Brighton & Hove City Council

Health Overview & Scrutiny Committee

Title:	**Health Overview & Scrutiny Committee**
Date:	**6 September 2017**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall**
Members:	**Councillors:** K Norman (Chair), Allen, Bennett, Bewick, Deane, Gilbey, Greenbaum, Morris, A Norman and Wealls **Co-opted Members:** Zac Capewell (Youth Council), Caroline Ridley (Community Sector Representative), Fran McCabe (Healthwatch), Colin Vincent (Older People's Council)
Contact:	**Giles Rossington** Senior Scrutiny Officer 01273 291084 karen.amsden@brighton-hove.gov.uk

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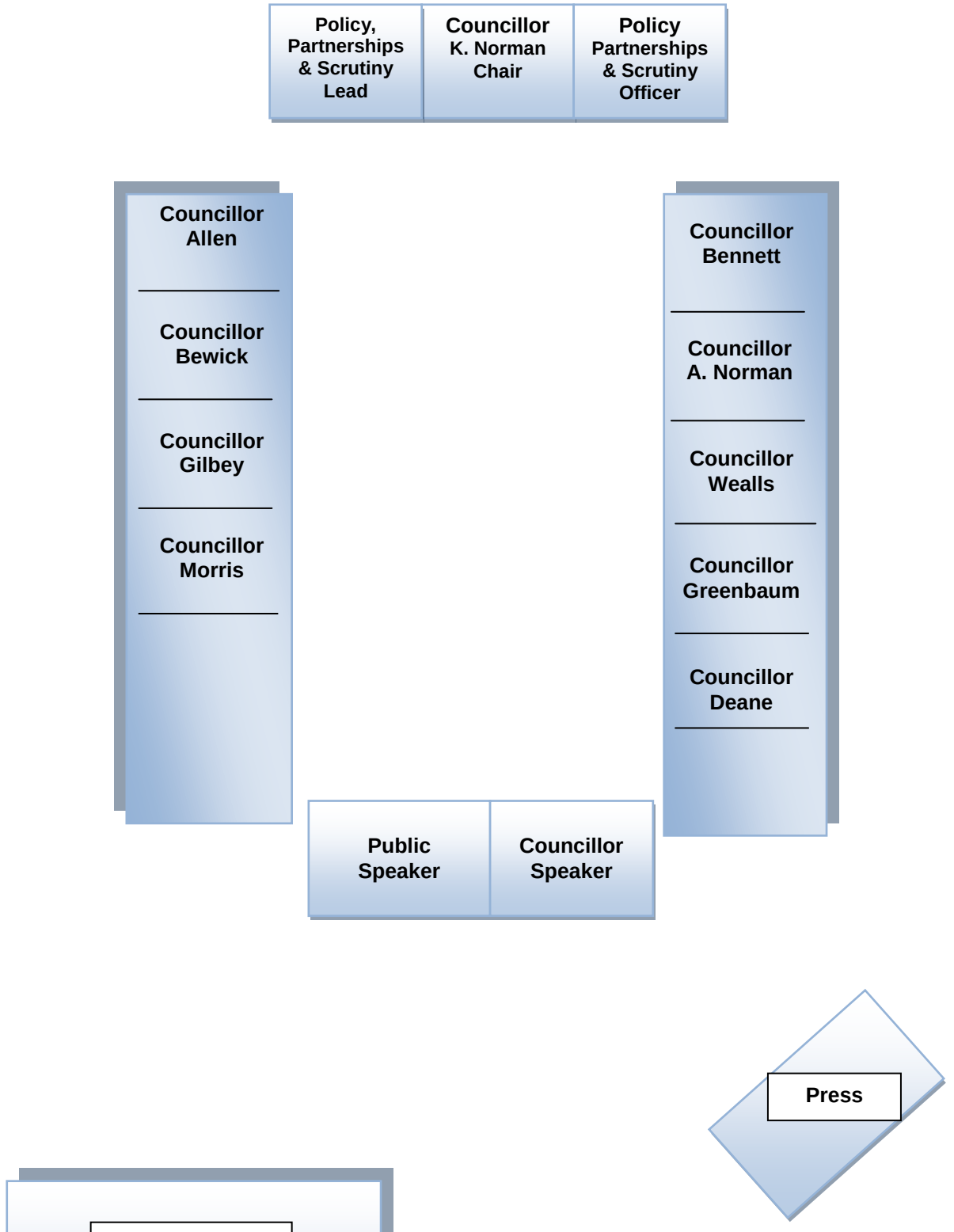
Democratic Services: Health Overview & Scrutiny Committee



AGENDA

PART ONE **Page**

12 PROCEDURAL BUSINESS

(a) **Declaration of Substitutes:** Where Councillors are unable to attend a meeting, a substitute Member from the same Political Group may attend, speak and vote in their place for that meeting.

(b) **Declarations of Interest:**

(a) Disclosable pecuniary interests;
(b) Any other interests required to be registered under the local code;
(c) Any other general interest as a result of which a decision on the matter might reasonably be regarded as affecting you or a partner more than a majority of other people or businesses in the ward/s affected by the decision.

In each case, you need to declare:
(i) the item on the agenda the interest relates to;
(ii) the nature of the interest; and
(iii) whether it is a disclosable pecuniary interest or some other interest.

If unsure, Members should seek advice from the committee lawyer or administrator preferably before the meeting.

(c) **Exclusion of Press and Public:** To consider whether, in view of the nature of the business to be transacted, or the nature of the proceedings, the press and public should be excluded from the meeting when any of the following items are under consideration.

NOTE: *Any item appearing in Part Two of the Agenda states in its heading the category under which the information disclosed in the report is exempt from disclosure and therefore not available to the public.*

A list and description of the exempt categories is available for public inspection at Brighton and Hove Town Halls and on-line in the Constitution at part 7.1.

13 MINUTES **1 - 8**

To consider the minutes of the previous Health Overview & Scrutiny Committee meeting held on 28 June 2017 (copy attached).

14 CHAIR'S COMMUNICATIONS

15 PUBLIC INVOLVEMENT 9 - 10

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

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

16 MEMBER INVOLVEMENT

To consider the following matters raised by Members:

(a) **Petitions:** To receive any petitions submitted to the full Council or to the meeting itself.
(b) **Written Questions:** A list of written questions submitted by Members has been included in the agenda papers (copy attached).
(c) **Letters:** To consider any letters submitted by Members.
(d) **Notices of Motion:** To consider any Notices of Motion.

17 BRIGHTON & HOVE CARING TOGETHER: UPDATE

Verbal Update on the progress of Brighton & Hove Caring Together

18 ADULT SOCIAL CARE: FUTURE VISION

Rob Persey, BHCC Executive Director, Health and Adult Social Care, will present on his priorities for services (verbal presentation)

19 GP SUSTAINABILITY 11 - 18

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

20 CLINICALLY EFFECTIVE COMMISSIONING 19 - 32

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

21 NHS 111 UPDATE 33 - 44

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

22 FOR INFORMATION: UPDATE ON THE PROGRESS OF HOSC WORKING GROUPS 45 - 58

Update on any meetings of the HOSC working groups that have taken place since the last committee meeting (June 2017). The HOSC working groups are:

- Brighton & Sussex University Hospitals Trust (BSUH) Quality Improvement (joint meeting with East Sussex HOSC and West Sussex HASC)
- South East Coast Ambulance NHS Foundation Trust (SECAmb) Quality Improvement (joint meeting with East Sussex, West Sussex, Surrey, Kent and Medway HOSCs). Minutes of the meeting held on 26 June 2017 are attached for information.
- Sustainability & Transformation Partnership (STP)

23 UPDATED HOSC 2017/18 WORK PROGRAMME **59 - 62**

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

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Date of Publication - Tuesday, 29 August 2017

BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00pm 28 JUNE 2017

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillors K Norman (Chair), Allen, Bennett, Deane, Gilbey, Greenbaum, Morris, A Norman and Wealls

Also in attendance: Caroline Ridley, Rob Persey (Executive Director, BHCC), Dr David Supple (CCG Clinical Chair), Pippa Ross-Smith, Jon Amos (Director of Strategy, SECAmb), Marianne Griffiths (CE, BSUH).

PART ONE

1 PROCEDURAL BUSINESS

1.1 There were no substitutes.

1.2 There were no declarations of interest.

1.3 Apologies were received from Adam Doyle, Cllr Tom Bewick and Zak Capewell.

1.4 There were no Part 2 items.

2 MINUTES

2.1 Paragraphs 49.1 and 49.5 should refer to 'she' rather than 'he' as Cllr Dee Simpson was chair of the previous meeting.

2.2 Paragraph 49.4 – the spelling of 'Daren' has been checked and confirmed as correct.

2.3 Cllr Allen spoke on a matter arising in relation to paragraph 49.5. Rob Persey was due to speak at the February meeting which he was unable to attend, and then the March meeting was cancelled so this still needs to be arranged. Rob Persey advised he was happy to attend the next meeting but would need some guidance on what the committee would like him to speak about. It was agreed that Rob would attend the next meeting and update the committee on the current position of the Adult Health and Social Care directorate and discuss the directorate plan.

ACTION: Rob Persey to attend the next meeting to discuss and update on the Adult Health and Social Care directorate.

2.4 In relation to paragraph 48.1 on the cost of managing the STP, Fran McCabe advised she had not yet received the information. This had been circulated previously but would be distributed again.

2.5 Cllr Morris identified that a section in the minutes only lists the questions that were asked at the previous meeting but not the resulting answers and would like more detail than this in the future. Apologies were given and it was confirmed that the reason for this was due to staff sickness and that there would be more detail recorded in future minutes.

3 CHAIR'S COMMUNICATIONS

3.1 Cllr Ken Norman introduced the meeting and welcomed new committee members. He told members that the meeting would hear from key figures in the health service about significant changes taking place.

4 PUBLIC INVOLVEMENT

A – Written Questions

4.1 There was a late public question on breast feeding from Valerie Mainstone. However, it was decided that it would not be heard in this committee as it has already been to the Health and Wellbeing Board (HWB) on 13th June and they are providing an answer. It was however agreed that Valerie would be able to make a brief comment on this situation.

4.2 Valerie explained she was disappointed at being unable to present this question as she had received a written reply from HWB and this question to HOSC was different based on the reply already received. The pilot in Portslade had been successful and it was thought to be a mistake to redeploy and dismiss workers rather than take the project and its benefits throughout the city.

4.3 Rob Persey thanked Valerie for her statement and advised that the HWB did ask for a report to come back on the subject of breastfeeding in order to provide reassurance. It is hoped that this report will be presented at the HWB in July. However more time may be required to gather and present the data so this could well be delayed until September.

B – Deputations

4.4 There was one deputation that had been presented to HWB in June 2017 and this had been referred to HOSC for information.

5 MEMBER INVOLVEMENT

5.1 There were no Member questions.

5.2 Pippa Ross-Smith provided an update on the Ridgeway practice which outlined that notice of intention to terminate was given at the end of May as the premises was no longer available for the NHS to use. The process for dealing with this is as follows:

- The CCG writes to patients to notify them of the closure and setting out how they can express their views. This step has been completed already.
- Responses are used to shape an options paper to set out commissioning decisions.
- The Options paper will be considered by the Primary Care Commissioning Committee.
- Patients are informed of the results of the meeting and told where and how to register at a new GP if required. Patients are supported through the process.

5.3 Questions were asked and the following points were clarified:

- Fran McCabe asked what actions were being taken to minimise the impact of GPs retiring on patients and fellow GPs, given that the city has an ageing population of doctors?
- It was confirmed that 6 months' notice is required that a GP is retiring.
- Dr David Supple confirmed that information on the number of GPs who are nearing retirement should be in the public domain and that this is something to be mindful of throughout the city. Pippa Ross-Smith advised that in the February meeting a request was made for a GP paper to be brought to the September meeting.

ACTION: PR-S to write General Practice report to be brought to the September meeting.

5.4 The idea of creating a working group on GP sustainability was discussed and it was decided that it would be best to wait until this report is received before deciding if a working group is required.

6 CARING TOGETHER - THE CITY'S RESPONSE TO THE SUSTAINABLE TRANSFORMATIONAL PARTNERSHIP (STP)

6.1 The presentation was introduced by Dr David Supple (CCG Clinical Care) and Rob Persey (Executive Director of Health & Adult Social Care, BHCC), and provided an update on the Caring Together (CT) programme and the city's response to the Sustainability & Transformation Partnership (STP).

6.2 The following aspects of Caring Together were outlined:

- There are seven work streams to support the CT programme, the structure for which is currently being prepared and will be brought to the Health & Wellbeing Board (HWB) in autumn 2017.
- The draft governance structure will receive feedback from HWB. This is needed to ensure relationships are built and communicated effectively.
- There are a series of engagement events, the first being the Big Conversation at the Brighton Dome on 4th July. The CCG will ensure that terminology is simplified to make information more accessible.
- If the STP didn't exist the CT programme would still be taking place. This plan is in the context of the public health report and is about what those involved in health care feel is needed.

6.3 In response to questions asked, the following was clarified:

- The *current* funding gap across the STP footprint is £55m (2017-18) which is not evenly distributed between each CCG. Meetings are taking place to decide how best

to close the gap but there is confidence that in Brighton there will be no discussions around closures of hospital wings or large scale resources.

- The Big Conversation engagement meeting is open to all. However there is a capacity issue with the venue. There will be other public meetings in the future and the CCG will ensure that they are accessible to all. There will be as many engagement events organised across the city as required and they will be properly advertised.
- The presentation given was an introduction and update on the CT programme but Brighton & Hove is looking at how public organisations can work more effectively together. Detailed discussions about accountable care organisation models have not yet taken place.

7 UPDATE ON MOBILISATION OF THE NEW SUSSEX PATIENT TRANSPORT SERVICE

7.1 Derek Laird introduced the item outlining that he had been asked to come and provide support and stability to the Sussex Patient Transport Service as part of the transition plan put in place after the termination of Coperforma's contract in October 2016. South Central Ambulance Service (SCAS) was awarded the contract and a detailed transition plan that all parties were a part of was put in place. Auditors also made ten recommendations, all of which have been implemented, including Derek's appointment.

7.2 It was explained that a phased approach to the transition was taken to reduce risk. Staff were given a lot of training before transferring to South Central Ambulance Service; subcontracted services continued to be used but were managed better; the transfer of data was achieved in a couple of weeks.

7.3 The service has now reached a business as usual stage with a quarterly review scheduled for August. Moving forward, discussions will take place with South Central Ambulance Service about using more central employment instead of relying on subcontractors.

7.4 Performance is significantly better compared to last year and targets are very close to being met.

7.5 The call centre received a lot of calls in the first couple of weeks, many of which were patients wishing to confirm their bookings. There is still quite a high level of calls so ongoing training with hospitals is taking place in order to improve the online booking figure to around 70%.

7.6 Work looking into specifically renal transport services in ongoing with an aim of improving the performance for patients. Renal is a large part of the contract and there is also a dedicated renal manager.

7.7 The following was clarified:

- Patients detained under sections of the Mental Health Act are not part of the PTS contract. Certain opportunities for this may exist but this area needs to first be better understood.
- In regard to concerns raised in CQC report about Thames as a service provider it was confirmed that the areas of concern included processes, patient control and

standard of equipment. In response to this Thames are continually updating the CCG and have regular update meetings.

- The increased number of calls received initially by the call centre was largely because patients were nervous and wanted to confirm that their booking was in place. A communications plan did exist to ensure patients were given the right information about the new service.
- A formal complaints and compliments process does exist and there is also a process where concerns can be raised by health care professionals. Hospital liaison officers are in place to help manage issues.
- A contact centre exists so that those patients that are unable to book online still have access to the service. The online service is open to patients and professionals and support and guidance for online booking is offered.

ACTION: To bring an update report to the first HOSC meeting in 2018.

8 MEET THE NEW SENIOR TEAM AT SOUTH EAST COAST AMBULANCE SERVICE (SECAMB)

8.1 Jon Amos (Director of Strategy, SECAmb) introduced the presentation outlining that since the last update in October there have been significant changes for the trust. Bi-monthly meetings with HOSC chairs from across the patch take place to provide detail on CQC actions and improvements.

8.2 The report from the CQC inspection is expected around September. Some immediate actions came as a result of the inspection which had already been identified. The key areas of focus are around consistent management of medicines and better quality of records moving to electronic. The quality of call recordings also needed improvement which has been addressed and 99.4% are now fully recorded but still aiming for 100%.

8.3 SECAmb has been in a period of recovery over the last year, and a new five year strategy is about to be published. This should be published in July 2017. The strategy is about how to move on from the recovery and recognising that there are still further improvements to be made.

8.4 There has been improved engagement with staff and a better management structure of support. Engagement from staff has been significant and they feel they are getting a response to the questionnaires.

8.5 The financial position is challenging in terms of demand growing more than contract income. There was a significant deficit at end of 2016/17 and a target to decrease to £1m by the end of this year.

8.6 SECAmb is performing well against targets in Brighton & Hove in terms of responding to Red 1 (immediately life threatening) and Red 2 (potentially life threatening) calls. This is regularly reviewed and there is an ongoing process to see if there are any adverse health outcomes as a consequence of potential delays.

8.7 There have been positive changes in the relationship with Royal Sussex County Hospital (RSCH). There is more work to do but both in a better place for working together.

8.8 There have been positive results from defibrillators that have been installed around the city.

8.9 Advanced preparations are happening for Brighton Pride and the trust is also planning ahead for the winter.

8.10 In response to questions asked, the following was confirmed:

- Jon Amos advised that the presentation today covered a broad remit but he would be happy to return with specific information and to answer more specific questions.
- There is a significant piece of ongoing work looking at how ambulance services are measured. Currently the measurement is very time focussed with little clinical base but the aim is to move toward a more clinical and metrics-focused way of measuring performance. SECAMB expects to receive national pilot recommendations in the next few weeks which should provide new metrics.
- Working with colleagues across the NHS and social care to deal with repeat callers. Using this multi-agency, coordinated approach has enabled the frequency of the top 10 callers to be dramatically reduced to almost 0.
- Using alternative response vehicles is being looked at with the aim to focus on ensuring the correct resource is sent to the call initially.
- The move to stroke centres is a positive and powerful change and a great example of improved patient care. In a proper stroke unit the patient is treated by experts and given the best possible care. Time has been spent with stroke nurses and there has been a recognisable impact on response times.

8.11 It was requested that the report on bullying and harassment is brought back to the board when it has been finalised.

9 UPDATE ON THE HOSC STP WORKING GROUP

9.1 Cllr Allen introduced the update outlining that the STP working group was established following the HOSC meeting on 7th December 2016 and the first meeting was held on 20th March 2017 where Adam Doyle was asked questions on governance, timetable and finance. The second meeting on 21st June was attended by Evelyn Barker (BSUH) and Mike Jennings (Sussex Community NHS Foundation Trust).

9.2 It was agreed in the Terms of Reference that the continuation of the STP working group would be reviewed in June 2017. So far there have only been twomeetings and there are still others lined up to attend including GPs. More information and feedback from local people is required before it can be said that the working group has achieved what it was set up to. It was therefore recommended that the committee agree to allow the working group to continue and review again after two further meetings.

DECISION: The STP working group will have two further meetings and then be reviewed again.

ACTION: Cllr K Norman to arrange for a Conservative Cllr to attend the working group meetings.

10 MEET THE NEW SENIOR TEAM AT BRIGHTON & SUSSEX UNIVERSITY HOSPITAL TRUST (BSUH)

10.1 Marianne Griffiths (CE of BSUH) introduced her colleagues and explained that she wanted to highlight to the committee what they want to achieve, how they will achieve it and what the challenges are.

10.2 The Care Quality Commission (CQC) has put the organisation into special measures – there are issues with quality (staff culture) and finances (a deficit of £65m at end of last year). This team of staff were brought in from West Sussex in April 2017 to undertake the leadership for a minimum of 3 years. BSUH has a link to West Sussex as a lot of patients are sent to specialist units in Brighton from West Sussex.

10.3 There arefive key things they want to achieve:

- Moving out of Quality Special Measures – The CQC left 63 issues to address, some of which were large problems including leadership, culture and governance. The CQC came back to re-inspect when this leadership team had only been in place for two weeks so it is unlikely this report will allow the exit from special measures. It is hoped that some significant change will have occurred in a year's time when the CQC return again.
- Moving out of Financial Special Measures – when the management agreement was signed B&H received a dowry from BSUH. £30m capital reinvestment to redesign A&E, £19m emergency fund for backlog maintenance and £2m for patient first programme.
- Building an organisational culture that will sustain improvement into the longer term – BSUH came out at the bottom from a staff survey. There is a need to re-win the trust of staff and front line staff are being worked with to try and improve morale and move the organisation forward.
- Building on A&E improvements – a full business case should be announced on Friday.
- Progressing the 3Ts programme – This is a complex programme but it is on track.

10.4 The main challenges exist around the workforce being demoralised. This is being dealt with through trying to win back trust of staff and also hiring the right people through an ongoing recruitment campaign. Regulators can also mean that there is little room to carry out improvements however it has been agreed that the regulators will only review once per month.

10.5 In response to questions the following was clarified:

- It was confirmed that the £65m figure for deficit was a negotiated settlement that allows a £65m deficit to be delivered with headroom for some investment and changes to be made.
- In relation to the restructure of the estates management department it was confirmed that the change was not managed as it should have been and lessons will be learnt from this. Should have been clear on how the new management structure was designed, the impact of this and support available but this was not done so they would like an opportunity to revisit.
- Partners are being engaged with including Adam Doyle who has been met with as he is part of the single plan. He agreed that there should be a stretch target of 1% for delayed discharges and having a different contract together to deal with

transformation was spoken about. It is felt that there has been a good start to the working relationship and that the right discussions are taking place. A positive start has been made with the commitments made and some improvements can already be seen from the action taken by partners and themselves.

- Vacancies have been advertised and there is the correct quality of person applying so it is hoped that in the near future there will be some stability in the organisation in terms of employees. The last 18-24 months has been looked at to see which employees have left and they are now being contacted and invited to events in July to encourage them to re-join.

11 CONSULTATION ON A PROPOSED HOSC WORK PROGRAMME FOR 2017/18

11.1 Cllr Allen reminded the committee that Rob Persey had been invited to the next HOSC meeting on 6th September to present facts, figures and performance for the Adult Health and Social Care directorate. Pippa Ross-Smith would also bring an update on GP sustainability to this meeting.

11.2 Cllr Wealls asked for confirmation on whether service provision around the reorganisation for children and health is being looked at by HOSC or CYPS.

11.3 It was suggested that a piece of work looking at the best models and challenges for service providers and commissioners be looked at in relation to social prescribing benefits.

11.3 The annual report for Healthwatch is almost complete so an agenda item on diabetes can come to the next meeting.

11.4 It was agreed that it would be useful for the agenda to be organised more strategically, looking at programme plans occurring so they can be scrutinised as they move along.

ACTION: Cllr K Norman to meet with lead members, Cllrs Allen and Greenbaum, to discuss the above.

The meeting concluded at Time Not Specified

Signed Chair

Dated this day of

Public Question for 06 September HOSC meeting

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

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

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

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

Chris Tresgold

HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 19 Brighton & Hove City Council

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

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 This report provides an update on local efforts to ensure that general practice (GP) services in the city remain sustainable.

1.2 Additional information on GP sustainability will be provided by Brighton & Hove Clinical Commissioning Group (CCG) at the committee meeting. It has not proved possible to circulate this information in advance of the meeting as it includes material that is not currently in the public domain and which is potentially commercially sensitive. This material will however be in the public domain by 06 September.

2. RECOMMENDATIONS:

2.1 That members note this report and the information provided by the CCG; and

2.2 Determine what further scrutiny of this issue is required, if any.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 GP practices are small business which contract with the NHS to provide a wide range of primary healthcare services. In recent years, General Practice has come under increasing strain, and there are now significant national concerns about the sustainability of the current service model. Problems include: GP recruitment and retention; the continuing relevance of the 'partnership' model; workload; quality; and the suitability of premises.

3.2 All these national issues are being experienced locally. For example, several local GP practices have shut in the past two years, and it was recently announced that the Ridgeway surgery will also close.

3.3 Brighton & Hove HOSC has been monitoring NHS plans to address local GP sustainability issues for a number of years, via a series of member workshops and reports to committee.

3.4 Members should note that NHS England (NHSE) has been responsible for commissioning GP services since 2013. Previous HOSC updates have consequently been led by NHSE. However, under 'co-commissioning' arrangements, Brighton & Hove CCG is now jointly responsible for GP commissioning and will present this and further updates.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 None to this report for information.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 None to this report. NHS commissioners undertake formal community engagement & consultation when making significant changes to GP services (for example if a surgery is closing).

6. CONCLUSION

6.1 Members are asked to note the update on local work to sustain General Practice.

6.2 Members are also asked to consider how to further scrutinise this issue: e.g. by requesting additional update reports.

7. FINANCIAL & OTHER IMPLICATIONS:

7.1 None to this report for information

Legal Implications:

7.2 There are no legal implications to this report.

Lawyer Consulted: Elizabeth Culbert *Date: 08/08/17*

Equalities Implications:

7.3 None directly. When contemplating making changes to GP provision, NHS commissioners must consider the equality risks and implications of their plans – e.g. the impact on vulnerable patients of losing continuity of care and/or having to travel further to access primary care services. This will usually be via a formal equality risk assessment process

Sustainability Implications:

7.4 None directly. The closure of local GP surgeries may potentially have an adverse impact on sustainability to the degree that patients are required to travel further in order to access a GP.

Any Other Significant Implications:

7.5 None identified.

SUPPORTING DOCUMENTATION

Appendices:

None

Documents in Members' Rooms
None

Background Documents
None

Appendix to GP Sustainability Report to HOSC

1. Longer Term - Caring Together

The joint strategy for transforming health and social care in Brighton and Hove is Caring Together. This has six Care Programmes as follows:

- Planned Care
- Medicines Management
- Mental Health/Children/Maternity
- Prevention/Community Services
- Primary/Urgent Care Access

These are supported by enabling programmes that include:

- Estates
- IT
- Workforce

Each of these Care Programmes is now developing its plans for the next 3-5 years.

Primary care is, in many ways, a cross cutting theme that underpins all of the Care Programmes to some degree and is supported, in its turn, by the Enabling Programmes.

A first cut primary care strategy for Caring Together is due to be developed during quarter 3. The strategy will develop key themes, including:

- creation of primary care at scale, to improve resilience and economies of scale
- integration across community based services (primary, community, mental health and social care)
- streamlining of care pathways across the whole system to improve both patient experience and value for money

2. Shorter Term – Stability and Resilience

However, in the shorter term, the CCG's approach is to bring greater stability and resilience to primary care, to provide a strong foundation for the strategic/ transformational work under Caring Together.

This work can be summarised as follows:

2.1 - Identifying vulnerable practices

A tool is being developed that brings together the different sources of data we hold for Practices. This is aimed at enabling the CCG to identify those practices that are vulnerable or could become vulnerable. The underpinning approach is to be supportive of practices in this situation and to understand the root causes of the vulnerability.

2.2 - A Practice Support Toolkit

This brings together the interventions at the CCG's disposal that can be brought to bear on vulnerable practices. These include:

- Recruitment (see also section on Workforce below)
- Demand and Capacity planning, to match work flow through the practice to available skills and staffing resources
- Training in internal efficiency, streamlining internal systems (for example, using the Productive General Practice programme, which is being implemented across our practices currently)
- Clinical skills training
- Non clinical skills training
- Working "at scale" across the local cluster of practices
- Finance, ensuring that the practice is maximising its NHS income
- Advice on use of premises (see section on Estates below)
- Medicines Management
- Informatics
- In some instances, a financial support package, aimed at enabling the practice to become sustainable in the longer term.

2.3 - Commissioning Additional Capacity

A telephone-led consultation service has been commissioned, with a view to reducing the operational pressure on our most pressured practices (which are concentrated in the city centre and the east of the city).

Subject to evaluation, the model could be replicated across all practices if it succeeds in providing additional capacity and reducing avoidable dependence on other NHS resources (e.g. A&E).

2.4 - Workforce Plan

A first cut plan on primary care workforce will be developed by the end of quarter 2. This will describe and analyse the current situation and the opportunities to address the challenges in the short to medium term. In the longer term, this work will be picked up by the Caring Together Workforce Enabling Programme.

2.5 - Estates Plan

A first cut plan on estates will also be developed by the end of quarter 2. This will begin to set out our current use of the primary care estate and a framework for using estates to facilitate the strategic change that is needed to deliver Caring Together. Again, over time, this will be taken over by the relevant Caring Together Enabling Programme.

3. Practice specific issues

3.1 - Ridgeway

The practice approached the CCG at the end of May and informed us that they were terminating their contract to provide services to patients as of 31.10.17. They are entitled to do this under the national GP contract regulations. They also indicated that the premises (which they own) would not be available to the NHS after this time.

In response to this situation, the CCG has analysed the different options available, which can be summarised thus:

- Reprocure a contract to serve the existing population; or
- Disperse the patients currently registered at the practice.

After due consideration and engagement with local patients, the decision was taken by the CCG's Primary Care Commissioning Committee to disperse the patient list, because a procurement of a new service for 2,200 patient would run counter to the strategic objective of achieving primary care at scale (see above).

The CCG is currently working with the practices that will be most affected by this change, to ensure that they are as prepared as possible to receive an influx of new patients.

3.2 - Ardingly Court

When The Practice Group gave notice to withdraw from its contract in Brighton and Hove to provide 5 practices, one of the practices concerned was taken on by the Ardingly Court practice – a well established and respected practice based in the city centre. The practice effectively doubled in size and started working across two sites, rather than its original single site.

Since that time, the operational pressures on the practice have increased considerably and, earlier in the year, the practice approached the CCG with a request to split the practice into two. The CCG has agreed this, on the basis that it creates the opportunity to achieve:

- One practice in the Whitehawk area of the city, focussed on the needs of that population and working to integrate their primary care services with the other services in the same building and locality
- A second practice in the city centre, focussing on the distinctive needs of the city centre population, and moving into the new Palace Place premises in the autumn of next year.

However, in order to achieve this under NHS primary care and procurement regulations, it is necessary to procure a new practice for the Whitehawk area on the open market and the Primary Care Commissioning Committee has agreed to this procurement moving ahead as of early September. The existing partners of the practice are fully appraised of the situation and all of the doctors and nurses

currently working in the practice have stated their intention to remain working at one or other of the practices in the future.

Patients will be engaged in the procurement process, which will be completed for the new practice to begin providing services as of 01.04.18.

HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 20 Brighton & Hove City Council

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

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 Members are asked to note a new regional NHS initiative: “Clinically Effective Commissioning”. Details of this initiative provided by Brighton & Hove Clinical Commissioning Group (CCG) are included as **Appendix 1** to this report.

2. RECOMMENDATIONS:

2.1 That members note the information on Clinically Effective Commissioning supplied by Brighton & Hove CCG (**Appendix 1**)

3. CONTEXT/ BACKGROUND INFORMATION

3.1 Clinically Effective Commissioning is a new regional NHS initiative which aims to improve the effectiveness and value for money of healthcare services by ensuring that commissioning decisions across the region are consistent, that they reflect best clinical practice, and that they represent the most sensible use of limited resources. More information on this initiative, provided by Brighton & Hove CCG, is included as **Appendix 1** to this report.

3.2 Clinically Effective Commissioning is a regional initiative which is being led locally by CCGs. South East Coast HOSC Chairs have agreed that scrutiny of this work-stream should initially be conducted by individual HOSCs, and a similar report will be presented to East Sussex, West Sussex and Surrey HOSCs. As Clinically Effective Commissioning progresses, and should substantive plans for changing services be identified, we may need to further explore whether these plans are better scrutinised individually or jointly.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 None for this information paper.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 None to date.

6. CONCLUSION

6.1 Members are asked to note the establishment of the Clinically Effective commissioning initiative. HOSCs are likely to become more involved in scrutinising aspects of this work-stream as it develops.

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: 03/08/17*

Equalities Implications:

7.3 Any substantive changes to healthcare commissioning are likely to have equalities impacts, and will require assessing. However, it is currently too early in the process to identify specific impacts.

Sustainability Implications:

7.4 None identified.

Any Other Significant Implications:

7.5 None identified.

SUPPORTING DOCUMENTATION

Appendices:

1. Information on Clinically Effective Commissioning provided by Brighton & Hove CCG

Documents in Members' Rooms
None

Background Documents
None

Clinically Effective Commissioning (CEC)

CEC Programme Team
August 2017

How do we address waste and achieve best value?

CEC focussed on planned care (rather than urgent care)

In order to help the whole system balance resources and demand there is a need to:

1. Decide what the system will and won't do (e.g. medicines, procedures or other treatments) based on a defensible and clinically led decision making process
2. Enact those choices in formal policies, embed them in systems and communicate our decisions widely
3. Keep those policies up to date and under continuous review to ensure they reflect clinical evidence as it emerges and the needs of our local populations
4. None of these discussions undermine the hard work of clinical redesign which is also required, but these hard decisions will create the space in which redesign can occur

Releasing resources

Key assumptions:

- As a system we have identified all areas of waste and have addressed them via savings schemes – if examples of pure waste are located these are being addressed as an absolute priority
- We recognise that there is no more money likely to be forthcoming – we need to manage within the resources we have been allocated
- Managers can do a lot to implement change and identify the issues and challenges, but ultimately as a clinically led organisations, it is the membership of the CCG which need to decide the priorities for the local population – led by our clinical leaders

Why this is good practice, even if there weren't financial challenges

Resources required for the innovation

Implementation of high value innovation e.g. troponin in heart disease funded by reduced spending on lower value intervention in the cardiovascular programme budget and control of innovation of uncertain value.

Innovation adopted

Resources freed by reducing lower value activity

Programme Governance

CCG commissioned, STP oversight

There are 8 CCGs in the STP – they commissioned the work as it is core business for CCGs, but ultimately as the implementation needs the whole system to play a role, so CEC is a key work programme for the STP

CEC Programme is governed as follows:

•Decisions to change must be made by the CCGs – clinical policies are 'owned' by each CCG – so each must come to their own decision, but work in common to arrive at the same result by:

•Overseeing the work via the CEC Programme Board (all 8 CCGs are represented)

•Reporting weekly and monthly progress and issues

STP oversees and reviews

•STP executive monthly – highlight report

•STP clinical board – advises on clinical issues which may have wider system impacts

Three CEC Objectives

1. Common Policies - Objective

There are 8 CCGs in the STP – and there are at least 5 main versions of each clinical policy (this means that Patients referred to the same hospital for the same treatment are subject to different threshold policies).

The different policies mean that patients get different access and outcomes. If a common, revised policy can be established there will be:

- **Greater equality of access to treatments across the whole STP footprint**
- **It will be cheaper for CCGs to maintain currency of common policies**

All policies are being reviewed and detailed assessment of evidence supporting the policy and the degree of difference between each policy is being assessed.

Latest information on what the 8 CCGs spend with local acute hospitals indicates that there is substantial variation in numbers of treatments per 100k population – which indicates that there is non-clinical variation which could be addressed to release resources.

In other locations, improved policies and increased effort on end-to-end processes and compliance has stopped 5 - 15% of the activity, which could release £3-6m in a full year after implementation of the total programme

Three CEC Objectives

1. Common Policies – Progress

A first group of policies are being finalised – these are policies where most CCGs already had an existing policy and there is strong evidence body of clinical evidence exists to support a common policy which will set a threshold for treatment.

- **STP clinical board has agreed that most of the policies are uncontroversial**
- **all CCGs have had multiple rounds of drafts to review.**
- **Final drafts to be provided to CCGs in August for decision making within CCG processes**

A second group of policies is being reviewed and developed. These are more complex, as CCGs have different existing policies, or there is more clinical debate required to find the appropriate standard.

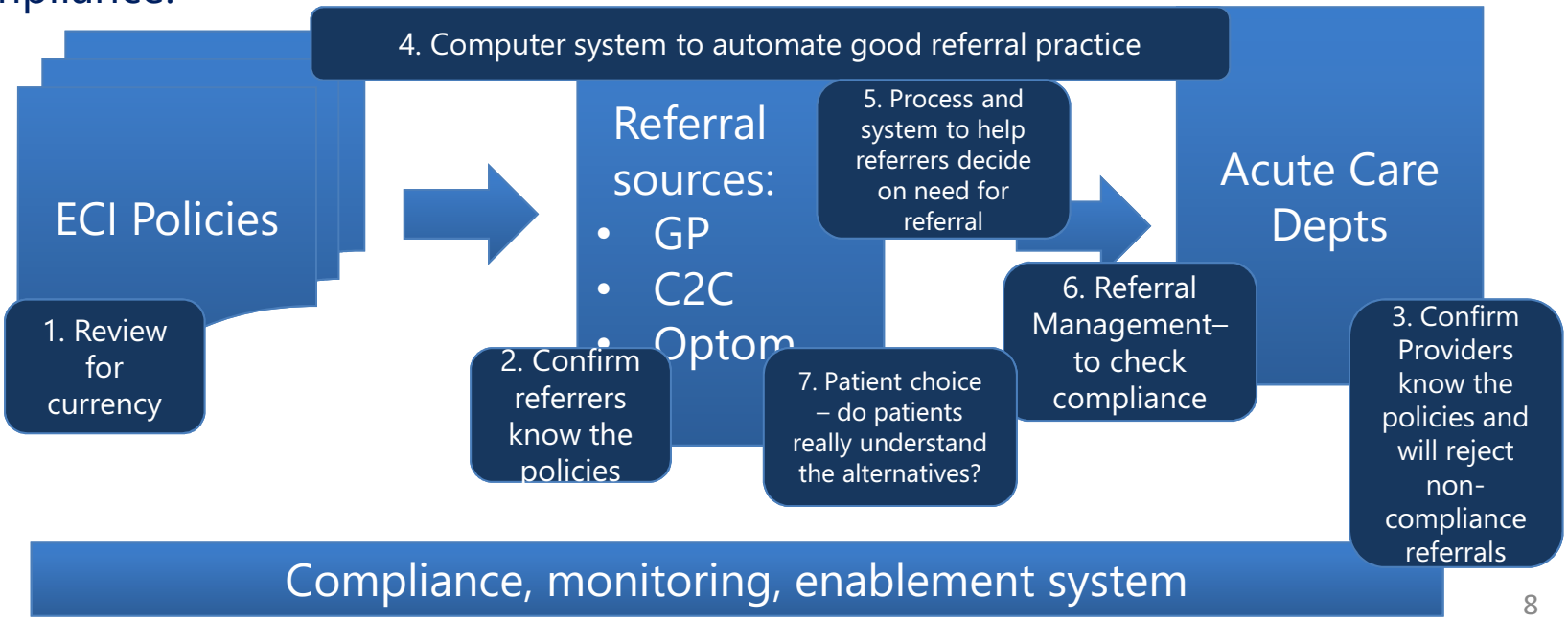
- Four clinical evidence review workshops have been booked for September – to bring acute providers, GPs, patient reps and others together to discuss the evidence base and as far as possible agree on an outline common policy
- If new policy proposals represent a significant change, then engagement and consultation processes will follow to ensure CCGs involved and engage all relevant stakeholders

CEC Objectives

2. Improved processes - Objective

There are 8 CCGs in the STP each of which have differing approaches to ensuring end to end compliance with existing policies. This leads to differing effectiveness of the thresholds – as in some cases there is evidence of significantly differing use of medicines and procedures, despite similar or identical policies.

There are significant advantages in the CCGs working together to develop best practice approaches and in some cases co-developing new processes and systems to aid compliance.



CEC Objectives

2. Improved processes - Progress

Each stage of the process has been analysed for each CCG.

The CEC programme has developed project outlines for 12 initial projects to improve each step of the process. Not yet been approved for implementation as there are key stakeholders who have yet to be involved.

- **PID 1**: Set up STP wide process to update, maintain and upload policy changes onto GP systems.
- **PID 2**: Help referrers work within the process (link to the introduction of supporting software e.g.. DXS)
- **PID 3**: Implement decision support tools to standardise GP referral
- **PID 4**: Harmonise uptake of E-referral (ERS) across Provider Trusts and support GPs to adopt
- **PID 5**: Standardise GP dashboard to review variation in GP referral patterns
- **PID 6**: Shared decision making and PDA processes to help patients make more fully informed decisions about their care
- **PID 7**: Align IFR processes to harmonise with prior approvals arrangements at Trusts
- **PID 8**: Advice & Guidance – Secondary care assistance to GP referrers – opportunity for common approach
- **PID 9**: Promote common approach to 'referral hub' function for validation of prior approvals.
- **PID 10**: Implement easy to use prior approval system in the four principal acute Trusts (BSuH, SaSH, ESHT, WSHFT). Capture C2C referrals.
- **PID 11**: Coding and costing optimisation supporting standardised reporting and compliance processes
- **PID 12**: Audits to demonstrate quality and compliance

CEC Objectives

3. Accelerating savings

There are 8 CCGs in the STP and an emerging cost pressure in 2017-18 for the Commissioners' budgets

Working across the CCGs, we aim to identify a range of opportunities which can be rapidly assessed and put in place across the system to improve the financial position.

This work takes place in the context of the Capped Expenditure Process, which required the whole system to demonstrate that all possible options has been considered then prioritised for further development based on criteria also developed in the project.

There are a small number of options which CCGs believe could be pursued in 2017-18 most of which involve the 8 CCGs working more closely together to share best practice and take advantage of the scale offered by the STP.

Further work to take place in August to gather more options, quantify the opportunities and examine the timescales for delivering sustainable change.

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

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

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 The NHS provides the public with advice and support for urgent, but non-emergency (i.e. 999), health issues via its NHS 111 telephone helpline.

1.2 The current NHS 111 contract, provided by South East Coast Ambulance NHS Foundation Trust (SECAmb), ends soon and a new Sussex-wide service will need to be procured by autumn 2018 to start operation in 2019.

1.3 More information on the NHS 111 plans will be presented at the meeting, and a submission from NHS colleagues is included as **Appendix 1** to this report.

2. RECOMMENDATIONS:

2.1 That members note the update on plans to change local NHS 111 services.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 The current NHS 111 service is a regional contract, which is led by Swale CCG. Coastal West Sussex CCG is the host CCG on behalf of the Sussex CCGs for the re-procurement of the NHS 111 service.

3.2 More information on NHS 111 services and the plans for change is included in **Appendix 1** to this report.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 Not applicable to this report for information.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 None directly to this report. However, public and stakeholder engagement should be an important facet of any major procurement project, and members may wish to seek assurances around these plans.

6. CONCLUSION

6.1 Members are asked to note this initial information about plans to re-procure a Sussex-wide NHS 111 service.

7. FINANCIAL & OTHER IMPLICATIONS:

7.1 None. This report is for information.

Legal Implications:

7.2 There are no legal implications arising from this report.

Lawyer Consulted: Elizabeth Culbert *Date: 03.08.17*

Equalities Implications:

7.3 None directly. This report is for information, however, members may be interested to explore the steps being taken to ensure that 111 or equivalent services can be accessed by everyone, including groups for whom a telephone helpline may be problematic (e.g. people with hearing loss; people who are not fluent in English; people with learning disabilities etc.

Sustainability Implications:

None directly. This report is for information. Effective use of NHS signposting services including NHS 111; should reduce unnecessary attendances at A&E or GP surgeries and this may have a positive sustainability impact on NHS services.

Any Other Significant Implications:

7.4 None identified.

SUPPORTING DOCUMENTATION

Appendices:

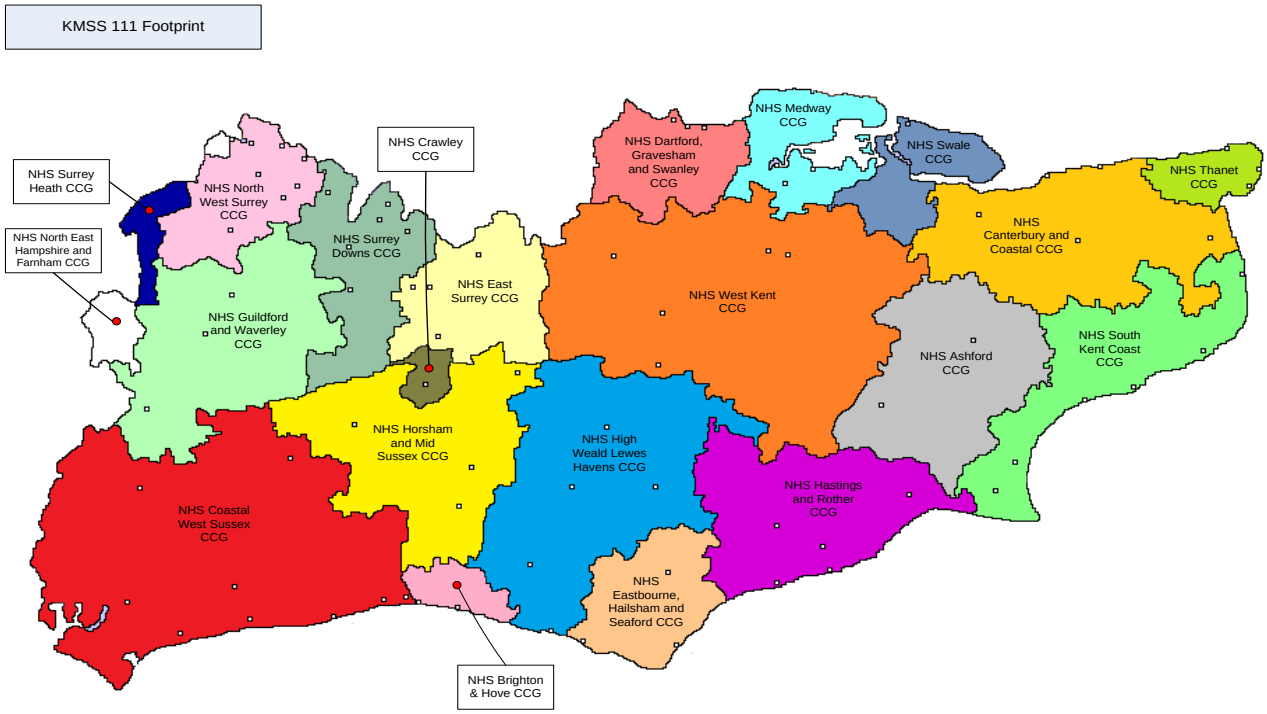
Appendix 1:

1. Background

NHS 111 - is the non-emergency number that people should call if they need medical help or advice but feel it's not a life-threatening situation. There are experienced call handlers and clinicians who are available to assess a person's needs and situation and direct them to the best local services for the care they need. The NHS 111 service is currently provided by South East Coast Ambulance service (SECAmb).

GP Out of Hours (OOH) – the service is provided by Integrated Care 24 (IC24) and works with our local GPs to provide out of hour's service to our local population.

The original contract for the NHS 111 service was a South East regional contract for Kent, Medway, Sussex and Surrey (KMSS) and consisted of 21 CCGs. The original contract expired on 31 March 2017. Out of the 21 CCGs across Kent, Medway, Sussex and Surrey (KMSS), 17 CCGs agreed to a two-year contract extension with South East Coast Ambulance service (SECAmb) until 31 March 2019.
The contract extension negotiations have been led by NHS Swale CCG as the lead commissioner for the original contract and therefor the extension.

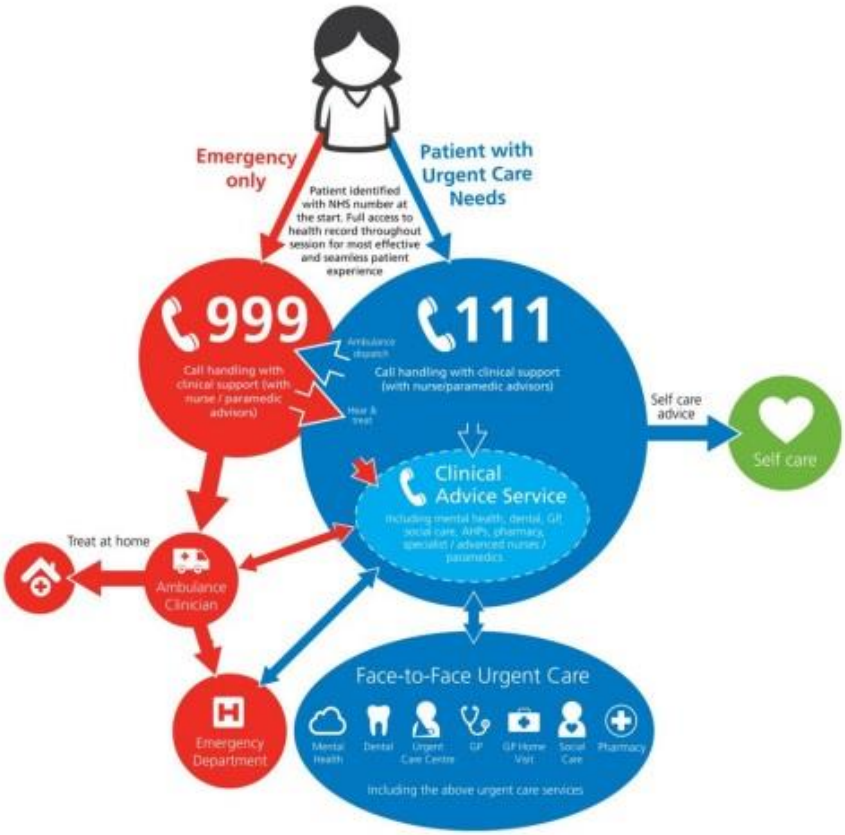


2. 111/Integration of Urgent Care Transformation Programme

In line with the NHS Five Year Forward View the redesign of urgent and emergency care services is developing across the Sussex and East Surrey STP footprint. The integration of urgent care services will provide the Sussex population (1.69m people) with an integrated seamless service for their urgent care needs of which includes the NHS 111 service.

The Urgent and Emergency Care Route Map was published in November 2015 as part of the Keogh Review. Included in the report was the deliverables for NHS 111 and the development of integrated Clinical Assessment Services (CAS).

The CAS modelling is seen as pivotal to bring urgent care services together with an Integrated Urgent Care model and the NHS 111 service is integral within its design - as shown below:



2a. Programme Objectives

The objectives of this programme are:

- To re-procure NHS 111 supported by an integrated Clinical Assessment Service (CAS) with all seven pan-Sussex CCGs
- To detail the options for the design and locations of face to face urgent and emergency care services and procure services as part of the wider urgent care model in line with the national recommendations, best practice and local need
- Ensure that our patients and public, providers, voluntary sector and social care partners are co-designers and formally consulted (as required) on the service model options
- Agree and seek the relevant approval to the chosen service model
- Decommission current services as appropriate
- Procure and implement the new service model
- Ensure the CCGs and local health economy remains on a sound financial footing in the future
- Ensure that the urgent and emergency care model compliments and aligns with the aspirations for the Sustainability and Transformation Plan (STP)
- Ensure key lessons learned from other large scale procurements in Sussex (for example Patient Transport Services, but also around the country are followed :-
    - Do not allow the programme to become isolated from the business / services / organisations (need to ensure all stakeholders are aware, understand and support the proposed approach). No surprises. Communication with decision makers is important and these individuals should be identified early in the project
    - A phased rollout rather than a big bang approach will be the approach for the go live of this service
    - Transition planning is key and should be tested and robustly challenged
    - As part of the transition planning, there should be specific planning around transfer of key data between the old and new providers. Business critical data should be identified and failure to transfer should be a go / no go issue.
    - Resourcing for procurement should not be underestimated. Key roles should be identified and filled with clear understanding of the requirements for each role and the time commitment required to deliver. The programme will use external sourcing for specialist roles where this cannot be met appropriately from within the organisation(s).

2b. Redesign Principles

In aligning to the national recommendations, a number of principles are suggested:

- The NHS 111 service will be part of an urgent and emergency care system that is able to meet the needs of the whole population, within the resources available, delivering improved quality and patient experience
- The patient will experience a service that is working as one integrated and whole system although provided by multiple agencies
- The patient will be seen at the right time, by the right person with the right skills to manage their needs, in the right place
- The patient will not experience any delay in receiving the most appropriate interventions through the whole pathway being able to respond to unpredictable fluctuations in demand
- Provide highly responsive urgent care services outside of the Accident and Emergency Department (A&E) so people no longer choose to attend A&E when they do not need to
- A single point of access to urgent care services
- Provide improved access to GPs or nurses working from community bases equipped to provide a much greater range of tests and treatments
- Empower ambulance services to make more decisions to treat more patients and allow them to make referrals in a more flexible way
- Provide better support and education for people to self-care and to enable a greater use of pharmacists
- Improved utilisation of the voluntary sector

3. The Model

Plans for achieving the vision of an integrated urgent care system will be achieved by progressing procurement of NHS 111 as a single point of entry supported by an integrated Clinical Assessment Service (CAS). A wider, joined-up approach to designing NHS 111 and the CAS will provide a more integrated, effective approach to these services.

The CAS will provide clinical advice to patients contacting NHS 111 or 999, GP speak to services as well as providing clinical support to clinicians, such as ambulance staff and emergency technicians so no decision is made in isolation, as detailed within the Integrated Urgent and Emergency Care Commissioning Standards.

This system will be supported by being functionally integrated with all the local urgent care models that are in development with further support of the model to be achieved by the technical integration of IT systems enabling the sharing of single patient records and the warm transfer of calls to available services to avoid re-triage at each step. The procurement will include the telephone triage aspects of the current out of hour's service. The face to face out of hour's service will be delivered locally but will be informed by the outputs from this model.

The model is developed in order to support navigation of patients away from Emergency Departments, when attending with symptoms appropriate for primary care intervention. It should be noted that although emergency services within the A&E departments are not part of this review, they should be positively affected by the programme, as patients attending these departments that do not require this level of expertise should be directed and treated elsewhere within the urgent care system.

The component parts of the Integrated Urgent Care Service are shown below, aspects of this will be delivered through the NHS 111 / Clinical Assessment Service (CAS) procurement and other functions will be delivered locally.

Key Principles of the new model		
	Current model	**Proposed model**
Contract	One organisation providing NHS111 for all of Kent, Surrey and Sussex OOH services for Sussex and East Surrey - IC24 • Area 1: Coastal West Sussex CCG • Area 2: Brighton & Hove CCG • Area 3: Hastings & Rother CCG, Eastbourne, Hailsham & Seaford CCG and High Weald Lewes & Havens CCG • Area 4: Crawley CCG, Horsham & Mid Sussex CCG and East Surrey CCG	A single contract with responsibility for 24/7 integrated service for NHS 111 across Sussex, and possibly larger. This may be delivered by a single organisation or (more likely) by a group of organisations working together. Face to face assessments / consultations would be delivered locally. A single contract, with a clearly designed specification, would make it easier for CCGs to hold providers to account for delivering the right outcomes and care for patients.
Clinical support	Heavily reliant on GPs for clinical support. Recruitment of GPs is increasingly difficult as there is a shortage of GPs nationally.	A range of clinical skills is available (nurses, paramedics, pharmacists and GPs) who could be used flexibly to provide clinical support. This means callers would be directed to the most appropriate clinician for what they need.
Assessment	People who require a GP urgently have to speak to at least two people (typically more) before they can get definitive clinical advice or an appointment.	People would be directed to the most appropriate service; usually by the first person they speak to.
Appointments	Some direct bookings –but patients usually need to hang up and call a different number to make an appointment with the appropriate service	Direct bookings for appointments for identified services. Primary care dispositions for see GP (in hours) will be warm transferred to the GP surgery reception and then use the processes of the practice to arrange an appointment

Medical history	Services have limited access to special patient notes for people with complex health and/or social care needs, and no access to routine medical history for NHS111 or OOH	Those involved directly in patient care would have consistent access to special patient notes and routine medical history for patients using the service
Equity of access	Access to OOH services is different depending on where people live	Access to OOH services would be the same, regardless of where people live and patients would have more choice
Professional contact	Currently unclear and inconsistent access to clinicians and other professionals	One place for all professionals to go to request advice, information and contact
Signposting	Currently signposting to information or appropriate services is limited (5%)	Increase of signposting (where appropriate and safe) and advice lines with existing conditions e.g. diabetes, cancer

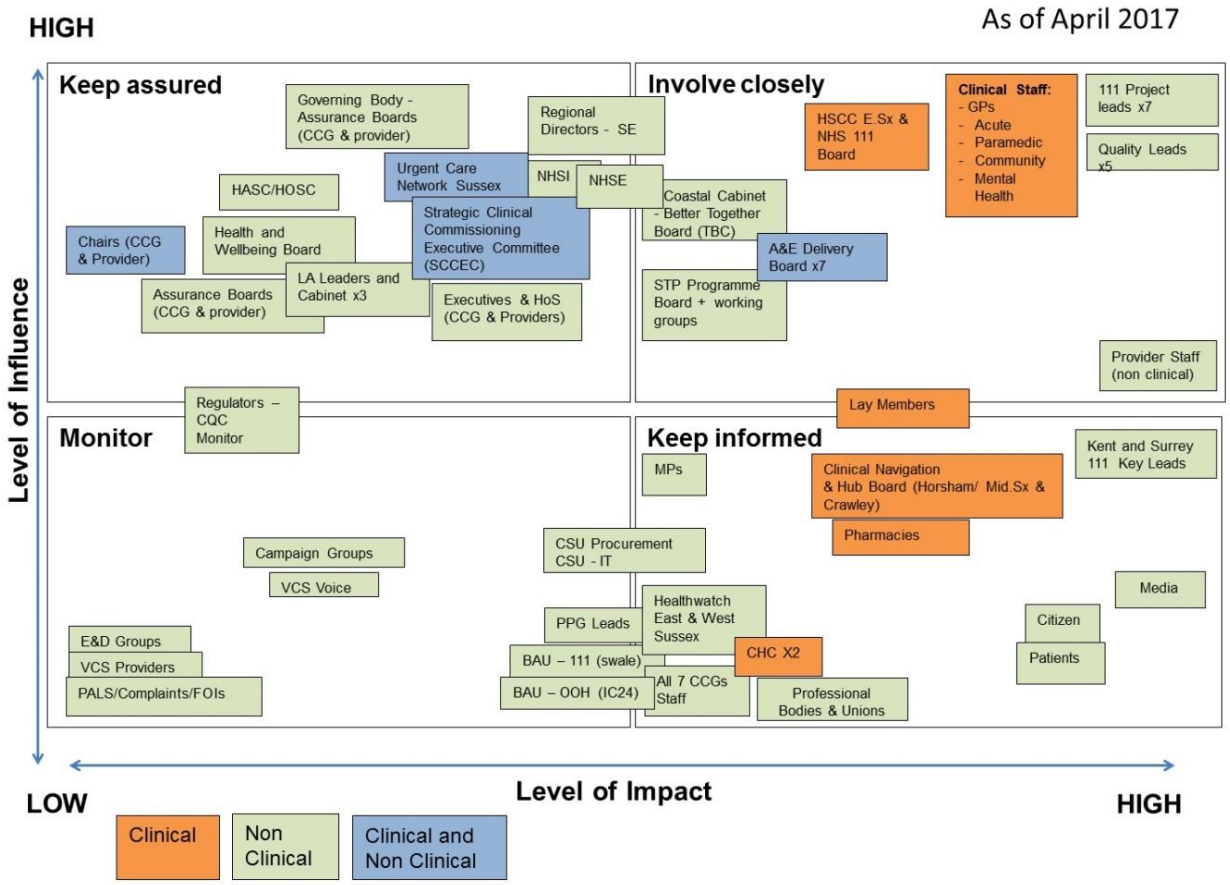
4. Communication and Engagement

The communications and engagement plan, for the programme, aims to consult, engage and fully communicate the 111/ Integrated Urgent Care programme. It will build people's trust and confidence not only in the 111 service but also in integration of urgent care services.

It will ensure the appropriate information and guidance is available in the right place, at the right time for both internal and external audiences.

Objectives

- To communicate and engage with patients and the public around the re-procurement of the pan-Sussex 111 service - **Public**
- To raise positive awareness of the 111 re-procurement and the changes GPs, Partners and Providers will see – **Clinical Services**
- To communicate and engage internally with staff across the seven CCGs, five acute trusts, three community trusts and two mental health trusts about their role to support the 111 communications and engagement activity – **Internal Chairs, Executives, Managers and Staff**
- To enhance patients' confidence and engagement with the 111 service and ensuring their voice and experience informs the design and procurement process - **Lay Members, Patients and Public**
- To ensure patients have the information and support to make informed choices about their health care and to encourage patients to use the appropriate services depending on their health care needs – **Public**
- To increase positive awareness and understanding of the NHS 111, pharmacies and the minor injuries unit – **Public**



5. Next Steps and Recommendations

The timescales for the programme are as follows:-

Stage 1: Service Redesign • Soft market testing and development of technology options • Process mapping and pathways • Business analysis & Financial modelling • Agreement of operating model and blueprint • Completion of Project documentation – PID, QIA • Business case and service design signed off	November 2016 – September 2017
Stage 2: Procurement Readiness • Patient engagement • Approval of service specification • Procurement Documentation • Clinical engagement	September 2017- December 2017
Stage 3: Procurement - the procurement approach is still to be confirmed • Commencement of PQQ / ITT process • Decision regarding appropriate procurement process (most capable provider, open tender)	January - September 2018

Stage 3: Deployment • Development of deployment and mobilisation plan, stakeholder list & benefits realisation plan • Engagement of incoming and outgoing providers in order to facilitate seamless transfer • Management of go-live activities, floor walking support, bug-fix and post go-live evaluation • Management of deployment to steady state and withdrawal, based on agreed criteria • Production of a project exit report detailing actions, issues and lessons learned	September – April 2019
Go Live	1 April 2019

The 111 Transformation Programme is complex and has a number of tight deadlines.

This paper seeks to update the Brighton & Hove City Council's Health Overview and Scrutiny Committee on the activity taking place around the NHS 111/ Integration of Urgent Care services.

Documents in Members' Rooms
None

Background Documents
None

South East Coast Ambulance Service NHS Foundation Trust – Regional HOSCs Sub-Group

Monday 26th June 2017, 2pm-4pm
SECAMB HQ, Nexus House, Crawley

MEMBERS

Brighton & Hove HOSC
Cllr Ken Norman (Chairman)
Karen Amsden (Officer)

East Sussex HOSC
Cllr Colin Belsey (Chair)
Cllr Ruth O'Keeffe (Vice-Chair)
Claire Lee (Officer)

Kent HOSC
Cllr Sue Chandler (Chair)
Vice-Chair (TBC)
Lizzy Adam (Officer)

Medway HOSC/Children's OSC
Cllr Wendy Purdy (Chair, HOSC)
Cllr David Royle (Chair, Children's OSC)
Jon Pitt (Officer)

Surrey Wellbeing and Health Scrutiny Board
Cllr Ken Gulati (Chairman)
Cllr Sinead Mooney (Vice-Chair)
Andrew Spragg (Officer)

West Sussex HASC
Cllr Bryan Turner (Chairman)
Cllr Dr James Walsh (Vice Chairman)
Helena Cox (Officer)

1. Introductions
Cllr Bryan Turner chaired the meeting and invited everyone to introduce themselves.

2. Apologies
Apologies had been received from Cllr Ruth O'Keeffe, Cllr Ken Gulati, Dr James Walsh, Cllr Wendy Purdy (Cllr Teresa Murray substituted), Cllr David Royle, Cllr Sue Chandler (Cllr Mike Angell substituted), Helena Cox.

3. Care Quality Commission (CQC) re-inspection
3.1 Daren Mochrie, the new SECAMB Chief Executive, confirmed that CQC had undertaken a re-inspection w/c 15 May. This had involved 40-50 inspectors looking at 999, emergency services, Hazardous Area Response Team (HART) and 111.

3.2 The Trust has yet to see a draft report but initial feedback was better than the previous year and there were no surprises. CQC saw clear evidence of improvements, robust plans and a Programme Management Office in place, and

recruitment to the new Senior Leadership Team underway. They were particularly positive about 111, which has seen significant improvements since last year, and about care given by staff across the Trust.

3.3 CQC's key areas of ongoing concern were:

- **medicines management** – there is now a robust plan and a new Chief Pharmacist but the Trust still needs to be doing more at speed.
- **recording of 999 calls** (audio recording - important for immediate review or later audit). There have been technical issues in being able to record appropriately which are now almost resolved. This issue does not affect 111.
- the need for speedier roll out of **electronic clinical records** and concerns about whether all details are being captured from paper records. There will be wider benefits from going electronic in passing information to hospitals and GPs and minimising any loss of records. It will also make audit and research easier. The Trust is working on connectivity with the wider system.
- appropriate recording and acting on **serious incidents** (SIs).

3.4 The following issues were covered in response to questions:

- CQC felt staff engagement was much better across the Trust and received positive feedback from unions and governors regarding the Trust's direction of travel. Daren and other senior staff have been getting out to meet staff and spending time on shift with crews. He has not been picking up significant bullying issues but recognises Trust leadership could be better at communicating and engaging with staff. The recruitment of a stable leadership team will also help with staff confidence.
- Professor Lewis's report on bullying and harassment is due by the end of July and will probably raise engagement issues. Daren assured Members that the Trust intends to embrace its findings and recommendations.
- The move to a single Trust HQ may enable more development of teamworking and this may include a social element.
- One of the areas the Trust is reviewing in detail is recording of SIs and use of Datix, which can be a good system for incident and risk management. SECAMB has found difficulties getting Datix working but now has a new Datix manager who has started addressing the issues. This is in addition to doing wider work on learning from incidents which is making progress.
- There was an aspiration to move out of special measures within 18 months – 2 years and CQC and NHS Improvement are keen to support trusts to move on but also to ensure that progress is sustainable. The Trust will look at the outcome of the latest inspection and the next steps from that point. If remaining in special measures the Trust will take advantage of the additional support this brings.
- CQC's process for sharing its findings will be as before – a formal report and Quality Summit probably in early September. HOSC Chairs will be invited.
- The roll out of ipads to staff has been done incrementally to ensure staff are trained and they are used properly. Their primary use is for the clinical record and this is the initial focus.
- SECAMB uses 5 or 6 private contractors to provide additional capacity at times of peak demand via an agreed framework, not ad hoc arrangements. The Trust monitors their performance and has been reviewing how appropriate assurance of standards is obtained. CQC also regulates private contractors but at a different

level to NHS Trusts and the Commission is currently looking at how they regulate these providers.

Action: HOSCs to be informed when Prof. Lewis's report is available.

4. Quality Improvement Plan (QIP) progress

4.1 Jon Amos, Interim Director of Strategy & Business Development, advised that SECAMB is starting to incorporate initial feedback from the recent CQC re-inspection into the QIP and will fully update it when the formal report is received. The key areas of challenge had already been highlighted and discussed in item 3 above.

4.2 The following additional points were made in response to questions:

- The additional time allocated to complete some actions reflects a balance between fixing immediate issues raised by CQC and then tackling wider issues which subsequently emerge. New issues have been added to the QIP as they are picked up by the Trust's governance systems and it is positive that these are being picked up internally.
- The medicines management issues are not related to significant concerns about the use of drugs. CQC are highlighting how the Trust can improve safe and consistent management, storage and efficient use of drugs. This is challenging for SECAMB as drugs are held in many diverse locations. The Trust now has a medicines optimisation plan, which includes ensuring legal requirements are met in relation to controlled drugs.
- The most challenging and long term actions are around meeting performance targets because this is partly linked to demand outstripping resource and some targets being outdated. In addition, embedding cultural change and sustainable change to management of medicines and SIs will take time.

5. Performance

5.1 Jon Amos introduced the paper which provided data for the period to the end of May 2017 and which would also be considered by the Trust Board this week.

5.2 The following headlines were highlighted from each section of the report:

Finance and workforce

- SECAMB has moved from 4 to 3 on financial rating which is linked to a reduction in use of agency staff and ensuring there are the right skills in place internally. The move to Crawley may be helping with recruitment of entry level roles, some of which now have a waiting list. But some specialist roles remain difficult to recruit. The increased vacancy rate reflects a recent increase in establishment as new permanent roles have been created.
- A new on line appraisal and 121 system will be rolled out to all staff by autumn 2017 – this will help to ensure they are recorded rather than relying on people uploading paper versions. Ipads can be used as part of this and the new team leader role will include time to do appropriate supervision on shift with staff. It will also roll out to volunteers in the next 18 months. The Trust is also changing how training is recorded to a rolling basis rather than starting from scratch each year.

Operational performance

- Performance reflects the improvement trajectory agreed with commissioners and regulators. This trajectory has a slight dip in Q2 reflecting the introduction of the new CAD which will have a short term negative impact but long term gains.
- Activity is up on last year but not as much as expected.
- Ongoing challenges around hospital turnaround. Good progress has been made with some Trusts which has demonstrated the benefit of strong focus – SECAMB will be sharing this work more widely. The impact of handover delays has been estimated at 7-8% effect on performance.
- There was a dip in May on the call pick up target, driven by committing time to training on the new CAD – each member of staff needs a week's training in a short period of time. Expect this to pick up quickly as new system comes in.
- 111 - slight dip in call answer performance in May – also reflected nationally, which may reflect bank holiday weekends but there was good planning for these. An increase in late evening calls may be related to Ramadan and the Trust will be looking to reflect this in future plans.

Clinical effectiveness

- ROSC performance is good but this does not seem to be translating into people surviving to hospital discharge. This may be a data issue which is being investigated with commissioners – there have been changes to the way data is obtained and it has required manual follow up for patients who have survived as there is no consistent recording across Trusts. There may also be variation in outcomes between acute hospitals. Some areas are starting to develop specialist centres for cardiac services and when the data is clearer SECAMB will discuss with clinical networks.
- Stroke – performance is slightly less timely on getting people to hospital but SECAMB is increasingly taking people longer distances to specialist centres.
- Clinical outcome data lag will reduce as electronic record comes in.

Action: group to receive follow-up information on the investigation into cardiac survival to discharge data.

Quality and safety

- The increase in the number of incidents is positive due to increased reporting.
- Complaints are significantly down – this is linked to the transfer of PTS in Surrey to SCAS.
- Timeliness of response to complaints has improved significantly – almost at target. The process is much improved.
- Safeguarding referrals – some changes are linked to PTS changes.
- Level 3 safeguarding training is slightly behind plan – there is a process in place to improve but this does impact on front line resource – an extra day has been allocated for training this year.
- The complaints category 'concerns about staff' is often related to staff attitude. Trusts do a lot of work around how best to communicate in stressful situations, but there can be alcohol involved or a mismatch between expectations and reality e.g. Trusts don't always dispatch an ambulance and need to explain how this approach is better for people.

- Clinical audit is mostly internally led by the medical department (separate from front line), but is checked by the external audit firm.

Finance

- Challenging year: £15m (7% of turnover) is needed in efficiencies to put additional resources where needed. SECAMB is further behind acute trusts on making efficiencies so there may be some easier savings still to achieve. The Trust is working with regulators and commissioners to assist on areas like handover delays and performance trajectories and ensuring efficiencies can be made safely.
- Savings targets are set by regulators and the Trust will make the case as needed to regulators for flexibility in return for improvements.
- The Trust has a 2 year contract with commissioners to April 2019 but is discussing amendments to this.

6. Surge management plan

6.1 Jon Amos advised that review and revision of the draft plan continues and that trials were undertaken during recent hot weather. The aim is to prioritise limited resources appropriately during peaks and making this more of a routine procedure as needed. It represents a significant change to past ways of working.

6.2 Jon confirmed that the plan will go to the Board once finalised and can be brought to the HOSCs group at the same time.

Action: Surge Management Plan to be brought to future HOSCs Sub-Group meeting when available.

7. Strategy

7.1 Jon Amos explained that the paper would be considered at a part 2 Board meeting this week but is also being shared with stakeholders for any general feedback. It sets out the general direction for the Trust but there will be a further detailed delivery plan to add an additional layer e.g. as the national ambulance response programme is finalised and other information becomes available.

7.2 Jon clarified that there would not be a formal consultation on the strategy but that it had drawn on a lot of work with CCGs and patient groups. It does not represent a major change of direction, more a reassertion and communication of the Trust's existing direction of travel.

7.3 It was noted that SECAMB covers 4 STP areas which is challenging, but is less complex than the 22 CCGs areas also covered by the Trust.

Action: any comments on the draft strategy to be sent to Jon Amos, particularly in relation to any local issues.

8. Next meeting

8.1 It was agreed to arrange a further meeting in early October to coincide with the release of the CQC report. This would be the primary focus of the meeting, along with updated QIP and performance report. A tour of the building will also be included.

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

21 JUNE 2017, 12PM-2PM

COUNCIL CHAMBER, BIGHTON TOWN HALL
MINUTES

Members Present

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

Others

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

Apologies

Cllr Nick Taylor
Caroline Ridley

6 PUBLIC INVOLVEMENT:

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

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

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

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

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

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

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

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

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

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

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

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

7 DECLARATIONS OF INTEREST

None

8 CHAIRS COMMUNICATIONS

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

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

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

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

9. MINUTES OF THE PREVIOUS MEETING

The minutes were agreed.

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

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

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

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

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

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

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

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

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

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

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

Questions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Questions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 AOB

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

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

V4 HOSC 2017/2018 Work Programme

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

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

HOSC Network Groups – no updates at committee

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

6th December 2017

Item and title	To invite
Chairs communications	
SPFT – meet the new Chief Executive	SPFT
Update on dementia services: i) Planned move back into single sex dementia beds for the acute in-patient	ASC, SPFT, CCG

service ii) Strategic approach, diagnosis & memory assessment	
B&H Caring Together - STP update	Standing item CCG, ASC
MH pathways from diagnosis through treatment	TBC
Mental Health and delayed discharge	Invite: SPFT & CCG
Functional mental health and Older People	TBC
Update on HOSC Working Groups	Standing Item: HOSC Members

February 2018

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

Patient Transport Services: Update	CCG (and High Weald Lewes Havens CCG)