecessary use of the hospital with specialist care in the community. They will test and widen new skills and roles for enhanced primary care teams, including for example increased use of pharmacists, community paramedics and advanced nurse practitioners. They will work more closely with the third sector. There will be a much stronger focus on empowering and supporting patients and their carers, to give them the knowledge, skills and confidence to manage their own condition. In East Grinstead, HMS CCG are running a vanguard pilot of the Primary Care Home model.	
Horsham and Mid Sussex	4 Communities of Practice / 23 general practices	Communities of Practice & Primary Care Home (PCH)		
High Weald Lewes Havens	4 Communities of Practice / 20 general practices	Connecting 4 you	Established four localities to develop 'Communities of Practice' to deliver integrated primary, community and urgent care services. Developing networks in the four localities to identify and deliver bespoke and agreed local priorities to improve primary care sustainability, access and outcomes. Launching the redesigned MSK, diabetes and dementia pathways, and OOH / urgent care plans. Improving care for the frail elderly and vulnerable population. A review of the services provided in primary care for people with learning disabilities. Further developing pathways for standardised approach to LTCs. Provision of responsive and children's services. High Weald is part of a pioneer site for maternity choice	
Brighton & Hove	6 Clusters / 44 General practices	Brighton & Hove Caring Together	B&H CCG have moved 5,000 patient pathways per year from hospital to community and primary care settings and contained growth in demand for hospital services - over the past five years A&E attendance has remained stable and emergency hospital admissions have decreased. To do this, they grew our crisis response services and run award-winning public communications campaigns. They use risk stratification, deliver proactive care through the clusters, deploy care coaches and health trainers and launched 'My Life' website.	

Appendix C

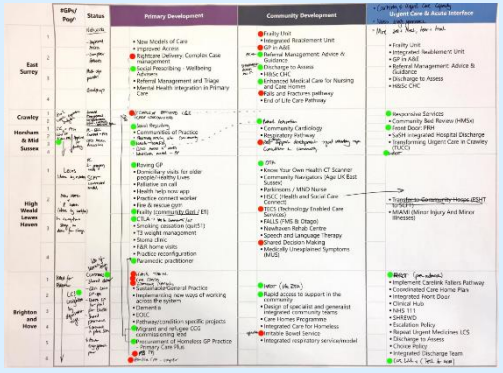
Parties involved in developing this plan

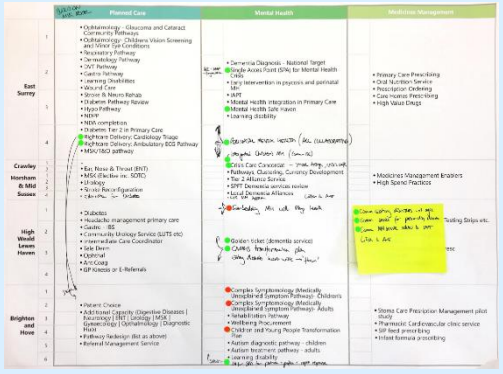
Workshops

Most content was generated through three workshops. Remaining content was established through a mixture of one-to-one conversation, and frequent review of iterated document drafts by all parties.

CCG integration leads

- Directors worked together to identify which projects and plans from each CCG could be easily shared and re-used across the place – and which areas of development needed collaborative thinking



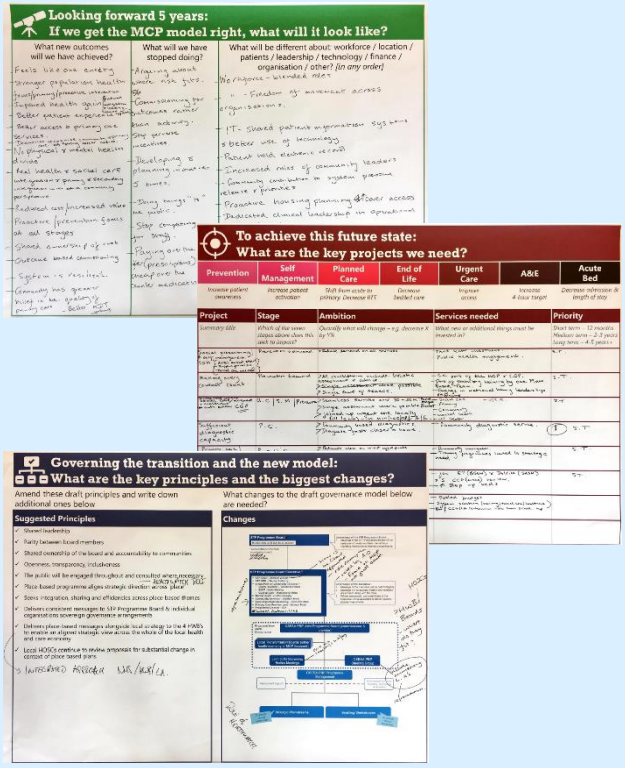


Providers

- Leaders of the following organisations worked on the place's vision, priority projects and governance
- **CCGs**: All 5
- **General practice**: ABC (East Surrey GP federation)
- **Acute**: Surrey and Sussex Healthcare, Queen Victoria Hospital, Brighton and Sussex University Hospitals
- **Community health**: First Community Health Care, Sussex Community Foundation Trust
- **Mental health**: Surrey and Borders Partnership, Sussex Partnership
- **Paramedic services**: SECAmb
- **Local authority**: West Sussex County Council, East Sussex County Council, Brighton and Hove County Council
- **Health education**: Kent, Surrey & Sussex Leadership Collaborative
- **Patients**: Healthwatch Surrey, Brighton & Hove

GPs

- A group of GPs and practice managers drawing from CCG clinical chairs, CCG clinical leads, GP federations and interested GPs discussed an early draft of the place based plan; and what it will take to drive engagement from primary care in this change



HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 42 Brighton & Hove City Council

Subject:		**Brighton & Sussex University Hospitals Trust (BSUH): New Working Arrangements with Western Sussex Hospitals NHS Foundation Trust**
Date of Meeting:		**07 December 2016**
Report of:		**Executive Lead, Strategy, Governance & Law**
Contact Officer:	**Name:**	**Giles Rossington** **Tel: 29-5514**
	Email:	**Giles.rossington@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 This report provides details of the new working arrangement between Brighton & Sussex University Hospitals Trust (BSUH) and Western Sussex Hospitals NHS Foundation Trust that was announced on November 10th.

1.2 It is recommended that the HOSC seeks assurances that these new arrangements do nothing to jeopardise the local focus of BSUH, its role as a tertiary provider of specialist services and the delivery of the 3Ts programme, and that these arrangements are reflected in the governance arrangements established, including the composition of the BSUH Board after 1st April 2017.

2. RECOMMENDATIONS:

2.1 That members note the information in this report; and

1.3 Agree that the HOSC Chair should write to BSUH, Western Sussex Hospitals and NHS Improvement (NHSi) to seek assurances that the new working arrangements will ensure that BSUH continues to be focused on the needs of Brighton & Hove residents, both as a provider of district general hospital and specialist services, and to the delivery of the 3Ts programme and that these arrangements are reflected in the governance arrangements established, including the composition of the BSUH Board after 1st April 2017.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 BSUH provides general hospital services for Brighton & Hove and Mid Sussex residents, and more specialist services on a regional footprint. BSUH manages the Royal Sussex County Hospital, Brighton (RSCH) and the Princess Royal Hospital, Hayward's Heath (PRH).

3.2 In August 2016 BSUH was placed in Special Measures by NHSi following a critical Care Quality Commission (CQC) inspection report which rated the trust as inadequate. More recently, BSUH was also placed in Financial Special Measures. The trust currently has an interim Chair and an interim Chief Executive.

3.3 Western Sussex Hospitals manages St Richard's Hospital, Chichester, and Worthing Hospital. The trust is rated as outstanding by the CQC and is forecasted to declare a surplus this year.

3.4 Under proposals published on November 10th, the Chair and Chief Executive of Western Hospitals will also assume these responsibilities at BSUH from 01 April 2017.

3.5 The current BSUH Board remains in control of the trust until April 2017. An Improvement Oversight Group, bringing together the leaders of both trusts with NHSi, will oversee the development of the long term relationship between the trusts. It is stressed that there is no plan to merge the two organisations, but that the intention is to move to a long-term partnership.

3.6 The news that a high performing local NHS organisation is to provide support to BSUH is obviously welcome. However, further details of the new working arrangements had not been made public at the time of writing this report. We do not yet know, for instance, what if any role the Western Hospitals Executive team will have at BSUH, or whether BSUH Non-Executive Directors will be asked to stay on with the remit to ensure that future executive decisions are in the interests of BSUH and of local residents.

3.7 It is clearly important for the city that our local hospital trust remains focused on the needs of the residents of Brighton & Hove. There is an obvious risk of this being lessened by the new working arrangements, although this risk could be effectively mitigated by appropriate governance measures. It is therefore recommended that HOSC members seek assurances that BSUH will maintain its current focus on the needs of local residents, and that this will be embodied in future governance arrangements – for example, by giving BSUH Non-Executive Directors a defined role to ensure that organisational decisions reflect the best interests of local people.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 Members could choose not to seek the assurances suggested above, or to seek additional assurances as they see fit.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 None to this report

6. CONCLUSION

6.1 The announcement of a new working relationship between BSUH and Western Hospitals is clearly good news in that it provides additional expert support for an organisation with well-documented governance and financial problems.

6.2 However, ceding control of any local organisation to a non-local organisation raises the risk that decisions will in future not reflect the best interests of local people, and it is therefore recommended that the committee seeks assurance that the local focus of BSUH will be maintained.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 None to this report for information

Legal Implications:

7.2 There are no legal implications arising from this report.

Lawyer Consulted: Elizabeth Culbert *Date: 22/11/16*

Equalities Implications:

7.3 None to this report for information

Sustainability Implications:

7.4 None to this report for information

Any Other Significant Implications:

7.5 None to this report for information

SUPPORTING DOCUMENTATION

None

HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 43 Brighton & Hove City Council

Subject:		**3Ts Update**
Date of Meeting:		**07 December 2016**
Report of:		**Executive Lead, Strategy, Governance & Law**
Contact Officer:	**Name:**	**Giles Rossington** **Tel: 29-5514**
	Email:	**Giles.rossington@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 '3Ts' is the programme to redevelop the Royal Sussex County Hospital, Brighton (RSCH); modernising the hospital and making it a regional centre for Teaching, Tertiary (specialist) services, and Trauma care.

1.2 3Ts is a major initiative, funded by around £400M NHS capital investment, and the works will take a number of years to complete. The project is complex, not just because of its sheer scale, but also because the RSCH must continue to operate as normal throughout the build.

1.3 The HOSC has been tracking the evolution of the 3Ts project for a number of years, and this is the latest in a series of updates.

2. RECOMMENDATIONS:

2.1 That members note the update on the 3Ts development of the Royal Sussex County Hospital.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 Brighton & Sussex University Hospitals Trust (BSUH) provides general hospital services for people living in and around Brighton & Hove and Mid Sussex. BSUH operates two large hospital sites: the RSCH in Brighton and the Princess Royal Hospital (PRH) in Hayward's Heath.

3.2 As well as providing general hospital services, the RSCH site has been used for a number of years for more specialist services, accessed both by local people and on a regional basis. The local health economy has long been committed to further develop the capacity of the RSCH as both a specialist hospital (including becoming the regional trauma care centre) and as a teaching hospital, and a bid for NHS capital funding to re-develop the RSCH site was submitted several years ago.

3.3 The bid for capital funding was eventually approved, and the 3Ts development is now underway.

3.4 When completed, 3Ts will provide vitally needed improvements to RSCH estates, particularly in terms of some of the 19th century buildings still being used to deliver front-line hospital services. HOSC members have previously supported the aims of 3Ts, as has the Health & Wellbeing Board and the city council.

3.5 However, HOSC members have previously expressed concerns about some aspects of the 3Ts project. These concerns include:

- The risks associated with continuing to run a very busy general hospital on the RSCH site whilst redevelopment works take place, particularly given longstanding capacity issues at the site: e.g. in relation to parking and to the A&E department.

- What happens to standard hospital services for local people as the RSCH increasingly becomes a specialist care centre: e.g. will people still be able to access routine hospital services at the RSCH? Will there be alternative local community provision of some services? Will more people have to travel to other Sussex hospitals (e.g. PRH or Worthing) for some services?

Members may therefore wish to explore these specific areas of concern with BSUH representatives.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 Not relevant to this update report.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 None directly to this report. The 3Ts programme has been through a full public engagement process and the HOSC has previously had sight of engagement plans.

6. CONCLUSION

6.1 Members are asked to note this update, with particular reference to: a) how project risks are being managed; and b) any adverse impact on local people's access to healthcare consequent to the 3Ts development.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 None to this report for information

Legal Implications:

7.2 None to this report for information

Equalities Implications:

7.3 3Ts will improve the hospital environment and will support BSUH in delivering better quality care. This will have a positive impact on some protected groups (particularly older people) who are disproportionately heavy users of hospital services.

Sustainability Implications:

7.4 Currently, the RSCH is the local general hospital for city residents. It is currently unclear whether the development of RSCH as a specialist centre will have a negative impact on access to standard hospital services for local people. This will depend on which if any services are provided in alternative locations, and the access arrangements for such locations.

Any Other Significant Implications:

7.5 None identified

SUPPORTING DOCUMENTATION

None

HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 44 Brighton & Hove City Council

Subject:	**Substance Misuse Inpatient Detoxification Beds**	
Date of Meeting:	**7th December 2016**	
Report of:	**Director of Public Health**	
Contact Officer:	**Name:** **Kathy Caley, Lead Commissioner for Substance Misuse**	**Tel: 29-6557**
	Email: **Kathy.caley@brighton-hove.gov.uk**	
Ward(s) affected:	**All**	

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 In December 2015 Sussex Partnership Foundation Trust gave notification that they would be terminating the substance misuse inpatient detoxification service from 31st March 2016. Commissioners were required to urgently establish alternative provision. A new service began on the 1st April 2016 and the substance misuse inpatient detoxification service is now provided by Cranstoun at their unit based in Islington. This report provides an update on the new service and sets out plans for future commissioning arrangements.

2. RECOMMENDATIONS:

2.1 That the Committee notes the update information provided regarding the Substance Misuse Inpatient Detoxification service.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 Adult community based substance misuse (drug and alcohol) services are provided by Pavilions, a partnership of organisations led by Cranstoun, which began providing services locally on the 1st April 2015. A range of treatment interventions are offered to support services users to work towards recovery in a community setting. Each person entering treatment services is allocated a 'care co-ordinator' to work specifically with them around their needs.

3.2 Until 31st March 2016, Sussex Partnership Foundation Trust (SPFT) provided inpatient detoxification services to individuals in Brighton and Hove who required this service. SPFT provided this service from Promenade Ward, which is part of Mill View Hospital in Hove. Contractual responsibility for this service sat with the Clinical Commissioning Group (CCG), and was part of the wider mental health block contract that the CCG has with SPFT.

3.3 In December 2015 SPFT provided formal notification that they would be terminating the contract for the provision of substance misuse inpatient

detoxification beds from the 31st March 2016. Therefore it was necessary to secure alternative provision from the 1st April 2016 onwards. The official notice period given by SPFT was three months, which was a relatively limited timeframe given the steps required to secure alternative provision. BHCC therefore opted to work with Cranstoun, the lead provider in the Pavilions Community Substance Misuse Services partnership, and use their inpatient detoxification unit in London. From the 1st April 2016, any Brighton and Hove resident with a clinical indication for an inpatient detoxification has been referred to 'City Roads' residential detoxification service based in Islington, north London. City Roads is a 21 bed unit that is staffed 24/7 by a clinical and social care team. Cranstoun have been providing this service from the City Roads location for a significant period of time, and patients come from many areas of the country.

3.4 A considerable amount of preparation work took place before the new service launched. This included service user consultation on the key areas of concern, patient pathway planning and visits to the new service base. Service users from Brighton and Hove now have to travel outside of the city to access inpatient detoxification services. However, as stated in the March 2016 report to the Overview & Scrutiny Committee, this is generally in keeping with what happens in other areas of the country, as local availability of this type of service is limited. The average length of stay is ten days. Contact with the outside world is usually restricted when a person is undergoing detoxification, and therefore being situated in an area that is not their home city may make detoxification more successful. After detoxification the individual returns to Brighton and Hove, and is supported to continue their recovery by linking to the existing local recovery community.

3.5 Pavilions oversee each referral to City Roads. Referrals are reviewed at a multidisciplinary team meeting where a pre-admission checklist is completed. This includes service preparation work to ensure that an individual understands what will be required of them once they are in residence at the unit. This preparation work helps to ensure that clinically appropriate individuals are referred to the service, and that individuals are referred at a point in their recovery journey where they are most likely to be successful. The aftercare support plan for once a person has successfully completed detoxification is also developed before the individual goes to City Road. This helps to ensure that the ongoing support a person will need to continue their recovery is in place.

3.6 The service began on the 1st April 2016. As at the 21st October 2016, 46 service users have undergone detoxification at City Roads. The majority of service users are attending City Roads for an alcohol detoxification (85%). To date, 80% of service users have had a 'successful completion'. A successful completion is taken to mean a person residing at the unit for the required length of time to fully detoxify from the substance/s they are using. To be classified as a 'successful completion' a person must be substance free when they leave. The successful completion rate of the City Roads service is comparable with the previous service provided by SPFT.

3.7 An area of initial concern was the fact that residents would now have to travel outside of Brighton and Hove to access this service. Extensive work was undertaken on this area, to ensure that the impact of the geographical change

was minimal. A service user's individual needs have been considered on a case by case basis. For some this has meant travelling to London with their care co-ordinator, for others it has meant undertaking the journey with a family member. Individuals usually travel on the train, and are met by a member of the City Roads staff at the station.

3.8 Service user feedback has been extremely positive in the main, with only one matter of negative feedback to date. This related to the need for greater information and awareness of the search policy that would be in place at City Roads. This has now been factored into the preparation stage, and individuals are now aware that they will be subject to search upon arrival, as is the process in detoxification units generally. The positive feedback from service users has focused on the excellent support arrangements in place for safe transport to and from City Roads and the excellent service they have received once at City Roads. There have also been reports of excellent communication between City Roads and other substance misuse services, such as Residential Rehabilitation, in Brighton and Hove. As with all services, service user feedback will continue to be collected and used to improve operational delivery.

3.9 Feedback from the annual substance misuse service user consultation has indicated that a small number of the wider community of individuals in treatment services still value a local inpatient detoxification unit. Whilst this is understandable, the current financial climate, alongside the high set up costs for such a service, makes this unmanageable. The cost of local private sector detoxification units are considerably higher.

3.10 There has been one case where a referral to City Roads has not been possible because of the individual's limited mobility, and the fact that the City Roads service is spread over a number of floors in converted terrace houses. In this case Pavilions and commissioners have worked together to source the most appropriate, value for money service elsewhere.

3.11 After detoxification at City Roads, the service user is supported to engage with substance misuse services in Brighton and Hove to continue their recovery journey. This could involve becoming a resident at a local residential rehabilitation unit, engaging with support groups within Pavilions aimed at relapse prevention or linking in to community based services such as Cascade Creative Recovery.

3.12 Initially, the City Roads service was for a period of one year, to allow commissioners to explore whether the new arrangements for inpatient detoxification would be a well-functioning aspect of the patient pathway. Commissioners set a key performance indicator of 75 to 80% for successful completion achievement. As previously stated, to date 80% of individuals have successful completed the detoxification service. The feedback received from service users and professionals has been very positive. The inpatient detoxification contract has now been aligned with the broader Cranstoun community contract which is due to run until the end of March 2020.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 Brighton and Hove could look to develop a framework agreement with a number of detoxification services across the country, as West Sussex has done. However, there is no additional value for Brighton and Hove residents in doing this, as they will still be required to travel outside of Brighton and Hove. As Cranstoun currently provide both community and inpatient detoxification services, communication channels between the two services are enhanced.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 There has been ongoing service user and partner consultation regarding the City Roads Substance Misuse Inpatient Detoxification service. This is collected by the independent Substance Misuse Service User Involvement worker, employed by Mind. Commissioners have also had ongoing discussions with relevant organisations within the city to ensure that any issues are identified and addressed immediately. A further discussion took place at the Substance Misuse Programme Board in October 2016, allowing for any other points to be raised. There has been a considerably amount of praise for the service and the way it is operating. A paper was also taken to the November 2016 Health and Wellbeing Board, which included a discussion on the inpatient detoxification beds.

6. CONCLUSION

6.1 Operation of the City Roads Substance Misuse Inpatient Detoxification service for service users in Brighton and Hove is proving to be successful. Cranstoun continue to provide the inpatient service, in line with their existing contract for community substance misuse services.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

There are no direct financial implications arising from the recommendation made in this report.

Finance Officer Consulted: Mike Bentley *Date: 04/10/16*

Legal Implications:

There are no legal implications arising from the recommendation in this report

Lawyer Consulted:Judith Fisher *Date: 6.10.16*

Equalities Implications:

7.1 Equalities, and the reduction of health inequalities, are considered in the service specification development of any Public Health service. Services will be developed to ensure that all individuals have equal access.

Sustainability Implications:

7.2 The approach outlined above ensures that substance misuse inpatient detoxification services can continue to be provided.

Any Other Significant Implications:

7.3 None

SUPPORTING DOCUMENTATION

Appendices:

1. Health and Wellbeing Board (15th March 2016) paper on Substance Misuse Inpatient Detoxification

2. Appendix to Health and Wellbeing Board (15th March 2016) paper on Substance Misuse Inpatient Detoxification

HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 45 Brighton & Hove City Council

Subject:		**Brighton & Hove Healthwatch Annual Report 2016/17**
Date of Meeting:		**07 December 2016**
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**). In addition, Healthwatch is also taking the opportunity to inform members about recent work it has undertaken in relation to services at the Royal Sussex County Hospital: RSCH (**Appendix 2**).

2. RECOMMENDATIONS:

2.1 That members note the Healthwatch annual report (**Appendix 1**) and note the additional information on recent Healthwatch work-streams relating to their statutory functions (**Appendix 2**).

3. CONTEXT/ BACKGROUND INFORMATION

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

3.2 Community Works was the successful bidder for the local Healthwatch contract, and Brighton & Hove Healthwatch became operational in April 2013.

3.3 Healthwatch incorporated as an independent Community Interest Company (CIC) organisation with an asset lock on the 14 October 2014 and operated under the new company as of 1st 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.

3.5 In addition to presenting its annual report, Healthwatch will also briefly describe some of its recent review work with regard to services at the Royal Sussex County Hospital, Brighton. A summary of this work is included as **Appendix 2** to this report; the full Healthwatch reports will be forwarded to the informal joint HOSC Working Group on the Brighton & Sussex University Hospitals Trust (BSUH) care Quality Commission (CQC) inspection.

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.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 The development of the Annual Report is based on the Healthwatch B&H's constant approach to seeking to hear people's stories about their experiences of health and social care services. 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 to inform their work.

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 None to this report as it is for information.

Equalities Implications:

7.3 Healthwatch B&H CIC have updated the actions from their EIA and have undertaken an Equality Impact Assessment in September 2016 on their

Healthwatch activity and 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

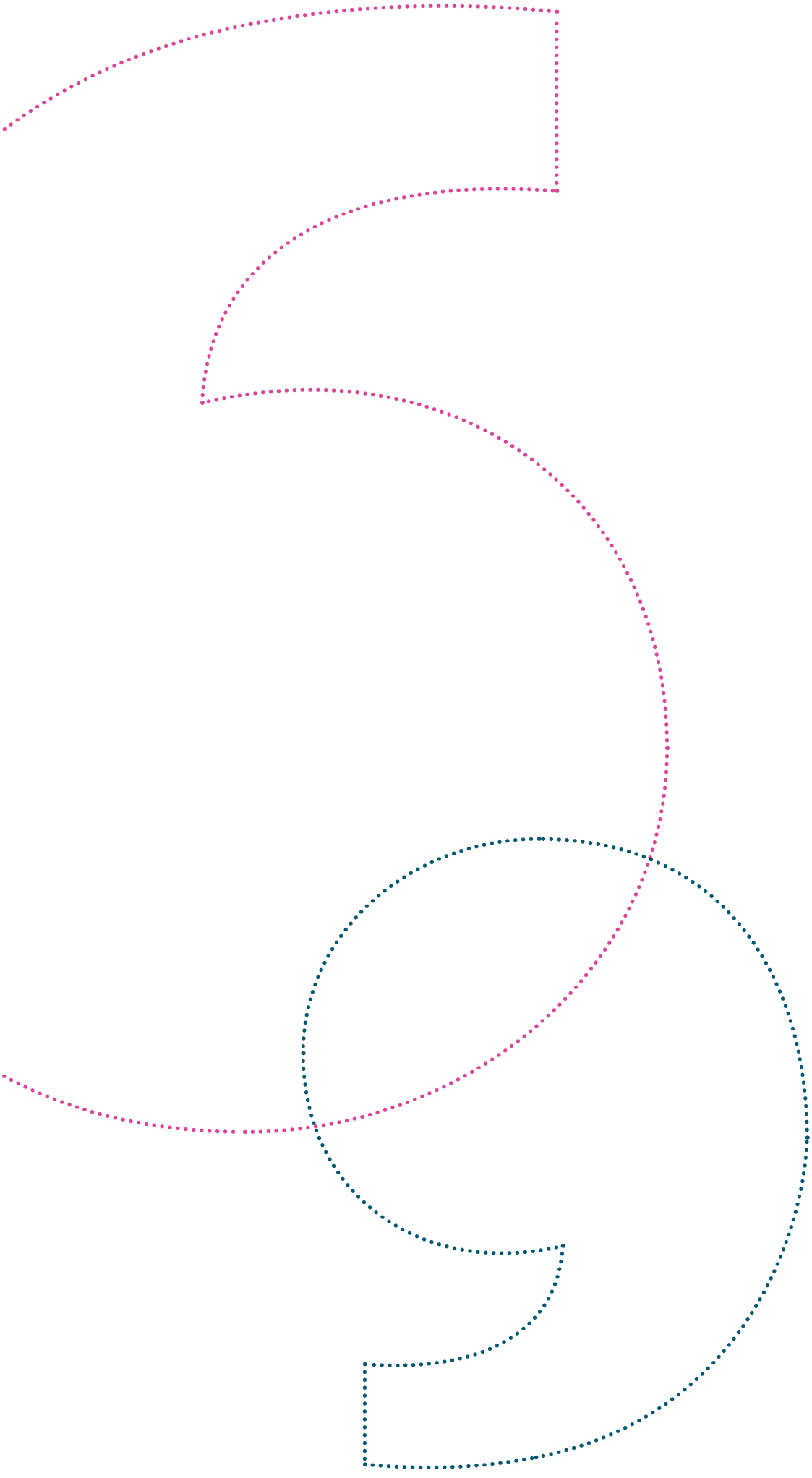
Appendices:

1. Healthwatch Brighton & Hove Annual Report 2015-16

2. Healthwatch Patients' Perspectives of the Royal Sussex County Hospital Outpatients' Department Executive Summary, 11 September 2016

healthwatch
Brighton and Hove

Healthwatch Brighton and Hove
Annual Report **2015/16**



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Message from our Chair

The theme for Healthwatch this year is 'the value we bring', and in Brighton and Hove we have delivered extra value through our volunteers, partnerships and collaborative work. We have listened to and spoken up for people who sometimes struggle to be heard. Most of all we have influenced decision-makers on a wide range of health and social care issues, including:

- proposals made by Healthwatch Brighton and Hove to improve the Urgent Care Centre in the A&E Department at the Royal Sussex County Hospital (RSCH) have been incorporated into their modernization plans – work starts in July 2016;
- an investment of £2 million in a building project to improve the Eye Hospital at the RSCH, prompted by an PLACE Report from Healthwatch Brighton and Hove;
- plans to improve GP practices across the city have been influenced and informed by local Healthwatch alongside local people and community leaders

Working with MindOut and the Clinical Commissioning Group (CCG), we helped fund the first Advocacy Worker in the UK specifically for the local Trans community, winning us a Healthwatch England national award.

Healthwatch Brighton and Hove volunteer representatives have attended over 200 meetings this year at which crucial decisions about local services were made, including funding, service design and quality and safety of services. Our Healthwatch 'watchdog' function provided added value for our city of over 2,000 hours of volunteering time on just one aspect of our work.

Our collaborative work with the Care Quality Commission and local Healthwatch neighbours in East and West Sussex and Kent won us a second national award from Healthwatch England.

"It has been a busy year full of challenges and achievements. Healthwatch Brighton and Hove brings the value of volunteers contribution into partnership working and representation. Our input into decision making processes has had a demonstrable impact on the safety and quality of health and care services for local people."

In April 2015, Healthwatch, became a not for profit Community Interest Company (CIC) and took over the contract for providing the local Healthwatch. This secures our status as fully independent, allows us freedom to respond to new challenges, and ensures that every penny of income we have is spent in the interests of local people.

Over the last year one Director, Clare Tikly, stood down. We will miss her work on GP Patient Participation Groups and liaison with the Sussex Community Trust. We gained several new Directors – Catherine Swann, Carol King, Geoffrey Bowden and Neil McIntosh. These Directors add expertise around mental health, public relations and the media, care quality and performance and children's issues. I would like to thank all Board members for the work they have done in this busy year. In addition, I want to thank Nicky Cambridge, who took a secondment from the Council to be our Chief Executive Officer. She built up our relationships and networks in the city and led us through a review of our work.

Frances McCabe

Healthwatch Brighton and Hove Independent Chair

Message from our Chief Executive

It was a privilege to act as the Interim Chief Executive Officer of Healthwatch Brighton and Hove. I joined at a time of immense change just as Healthwatch was becoming an independent CIC in April 2015. Over the year, the organisation worked hard to ensure it had the right organisational structure to sustain its future. This included forming a Board, recruiting new Directors to enhance its leadership, restructuring its staff team to better meet the needs of the task, undertaking a 360 degree review to assess strengths and weakness, and establishing a Community Spokes programme to increase its reach into less heard communities.

"It has never been more important for Healthwatch to make sure health and social care organisations keep their promises and improve services for local people."

At the same time, our volunteers visited 59 health and social care practices and reached thousands of people. They engaged with a huge range of health and social care developments including the Care Quality Commission's inspection of our local acute trust and the loss of several GP practices in the city. We raised concerns about hospital waiting times, safeguarding policy and practice in GP surgeries, and produced a best practice guide to social activities in care homes. We heard from 534 people about their experiences of GP practices in the city. We contributed to the national learning on how best to engage and support patients when their surgery closes, using our experience of an unprecedented overnight closure of a GP practice by the Care Quality Commission (CQC).

Our volunteers, Board members and staff consistently rose to the challenge, and with such a small staff team I am hugely grateful for their dedication and support. I hope you enjoy this annual report and I am very happy to be handing over the permanent CEO reigns to David Liley and his new team. I wish Healthwatch Brighton and Hove every success for the coming year.

Nicky Cambridge

Healthwatch Brighton and Hove Interim CEO

The year at a glance

Practice visits leading to service improvement

We undertook **59** visits to health and social care services to talk to people about their experiences and made observations about practice

28 Enter and View visits to GP surgeries, A&E and Care Homes

15 visits to GP surgeries undertaken by Right Here young person project

7 Sit and See sessions in A&E

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

142
recommendations to services were made as a result of these visits which led to **121 actions** to improve practice: benefitting patients

Communicating the voice of the patient through media

We issued **14** press releases raising the voice of the patient on critical issues

We produced **12** copies of our Healthwatch magazine, reaching an estimated audience of **5,000** people across Brighton and Hove

24,000
website hits
a 22% increase on the previous year

34 interviews

We did **34** interviews for local radio, newspapers and television

1,350 **443**

We made **443** Facebook friends and **1,350** Twitter followers

Using volunteers to maximise value

Volunteers' contributed an average of **26** hours on health and social care visits

Volunteers' contributed work worth **£23,000** for the 59 site visits

23,000

Who we are

Healthwatch Brighton and Hove is here to make health and social care services work more effectively for the people who use them. Everything we say and do is informed by our connections to local people.

Our focus is on listening to and understanding the needs, experiences and concerns of people of all ages who use services, and to speak out on their behalf. We work with other organisation who share our values and ethos but we are the only organisation that has the span of responsibility in the city.

As part of a national network, with a local Healthwatch in every local authority area in England, Healthwatch Brighton and Hove is uniquely placed to provide not only a local service but learn from peers, and contribute to and influence the national agenda.

Our role is to ensure that local decision-makers and health and social care services put the quality of experiences of people at the heart of their work.

Our Vision:

We are working towards a society in which all of our health and social care needs are heard, understood and met.

Achieving this vision will mean that:

- people shape health and social care delivery
- people influence the services they receive personally
- people hold services to account.

We achieve this by:

- listening hard 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 so that they better meet people's needs now and in the future
- informing and empowering people to get the most from their health and social care services and supporting other organisations to do the same
- working with the Healthwatch network to champion service improvement and empower local people.

Healthwatch Brighton and Hove staff and volunteers: Sue Seymour, Elaine Elliott, Hilary Martin, Denise Bartup, Robin Guilleret, Peter Lloyd, Tim Sayers, Tony Benton, Paul Wilson, Steve Turner, Kerry Dowding, Tressa Davey, Maureen Smalldridge, Slyvia New, Alexandre Barnes, Magda Pasiut, Maggie Gordon-Walker, Eimear Adair, Barbara Harris, Farida Gallagher, Nicky Cambridge, Mayor, Juilet Enver, John Davies, Neil McIntosh, Ann Li, Eva Lopez, Georgina Wall.

Our priorities

Our priorities for the next year will be:

- to help increase consumer confidence in local services by ensuring that decision-makers keep their promises and by helping to improve heath and care commissioning
- to provide evidence of consumer experiences of health and care services using our Enter and View statutory powers and other methods. Over the next year this will mainly focus on social care services but is likely to include service reviews in the NHS
- to provide evidence from people with protected characteristics and seldom heard communities including children, young people, people with mental health issues and frail older people: and improve health and care services for them
- to inform and influence decision-makers by providing evidence and information on topical health and care issues.

Health and social care statutory organisations are going through major transformation in Brighton and Hove. This causes uncertainty but provides opportunities for Healthwatch to add value and influence service changes towards improved care. The instability in the agenda and the number of serious problems in health services has challenged a small organisation to keep on top of the agenda and to deliver the capacity to react; and, at the same time, to plan other work.

Some of the areas where Healthwatch has actively already engaged, which is ongoing, are:

- The Clinical Commissioning Group (CCG) is organising general practice into clusters, with an emphasis on greater integration with community and social care service, prevention and changes in practice. It will take over more responsibility for general practice from NHS England. These major changes are going on when there is a recognised shortage of GPs and nurses and other care workers to implement them.
- People of Brighton and Hove have been affected by changes or proposed changes in their general practice in the last year. 26,000 patients have been affected by GP closures or proposed contract changes. There is a plan devised by NHS England and supported by the local CCG to transfer patients, whose GP practices are closing to another practice. For some this will be a simple process and they will be treated in the same building as before. For others it may mean travelling some miles to see their GP with additional inconvenience and travel costs.
- The CQC inspection found problems with the quality of care and patient safety and has put five GP Practices into Special Measures and on one occasion closed a GP practice.
- The Royal Sussex County Hospital is the main hospital in Brighton and Hove. It is a teaching hospital, a major trauma centre and the base for a number of specialist regional services. It was inspected by the CQC in 2014 and 2015 and on both occasions' problems with service quality and patient safety were identified and action was required to ensure the hospital complied with CQC regulations.

- The CQC visited again early in 2016 and was provided with a report on patient experiences at the A&E department by Healthwatch Brighton and Hove. At the time of writing (June 2016) the CQC has issued a serious warning to Brighton and Sussex University Hospitals Trust (BSUHT) about failures in quality and patient safety.
- There have also been significant problems with ambulance and patient transport services in this last year. The ambulance service provided by the South East Coast Ambulance Service NHS Foundation Trust (SECAmb) was investigated over unauthorised measures taken to response times to Red 2 urgent cases, which impacted on patient care. Following a recent CQC inspection, SECAmb declared itself as 'failing' when measured against its own key performance indicators for a range of measures, including turnaround times at hospitals. There was also an allegation of unacceptable cultures and behaviours.
- In April 2016 a private company called Coperforma took over non-urgent ambulance services. There was an immediate crisis in service provision with many people not getting the service they required, with long waits at home and hospital, an unreliable service and a call-handling service that could not cope with the volume of calls. After more than two months into this new contract, there have been some improvements, the service is still performing poorly.

These flaws and failings in NHS services are happening amid a dramatic funding loss to social care. With an increasing demand, a local council under severe financial pressure and a possible 30% funding reduction over the next three years for the city's voluntary and community sector, Healthwatch Brighton and Hove is set for a challenging year ahead.

We acknowledge the great work being done by thousands of health and social care staff across the city, often under extreme pressure, to provide some excellent services. Brighton and Hove remains one of the great volunteering cities in the UK. In addition, families, friends and carers continue to provide support for people without which statutory services would be unable to cope. However we cannot ignore what are very real and clear deficits in public services. In our view urgent action is required by decision-makers across the whole health and care economy to address problems with patient safety and the quality of services.

Gathering experiences, understanding needs

We gather information when people meet us at public events, ring or email us, or use other social media. Healthwatch is constantly seeking to hear people's stories about their experiences of health and care services. Using our statutory powers to Enter and View any premises where publically funded health or care services are being provided, we are uniquely positioned to interview people and observe behaviours and feed them directly to decision makers.

Healthwatch also gathers information and insights by sending volunteer representatives to a wide range of public meetings, specialist and strategic committees and decision-making forums.

Community Spokes programme

From the Community Spokes network of 17 community organisations, seven organisations were funded to undertake detailed research on the health concerns experienced by some minority and seldom heard communities.

The Spokes organisations were:

- **Right Here** (YMCA Downslink) – young people with mental health difficulties
- **Amaze** – adults and children with disabilities
- **Parent Carers' Council (PaCC)** – Black, Asian and minority ethnic (BAME) populations with children with Special Educational Needs (SEN)
- **Friends Families and Travellers (FFT)** – incontinence, urinary tract infections and bowel problems in traveller communities
- **Brighton and Hove Impetus** – adults with Asperger's and other Autism Spectrum Conditions (ASCs)
- **Sussex Interpreting Services (SIS)** – Black and minority ethnic women
- **Hangleton and Knoll Project** – Health Champions working in disadvantaged communities.

The research reports are available on the Healthwatch website here:

www.healthwatchbrightonandhove.co.uk/how-to-get-involved/community-spokes

Overall, findings indicated that health services need to be more proactive in serving these communities, providing preventative primary care that adapts and is sensitive to the particular needs of communities.

Trans community project

Trans people experience significant discrimination and barriers to accessing health and social care services. Brighton and Hove has a large Trans community and the city has recently led the way in pioneering projects such as the country's first Trans Needs Assessment and the establishment of Trans Pride.

Despite this, Trans people have shared numerous stories of poor experience accessing primary and second health and social care services. Issues such as a lack of awareness from GPs, waiting times at Gender Identity Clinics and problems with access to hormones in pharmacies were some of the stories shared with Healthwatch over the last year. In response to this, Healthwatch working with MindOut, a local mental health charity for LGBTQ people, developed a successful proposal for a specialist Trans advocate.

Funded by the CCG and Brighton and Hove City Council and Healthwatch for an initial year, the advocate supports Trans people navigating services. They will gather individual stories, to gain understanding which can inform the future services for the local Trans community. Healthwatch will continue to support the case for lasting change and improvement to local services. We understand this to be the first post of its kind in the country and we are delighted that it was Highly Commended at the 2016 Healthwatch England awards.

Kaisen project

The aim of research undertaken by the Kaisen project was to gain an understanding from hard to reach communities of how people relate to health services. This included younger people and people who will not typically attend events or contribute to consultation exercises or surveys about health and care. We wanted to reach the kind of people you meet in the streets of Brighton and Hove any night of the week. The project used street engagement to target hard to reach groups and gain an understanding of the barriers and incentives to people using GP services. Interviews were carried out with 550 people: 213 people were engaged through 69 street focus groups across the city; and a further eight interviews were conducted with clinicians and community engagement specialists. The research found that a majority of respondents (58%) would only go to a GP if they had felt unwell for a few weeks. A third of respondents said that difficulties in booking an appointment got in the way of them going to see their GP. However, 45% said they would be happy to have a phone consultation instead of a face-to-face appointment with a GP.

The Kaisen report is available on the Healthwatch website:

www.healthwatchbrightonandhove.co.uk/what-weve-done/healthwatch-reports

> "I had a lot of fun sharing my experiences and hearing others people's from different backgrounds."
>
> Workshop participant's feedback

Healthwatch events

Workshops on NHS Constitution for young people aged 16-25

Last year, in partnership with Sussex Partnership NHS Foundation Trust (SPFT) and Speak Your Mind Young People's Advocacy Project, we held two workshops for young people aged 16-25 with mental health needs. The focus of discussion was on the NHS Constitution and rights for young people. The workshops were part of a pilot project run by the National Children's Bureau and the Council for Disabled Children, which developed a set of resources to be used in the sessions.

The workshops generated lively discussions on barriers to accessing local health services for young people with mental health needs. The first workshop concluded with a presentation on the support offered by community Child and Adolescent Mental Health Services (CAMHS) services, gathering feedback on a newly designed CAMHS leaflet, and support offered by other mental health organisations in the city.

Insights from the sessions were shared with national partners, which led to the improvement of resources and the development of an interactive website. The website included videos of the young people telling their stories about how knowing about their rights has made a difference to them, and of professionals explaining why they value young people's rights.

Healthwatch Brighton and Hove public Board meetings

We held four public Board meetings and an Annual General Meeting (AGM). Members of the public were given an opportunity to submit questions prior to the meeting or ask during a 'Question and Answer' session. 55 individuals representing community groups and organisations attended our AGM.

"I've met a lovely lady at the local community festival who not only listened to my horrible experience at the Royal Sussex County Hospital, but also provided me lots of useful information. She encouraged me to not let the issue go, but to speak to her colleague [at the Healthwatch Helpline] who eventually helped me to resolve all my issues."

Person met on People's Day

Community Groups and Events

During the year Healthwatch had a stall at 40 community events. These events ranged from community festivals across the city to events aimed at particular health conditions, for example cancer and learning disabilities.

We carefully selected events at which to have a stall, aiming as far as possible to be inclusive and reach disadvantaged and vulnerable communities across the city.

The events we attended included:

- community festivals in deprived areas such as Whitehawk, Moulsecoomb and Hangleton and Knoll
- a Macmillan Cancer Support event
- an LGBT and Friends event for LGBT people with learning disabilities
- the Big Picnic event to celebrate Young Carers Day for young carers and their families
- a One Voice 'Newroz' event to celebrate Kurdish new year
- Trans Pride for the Trans community
- an Active Forever event and dementia conference for older people
- a PSHE (Personal , Social and Health Education) day at Brighton Aldridge Community Academy for young people
- general community events including the People's Day, City Assembly, and Brunswick Community Festival.

Communication

This year we increased our local media and online presence. We issued calls on a regular basis for the public to share their experience on topical issues related to local health and social care services. These issues included experiences of general practice, delayed transfers of care, closure of GP practices, and experiences in hospital A&E.

We issued 14 press releases communicating the voice of the patient on high profile issues of concern to services in health and social care. This year, press releases covered a Care Quality Commission report on the Royal Sussex County Hospital A&E, concerns over waiting times for hospital services and problems with the South East Coast Ambulance Service.

We significantly increased the amount of content published via the Healthwatch Brighton and Hove website, social media and in our monthly Healthwatch magazine. Our approach was to provide timely and relevant information, which was accessible to a wide audience. Reflecting local concerns, this year we produced themed editions of the magazine on cancer screening and mental health.

> **"I find it ever so useful ... it's fantastic. I even read it in bed!"**
>
> Healthwatch magazine subscriber

As of March 2016 the Healthwatch magazine had 940 individual subscribers who received a paper copy and 500 subscribers who received a digital copy. Copies of the magazine were distributed widely by health providers and voluntary organisations including the Sussex Community NHS Foundation Trust, GP surgeries, day and community centres, outpatient departments at the Royal Sussex County Hospital (Cardiac, Main Outpatients, Ear Nose and Throat), the University of Sussex Information Centre, the Samaritans, Interact, and Brighton and Hove Speak Out.

Healthwatch was proactive in communicating and engaging with the public via the web and social media. At the end of the year we had 443 Facebook Friends and 1,350 Twitter Followers.

We had 24,400 website hits over the year, an increase of 22% on the previous year.

What we've learnt from visiting services

Enter and View visits

Carrying out Enter and View visits is a key role for all local Healthwatch organisations, and is a unique statutory power. The Health and Social Care Act 2012 allows us to observe service delivery and talk to service users, their families and carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists and pharmacies.

Local Healthwatch Authorised Representatives carry out these visits to health and social care services to find out how they are being run and then make recommendations where there are areas for improvement. This year we undertook 28 Enter and View visits to local health and social care services. We also undertook a further 31 site visits. Our priority was on visiting services for older people (care homes), primary care (GP practices), and the Royal Sussex County Hospital (A&E and hospital discharge).

Healthwatch Authorised Representatives – our eyes and ears

This year we had a dedicated group of 11 volunteers who undertook Enter and View visits on behalf of Healthwatch Brighton and Hove. These Authorised Representatives were lay people from the local community who carried out the observations and asked people what they thought of services using tested questions and an observation checklist created by Healthwatch. Authorised Representatives received full Enter and View training, which included safeguarding adults at risk.

GP surgery visits

We undertook a programme of visits to GP surgeries across the city. The rationale for choosing general practice was the high volume of calls about it through our Helpline and concerns in the city about practice closures and their impact on other services. We were also mindful of the transformational changes going on in general practice in the city, and we wanted to get a baseline of patient satisfaction so that we can return and ask patients in the future about what has changed and its impact. As with many other parts of the country, the provision of primary care in Brighton is not only experiencing severe financial pressures, it is suffering from a shortage of GPs and other ancillary staff.

The Enter and View programme consisted of 15 visits to GP surgeries. These visits were complemented with a major online survey that was widely completed around the city. They survey attracted a high response rate gathering feedback from over 500 patients from 44 practices (97% of general practices in the city).

The visits and survey elicited patient dissatisfaction with telephone consultations as an alternative to in person appointments. We also found that awareness of the availability of annual health checks was low and only small numbers of patients were being invited to have one by their practice. Finally, we found that the availability of information on cancer screening was variable across practices.

The Enter and View programme generated 83 recommendations with an average of five recommendations for each surgery visited.

Recommendations highlighted a range of patient issues including the following:

- lack of treatment choice offered to patients
- difficulties in receiving test results over the phone
- low awareness of NHS health checks and annual health checks for patients with long term conditions
- long waiting times in surgery before being called in for appointment.

78% of the recommendations made led to changes in practice by the respective GP surgery.

Changes were usually made as a result of a constructive dialogue between Healthwatch and the GP practice. Recommendations were made as part of the report for each surgery and the practice was asked to respond to each recommendation. A dialogue then unfolded with an appropriate response agreed between Healthwatch and the practice. With a change agreed, Healthwatch then followed up three months later to confirm that the action had been implemented.

CASE STUDY

Recommendation leading to improved practice in a GP surgery

Healthwatch reported that a number of patients at the GP surgery felt that some reception staff communicated poorly. Healthwatch recommended that the practice consider additional communication training for frontline staff and to monitor this situation in the short term.

Outcome

The surgery held a customer relations training session for staff using an audio recording of telephone encounters with patients. The surgery also introduced regular monitoring of staff communication with patients.

Care Home Visits

In response to concerns about primary care in local residential care homes we undertook an Enter and View programme focused on older people's care homes. Callers to our Helpline had raised concerns about the quality of primary care in some care homes, and Brighton and Hove City Council (BHCC) had also shared with us similar concerns that had been flagged in audits.

After close consultation with the Care Quality Commission (CQC), the Brighton and Hove Clinical Commissioning Group (CCG) and BHCC's Adult Social Care, we identified five homes to visit. The homes were visited in March 2016 when representatives talked to patients, visitors and staff about their experiences of care and access to services and observed the care homes' communal areas.

> **"It was an informative experience that helped us improve how we care for our residents."**
>
> Simone Morgan, Hazelgrove Nursing Home Manager

CASE STUDY

Recommendation leading to improved practice in a Care Home

Healthwatch reported that all residents spoken to during the visit said they did not attend dental check-ups offered by the care home. Healthwatch recommended that staff be more proactive in encouraging residents to use the dental service.

Outcome

The care home introduced the topic of oral hygiene as part of residents' health review conducted every three months. Staff now encourage residents to use the dental service and note their response if they decline. Staff support residents to make and attend dental appointments where needed.

The Enter and View programme resulted in 15 recommendations for the five care homes visited.

Recommendations included the following:

- lack of regular hearing tests for residents
- need for information on noticeboards and menus to be accessible for visually impaired residents
- need to engage with residents about oral hygiene
- use of electronic prescription service (EPS) to save staff time.

10 of the recommendations led to changes in practice by the respective care home.

A&E visits

Following a critical report from the Care Quality Commission (CQC) Healthwatch Brighton and Hove decided to conduct a combined programme of Enter and View visits and Sit and See observations at A&E at the Royal Sussex County Hospital. The purpose of the programme was to evaluate the impact on patients of delays in handover from ambulance to hospital services and long waits in A&E.

The programme of work required considerable preparation as we had to devise a methodology that would gather accurate information but not impede the work of staff or inappropriately disturb very ill people in crisis. The Sit and See observation tool proved very useful as it was unobstructive yet gathered valuable quantitative and qualitative information on the quality of care.

The visits highlighted a number of significant concerns about waiting times and overcrowding especially in the area where patients are handed over from paramedics to hospital nursing staff. Our detailed report made a number of recommendations including the following:

- triage in the urgent care centre to take place at the earliest possible stage in admission
- staff to be more visible, greater clinical oversight on patients whilst they were waiting for treatment
- more frequent and real time information to patients about waiting times and progress with their assessment and care
- environmental changes, such as comfortable chairs
- increased roles for volunteers in providing information and signposting.
- the need for a whole systems approach to resolve the build up of patients and delays in A&E Majors Emergency Department

The report was shared with commissioners and health providers and has helped inform a recent CQC inspection of the Brighton and Sussex University Hospitals Trust. Management at the hospital responded positively to the report. Recommendations about the Urgent Care Centre are incorporated in their modernisation programme. Others are going to the hospital Board. Healthwatch will continue to demand urgent improvements to the service in 2016.

Hospital Discharge

Healthwatch Brighton and Hove conducted a further Enter and View programme at the Royal Sussex County Hospital alongside the work of the Emergency Care Improvement Programme (ECIP). As part of ECIP the hospital introduced a 'Discharge to Assess' system to better handle hospital discharge. Healthwatch representatives interviewed patients who had been discharged under the new process to evaluate the quality of care and whether patients' needs had been met.

> **"Heathwatch brought an excellent focus for patient understanding of their discharge with their questionnaires."**
>
> CCG evaluation report

The report produced for the ECIP project acknowledged the value of Healthwatch's work in helping to evaluate how patients' interests were being handled under the new system.

PLACE visits

Every year each NHS Trust is required to undertake Patient-Led Assessments of the Care Environment (PLACE). These assessments look at the cleanliness, condition, appearance and maintenance of the environment in which care takes place. They also assess food quality and service, the extent to which the environment promotes the privacy, dignity and wellbeing of patients, as well as the consideration given to people with dementia. The assessments are undertaken by teams comprising a mixture of patient assessors and staff from the trust.

Our volunteers acted as patient assessors in PLACE visits for Brighton and Sussex University Hospitals NHS Trust and Sussex Partnership NHS Foundation Trust. They assessed the Sussex Eye Hospital, the Royal Alexandra Children's Hospital, A&E, several wards in the Royal Sussex County Hospital, the Lindridge Centre, Mill View Hospital, and the Rutland Gardens rehabilitation unit. The PLACE visits provided valuable insight on how the environment in services supports clinical care, including assessment of privacy and dignity, food, cleanliness and general building maintenance.

Some of the recommendations take time to deliver. In 2015-2016, a major works programme has been done in the Eye Hospital as a result of concerns raised with the CEO of the RSBH in 2014.

The results of the 2015 PLACE surveys are available at the Health and Social Care Information Centre:

www.hscic.gov.uk/catalogue/PUB18042

Giving people advice and information

Helping people to get what they need from local health and care services

The Healthwatch Brighton and Hove Helpline provided valuable advice and information about local health and social care services to the general public. The Helpline service was accessible through a dedicated phone line, email and the Healthwatch social media channels (Facebook and Twitter), provided support to users navigating the health and social care system.

From October 2015, we increased the operating hours of the phone line to 9.30am to 12.30pm Monday to Friday. Over the year the Helpline service received 353 enquiries, 330 from individuals and 23 from organisations. 60% of these enquiries were made via phone and 27% via email, with the remainder via outreach or social media.

As in previous years, we dealt with many issues relating to GP and dental practices, and liaised with practice managers and other practice staff on behalf of patients to resolve issues. Some issues raised in Helpline enquiries included the following:

- quality of care and treatment in residential care homes
- coordination of care at home following stays in hospital
- problems with adult social care
- issues relating to NHS 111 and Patient Transport
- right to choose a specific GP, consultant or hospital
- access to health services or information, e.g. for people with disabilities
- waiting times for a GP appointment
- patient pathway, e.g. lack of communication, coordination of services
- difficulties with repeat prescriptions
- long waiting times for hospital appointments
- closure of Goodwood Court Medical Centre
- situation with The Practice Group plc (where a contract to deliver GP practices has been returned to the NHS England)
- clarity of dental charges
- staff attitudes.

> **"I first heard about Healthwatch after the closure of the Goodwood Court Medical Centre. You were very helpful to me with information and kept me up to date with events. I am now happily with The Charter Medical Centre."**
>
> Janice Byrne, Helpline user

We continued to have a very good working relationship with the PALS (Patient Advice and Liaison Service) teams from the local NHS Trusts and Brighton and Hove Clinical Commissioning Group (CCG). Helpline staff at Healthwatch East Sussex and Healthwatch West Sussex assisted us in responding to Helpline enquiries where issues crossed regional boundaries.

We worked closely with Brighton & Hove Independent Complaints Advocacy Service (ICAS), and referred 16 cases to them this year. We also signposted people to ICAS and many other advocacy services for more specialised support depending on the needs of enquirers. The Helpline Coordinator participated in a peer review focus group for ICAS in March 2016 along with other local health complaints advocates from MindOut, ICAS West Sussex and Dorset Advocacy.

> **"Excellent service and you assisted in getting my issues resolved quickly. I have also recommended you to a colleague. You personally were also very helpful and kept in regular contact to make sure everything was resolved."**
>
> Travana Pither, Helpline user

How we have made a difference

Our reports and recommendations

Healthwatch Brighton and Hove Enter and View work in reviewing health and care services resulted in 142 recommendations being made to hospitals, GP surgeries and care homes. Our recommendations and findings created constructive dialogue with service providers.

The impact of our findings was that 121 recommendations for improving services were accepted and implemented across GP surgeries, Care Homes and the hospital A&E Department. In the coming year we will check that our recommendations have been fully implemented and that people have kept their promises.

Working with other organisations

Partnership and collaboration are essential parts of getting things done effectively in Brighton and Hove.

Better Care Board, Systems Resilience and Sustainability Boards, and Primary Care Transformation Group

Healthwatch Brighton and Hove was represented on strategic health boards in the city including the Better Care Board (BCB), Systems Resilience Board (SRG) and the Primary Care Transformation Board (PCTB). Through regular attendance at these boards Healthwatch was able to keep the user perspectives firmly on the agenda whilst also acting as critical friend to health commissioners and providers. This has led to Healthwatch being a key player in the development and integration of the issues in the Better Care Plan and Systems Resilience Plans.

Health and Wellbeing Board and Overview and Scrutiny Committee

Over the last year Healthwatch Brighton and Hove increased its profile on the Health and Wellbeing Board and Overview and Scrutiny Committee. We put items on the agenda, such as safeguarding issues in general practice, general concerns over general practice in the city and the closure of GP services. We were an active contributor to all the items at meetings and sought intelligence from user groups when appropriate, such as in response to changes in the special educational needs services.

Working with the local authority

Healthwatch was represented at the Brighton and Hove City Council group on the forthcoming contracts for home care. Providing effective complaints mechanisms for home care was and remains a priority area of work for Healthwatch, especially in relation to service users with dementia, who are less able to communicate concerns they may have about their service. Healthwatch influenced the contract design to increase the focus on quality, personalised care, and complaints processes.

- Healthwatch Brighton and Hove, along with local Healthwatch in East and West Sussex, Kent and Surrey, work closely with the health and care inspectors from the Care Quality Commission (CQC). This close collaboration enables us to share best practice when we see it and any areas of concern. This collaboration of the South East Healthwatches with the CQC was recognised with a Highly Commended award from Healthwatch England.
- The CQC has three parts, covering care homes, hospitals and other health and care services. We meet regularly with all three parts of the CQC, and with Brighton and Hove City Council who purchase many social care services on behalf of local people.
- To help us work more effectively, we strongly encourage local people to share their personal and family experiences of health and care services. Your story will be taken seriously and can make a real impact.

Healthwatch also working closely with Community Works, a leader in the local community and voluntary sector, and Impetus, who provide NHS Independent Complaints Advocacy locally.

Involving local people in our work

Local people are involved directly in Healthwatch in the city:

- Spokes – our outreach to minority communities and seldom heard voices
- our outreach programme visiting local public meetings, community events and special interest groups
- our volunteers – over 30 local people involved in Enter and View service reviews, representing Healthwatch, promotional, administrative and support activities
- networking facilitating and enabling community organisations and special interest groups to be involved with health and care decision making e.g. through the Transforming Primary Care Board, Better Care Board and the Patient Experience Group at the Royal Sussex County Hospital.

Our work in focus

Closure of GP practices

Brighton and Hove experienced an unprecedented number of closures of GP practices over the year, affecting six practice. Healthwatch Brighton and Hove was proactive in providing support to patients, helping them navigate the changes and find new GP services.

The experience of the closure of Eaton Place surgery in Kemptown in early 2015 helped shape Healthwatch's model for dealing with later closures. The Eaton Place surgery served 5,600 people in Brighton, and communication with patients was poorly managed by NHS England. In the light of this experience, Healthwatch requested early notification in the event of future closures, giving us an opportunity to work with NHS England, the Clinical Commissioning Group and Patient Participation Groups to keep patients properly informed. With subsequent news of closures (Goodwood Court and five surgeries run by The Practice) we provided up to date information to patients on our website and via our Helpline. Our involvement provided valuable information to patients at a time of great uncertainty.

Ambulance services

In November the South East Coast Ambulance Service (SECAmb) was criticised by Monitor for having changed the criteria for responding to urgent 111 services (Red 2s). This change in policy led to delays, meaning a large number of ambulances failed to respond to emergency calls within target times. It also led to the resignation of the chair.

Healthwatch Brighton and Hove issued a response to the report, and with neighbouring Heathwatches, met with the SECAmb CEO. This led to assurances from SECAmb that user perspectives provided by Healthwatch would be used to inform the future design and delivery of the service. SECAmb has since been subjected to further investigation, and Healthwatch has contributed to the discussion about the service at the Brighton and Hove Overview and Scrutiny Committee and Health and Wellbeing Board. The second investigation led to the resignation of the chief executive. Healthwatch will continue to closely monitor SECAmb and the Patient Transport Service in 2016.

Safeguarding issues in General Practice

During the year Care Quality Commission (CQC) inspections of some GP surgeries in Brighton and Hove noted a high number of safeguarding problems. One problem was the failure of surgeries to do Disclosure and Barring Service (DBS) checks on chaperones, who could be present during intimate examinations. A further issue highlighted was that sometimes staff are not being provided with safeguarding training.

Healthwatch Brighton and Hove provided an analysis of the issue in the city that and this was shared with the CQC, the Overview and Scrutiny Committee and the Brighton and Hove Safeguarding Panel. Healthwatch decided that the seriousness of the issue merited a formal escalation notice to Healthwatch England. The inadequacy of safeguarding processes in general practice has since been highlighted in national reports.

The Clinical Commissioning Group has agreed to monitor and review progress in safeguarding practice against the national standards, and Healthwatch will continue to monitor the situation in 2016.

Mental health

Healthwatch Brighton and Hove worked closely throughout the year with Sussex Partnership Foundation Trust (SPFT) to strengthen the service user and carer voice within mental health services. A Healthwatch representative was part of a clinician-led working group surveying service users and carers to establish the key care issues that matter most to them. The representative was involved in the planning and running of a service user workshop as the next step in an ongoing process to ensure that people who use mental health services have a meaningful say in their development and delivery.

Further work was done with SPFT across a broad range of issues, including input to a new Trust-wide Patient Involvement Strategy due for roll-out in 2016, participation in the programme of Patient-led Assessments of the Care Environment (PLACE), including follow-up to ensure any necessary improvements are followed through, and critical input to the Trust's annual process of setting and reporting against quality standards. Representatives from Healthwatch, along with those from Healthwatch in East and West Sussex, met regularly with the Trust to ensure that any concerns arising relating to service user care were flagged and addressed at the earliest opportunity.

Short term care and hospital discharge

Along with a number of other trusts, Brighton and Sussex University Hospitals Trust (BSUHT) has a problem with the number of delayed discharges from hospital. The Clinical Commissioning Group (CCG) and Brighton and Hove City Council worked together to commission a number of schemes to improve the flow of patients through the system. Healthwatch Brighton and Hove was present at regular multidisciplinary meetings to monitor the progress and improve the schemes. These meetings enabled us to communicate the views of patients and carers on their actual experiences and make suggestions about future developments.

Community Short Term Services (CSTS) cover a range of bed-based and home-based services that give people the rehabilitation and re-ablement they need to maintain their independence. Due to the increasing numbers of complex cases requiring bed units, a decision was made to develop a new model of care for the CSTS beds starting in April 2017. Healthwatch was involved in shaping the details of the new specification and we emphasised the need for adequate information and communication to be given to patients and their carers.

Discharge to Assess (D2A) is another process used to expedite the movement of patients out of the hospital. Patients who are medically fit for discharge are sent home with support from a multidisciplinary team. The team makes a needs assessment with the advantage of seeing the patient in their normal surroundings. The numbers of patients slowly increased during the year and Healthwatch will continue to monitor the situation.

Cancer services

The improvement of services for people with cancer is a national and local priority and a key issue for Healthwatch Brighton and Hove. Two experienced volunteers regularly attended meetings during the year, including the Cancer Action Group. We raised concerns about a number of issues, for instance the low take up rates for bowel cancer screening. We supported the Clinical Commissioning Group's (CCG) involvement in the Local Cancer Services scheme and helped to shape this service. Healthwatch had a scoping meeting with the Cancer Research UK Health Professional Engagement Programme for the South East, which is to develop a programme to raise the awareness of cancer screening programmes within local GP practices.

Our volunteer representatives have also supported a number of Brighton and Hove CCG initiatives, including Living with and Beyond Cancer. For the Cancer Peer Research Programme, one Healthwatch volunteer presented a well-received personal account entitled 'My Story'. More broadly, Healthwatch has been tracking cancer targets on waiting times for appointments and treatment, and has raised concerns about fluctuations in activity.

Sussex Community NHS Foundation Trust

Healthwatch Brighton and Hove has always had an open and constructive relationship with the Sussex Community NHS Foundation Trust (SCT), with a Board member meeting the Trust's Chair and CEO regularly, and other volunteers attending patient participation meetings. This good relationship has meant that any time there has been a problem identified with services, Healthwatch could pick up the phone and it would be taken seriously and addressed. Issues raised included uncertainties about who was responsible for supplying incontinence pads and mobility equipment, and waits for the podiatry service. Healthwatch also liaised with the Trust over concerns being raised with us about the potential impact on the recommissioning of the Patient Transport Service, and this was taken forward to the Clinical Commissioning Group by the Trust. Concerns about the iniquity of community service provision for people in care homes led to an Enter and View programme, the results of which will be shared with Sussex Community Trust.

Referral to treatment times

During 2014-5, by analysing regular data, Healthwatch Brighton and Hove identified that complaints to the Brighton and Sussex University Hospitals NHS Trust (BSUHT) were increasing rapidly in some specialities. We took our concerns to the CEO. Over time, it emerged that there was an excessive backlog of patients waiting for outpatient and inpatient treatment, who were not being seen within the eighteen-week referral from GP to treatment time as set out in the NHS Constitution. Healthwatch made a formal request for information under the Freedom of Information Act for the precise details, and issued a press release so that the public were able to make choices about their care in this unsatisfactory situation. The episode created challenges for Healthwatch as there were reservations by the statutory agencies about whether this information should become public and how. Nevertheless, we worked with BSUHT's and the CCG's communications department to provide an acceptable public communique.'

Maternity services

Healthwatch Brighton and Hove had a representative on the city's Maternity Service Liaison Committee (MSLC), which worked to improve outcomes and the patient experience. The committee brought together mothers, maternity staff and commissioners to look at maternity care, childbirth and post-natal support.

The major themes discussed this year included:

- midwife staffing levels
- improving breastfeeding rates
- establishing a midwife-led birthing unit (MLU) in Brighton. This was agreed in principle but no further action was taken. The MSLC set up a petition to raise its profile and Healthwatch included an article about the MLU in its magazine

- a poster telling mothers about their home birth option. This was produced and sent to all GP surgeries in the city. The Healthwatch representative ensured it was distributed to all the Patient Participation Groups (PPGs) in the city, and raised it at the PPG Network meeting.

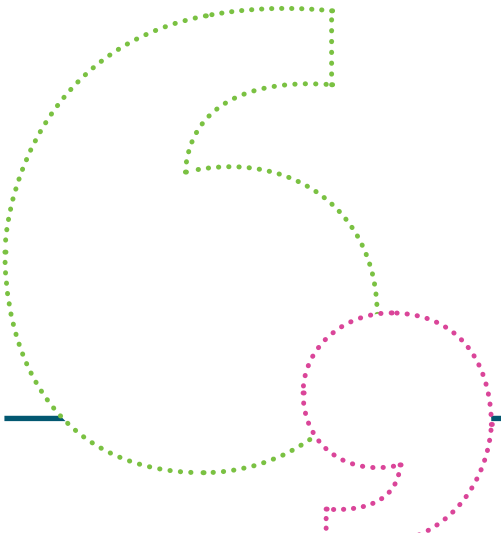
Our plans for next year

Future priorities

Healthwatch Brighton and Hove has a challenging year ahead. We acknowledge the great work being done by thousands of health and care staff across the city to provide some excellent services. Families, friends and carers continue to provide support for people, without which statutory services would be unable to cope. In addition Brighton and Hove remains one of the great volunteering cities in the UK. However we cannot ignore what are very real and clear deficits in public services. In our view urgent action is required by decision makers across the whole health and care economy to address problems with patient safety and the quality of services.

Our priorities for the next year will be:

- to help increase consumer confidence in local services by ensuring that decision-makers keep their promises and helping to improve heath and care commissioning
- to provide evidence of consumer experiences of health and care services using our Enter and View statutory powers. Over the next year this will focus on social care services but is likely to include service reviews in the NHS
- to provide evidence, to improve health and care services, from people with protected characteristics and seldom heard communities including children and young people and people with mental health issues and frail older people
- to help decision-makers by providing evidence and information on topical health and care issues.



Extending our Reach

We want Healthwatch Brighton and Hove to be well established in the public arena. Raising public awareness of what we do and how they can use us is a major challenge for the future. We will deliver at least one major public engagement activity, which will aim to have impact, while still being fun. Apart from promoting the work of Healthwatch, it will provide information and ask the question "What does good look like?" for local health and care services.

We will continue to extend our reach using the Healthwatch magazine, website, public events and other activities. We will increase our impact on social media such as Twitter and Facebook. Our targets include 24,000 website hits, 1,000 people subscribing and reading the magazine, and at least 100 people at our public event. We will increase our reach by engaging with young people in colleges and universities by recruiting a team of community researchers in collaboration with the local Clinical Commissioning Group.

In the coming year we intend to build on the excellent working relationship we have with local TV, radio and newspapers. In the past year that has included:

- leading a media campaign on hospital waiting times, where Healthwatch prompted additional transparency and ensured that important information on hospital waiting times was put in the public domain
- regular TV interviews for a local on line TV station on topical health and care issues
- BBC TV and Radio and newspaper interviews concerning Coperforma and non-urgent hospital transport services
- radio and newspaper interviews on GP services.

Healthwatch is now established as an authoritative source of information and comment for all forms of local media. In the next year we will build on that, taking a more proactive approach to communicating messages directly to the public. All our events, public meetings and report launches will be supported by a media plan, press release and invitations to the local press to attend.

We work increasingly closely with Healthwatch in East and West Sussex and in a regional network of local Healthwatches that includes Surrey and Kent. At the 2016 Healthwatch National Conference, the regional group of Healthwatches was Highly Commended in the Healthwatch National Awards for its collaborative work with the Care Quality Commission. In the coming year we will build on those sound foundations, and we are planning to create Sussex Voices – a combined Healthwatch consumer voice across the whole of Sussex.

Over the last year we have actively engaged with minority communities and seldom heard voices through our Community Spokes programme. The Spokes network consists of 27 community organisations, seven of which were funded to undertake research projects focusing on health issues facing vulnerable communities in the city. Next year we want to redesign the programme taking on the valuable and positive lessons learned from our first attempt at this kind of collaboration. At its best this is a two way process with Healthwatch providing help and support to small organisations:

- Healthwatch sharing its privileged access to high level decision makers
- Healthwatch sharing skills and expertise in research and planning to produce creditable messages and evidence
- Healthwatch giving minority communities a platform and a voice.

In return, these community organisations will be able to:

- represent their communities and make an impact otherwise unavailable to them
- build capacity and confidence for the future
- promote their message and make their voice heard by audiences not usually accessible to them.

Over the summer and autumn this year we will be working with our existing Spokes network and others to design and provide a new programme of work.

Intelligence, Insight and Policy

For this coming year the Healthwatch Brighton and Hove team has been strengthened by the addition of an Evidence and Insight Manager, Dr Roland Marden, an experienced research professional. The city has an excellent Public Health Department that produces high quality research and Joint Strategic Needs Assessments. We aspire to supplement and complement their work with service reviews and case study insights providing the consumer's perspective. In the last year we worked with the local Clinical Commissioning Group and commissioned research, undertaken by Kaisen, into attitudes to health and care from over 700 local people approached in the street. Our aim was to capture views from some of the people we often find it difficult to reach, including working age adults, young people, and people from minority communities. At Healthwatch this research was nicknamed the 'Kebab Shop' project, which captures the type of street engagement used by the Kaisen research team and the intention to capture voices of people who are rarely heard in health engagement exercises: we wanted to hear the voice of the kind of people you might meet in the local kebab shop on a Saturday night.

We will find ways of using the results of the Kaizen research to influence service planning and design. The research provides a baseline against which we can test assumptions about the 'public view'. Our view is that it is important to capture the voice of those people who do not have fixed and predetermined views, and who are not organised around single issues. The reality seems to be that most people most of the time do not have health and care issues at the forefront of their minds. Getting involved in those issues by being part of Healthwatch is not a priority for the vast majority of local people. However, when health and social care problems enter people's lives and families it often becomes the single most important thing on their minds.

We intend to influence and improve the nature of public consultation across the city. There are a number of voluntary and community organisations providing excellent community engagement and advocacy services in the city, and Healthwatch works in close collaboration with Community Works and Brighton and Hove Impetus. Healthwatch contributed in the last year to engagement exercises in community and primary health care, mental health, hospital care, the integration of health and social care, prevention of hospital and care home admission, and psychological and wellbeing service changes.

A discussion is emerging in the city not just about services that are under pressure, but also about how services are commissioned and how that process can be improved. A key element in the commissioning processes is public engagement and public consultation. We believe there may be a valuable role for Healthwatch in providing assurance that those processes have been carried out to a high standard, with statutory and regulatory obligations being met, and consistent with best practice. We will be working with the Consultation Institute to bring forward a plan to improve this aspect of commissioning in the City.

Representation and Influence

Healthwatch Brighton and Hove has privileged access to senior decision-makers, and we are able to represent consumer views and influence decisions about how services are designed, funded and provided. We have done that vigorously in the past year, influencing the agendas of the Brighton and Hove City Council's (BHCC) Health and Wellbeing Board and the Overview and Scrutiny Committee by representing the consumer view.

Over the next year we will provide representatives to the following decision-making groups and forums:

- the Health and Wellbeing Board – a BHCC committee that co-ordinates all health and social care in the city
- the Health Overview and Scrutiny Committee – a BHCC committee that scrutinises changes in health and adult care services in the city
- the Adult Safeguarding Board, which oversees Adult Safeguarding issues in the city
- the Strategic Transformation Plan group charged with long term resorganisation of health across Sussex and East Surrey
- the Systems Resilience Group – a chief officers group for Brighton and Hove chaired by the clinical lead for the Clinical Commissioning Group and attended by health and care providers including the BHCC Director of Adult Social Care
- the Quality Surveillance Group – a regional group involving the Care Quality Commission, NHS England and CCGs sharing information and concerns about the quality of care and patient safetythe Better Care Board – a joint initiative by BHCC and the NHS, coordinating the integration of some aspects of health and care services
- the Primary Care Transformation Board – an NHS England and CCG forum overseeing changes in the provision of GP services in the city.

In addition we will continue to provide representatives to a wide range of advisory forums covering:

- mental health
- cancer services
- equality, diversity and LGBT
- supporting the patient voice at the Royal Sussex County Hospital.

Healthwatch is currently working on issues of topical concern that will help define some of our activities in the year ahead including Coperforma – non urgent patient transport services. Healthwatch Brighton and Hove together with Healthwatch East and West Sussex is calling for:

- the Independent Review to be made public
- a learning event to be held ensuring that lessons are learnt
- Healthwatch to be commissioned to gather evidence of the impact of this service on consumers in the future
- concerns raised by CQC over the quality of SECAmb services and failure to meet performance targets.

Healthwatch Brighton and Hove in collaboration with Healthwatch East and West Sussex is arranging:

- Enter and View observations and tracking of patients at A&E departments
- Enter and View work on delayed transfers of care
- a programme of support to ensure the consumer view is heard by senior managers and decision-makers in the ambulance service
- Healthwatch visits to ambulance control to observe the dispatch process
- a review of Care Quality Commission concerns about Royal Sussex County Hospital service quality and patient safety.

Healthwatch Brighton and Hove has offered a support plan including:

- a rolling programme of Enter and View visits – reviewing services from the consumer's perspective
- improving patient feedback using community representatives
- a Healthwatch presence in the hospital
- PLACE visits – a national annual review of the hospital environment
- an independent audit of patient complaints.

Our people

Decision-making

Healthwatch Brighton and Hove became an independent Community Interest Company (CIC) on 1st April 2015. Healthwatch Brighton and Hove CIC was commissioned by Brighton and Hove City Council to deliver the statutory local Healthwatch functions with Department of Health funds. We had four public meetings last year. We have Finance and Governance sub group an Intelligence and Communications Sub group that report to the main Board.

Our board 2015/16

Frances McCabe – Chair
Bob Deschene – Director
Carol King – Director
Catherine Swann – Director
Clare Tikly – Director; resigned November 2015
Doris Ndebele – Director
Geoffrey Bowden – Director
John Davies – Director
Karin Janzon – Director
Neil McIntosh – Director
Sophie Reilly – Director

We also have three people who can attend the Board to offer expertise who are not Directors:

Barbara Harris – equalities, inclusion and social justice
Tony Benton – safeguarding
Dr Frances Forester – general practice and clinical issues

How we involve the public and volunteers

Healthwatch Brighton and Hove is an organisation led by and for local people, and throughout last year, as always, we aimed to involve local people in all aspects of our organisation.

During the year we recruited 13 new volunteers with a wide range of expertise and nine left, meaning that we ended the year with 32 volunteers in total. Two of the new recruits were Enter and View Authorised Representatives; this provided us with a team of seven, ensuring that we were able adequately to undertake our statutory right of Enter and View. Three recruits were Engagement and Communications Assistants, providing our Engagement and Communications Coordinator with a strong and diverse team to help reach local communities.

Two recruits were Helpline volunteers, which enabled us to increase the reach and capacity of the Helpline service. Also, three new Admin Assistants were taken on, providing us with a strong team of volunteers to help us in our busy office. One person joined us as a Healthwatch Representative to help us with our role in representing the views of patients and service users on decision-making bodies across the city.

We also recruited two new members to our team of Hospital Complaints Peer Reviewers, bringing its strength up to four volunteers. Their role was to regularly review a sample of Brighton and Sussex University Hospitals NHS Trust responses to complaints about its services. This has ensured that members of the community have played a role in monitoring complaints made about a local NHS trust.

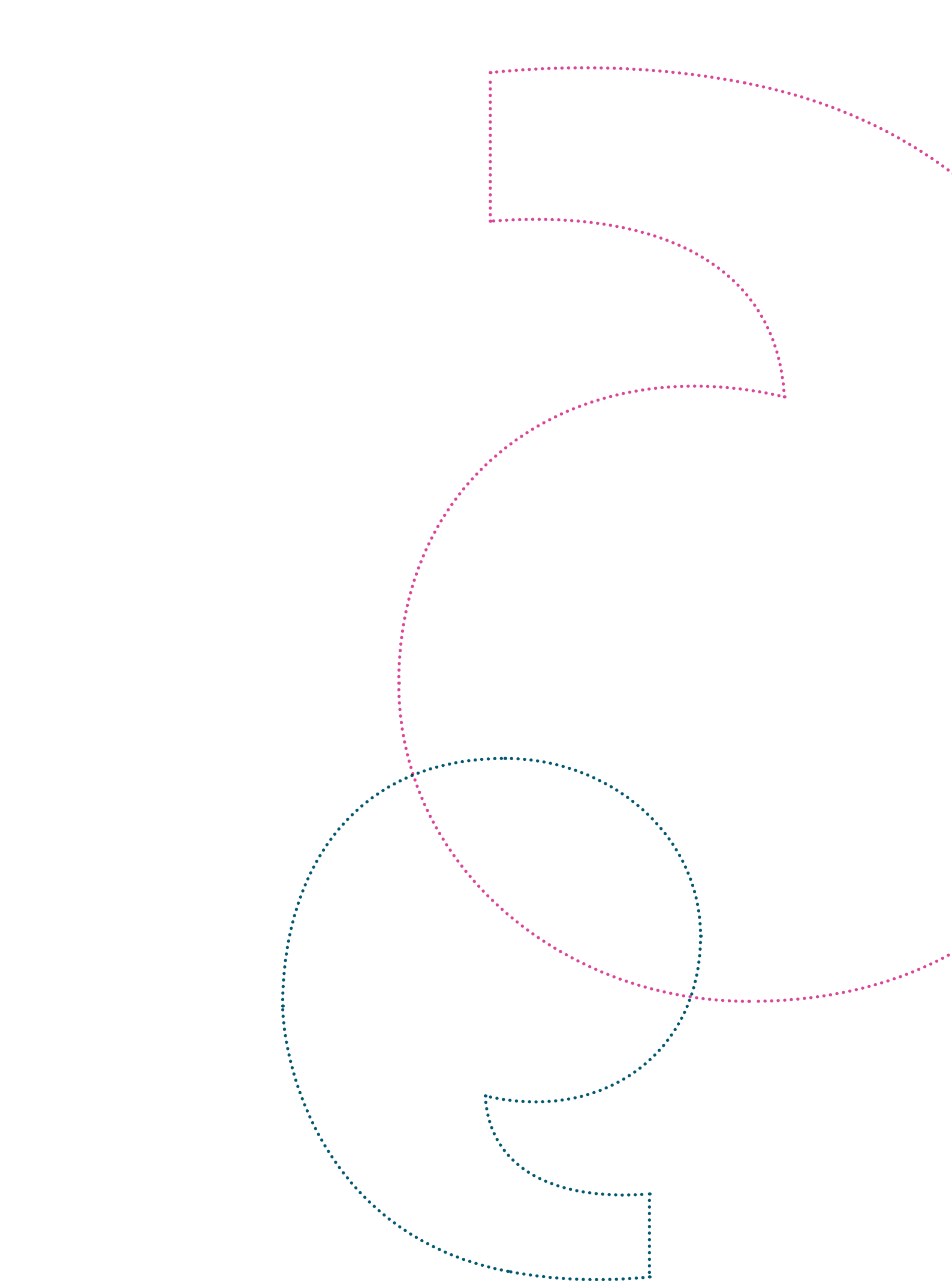
We also had twelve volunteers known as 'Papermates'. This is a group of people with learning disabilities who have been volunteering for the past three years helping to distribute our Healthwatch magazine. Each month they have tirelessly stuck on labels and stuffed and franked envelopes for postal copies of the Healthwatch magazine.

At the end of the year, all of our volunteers attended a reception and celebratory event hosted by the Mayor of Brighton and Hove at Brighton Town Hall to thank them for their hard work and dedication throughout the year.

Our finances

Income	
Funding received from local authority to deliver local Healthwatch statutory activities	£234,000
Additional income	£7,095
Total income	**£241,095**

Expenditure	
Office costs	£57,535
Staffing costs	£166,798
Direct delivery costs	£23,674
Total expenditure	**£248,007**
Current year loss	- £6,912



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healthwatch
Brighton and Hove

HOSC 2016/17 Work Programme v7

7th December 2016 – Meeting at Royal Sussex County Hospital

Issues	To invite
Sustainability & Transformation Plan (STP)	CCG (and/or STP leaders)
Healthwatch Annual Report 2015/16	Healthwatch
Healthwatch: Update on Outpatients work	Healthwatch
3Ts development of Royal Sussex County Hospital	BSUH
Substance Misuse Inpatient Detoxification: report back (requested March 16 OSC)	Public Health
New working arrangements between BSUH and Western Hospitals	BSUH

1st February 2017

Issues	To invite
Update on dementia services i) Planned move back into single sex dementia beds for the acute in-patient service ii) Strategic approach, diagnosis & memory assessment	ASC, CCG, SPFT

Still births and Multiple births	Public Health
Mental health & delayed transfers of care	CCG/SPFT
6 month update on planning for GP sustainability – including data on impact of previous closures	CCG & NHSE
Patient Transport Services: update on the PTS situation to focus on the transfer of provider. Healthwatch will also present their findings on PTS	HWLH CCG/BH CCG/Healthwatch
Report Back on progress of joint BSUH quality improvement working group and on joint SECAmb quality improvement working group	Update from Chair

22nd March 2017

Issues	To invite
Diabetes	
Functional mental health and older people	
Patient Transport Services	High Weald Lewes Havens CCG/B&H CCG/Coperforma
Report Back on progress of joint BSUH quality improvement working group and on joint SECAmb quality improvement working group	Update from Chair
Adult Social Care – Introduction to the new Executive Director of Care & Health + information on ASC performance	Rob Persey

Additional Issues TBC:

- Outpatients (if not a major part of CQC inspection report)
- MH pathways from diagnosis through treatment
- Access to information about city health and care services
- ASC performance

Workshop(s)

1. Children & young people – mental health and wellbeing