Brighton & Hove City Council

Health Overview & Scrutiny Committee

Title:	**Health Overview & Scrutiny Committee**
Date:	**23 January 2019**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall**
Members:	**Councillors:** K Norman (Chair), Allen (Group Spokesperson), Bennett, Bewick, Deane, Gilbey, Barnett, Greenbaum, Morris, Marsh and C Theobald **Co-opted Members:** Zac Capewell (Youth Council), Caroline Ridley (Community Sector Representative), Fran McCabe (Healthwatch), Colin Vincent (Older People's Council)
Contact:	**Giles Rossington** Senior Policy, Partnerships & Scrutiny Officer 01273 295514 giles.rossington@brighton-hove.gov.uk

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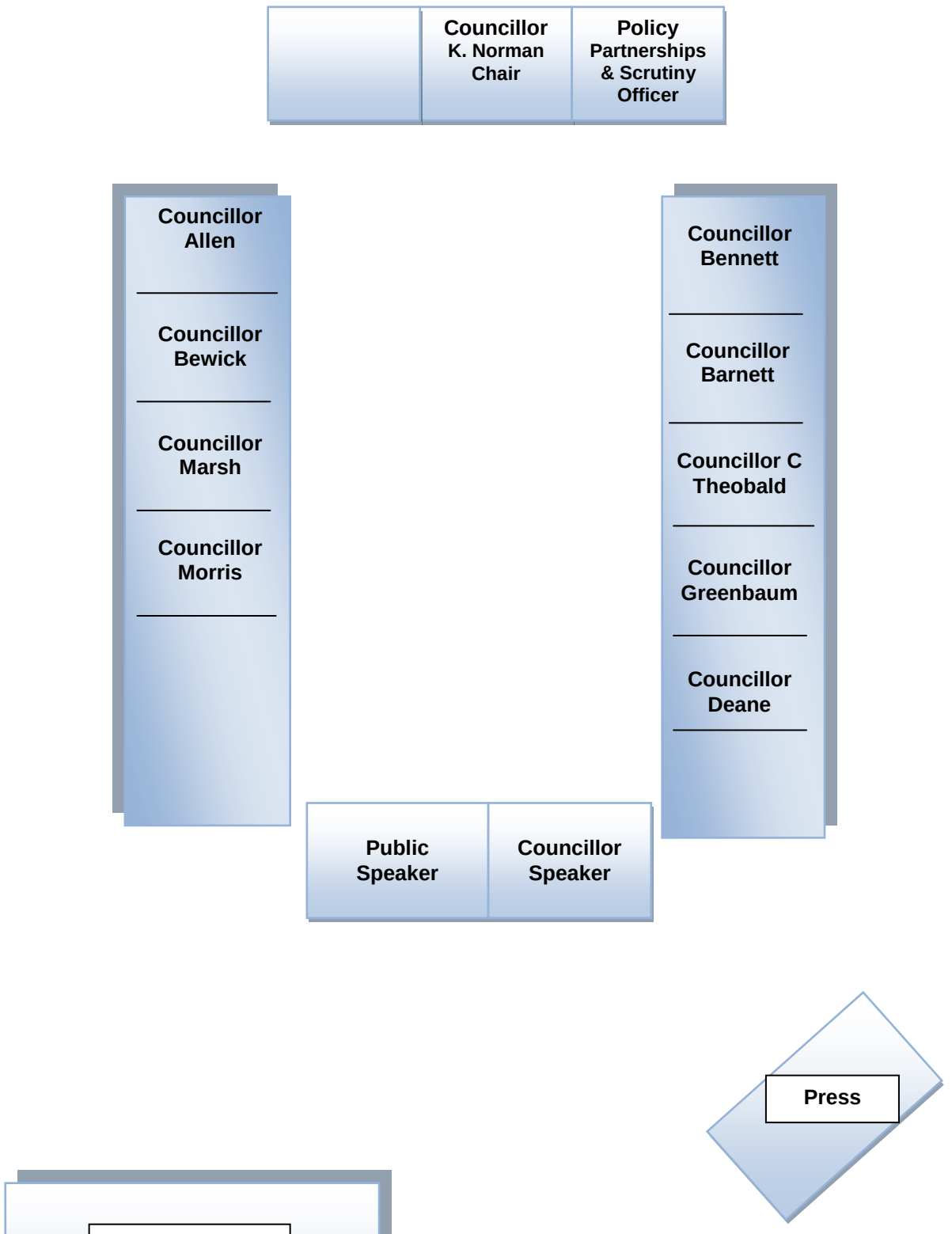
Democratic Services: Health Overview & Scrutiny Committee



AGENDA

PART ONE **Page**

21 APOLOGIES AND DECLARATIONS OF INTEREST

(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.

22 MINUTES **7 - 12**

To consider the minutes of the last meeting held on the 17th October 2018 (copy attached)

23 CHAIRS COMMUNICATIONS

24 PUBLIC INVOLVEMENT **13 - 14**

(a) The committee will consider a public question from Ms Linda Miller (copy attached)

25 MEMBER INVOLVEMENT

To consider the following matters raised by councillors:

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

26 SUSSEX COMMUNITY NHS FOUNDATION TRUST: PLANS TO DEVELOP A COMMUNITY HEALTH HUB ON THE BRIGHTON GENERAL HOSPITAL SITE **15 - 32**

Report of the Executive Lead for Strategy, Governance & Law on Sussex Community Foundation Trust plans to develop a Community Health Hub on the Brighton General Hospital site (copy attached)

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

27 SOUTH EAST COAST AMBULANCE NHS FOUNDATION TRUST (SECAMB): UPDATE ON QUALITY & PERFORMANCE **33 - 52**

Report of the Executive Lead for Strategy, Governance & Law, providing an update on SECAmb activities (copy attached)

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

28 NHS 111 PROCUREMENT: JANUARY 2019 UPDATE **53 - 58**

Report of the Executive Lead for Strategy, Governance & Law, on NHS plans to procure a new provider for the 111 call service (copy attached)

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

29 DIRECTOR OF PUBLIC HEALTH: ANNUAL REPORT **59 - 62**

Report of the Executive Lead for Strategy, Governance & Law presenting the Director of Public Health Annual Report (copy attached)

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

30 ESTABLISHING A JOINT HOSC (JHOSC) **63 - 78**

Report of the Executive Lead for Strategy, Governance & Law, on proposals to establish a Joint Health Overview & Scrutiny Committee (JHOSC) (copy attached)

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

31 UPDATE FROM HOSC JOINT WORKING GROUPS **79 - 92**

The minutes of relevant HOSC Joint Working Groups are included for information:

- Joint Sussex HOSCs informal meeting with BSUH 31.10.18 (p77)
- Joint Sussex HOSCs informal meeting with SPFT 11.09.18 (p83)

32 HOSC DRAFT WORK PLAN/SCRUTINY UPDATE **93 - 94**

The 2018-19 HOSC work plan is attached for information (copy attached)

33 FOR INFORMATION - CORRESPONDENCE WITH BRIGHTON & HOVE CCG **95 - 102**

For information:

a) a letter from the HOSC Chair to the Chair of Brighton & Hove CCG regarding Clinically Effective Commissioning
b) a response from the CCG to the above letter
c) a letter from Sussex and East Surrey CCGs regarding the permanent appointment of Adam Doyle as Accountable Officer (copies attached)

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Date of Publication - Tuesday, 15 January 2019

BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00pm 17 OCTOBER 2018

THE RONUK HALL, PORTSLADE TOWN HALL - PORTSLADE TOWN HALL

MINUTES

Present: Councillor K Norman (Chair)

Also in attendance: Councillor Allen (Group Spokesperson), Bennett, Deane, Barnett, Greenbaum, Marsh, C Theobald and Hill

Other Members present: Zac Capewell (Youth Council), Colin Vincent (Older People's Council), Fran McCabe (Healthwatch)

PART ONE

12 APOLOGIES AND DECLARATIONS OF INTEREST

12.1 Apologies were received from Caroline Ridley.

12.2 Cllr Tracey Hill attended the meeting as substitute for Cllr Adrian Morris.

12.3 There were no declarations of interest.

12.4 It was resolved that the press and public be not excluded from the meeting.

13 MINUTES

13.1 Cllr Hill noted that the CCG had agreed at the previous meeting to circulate information on in-year CCG savings plans to members. The scrutiny officer confirmed that information had been circulated. This will be re-sent in case any members missed it.

13.2 Fran McCabe noted that the item on young people's mental health that members wanted to scrutinise was currently not on the committee work programme. The scrutiny officer promised to add it.

13.3 RESOLVED – that the minutes of the 27 June 2018 meeting be agreed as an accurate record.

14 CHAIRS COMMUNICATIONS

14.1 There were none.

15 PUBLIC INVOLVEMENT

15.1 There was a Public Question from Linda Miller. Ms Miller asked:

I would like to ask this committee if they are concerned:
· that the number of treatments the CCG is proposing to remove from NHS provision has increased from 39 to 107, and that the list is now open-ended
· that, when told a particular procedure is not available, patients will face a choice: pay and go private, or go without, which will greatly increase health inequality.
· that "noting" what NHS England and the CCG are doing to our NHS may not be an adequate response if we want to prevent the creation of a two-tier health service.

15.2 The Chair responded:

"The HOSC is interested in the Clinically Effective Commissioning initiative and has been following its development for several months.

We have noted the expansion of CEC, but it is important to recognise that the majority of procedures added are in tranches 0 and 1, where the NHS is recalibrating its approach to ensure that treatment is consistent and most importantly evidence-based. We recognise that CCGs are focused on ensuring that all policies are based on robust clinical evidence.

As you point out, we do not yet have details of the later tranches of CEC. Whilst there is little point in speculating about what this might involve, we are committed to undertaking robust scrutiny of any plans to substantially change services. To this end we intend to form a joint committee with HOSCs from East Sussex, West Sussex and Surrey which will examine any substantial change plans in depth and in public."

15.3 Ms Miller asked a supplementary question:

Treating people according to need and not ability to pay is one of the founding principles of the NHS – and we expect our Councillors to support our right to free treatment for all.

We would like to know how many people were referred for these 107 procedures in the last year, and exactly what changes are being proposed, so we can thereby estimate how many people are going to be affected by these cuts every year.

How many people need to be denied treatment for a change to represent a Substantial Variation in Service triggering a formal consultation?

15.4 The Chair told Ms Miller that a written answer to her question would be provided. The following response was subsequently sent to Ms Miller:

"Thank you for your supplementary question. Following the October 2018 HOSC meeting I have written to Brighton & Hove CCG to seek more information about the Clinically Effective Commissioning programme. For information, please see the attached

letter and response (these will be included in the January 2019 HOSC papers). I have asked the CCG to provide some additional clarification following their response and this will be brought to a future HOSC meeting.

In response to your question on definitions of Substantial Variations in Service (SViS), there is no definition in legislation of what constitutes a SViS, this being left largely for local agreement between HOSCs and NHS bodies. However it is broadly accepted that a change plan may constitute a SViS even if it only affects a few patients, should there be the potential for a significant detrimental impact on those patients. Change plans that have little or no impact on patients, or which will lead to improvements in outcomes, are unlikely to be categorised as SViS, particularly if they affect small numbers of people."

16 MEMBER INVOLVEMENT

16.1 There was none.

17 PATIENT TRANSPORT SERVICES (PTS): UPDATE

17.1 This item was introduced by Lola Banjoko, CCG Deputy Managing Director South. Ms Banjoko told members that South Coast Ambulance Service NHS Foundation Trust (SCAS) had continued to improve its performance, particularly in terms of services for renal patients. However, SCAS is not hitting all of its KPIs, and has consequently developed a Service Development Improvement Plan. Feedback from users and from hospital staff on SCAS is generally good. SCAS is due to launch a patient forum in the near future.

17.2 Members were also informed that it was still not possible to discuss financial details of the previous Patient Transport contract as legal proceedings in relation to this contract are ongoing.

17.3 In response to a question from Cllr Theobald expressing disappointment at performance against some indicators, members were told that SCAS does need to address areas of underperformance. The trust has been running this PTS contract for long enough to understand the demand levels.

17.4 In answer to a query from Cllr Hill as to why renal performance is separate from other performance indicators, Ms Banjoko explained that dialysis is a critical service (i.e. patients must be able to access it at the right time or risk their health deteriorating), whereas most PTS services are non-critical.

17.5 In response to a question from Cllr Hill on different types of PTS pick-up at discharge, members were told that it was relatively easy to prepare for discharge from electives; more complex for the discharge of in-patients; and harder still for discharge from A&E.

17.6 In answer to a question from Fran McCabe as to whether significant performance improvement was possible within the current financial envelope, members were told that improved performance is achievable: there is a good deal that can be done to get SCAS and hospitals working more smoothly together.

17.7 In response to a query from Colin Vincent on engagement, members were told that this work is progressing with the assistance of CCG and acute trust engagement staff. Healthwatch will be included in this.

17.8 In answer to a question from Cllr Hill on KPIs underperformance relating to data recording, members were informed that SCAS records all calls, but sometimes does not correctly code the nature of the call. This issue will be addressed via the Improvement Plan.

17.9 RESOLVED – that the report be noted.

18 CLINICALLY EFFECTIVE COMMISSIONING (CEC): UPDATE

18.1 This item was introduced by Lola Banjoko, CCG Deputy Managing Director South. Members were told that the Clinically Effective Commissioning (CEC) initiative aims to standardise clinical practice and thresholds across Sussex, ensuring that NHS services follow best practice and that providers are not required to work to multiple commissioner policies.

18.2 Cllr Greenbaum argued that HOSC members had not been given sufficient information on CEC to date, and in particular had not been consulted on whether any of the changes in CEC tranches 0, 1 and 2 should be deemed to be Substantial Variations in Service (SViS).

18.3 Cllr Allen echoed Cllr Greenbaum's concerns, noting that this was effectively rationing of NHS services.

18.4 Cllr Marsh and Cllr Deane concurred. Cllr Deane noted that she was also interested in finding out what the local NHS exposure to pfi costs is, but has not received an answer to this question from the CCG.

18.5 Cllr Theobald agreed, noting that she was concerned about the availability on the NHS of routine procedures such as varicose vein surgery and joint replacements. Ms Banjoko noted that varicose vein surgery and other procedures would continue to be available on the NHS, but that there may be changes to the threshold at which NHS patients could access them.

18.6 Cllr Greenbaum proposed the following amendment (to be added as point 2 to the resolution): "That members request that the CCG provides the HOSC with detailed evidence for each treatment area in all tranches of the CEC initiative as soon as it becomes available."

18.7 The amendment was seconded by Cllr Allen and unanimously agreed.

18.8 RESOLVED – that:

(1) the report be noted; and
(2) members request that the CCG provides the HOSC with detailed evidence of each treatment area in all tranches of the CEC initiative as soon as it becomes available.

19 ESTABLISHMENT OF A JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE (JHOSC)

19.1 This item was introduced by the scrutiny officer, who explained that under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, councils must establish a joint health overview and scrutiny committee (JHOSC) to respond to consultation on proposals for substantial variation in health services (SViS) affecting more than one local authority area.

19.2 Chairs of the HOSCs within the STP footprint have been advised by local NHS leaders that there are likely to be SViS affecting more than one local authority area emerging in the near future; hence there is a requirement for a JHOSC to be established. Suggested Terms of Reference and Ways of Working for the JHOSC had been drawn up by support officers and approved by HOSC Chairs and were presented to the committee for its approval.

19.3 Because of the way that the Brighton & Hove HOSC is constituted, its formal legal powers are held by Full Council rather than by the HOSC. This means that any decision to establish a JHOSC would need to be taken by the Full Council following a HOSC recommendation.

19.4 Cllr Allen stated that he was sceptical of the wisdom of the HOSC considering issues relating to a JHOSC when there were local elections in May 2019. Rather than seeking to bind a future HOSC it would be more sensible to defer any decisions until after the local elections.

19.5 In response to a question from Cllr Marsh on whether the HOSC was obliged to join a JHOSC, the scrutiny officer explained that the HOSC could not be required to actively participate in the JHOSC. However, there is no way in which an individual HOSC can formally scrutinise an issue in parallel to a JHOSC, since HOSC statutory scrutiny powers relating to SViS affecting more than one local authority area are automatically delegated to the JHOSC. Therefore, if the HOSC wants to scrutinise substantial cross-boundary change plans, it can only practically do so via a JHOSC.

19.6 In answer to a question from Colin Vincent on having co-optees on the JHOSC, members were told that this had been discussed, but that it would be difficult to include co-optees from all four STP footprint HOSCs on the JHOSC without making it unmanageable. However, this is an issue that can be explored again with the other HOSCs.

19.7 In answer to a query from Mr Vincent on how the JHOSC would be reported to local people, the scrutiny officer noted that the JHOSC would meet in public and would have publicly accessible papers etc. It would be up to the HOSC to determine whether there should be additional local measures: e.g. a briefing on JHOSC activity at each HOSC meeting or agreeing that the HOSC's JHOSC members would present issues of local concern at JHOSC meetings. As these arrangements would apply only to individual HOSCs there would be no need for all JHOSC HOSCs to jointly agree to adopt the same measures.

19.8 Fran McCabe told members that she shared Mr Vincent's concerns. She specifically noted that a JHOSC which would presumably be meeting in several different locations would not be easy for local people to access; and that co-optees could potentially provide an in-depth understanding of issues that newly elected Cllrs may not possess.

19.9 The Chair noted that he saw little point in appointing members of the HOSC to the JHOSC if there was no prospect of those members remaining on a post-May JHOSC.

19.10 There was discussion as to whether it was practically possible to defer this decision until the next (January 2019) HOSC meeting. The scrutiny officer confirmed that this would be possible. This would mean that Brighton & Hove would be amongst the last councils to make decisions on the JHOSC, but it would not significantly delay its establishment. There was general agreement that it would be sensible to defer these decisions. This would give officers time to talk with the council's lawyers and with their counterparts in other authorities to produce an improved report. Issues that should be considered include: the precise legal requirements regarding JHOSCs; the issue of having JHOSC co-optees; means of ensuring that there is appropriate local influence on the JHOSC; how to ensure that local residents have means to engage with the JHOSC.

19.11 RESOLVED – that this decision be deferred until the January 2019 HOSC meeting.

20 OSC DRAFT WORK PLAN/SCRUTINY UPDATE

20.1 Fran McCabe suggested that there should be an item on cancer added to the HOSC work plan (for March 2019).

20.2 Cllr Deane suggested that the HOSC should look at the appointment cancellation rate at the Royal Sussex County Hospital. Ms McCabe added that this might usefully be expanded to look at waiting times across the planned care referral process. Cllr Theobald noted that one of the problems was that it was extremely difficult for patients to cancel appointments, since phone calls to RSCH departments frequently go unanswered.

20.3 members agreed that items on young people's mental health, cancer and RSCH cancellations/planned care waiting times should be added to the HOSC work plan for the March 2019 meeting.

The meeting concluded at 6:30pm

Signed Chair

Dated this day of

Public Question from Ms Linda Miller to 23 January 2019 HOSC

I would like to draw the HOSC's attention to the information provided by the BBC's NHS Tracker about the standard of NHS provision in Brighton and Hove https://www.bbc.co.uk/news/health-41483322

Patients treated or admitted within four hours of arrival at A&E
October 2018 figures
TARGET
95.0%
YOUR TRUST (BSUH)
80.7%
ENGLAND
89.1%
Brighton & Sussex University Hospitals NHS Trust ranked 113 of 130 trusts

Patients starting cancer treatment within 62 days of urgent GP referral
September 2018 figures
TARGET
85.0%
YOUR TRUST (BSUH)
74.1%
ENGLAND
78.2%
Brighton & Sussex University Hospitals NHS Trust ranked 101 of 131 trusts

Patients having planned operations & care within 18 weeks of referral
September 2018 figures
TARGET
92.0%
YOUR TRUST (BSUH)
80.7%
ENGLAND
86.7%
Brighton & Sussex University Hospitals NHS Trust ranked 106 of 126 trusts

Patients starting mental health therapy within six weeks of referral
Apr - Jun 2018 figures
TARGET
75.0%
YOUR AREA
48.0%
ENGLAND
89.5%
NHS Brighton & Hove ranked 192 of 195 CCG areas

The NHS services provided to Brighton and Hove residents are falling far short of national targets and national averages. Do you agree that disbanding our local HOSC, in favour of a Sussex and Surrey-wide JHOSC, would weaken our ability to oversee and scrutinise, and hopefully improve, what is happening to our local NHS?

HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 26 Brighton & Hove City Council

Subject:		**Sussex Community NHS Foundation Trust: Development of a Community Health Hub at the Brighton General Hospital Site**
Date of Meeting:		**23 January 2019**
Report of:		**Executive Lead, Strategy, Governance & Law**
Contact Officer:	**Name:**	**Giles Rossington** **Tel: 01273 295514**
	Email:	**giles.rossington@brighton-hove.gov.uk**
Ward(s) affected:		**(All Wards);**

FOR GENERAL RELEASE

Glossary/Explanation of Terms

- **BGH:** Brighton General Hospital site
- **SCFT:** Sussex Community NHS Foundation Trust (local NHS community services provider)
- **CHH:** Community Health Hub
- **BSUH:** Brighton & Sussex University Hospitals Trust (local NHS acute provider)
- **SViS:** Substantial Variation in Services (NHS bodies are legally required to formally consult with HOSCs when planning to make substantial changes to patient services)

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 Sussex Community NHS Foundation Trust (SCFT) plans to redevelop the Brighton General Hospital site, developing a Community Health Hub (CHH) as well as re-purposing land for housing.

1.2 SCFT brought a paper to the 27 June 2018 HOSC meeting, outlining various options for redevelopment of the BGH site. This report provides an update on progress.

2. RECOMMENDATIONS:

2.1 That the Committee notes the contents of the report.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 The BGH site is located at the top of Elm Grove, near Brighton racecourse. The site is no longer used for inpatient care (the last inpatient beds were removed in 2009), but does host a range of community health, mental health, rehabilitation

and outpatient services as well as providing a base for a range of NHS and council community teams. SCFT, Sussex Partnership NHS Foundation Trust, Brighton & Sussex University Hospitals Trust (BSUH) and Brighton & Hove City Council all operate from the site.

3.2 Many of the facilities at BGH are very old and are no longer fit for purpose. Due to the condition of buildings and the way that the site is configured, only around 50% of facilities are currently being used.

3.3 SCFT developed a series of options for the redevelopment of the BGH site. These varied from doing nothing to various plans to construct a Community Health Hub (CHH) on part of the site or on adjacent land. The CHH would be a state of the art facility offering a range of health services to local communities. Developing a CHH would be self-funding on a capital basis: the costs of developing the CHH would be covered by the sale of land and assets on other parts of the BGH site.

3.4 After engaging with stakeholders and the public on these options, SCFT has decided to progress one of the options. This will see the construction of a CHH facing Elm Grove and the development of much of the remainder of the site for housing. Under this option, none of the community health services currently provided at the site will need relocating. (Some BSUH out-patient services, located at BGH will cease to be provided from the BGH site. These services include dermatology, rheumatology and some acute outpatient physiotherapy, which are planned to be located at Royal Sussex County Hospital as part of the 3Ts development – less than 1.5 miles away and less than 10 minutes' drive and 15 minutes public transport travel time).

3.5 At the June 2018 HOSC meeting, the committee resolved to require formal consultation with SCFT on the basis that some of the options being considered potentially constituted a Substantial Variation in Services (SViS), since they might involve the relocation of some community patient services. NHS bodies are obliged to consult formally with HOSCs on all SViS plans. However, since SCFT is now progressing an option that does not require the relocation of any patient services, there are no obvious grounds to classify the plans as a SViS, and hence no requirement for formal consultation with the HOSC under legislation relating to SViS. This is a largely semantic distinction, since the HOSC may still scrutinise this initiative using its general powers of scrutiny, receiving updates on developments and making recommendations to SCFT should members choose to do so.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 Not relevant to this report for information.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 None undertaken by HOSC. However it should be noted that extensive engagement has taken place, led by SCFT and delivered through a plan developed in partnership with communications managers at Brighton & Hove CCG, Brighton & Hove City Council and all statutory health and care providers in

the city.

5.2 The engagement activity included:
- A public engagement event in the Brighthelm Centre in June 2018, which was attended by over 60 people
- 22 'roadshow' meetings with community groups, including voluntary organisations, patient groups and neighbourhood and community groups reaching over 150 people
- A web and paper based survey with over 200 responses from staff (including staff from other providers based at the site) and 500 responses from patients and members of the public

5.3 There is overwhelming community support for the proposals, including 80% of all people responding supportive of development, the support for GP services being provided from the site has 80% staff and 85% patient/public support.

5.4 The priorities that respondents to the survey saw as most important are improved disabled access and public transport access.

5.5 There is widespread support for housing development on surplus land and the contribution of affordable and keyworker housing has strong support.

6. CONCLUSION

6.1 Members are asked to note the progress of the scheme to redevelop the BGH site, and in particular SCFT's decision to progress an option that will retain all current health services on the site.

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: 03/01/19

Equalities Implications:

7.3 None identified. As the plans being progressed do not involve the relocation of any patient services, there is no obvious detrimental impact on any protected group. However, it should be noted that the site gradient and current configuration of services in multiple buildings presents barriers to physical accessibility. The new proposal, which will see level access to buildings in a more compact campus and close to Elm Grove, will ensure a substantial improvement in disability and general access.

Sustainability Implications:

7.2 None identified.

Any Other Significant Implications:

7.3 None identified.

SUPPORTING DOCUMENTATION

Appendices:

1. Presentation to HOSC on Brighton General Hospital 23 January 2019.

BRIGHTON GENERAL
COMMUNITY HEALTH HUB

NHS
Sussex Community
NHS Foundation Trust

Brighton General Community Health Hub

Health Overview and Scrutiny Committee – 23 January 2019

Excellent care at the heart of the community

Purpose of the Presentation

- Update HOSC on Brighton General Community Health Hub Project progress
- Present preferred option for services and estates
- Advise on programme and next steps
- Discuss future engagement requirements

Contents

- Summary of current progress
- Preferred option for Health Hub
- Next steps and recommendations

Summary of current progress

Brighton General Community Health Hub – Summary of Progress

- **Case for change articulated**
  - Fragmented service delivery, poor utilisation and much of the existing estate beyond economic repair
- **Widespread engagement**
  - Community engagement event at Brighthelm Centre, 22 community events, over 700 responses (staff, patients and public) to survey
  - Overwhelming support for principles of development and project progress
- **Preferred option chosen**
  - Based on Option 5, which delivers a health hub Elm Grove and forms basis for future project development
- **Outline Business Case approved by SCFT Board**

BRIGHTON GENERAL
COMMUNITY HEALTH HUB

Community Health Hub – Service Provision

After considering all existing services and functions on the current BGH site, the following services will be located in the new Community Health Hub:

- Falls Prevention
- Therapies and Podiatry
- Health and Wellbeing Hub
- Mental Health Services
  - Brighton Integrated Care Services
  - Recovery/Assessment & Treatment
  - Wellbeing Service
  - Homeless Team
- Children's services (inc CDC & CSARC)
- Nursery
- Early Parenting
- Sussex Rehabilitation Centre (limb Centre)
- Offices for community nurses & therapists
- Primary Care (GP) – *new service*
- Pharmacy Dispensing - *new service*
- SECAmb Community Response Post

The Health Hub will also be designed to support and facilitate a more integrated way of working. The building will be flexible and adaptable so that other new services could be added at a future date if required.

Relocation of Other Services

Sussex Community NHS Foundation Trust

The following SCFT teams could be relocated to other sites in the Brighton area. None of these services are patient facing:

- Trust Facilities Management and Maintenance Teams
- West Brighton Community Responsive Services Team*
- Central Brighton Community Responsive Services Team

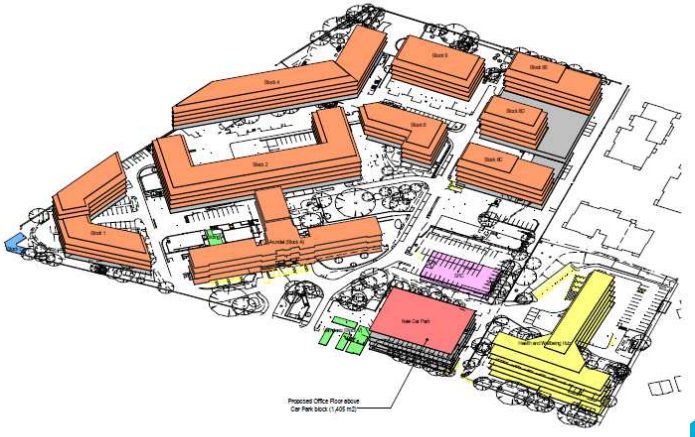
Brighton & Sussex University Hospitals NHS Trust

- All current BSUH services on BGH site will be relocated to another BSUH site, in line with the Trust's strategy to consolidate its estate through the 3Ts project at the Royal Sussex County Hospital.
- * Responsive Services is a multidisciplinary nursing and therapies team. It provides complex care for patients in their own homes with a view to supporting timely discharge from hospital or avoid hospital admission altogether. Our Responsive Services teams are being reorganised to support the 6 clusters/communities of practice in the city.

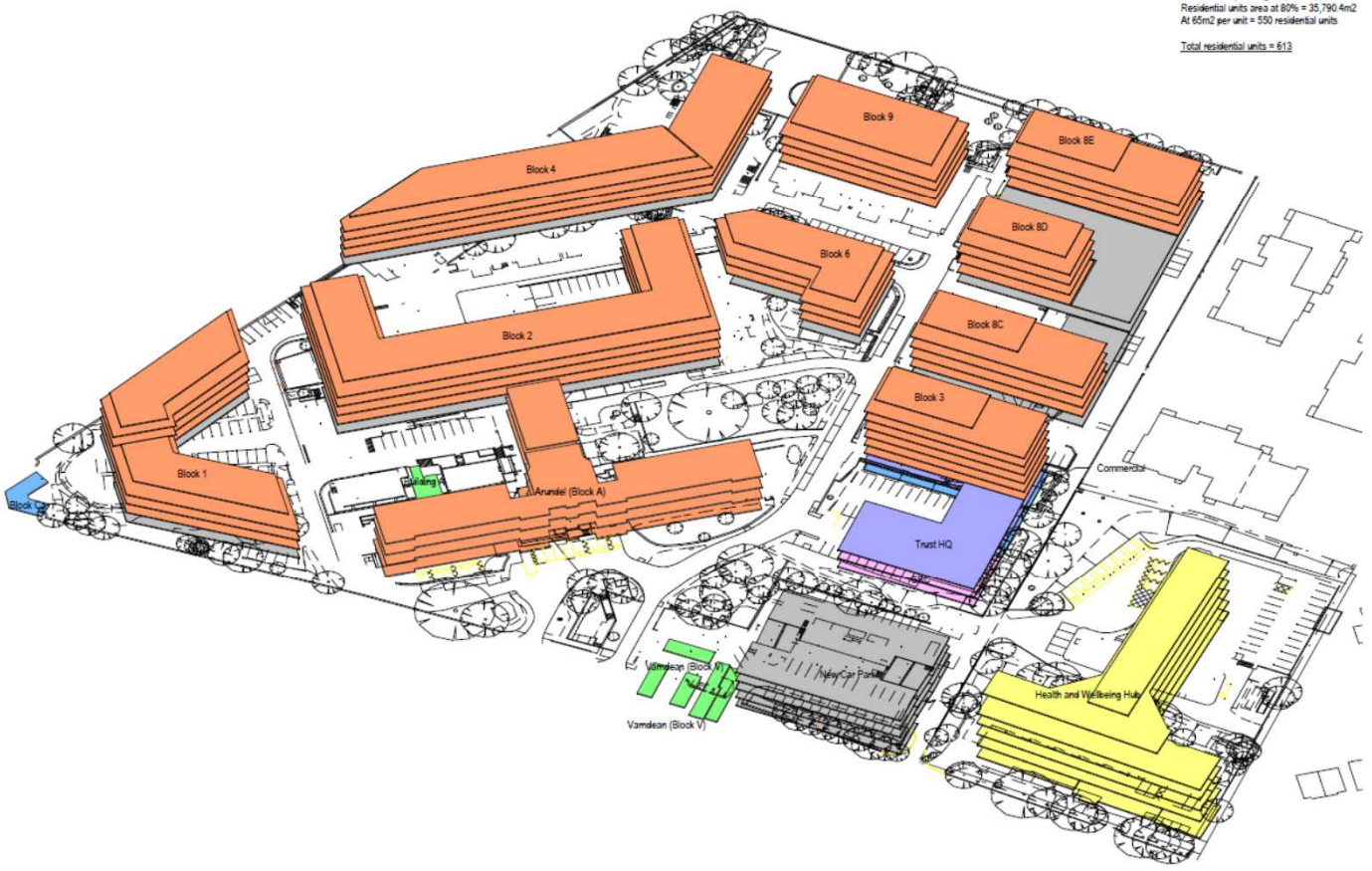
Proposed Solution For New Community Health Hub

Proposed solution (preferred option)

- The need to create a health hub is the main driver for the business case
- The disposal of surplus land for housing will fund substantial investment in the new community health hub.
- Delivers greatest benefit and was the preferred choice of patients and public, staff and Trust Executive Team.
- It also was the most affordable option (looking at capital investment and running costs)



Proposed solution (preferred option)



RESIDENTIAL UNITS

Existing residential GIA = 5888m2
Circulation & planning at 30% = 1,766.4m2
Residential units area at 70% = 4,121.6m2
At 65m2 per unit = 63 residential units

New residential GIA = 44,738m2
Circulation & planning at 20% = 8,947.6m2
Residential units area at 80% = 35,790.4m2
At 65m2 per unit = 550 residential units

Total residential units = 613

KEY

- Residential Buildings
- Healthcare Buildings
- Commercial Buildings
- Community Buildings
- Additional Pattern for New Buildings
- Parking
- Sussex Rehabilitation Centre
- Trust HQ

Block A — Block Name (Number)

GF+2 — Number of Storeys

Option 5A - Areas summary

Building Purpose	GIA	Phase Created
Commercial	88 m²	Existing
Commercial	916 m²	New Construction
Community	335 m²	Existing
Healthcare	8942 m²	New Construction
Residential	5888 m²	Existing
Residential	44738 m²	New Construction
SRC	1307 m²	New Construction
Trust HQ	1806 m²	New Construction
Grand total	64020 m²	

Rider Levett Bucknall
Sussex Community NHS Foundation Trust

IBI Intelligence Buildings Infrastructure

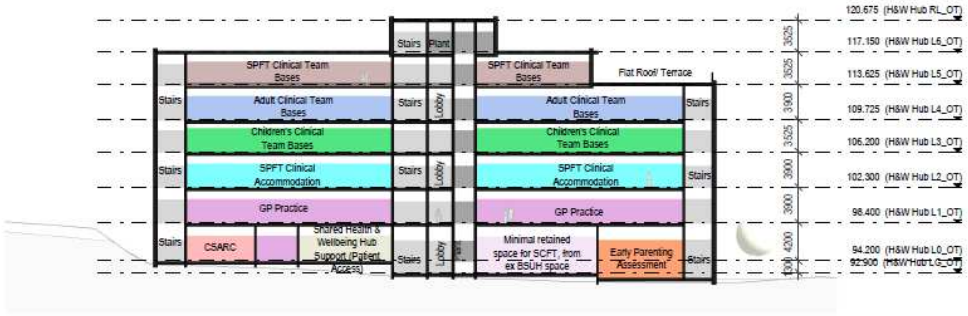
Brighton General Hospital Masterplan

Site 3D View, Option 5A

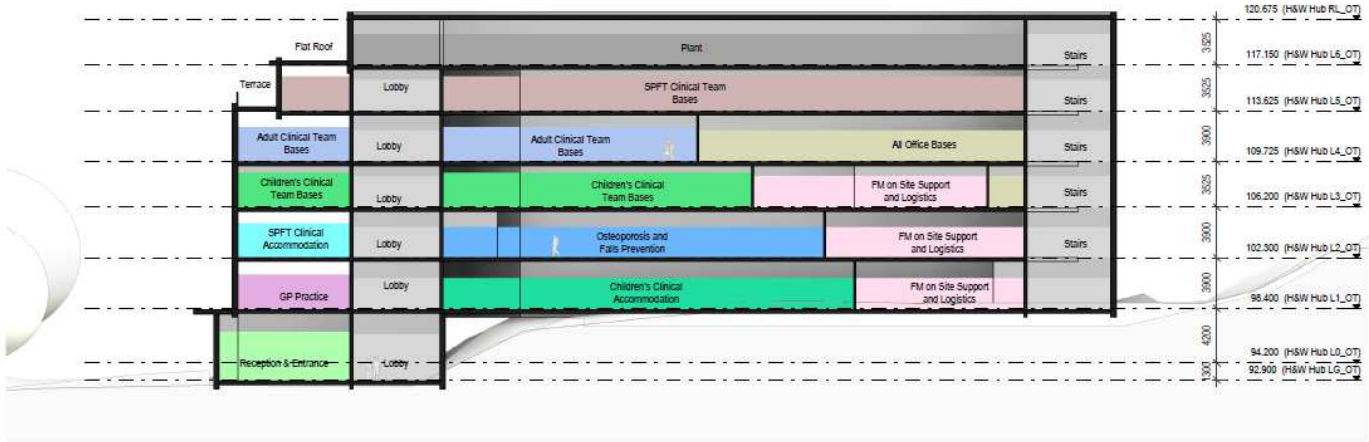
112592 | October 2018 | 1 : 1000 | Information

112592-IBI-WS-XX-M3-A-100-104

Health Hub Sectional View



Section 1



Section 2

Health Hub Elevation

Target programme

- OBC and preferred approved by SCFT Trust Board – Approved 25 October 2018
- OBC to be presented to CCG governing body (December 2018)
- NHS Improvement (Regulator) approval (expected early 2019)
- Detailed brief development – Spring 2019
- Developed design of health hub, site masterplan and planning application – late spring 2019
- Procurement of JV developer partner – Competitive Dialogue (summer/autumn 2019)
- Full business case complete – Early 2020
- FBC determined early – mid 2020
- Offsite moves, works to site begin - 2020
- Health hub (2 phases of health building development) complete- 2023

HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 28 Brighton & Hove City Council

Subject:		**South East Coast Ambulance NHS Foundation Trust (SECAmb): Update on Quality & Performance**
Date of Meeting:		**23 January 2019**
Report of:		**Executive Lead for Strategy, Governance & Law (Monitoring Officer)**
Contact Officer:	**Name:**	**Giles Rossington** **Tel: 01273 295514**
	Email:	**giles.rossington@brighton-hove.gov.uk**
Ward(s) affected:		**(All Wards);**

FOR GENERAL RELEASE

Glossary/Explanation of Terms

- **SECAmb:** South East Coast Ambulance NHS Foundation Trust
- **CQC:** Care Quality Commission (statutory regulator of NHS trusts)
- **Deloitte:** independent organisation providing audit and consultancy services to NHS providers
- **ORH** (Operational Research in Health): independent organisation providing audit and consultancy services to NHS providers
- **Ambulance Response Programme Standards (ARP)**: national standards for ambulance performance (time taken to respond to various categories of call-out etc.)
- **NET** (Non-Emergency Transport): a category of ambulance journeys which do not require rapid transfer to a hospital emergency department. Not to be confused with PTS: planned transport to hospital for patients, which is a separate service/contract and is not provided by SECAmb.

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 South East Coast Ambulance NHS Foundation Trust (SECAmb) provides emergency ambulance services across Sussex, Surrey and Kent.

1.2 HOSCs have a statutory duty to monitor the quality and performance of local NHS trusts. This report provides members with an update on SECAmb's quality and performance as well as outlining some important recent developments at the Trust.

2. RECOMMENDATIONS:

2.1 That the Committee notes the information contained in this report.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 SECAmb is an NHS ambulance trust providing services across the South East of England. Emergency ambulance services are commissioned jointly across the patch, with North West Surrey CCG acting as Lead Commissioner, although each CCG is accountable for services in its area.

3.2 HOSC's have a duty to monitor the performance of local NHS providers. In recent months, scrutiny of SECAmb has been undertaken via an informal meeting between Trust executives and regional HOSC chairs which was then reported back to the individual HOSCs. This arrangement has recently been discontinued by mutual agreement and future scrutiny will be undertaken by individual HOSCs.

3.3 **South East Coast Ambulance Service Update** (attached as **Appendix 1**)
This report updates the committee on:

- the South East Coast Ambulance Service CQC report
- Executive leadership development; the Ambulance Response Programme
- the Demand and Capacity review and resulting Strategic Transformation and Delivery Programme
- Also included are other strategic performance updates and local performance and development initiatives for Brighton & Hove.

3.4 CQC Inspection
The Care Quality Commission (CQC) is the regulator of NHS trusts. The CQC has recently inspected SECAmb services, rating the trust as **Requires Improvement**. The detailed CQC inspection report can be found here LINK Key summary findings are included in the South East Coast Ambulance Service Update **(Appendix 1)**. The trust, working closely with partners, is drawing up an action plan in response to the CQC's findings.

. .

3.5 Demand and Capacity Review.
During 2017- 2019, following the identification of a gap in funding for SECAmb to deliver its existing model and achieve all performance targets, Commissioners and SECAmb jointly commissioned (with the Support of NHS England and NHS Improvement), Deloitte and ORH to undertake a review of existing and future operating models. This was a review of the resources required to meet rising demand for urgent and emergency ambulance services and how best to deliver the new Ambulance Response Programme Standards.

This report has been delivered and CCGs have agreed to additional funding to support the proposed Targeted dispatch model. Work has already begun on the delivery of this model through the Strategic Transformation and Delivery (STAD) Programme implementation with staff recruitment and fleet procurement underway. A key part of the delivery is that Q1 2019/20 will see C1 performance achievement on a sustainable basis, and the introduction of the full model for all categories of performance, with sustainability fully achieved by Q4 2020/21. Further details of this are included in the attached South East Coast Ambulance Service Update

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 Not relevant to this report for information.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 None undertaken.

6. CONCLUSION

6.1 Members are asked to note this report.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 None to this update report for information.

Legal Implications:

7.2 There are no legal implications arising from this report

Lawyer Consulted: Elizabeth Culbert Date: 03/01/2019

Equalities Implications:

7.3 None directly; however the CQC inspection report looks at how the trust meets the needs of all residents including members of protected groups.

Sustainability Implications:

7.4 None directly.

Any Other Significant Implications:

7.5 None identified

SUPPORTING DOCUMENTATION

Appendices:

1. South East Coast Ambulance Service Update

Documents in Members' Rooms

None

Background Documents

None

APPENDIX 1

SOUTH EAST COAST AMBULANCE SERVICE UPDATE

Report from:	Daren Mochrie, Chief Executive, SECAmb
	Steve Emerton, Director Strategy & Development
Author:	Helen Wilshaw-Roberts, Strategy & Partnerships Manager, SECAmb

Summary
This report updates the committee on the South East Coast Ambulance Service CQC report, Executive leadership development, the Ambulance Response Programme, the Demand and Capacity review and resulting Strategic Transformation and Delivery Programme, alongside other strategic performance updates and local performance and development initiatives for Brighton and Hove.

1. Budget and Policy Framework

1.1 Under the Local Authority (Public Health, Health and wellbeing Boards and Health Scrutiny) Regulations 2013 the Council may review and scrutinise any matter relating to the planning, provision and operation of the Brighton and Hove City health service.

1.2 The terms of reference for the Health and Adult Social Care Overview and Scrutiny Committee (Chapter 4 Part 5 paragraph 21.2 (c) of the Constitution) includes powers to review and scrutinise matters relating to the health service in the area, including NHS Scrutiny.

2. Background

2.1 On 29 September 2017, the CQC published their findings following their inspection of the South East Coast Ambulance Service (SECAmb) which saw an overall rating of 'inadequate' for the 999 service and an overall 'good' for the 111 service. The Trust was recognised as good for caring throughout.

2.2 Following this rating, SECAmb implemented a delivery plan with a clear focus on the key areas for improvement as indicated by the CQC.

2.3 SECAmb has also continued to recruit to its Executive Team and Board

- Steve Emerton was appointed to the role of Executive Director of Strategy and Business Development on 2nd January 2018.

- Ed Griffin was appointed to the role of Executive Director for HR on 7th March 2018.

- Bethan Haskins, has been appointed to the role of Executive Director of Nursing and Quality and started on the 1 April 2018.

- Dr Fionna Moore, has been appointed as the Trusts Substantive Executive Medical Director, following an interim period of the past 14 months.

- Following the departure of the Trusts Chairperson, Richard Foster, David Astley was appointed in September 2018. We also welcomed our new Non-Executive Director Michael Whitehouse.

2.4 In November 2018, the Trust announced that Chief Executive, Daren Mochrie, would be leaving SECAmb to take up a new role as Chief Executive of the North West Ambulance Service from 1 April 2019. The process to recruit Daren's successor is already underway, led by Chair David Astley. The first round of interviews is due to take place in January 2019.

3 CQC Update

3.1 Following the CQC published report on the 29th September 2017, the result of which saw the Trust placed into special measures, SECAmb has been on an improvement trajectory. Further unannounced visits from the CQC saw their formal recognition of the progress that the Trust was making, largely achieved through a comprehensive work programme overseen by the Trust's Programme Management Office (PMO).

3.2 The Trust was inspected by CQC in July and August 2018 and the subsequent report published on 8th November 2018 (**Appendix A** shows key excerpts). The Trust's rating moved from 'inadequate' to 'requires improvement'.

3.3 Whilst the Trust is rated as 'requires improvement', the CQC acknowledged a number of areas where the Trust has made significant progress and again rated the care given by staff to patients as good, with several other areas recognised as outstanding.

3.4 Some of the key areas of feedback are:

- Staff cared for patients with compassion. All staff inspectors spoke with were motivated to deliver the best care possible and feedback from patients and those close to them was positive

- The Trust promoted a positive culture that supported and valued staff. Inspectors found an improved culture across the service since the last

inspection. Most staff felt the culture had improved and felt able to raise concerns to their managers

- Medicines management was robust and effective with a marked improvement since the previous inspection. Inspectors found elements of outstanding medicine management, for example, the way the Trust handled Controlled Drugs. An external review also recognised the impressive turnaround in performance

- A new Well-Being Hub, which enables staff to access support in a variety of areas. The service was widely commended by staff during the inspection.

- A significant improvement in the process for investigating complaints and the quality of the Trust's response to complaints since the previous inspection

3.5 Following the publication of the report and its findings, the Trust will be working with its PMO on a delivery plan to continue the progress and improvements required. **Appendix A** shows the Must Do and Should Do areas required.

4 Ambulance Response Programme

4.1 Following the NHS England commissioned review of urgent and emergency care in 2013, it was recognised that the ambulance service response standards (England) had not been reviewed since the mid 1970's. There was a review and new standards introduced in March 2001 where we moved away from the Rural/ Urban ORCON standards and Cat A, B and C prioritisation was introduced at this time. This has since been superseded.

4.2 In 2015, NHS England commissioned Sheffield University to undertake a study into ambulance responses. The result of this study was the introduction of the Ambulance Response Programme.

4.3 The Ambulance Response Programme (ARP) is a change to the way in which ambulance services (in England) receive and respond to emergency calls. On 22nd November 2017, ARP went live at SECAmb.

4.4 A key element of ARP was the re categorisation of 999 call priorities, whilst maintaining a clear focus on the clinical needs of patients and ensuring that the right resource is dispatched **(Table 1)**.

5 Performance

5.1 The variance in performance for SECAmb across the three counties (Kent, Surrey, Sussex) is minimal. Since ARP implementation, SECAmb has performed close to the national average for C1, better than average for C2. C3 and C4 responses remain challenging **(Table 2a)** The Demand and Capacity Review **(section 6)** was set to review a potential gap in funding and the Trust's ability to deliver to ARP standards.

5.2 The Brighton & Hove City Council area is mapped by the Brighton and Hove CCG and SECAmb's Brighton Operating Unit. **Table 2b** illustrates the current November month and year to date cumulative 999 performance.

5.3 Category 1 and Category 2 mean response and 90th centile performance is significantly within target.

5.4 Category 3 90th centile target is missed but at 2hrs 21 mins in November'18, Brighton is the highest performing operating unit Trust wide and showing an improving trend as shown in **Table 2b.**

5.5 Category 4 90th centile target was achieved for Brighton and Hove CCG area November'18 and the Brighton Operating Unit has improved dramatically since April '18 as a result, in part, of the local initiative " the Longest One Waiting Vehicle".

6 Demand and Capacity Review

6.1 During 2017- 2019, following the identification of a gap in funding, for SECAmb to deliver its existing model and achieve all performance targets, Commissioners and SECAmb jointly commissioned (with the Support of NHS England and NHS Improvement), Deloitte and ORH to undertake a review of existing and future operating models.

6.2 The approach from Deloitte and ORH was in the form of a 'Demand and Capacity' review to understand the relationship between resources, performance, and finances.

6.3 The focus of the review was on two operating models: 1) Paramedic Led Ambulance Model and 2) The Targeted Dispatch Model. Both identified a requirement to increase not only the number of front line staff, but also the fleet resource.

6.4 The conclusion of this review to recommend the 'Targeted Dispatch Model', which focused on getting clinically appropriate resources to patients by using specialist paramedics in cars, paramedics on ambulances and the introduction of a lower acuity mode of ambulance to specifically support those patients that fall into category 3 & 4 calls. Non-Emergency Transport (NET) vehicles have since been procured and are being rolled out across the Trust by March 2019.

6.5 The NET vehicles will support The Trust to improve response to patients who are not in a serious or life-threatening condition. Primarily they will serve patients who have been assessed by a Health Care Professional, such as a Paramedic or GP and who require non-emergency urgent transport to a healthcare facility. However, all NET vehicles will be equipped with essential life-saving equipment and will be able to attend as a first response to life-

threatening calls. The NETs will be crewed by Emergency Care Support Workers, Associate Ambulance Practitioners and Ambulance Technicians.

6.6 Another key element of the 'Targeted Dispatch Model' is that it builds on our work with the wider system to enable and facilitate alternatives to conveyance to an Emergency Department. That is, increase 'hear and treat' and 'see and treat' or refer into jointly developed and clear care pathways to deliver continued benefit to patients and the system.

6.7 Work has already begun on the delivery of this model through the Strategic Transformation and Delivery (STAD) Programme implementation with staff recruitment and fleet procurement underway. A key part of the delivery is that Q1 2019/20 will see C1 performance achievement on a sustainable basis, and the introduction of the full model for all categories of performance, with sustainability fully achieved by Q4 2020/21.

6.8 In the Brighton Operating Unit area, there is an increase in staff and vehicles over the next 18 months with 2 new NET vehicles in place by March 19. This extra resource, alongside the protected targeted dispatch model and Paramedic Practitioners tasked to focus on admission avoidance initiatives, will support increasing our 'see and treat' and referrals into alternative care pathways and reduce the time to respond to lower acuity Category 3 & Category 4 incidents.

7 Fleet

7.1 SECAmb has invested in 101 new ambulances with a vehicle roll out programme during the next 12 months. July saw the first of 42 new ambulances, 'Mercedes Sprinters', being rolled out at a rate of 3 to 4 per week and will replace some of the Trust's older vehicles by October. The Trust is also in the process of trialling 16 new Fiat van conversion ambulances across the Trust.

7.2 In addition and to further support ARP, the Trust has invested in 30 second-hand Fiat ambulances, operating at Non-Emergency Transport (NET) vehicles, which are converted to attend the lower acuity non-life threatening calls and will carry slightly different equipment. These vehicles are being introduced in a phased approach commencing mid December 2018: full operational roll out is expected to be complete by March 2019.

7.3 During 2019/20 further investment is planned in up to a further 50 ambulances as well as a replacement programme for the Trust's rapid response cars and 4x4 vehicles.

8 Handover Delays

8.1 SECAmb is leading on a system wide programme of work focusing on reducing ambulance hours lost at hospital sites due to handover delays. The programme is led by a Programme Director.

8.2 Some good progress has been made overall, and for the month of November 2018 the total ambulance hours lost >30 minute turnaround was 4354 hours which is equivalent to 362, 12-hour ambulance shifts for the month, or 12 per day. This is a reduction when compared to the same period last year (5248 hours) but remains of significant concern. Most hospital sites are losing fewer hours than in November last year but there are some significant outliers where hours lost are more compared to the same time last year.

8.3 A key part of the work stream has been to develop together with each acute hospital, a handover action plan to streamline the process of handover delays including best practice e.g. dedicated handover nurse and admin, Fit2Sit, front door streaming and direct conveyance to non ED destinations.

8.4 A number of live conveyance reviews have also taken place where a representative from the ambulance service, hospital, primary care, community trust, and CCG have reviewed all decisions to convey to hospital with an aim to ensuring that all existing community pathways are maximised.

8.5 The reviews undertaken so far, have given a clear indication that community pathways are being maximised where they are in place. The results are being presented for further discussion with local system partners in order to explore new community pathways, where required.

8.6 Peer reviews looking at the handover process at individual sites have also taken place at some hospitals, where the Chief Operating Officer from another acute hospital, supported by a member of the Emergency Care Intensive Support Team (ECIST), visits another hospital and reviews the ambulance pathway through the department. The peer reviews have been received positively and have been a good way to share best practice across hospital sites.

9 Brighton & Hove City Update

9.1 The most significant news was the recent announcement by the Secretary of State for Health & Social Care, Matt Hancock of a £5.52m grant for the new Make-Ready Centre at Falmer. Following Trust Board approval of the Business Case, to comply with planning permissions, the building works will commence on Monday 7th January 2019 with completion anticipated in late 2019 and full occupation in early 2020.

9.2 This new state-of-the-art facility will replace the existing Ambulance Stations at Brighton, Hove and Lewes. The Brighton Ambulance Station will be redeveloped as part of the proposed development of the Brighton General Hospital Site into a purpose built Community Health Hub for patients from across Brighton & Hove, and Sussex. When complete, this will also provide an Ambulance Community Response (ACRP) site on Elm Grove. The Lewes Ambulance Station site will be redeveloped for a new Fire & Rescue Service station with an ACRP. The Hove Ambulance Station will initially remain as an

ACRP but we will look for opportunities to relocate near to the junction of Old Shoreham Road and A293.

9.3 The new Make Ready Centre at Falmer will house about 230 people including operational, fleet and make-ready staff. There will be accommodation for vehicle servicing, cleaning and equipping, as well as a suite of training and meeting room facilities. This will provide a 21st century base fit for the City where the first paramedics went to patients back in 1971.

9.4 The vibrancy of life in the City does bring challenges to the Ambulance Service, particularly with the number of large-scale public events. The Trust fully supports these events, but ask Councillors to be mindful of the pressures put on the ambulance services and the effects that they can have on the whole community. We discuss these at the City Safety Advisory Group but it is not possible to mitigate for all consequences of such events.

9.5 We are fortunate to have a fully-staffed, highly-motivated, skilled, diverse and dynamic workforce in the City. The Demand & Capacity Review provides for a significant uplift in staffing, primarily recruiting additional paramedics as new graduates from the University of Brighton. We have also promoted a number of staff into new positions in recent months and there is a positive culture within the team.

10 Five-Year Strategy

10.1 The Trust has developed a strategic plan for the next 5 years, 2017-22, and is focussed on the delivery of 4 strategic themes; Our People, Our Patients, Our Partners, and Our Enablers. We are currently refreshing our strategy to take account of internal and external developments since publication in July 2017 and this will be presented to the Trust Board in the next few months.

11 Alliances

11.1 On 22 November 2018, the Trust announced that it was working to form an alliance with West Midlands and South Western Ambulance Services that will see us working closely together to deliver efficiency savings to invest in front line services.

11.2 The alliance expects to deliver savings through initiatives such as the joint procurement of supplies, including equipment and fuel. In addition, we will work collaboratively to share best practice for the benefit of patients and staff and will also work on improving resilience between the organisations for planned events and major incidents.

11.3 The work will draw upon existing benchmarking and evidence from the National Audit Office investigation into ambulance services, and more recently, the report from Lord Carter into efficiency and productivity.

11.4 It is important to stress that there are no plans to merge services or re-structure existing operations, but the alliance will mean that the three Trusts can make every pound of taxpayers' money work as efficiently as possible.

11.5 This is very much the start of the process and further work will follow overcoming months through our Board and governance framework. However, by forming this partnership, we will be able to bring together the knowledge and experience of the three Trusts to explore ways to reduce variation and develop new joint initiatives

12 Winter Planning

12.1 SECAmb has a proven methodology in its approach to winter preparedness. This is achieved with the use of historic data and current activity trends, combined with 'lessons learnt' from prior years.

12.2 An overarching Trust winter plan is developed, supported by a tactical plan, as well as local 'Operating Unit' (OU) plans. The local OU plans feed in to local system plans.

12.3 The SECAmb 111 winter plan covers North and West Kent as well as Surrey and Sussex (excluding East Kent). The Winter Plan Structure Framework in shown in **Table 3**.

12.4 During winter (November 1st to March 31st), the Senior Operations Leadership Team (SOLT) will constantly review the level of resource available against predicted demand enabling the Trust to predict, monitor and mitigate to maintain service delivery during surges in demand or reduced capacity.

12.5 In line with Trust policy, the level of annual leave is reduced to 50% of normal levels across the two-week Christmas/ New Year period and as in previous years, enhanced rates or incentives are offered, as needed, to ensure that priority shifts are covered.

13 Finances

13.1 At the year-end (2017/18), the Trust achieved its control total of £1.0m deficit, this includes the agreed Sustainability and Transformation Funding (STF) of £1.3m. In addition, the Trust achieved a further STF (incentive plus bonus) of £1.4m and a CQUIN risk reserve of previously held by commissioners of £0.8m, resulting in a reported surplus of £1.3m.

13.2 The Trust also achieved Cost Improvements of £15.5m. This was greater than the target of £15.1m.

13.3 For 2018/19, the Cost Improvement Plan (CIP) target is £11.4m.
As at October '18, £5.1m has been delivered to date, an increase of £0.1m against Plan. It is projected that the full year target will be met. 'CIPs'

represent increased efficiency and are never a reduction of resources to provide front line services.

Daren Mochrie	**Steve Emerton**
Chief Executive Officer	**Executive Director, Strategy and Business Development**

Lead Officer Contact:

Helen Wilshaw-Roberts, Strategy & Partnerships Manager, SECAmb

Email : helen.wilshaw@secamb.nhs.uk

Appendices

APPENDIX A : CQC REPORT SUMMARY FINDINGS – 8th November 2018
APPENDIX B : ARP, Performance and Winter Planning

Table 1 : **ARP Performance Categories**
Table 2a: **National ARP AQI's November 2018**
Table 2b: **SECAmb Performance for November 2018 and Year To Date**
Table 3: **Winter Plan Structure Framework**

Background Papers

None

APPENDICES

APPENDIX A : CQC REPORT SUMMARY FINDINGS – 8th November 2018

Overall trust

Our rating of the trust improved. We rated it as requires improvement because:

- In both the emergency operations centre (EOC) and emergency and urgent care (EUC) we rated safe, effective, responsive and well-led as requires improvement and rated well-led in resilience as requires improvement.
- We rated safe, effective and responsive in the trust's resilience core service as good. We rated caring as good across all three core services.
- In rating the trust, we took into account the current ratings of the 111 service, which was not inspected this time.
- We rated well-led for the trust, overall, as requires improvement.

Ratings

Overall rating for this trust	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

1 South East Coast Ambulance Service NHS Foundation Trust Inspection report 08/11/2018

Outstanding practice

Emergency Operations Centre

- Support for maternity patients was excellent. A new pregnancy advice and triage line for pregnant women had been introduced within the Crawley EOC.

Emergency and Urgent Care

- The Crawley triage scheme, which had led to a reduction in conveyancing to hospital for people with mental health conditions from 53% to 11%.
- We found elements of outstanding medicine management, for example the way the trust handled Controlled Drugs (CD's). We found suitable audit and quality control processes to ensure the high standards achieved by the organisation were continuously monitored.
- The trust initiative to provide physical and mental health support for staff through the 'wellbeing hub' was widely commended by staff during the inspection.
- There was a multidisciplinary multiagency approach to training in the Kent area. This meant staff were training to deal with unexpected situations should they occur.

- Brighton station had a dedicated homeless lead who took responsibility for and oversight of this vulnerable group. This role included undertaking outreach work, as well as working with local services to meet the needs of these patients.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve services in both the emergency operations centre and in emergency and urgent care.

- The trust **must ensure** that their processes to assess, monitor and improve the quality and safety of services and also to assess, monitor and improve the assessment of risk relating to the provision of the service are operating effectively.

Action the trust SHOULD take to improve the emergency operations centre

- The trust **should ensure** they take action to continue to have effective systems and processes to assess the risk to patients and people using the services and they do all that is reasonably practicable to mitigate those risks, specifically in relation to the risk assessment of patients awaiting the dispatch of an ambulance.
- The trust **should ensure** they continue to monitor the effectiveness of the clinical safety navigator role to ensure continued oversight on the safety of patients waiting for an ambulance.
- The trust **should ensure** there are a sufficient number of clinicians in each EOC to meet the needs of the service.

Action the trust SHOULD take to improve emergency and urgent care

- The trust **should ensure** the processes for providing staff with feedback from safeguarding alerts is improved to strengthen and develop learning.
- The trust **should ensure** that maps in all vehicles are current, up to date and replaced regularly.
- The trust **should ensure** that all staff adhere to the trust policy on carrying personal equipment and the regular servicing of such equipment.
- The trust **should ensure** that pain assessments are carried out and recorded in line with best practice guidance.
- The trust **should ensure** response times for category three and four calls is improved.
- The trust **should consider** producing training data split by staff group and core service area for better oversight of training compliance.

Action the trust SHOULD take to improve Resilience

- The trust **should ensure** they collect, analyse, manage and use data on meeting response times for Hazardous Area Response Team (HART) incidents.

APPENDIX B : ARP, Performance and Winter Planning
Table 1:

ARP Performance Categories

Category	Types of Calls	Response Standard	Likely % of Workload	Response Details
Category 1 (Life-threatening event)	**Previous Red 1 calls and some Red 2s including** • Cardiac Arrests • Choking • Unconscious • Continuous Fitting • Not alert after a fall or trauma • Allergic Reaction with breathing problems	**7 Minute response** (mean response time) **15 Minutes 9 out of 10 times** (90th Centile)	Approx. 100 Incidents a day (8%)	Response time measured with arrival of first emergency responder Will be attended by single responder and ambulance crews
Category 2 (Emergency, potentially serious incident)	**Previous Red 2 calls and some previous G2s including** • Stroke Patients • Fainting, Not Alert • Chest Pains • RTCs • Major Burns • Sepsis	**18 minute response** (mean response time) **40 minute response** (90th centile)	(48%)	Response time measured with **arrival of transporting vehicle** (or first emergency responder if patient **does not** need to be conveyed)
Category 3 (Urgent Problem)	• Falls • Fainting Now Alert • Diabetic Problems • Isolated Limb Fractures • Abdominal Pain	**Maximum of 120 minutes** (120 minutes 90th centile response time)	(34%)	Response time measured with arrival of **transporting vehicle**
Category 4 (Less Urgent Problem)	• Diarrhoea • Vomiting • Non traumatic back pain	**Maximum of 180 minutes** (180 minutes 90th centile response time)	(10%)	May be managed through hear and treat Response time measured with arrival of **transporting vehicle**

Table 2a: National ARP AQI's November 2018

	C1	Mean
	England	**00:07:11**
1	North East	00:06:13
2	London	00:06:16
3	West Midlands	00:06:53
4	South Central	00:06:56
5	South Western	00:06:58
6	Yorkshire	00:07:02
7	South East Coast	00:07:31
8	North West	00:07:42
9	East Midlands	00:07:52
10	East of England	00:08:11
11	Isle of Wight	00:11:23

	C1	90th
	England	**00:12:32**
1	London	00:10:30
2	North East	00:10:47
3	West Midlands	00:11:50
4	Yorkshire	00:12:13
5	South Western	00:12:44
6	South Central	00:12:49
7	North West	00:12:52
8	East Midlands	00:13:57
9	South East Coast	00:13:59
10	East of England	00:14:36
11	Isle of Wight	00:20:40

	C2	Mean
	England	**00:21:56**
1	West Midlands	00:12:46
2	South Central	00:16:56
3	London	00:18:46
4	Isle of Wight	00:19:07
5	South East Coast	00:19:24
6	Yorkshire	00:20:29
7	North West	00:23:16
8	North East	00:23:42
9	East of England	00:25:48
10	South Western	00:28:11
11	East Midlands	00:31:01

	C2	90th
	England	**00:44:53**
1	West Midlands	00:23:29
2	South Central	00:34:06
3	South East Coast	00:36:44
4	London	00:38:11
5	Isle of Wight	00:38:37
6	Yorkshire	00:42:36
7	North East	00:48:44
8	North West	00:49:50
9	East of England	00:52:20
10	South Western	00:59:15
11	East Midlands	01:04:42

	C3	Mean
	England	**01:03:16**
1	West Midlands	00:39:30
2	Yorkshire	00:48:58
3	South Central	00:51:45
4	London	00:52:31
5	Isle of Wight	01:01:03
6	North West	01:08:07
7	East Midlands	01:14:08
8	South Western	01:14:17
9	South East Coast	01:23:05
10	East of England	01:25:46
11	North East	01:26:38

	C3	90th
	England	**02:28:30**
1	West Midlands	01:27:56
2	Yorkshire	01:58:25
3	South Central	02:01:20
4	London	02:06:02
5	Isle of Wight	02:28:27
6	North West	02:42:57
7	South Western	02:51:58
8	East Midlands	02:55:19
9	South East Coast	03:13:49
10	North East	03:19:11
11	East of England	03:27:03

	C4	Mean
	England	**01:25:38**
1	West Midlands	00:57:51
2	East Midlands	01:04:04
3	Yorkshire	01:09:52
4	South Central	01:14:36
5	London	01:16:38
6	North East	01:24:03
7	North West	01:27:54
8	East of England	01:42:03
9	Isle of Wight	01:48:24
10	South East Coast	01:50:32
11	South Western	02:00:57

	C4	90th
	England	**03:17:08**
1	West Midlands	02:22:26
2	Yorkshire	02:43:41
3	East Midlands	02:45:58
4	South Central	02:50:28
5	London	02:52:13
6	North West	03:08:59
7	North East	03:37:55
8	Isle of Wight	04:05:39
9	East of England	04:11:47
10	South East Coast	04:12:29
11	South Western	04:17:40

Table 2b:

SECAmb Performance for November 2018

Nov 18 @ 05/12/2018	CCG	Cat 1 Mean Response Time (00:07:00)	Cat 1 90th Centile (00:15:00)	Cat 2 Mean Response Time (00:18:00)	Cat 2 90th Centile (00:40:00)	Cat 3 90th Centile (02:00:00)	Cat 4 90th Centile (03:00:00)
NHS Brighton & Hove CCG	Sussex	00:05:02	00:08:26	00:13:24	00:26:27	02:21:03	02:50:19
SECAmb commissioned Totals	SECAmb	00:07:30	00:13:58	00:19:24	00:36:51	03:13:09	04:09:35

SECAmb Performance for November and Year to Date

Apr - Nov 2018 @ 05/12/18	CCG	Cat 1 Mean Response Time (00:07:00)	Cat 1 90th Centile (00:15:00)	Cat 2 Mean Response Time (00:18:00)	Cat 2 90th Centile (00:40:00)	Cat 3 90th Centile (02:00:00)	Cat 4 90th Centile (03:00:00)
NHS Brighton & Hove CCG	Sussex	00:05:08	00:09:03	00:13:26	00:26:24	02:42:13	04:14:19
SECAmb commissioned Totals	SECAmb	00:07:39	00:14:12	00:18:22	00:34:54	03:05:15	04:24:05

Brighton Operating Unit : Category 3 and Category 4 Performance

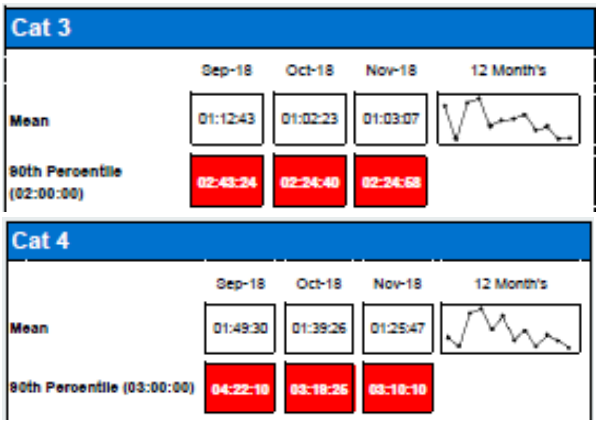
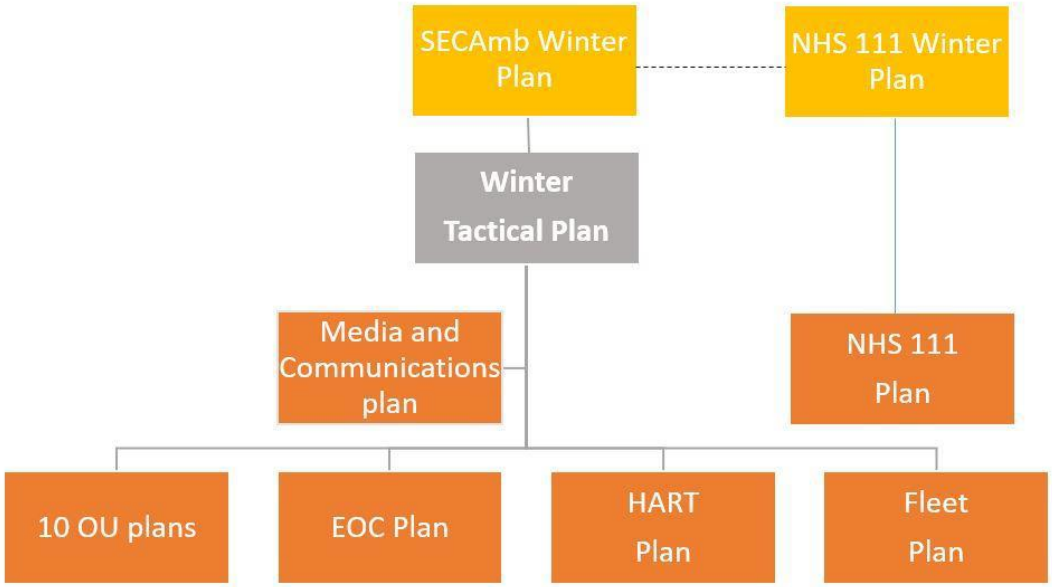


Table 3:

Winter Plan Structure Framework


SECAmb Winter Plan
NHS 111 Winter Plan
Winter Tactical Plan
Media and Communications plan
NHS 111 Plan
10 OU plans
EOC Plan
HART Plan
Fleet Plan

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

Subject:		**NHS 111/Clinical Assessment Service (CAS) changes**	
Date of Meeting:		**23 January 2019**	
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

Glossary/Explanation of Terms

111: NHS telephone helpline for urgent, but non-emergency issues
GP OOH: Out of Hours service providing GP support for patients when surgeries are closed

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 Kent, Medway and Sussex-wide service will need to be procured by autumn 2019 to start operation in 2020.

1.3 The HOSC received an initial report on plans to re-procure 111 at its 06 September 2017 meeting and a follow-up report in December 2017. The original intention was to have a further update on the outcomes of the 111 procurement in summer 2018. However, the tender process was subsequently suspended and NHS commissioners modified their plans for the service. A submission from NHS colleagues, explaining how and why their plans have changed, 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.

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 Public and stakeholder engagement is fed into this procurement on a regular basis from Sussex via the NHS 111 Public Members Network and stakeholder engagement either directly by the NHS 111 Transformation Team or via the Managing Directors for the Sussex CCGs.

6. CONCLUSION

6.1 Members are asked to note plans to re-procure a Kent, Medway and Sussex-wide NHS 111 service.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial 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: 03.01.19*

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.

Appendix 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 hours service to our local population.

In Sussex we need to develop the nationally mandated Integrated Urgent Care Services (IUCS) delivering an improved NHS 111 service, enhancing it with the inclusion of a Clinical Assessment Service (CAS), from the current signposting and referral service to a 'consult and complete' model.

Both Kent and Sussex stopped their procurements in June 2018. However, to ensure we have an enhanced NHS 111 and GP Out of Hours service from 1 April 2019 we have entered into a 12-month interim contract with our existing providers to continue providing this service to our patients and local population - this was agreed at the September CCG Governing Bodies.

As Surrey has awarded their contract, but like Sussex, Kent did not, NHS England (NHSE) challenged both Kent and Sussex CCGs to review the concept of a joint procurement. This had not been an option previously because:

- Kent had a different delivery model to Sussex. Kent's model was to procure both the NHS 111/CAS and the face-to-face Urgent Treatment Centres (UTCs) and Visiting as separate lots in one procurement. This was different to Sussex, as UTCs would be procured separately by each of the seven Sussex CCGs
- No financial savings - as the Kent, Surrey and Sussex models were all very different there was no financial benefit to procure together.

Summary

At the July 2018 CCG Governing Bodies we agreed to bring back a proposed new procurement approach. With NHSE's challenge, the NHS 111 Transformation Team carried out a substantial amount of work to look at alternative options. This also included conversations with Kent to see if there were any benefits to running a joint procurement.

What we discovered is:

- Kent has changed their procurement model. They are now looking at procuring an NHS 111/CAS separately from their local face-to-face services. This aligns more to the Sussex model.
- Following clinical conversations in the summer, if Sussex Governing Bodies agree to change our model and run a separate procurement for the OOH visiting service (for six CCGs) our NHS 111/CAS model is the same as Kent's
- If we procure with Kent, there is the potential to make around £2million in efficiencies across the two regions.
- With the OOH visiting service removed from our Sussex model, we can procure one NHS 111/CAS on a wider scale, which will help with the universal challenges around workforce, offering greater resilience within the system, and economies of scale in utilising staff (both Admin and Clinical).
- Clinically our Sussex Clinical Leads have agreed through our robust Clinical Governance process that procurement at scale for NHS 111/CAS is preferred. In addition, our Sussex Clinical Leads agree with taking the OOH visiting services out of the current service specification - this decision is due to be ratified on Tuesday 20 November at our next Clinical Governance meeting.

Governance

In December 2018, all 15 CCG Governing Bodies across Kent, Medway and Sussex agreed to run a joint procurement for the new NHS 111/CAS service.

The Sussex STP including the following CCGs:

- NHS Coastal West Sussex CCG [Acting as the lead commissioner];
- NHS Brighton and Hove CCG;
- NHS Horsham and Mid Sussex CCG;
- NHS Crawley CCG;
- NHS High Weald Lewes Havens CCG;
- NHS Eastbourne, Hailsham and Seaford CCG;
- NHS Hastings and Rother CCG;

For Kent and Medway STP this includes the following CCGs:

- NHS West Kent CCG;
- NHS Dartford, Gravesend and Swanley CCG;
- NHS Medway CCG;
- NHS Swale CCG;
- NHS Ashford CCG;
- NHS Canterbury and Coastal CCG;
- NHS South East Coast CCG;
- NHS Thanet CCG.

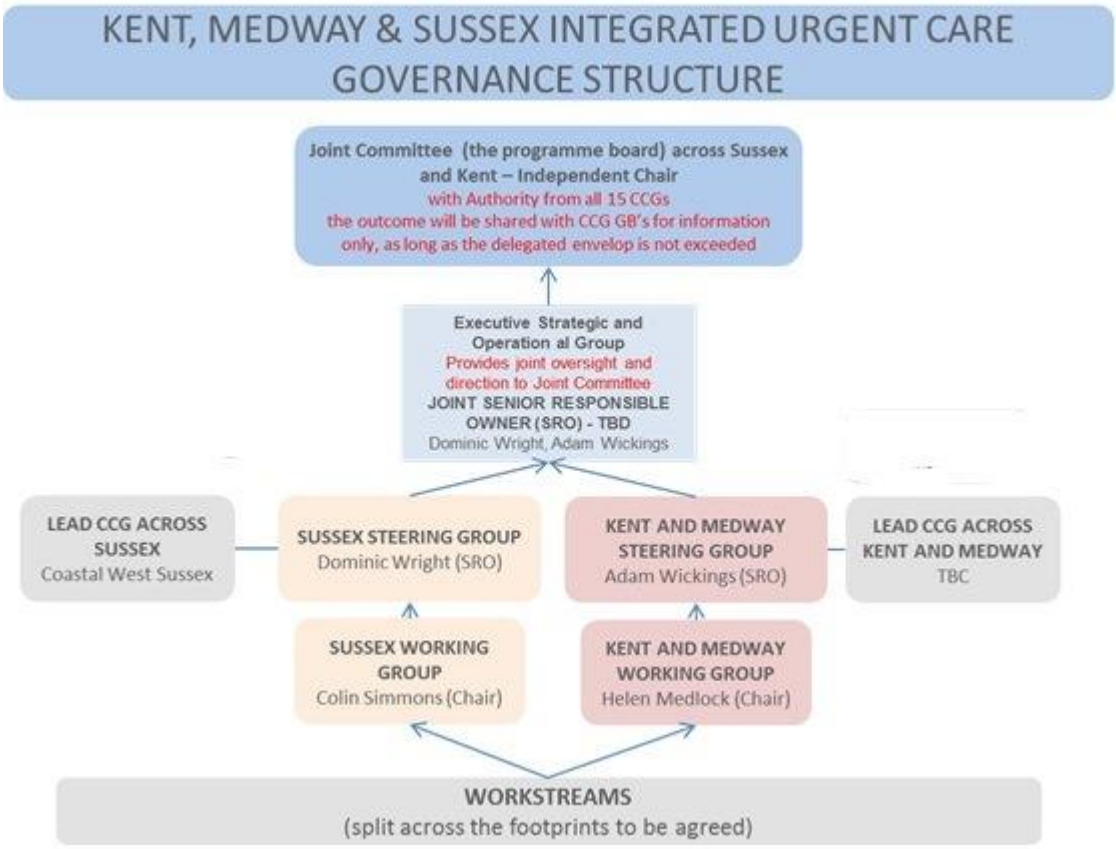
The Governing Bodies also agreed to have a Delegated Decision making process, entailing the establishment of a Joint Committee to which Authority from all 15 participating CCGs will be delegated. The final procurement outcome will be shared with CCGs Governing Bodies for information only.

The Joint Committee are to be responsible for commissioning NHS 111 and Clinical Assessment Services; to oversee, direct and mobilise arrangements for the

procurement and implementation of new NHS 111 and Clinical Assessment Services arrangements for all participating CCGs.

As part of the governance structure, programme boards for both Kent/Medway and Sussex will continue as steering groups for this procurement but will make decisions on local urgent care services, such as the Visiting service for Sussex, which is to be a separate commissioning process.

Please see attached draft governance structure respectively. The SRO is still to be decided formally.



The NHS 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.

HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 30 Brighton & Hove City Council

Subject:		**Director of Public Health: Annual Report**	
Date of Meeting:		**23 January 2019**	
Report of:		**Executive Lead for Strategy, Governance & Law (Monitoring Officer)**	
Contact Officer:	**Name:**	**Giles Rossington**	**Tel: 01273 295514**
	Email:	**giles.rossington@brighton-hove.gov.uk**	
Ward(s) affected:		**(All Wards);**	

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 The Directors of Public Health are required to produce an independent annual report on the state of local public health. There are no specified requirements as to the content or format of the report.

1.2 This year's report *The Art of Good Health* focuses on the links between the arts and health and wellbeing. The Director of Public Health will make a presentation on the report. The report can be accessed online at: https://www.brighton-hove.gov.uk/content/health/public-health-brighton-hove/annual-report-director-public-health

2. RECOMMENDATIONS:

2.1 That the Committee notes the Director of Public Health Annual Report.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 This year's Annual Report of the Director of Public Health examines the contribution that arts and culture make to health and wellbeing in Brighton & Hove.

3.2 The report starts by looking at the health and wellbeing benefits of the arts. It draws on the published evidence base including *Creative Health*, the 2017 report of the All Party Parliamentary Group on Arts, Health and Wellbeing.

3.3 Evidence indicates that arts can have a positive impact on health and wellbeing in a number of ways, including:

- As a social determinant of health, good access to arts and culture influences wellbeing across the whole population
- The arts can have a role in raising awareness, reducing stigma and influencing attitudes

- Engagement with the arts can prevent ill health, for example stress and anxiety, and falls
- For those who are unwell the art can improve symptoms, for example dance can be helpful for those with Parkinson's disease.

3.4 Data indicates that engagement with the arts is higher in Brighton & Hove than the England average. However similar to elsewhere in England, some groups (e.g. carers, people with disabilities) and residents in our more deprived neighbourhoods are less likely to be engaged with the arts and culture. There is a risk that unequal access to the arts contributes to health inequalities highlighting the need for a strong focus on access and participation.

3.5 Four sections in the report follow the life course - start well, live well, age well, die well – an approach that will be taken in our forthcoming Health and Wellbeing Strategy.

3.6 These describe some of the key health and wellbeing issues for each life stage and discuss the contribution that the arts can make in addressing them.

3.7 A section on arts and health & care settings explores how arts can be integrated in health and care services, for example through social prescribing, and how health and wellbeing is being incorporated into cultural settings such as our museums and libraries, and key city festivals.

3.8 The report closes with five recommendations to support developing Brighton and Hove as a Centre of Excellence for arts and health. The recommendations address the following areas:

- Leadership
- Evidence
- Skills and Knowledge
- Access
- Delivery

The recommendations are aimed at:

- local health and care commissioners and providers, arts practitioner and organisations, the community and voluntary sector, local universities.
- the Living Well group, that will be taking forward plans to develop a Centre of Excellence under the auspices of the Brighton & Hove Cultural Framework.

3.9 Throughout the report a diverse range of local case studies are featured including BHCC, NHS, community and voluntary sector, highlighting some of the excellent practice in place locally.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 Not relevant to this report for information

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 None to this report. Details of community engagement for the DPH Annual Report are included in the body of the Annual Report.

6. CONCLUSION

6.1 Members are asked to note the 2018 DPH Annual Report.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 There are no direct financial implications from the recommendations of this report. The total Public Health budget for this financial year is £21.484m of which £20.090m comes from the ring-fenced Public health grant for 2018/19, other funding comes from agreed carry forward of grant from 2017/18 and some non-grant funding.

Finance Officer Consulted: Sophie Warburton Date: 15/10/2018

Legal Implications:

7.2 The NHS Act 2006 and the Health and Social Care Act 2012 require Directors of Public Health to write an annual report on the health of their local population. The content and structure can be determined locally.

Lawyer consulted: Elizabeth Culbert *Date: 15.10.2018*

Equalities Implications:

7.3 The report presents analysis relating to local inequalities in health and wellbeing, and in relation to engagement with the arts and creative activities. A key recommendation is to prioritise engagement and participation in the arts to reduce health and social inequalities, with a focus on widening participation among groups that are currently less likely to engage.

Sustainability Implications:

7.4 None identified

Any Other Significant Implications:

7.5 None identified

SUPPORTING DOCUMENTATION

Appendices:

None

Documents in Members' Rooms

None

Background Documents

None

HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 27 Brighton & Hove City Council

Subject:		**Establishment of a Joint Health and Overview Scrutiny Committee (JHOSC) January 2019**
Date of Meeting:		**23 January 2019**
Report of:		**Executive Lead for Strategy, Governance & Law (Monitoring Officer)**
Contact Officer:	**Name:**	**Giles Rossington** **Tel: 01273 295514**
	Email:	**giles.rossington@brighton-hove.gov.uk**
Ward(s) affected:		**(All Wards);**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 This report outlines the legislative background to JHOSCs and proposes that members agree to recommend that a JHOSC be established with HOSCs from East Sussex, West Sussex and Surrey in anticipation of the announcement of specific NHS change plans, this in the terms indicated below.

1.2 The proposal to establish a joint committee with other authorities is a matter for full Council and as a result HOSC is asked to make recommendations in the terms outlined below.

2. RECOMMENDATIONS:

2.1 That HOSC approve the establishment of a JHOSC in principle.

2.2 That the HOSC recommends that Full Council agrees to establish a JHOSC and approves the Terms of Reference appended to the Report as well as the Ways of Working also appended hereto; and

2.3 That it recommends that Full Council grants delegated authority to the Monitoring Officer to amend and re-publish the Constitution to include reference to the JHOSC; and

2.4 That it recommends that Full Council appoints a member of HOSC from each of the main political groups to sit on the JHOSC; and

2.5 That Full Council appoint one of the HOSC's co-optees as a non-voting co-optee to the JHOSC.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 Health scrutiny legislation states that, if there is a proposal for a 'substantial development of the health service in the area of the local authority or for a substantial variation in the provision of such a service' ('SViS'), there is an

obligation on the NHS body or health service provider to consult the relevant HOSC.

3.2 Where the NHS body or health service provider must consult more than one local authority, as the area covered by the change affects several local authority areas, then the relevant local authorities must establish a Joint HOSC (JHOSC) to scrutinise these plans. The JHOSC will assume all the statutory powers and responsibilities of its constituent HOSCs with regard to the SViS in question, with the exception of the power to refer a SViS plan to the Secretary of State for Health which may either be delegated to the JHOSC or retained by individual local authorities.

3.3 This is mandatory: there is no option for individual HOSCs to separately scrutinise an issue once the conditions requiring a JHOSC have been met (i.e. the formal announcement of plans for a SViS that impacts on two or more local authority areas and of a deadline by which HOSC comments are to be received). All affected HOSCs must join a mandatory JHOSC; any HOSC that declined to do so would be in breach of its statutory duties and the local authority could be directed to join the JHOSC by the Secretary of State.

3.4 In addition to mandatory JHOSCs, HOSCs may also choose to form voluntary HOSCs to jointly scrutinise issues (e.g. a JHOSC might jointly scrutinise NHS change plans that do not meet the bar requiring the establishment of a mandatory JHOSC). Membership of a voluntary JHOSC is optional.

3.5 There has not been a JHOSC involving Brighton & Hove and our direct neighbours for a number of years, the last being the 'Fit For the Future' initiative to reconfigure West Sussex hospitals in 2006-2008. However, recent developments in the region, including the establishment of the Sussex & East Surrey STP and the creation of a CCG Alliance, have increased the likelihood of the NHS instigating SViS plans on a wide geographic scale. Local HOSC Chairs consequently asked NHS leaders to give them advance warning of possible SViS plans in order to give the HOSCs time to establish a JHOSC.

3.6 In autumn 2018 Chairs were informed that it was likely that SViS plans affecting more than one local authority area would be published in the next few months and that in consequence HOSCs might wish to begin planning to establish a JHOSC encompassing the STP area (Brighton & Hove, East Sussex, West Sussex and Surrey HOSCs). SViS plans were likely to include elements of the NHS Clinically Effective Commissioning (CEC) programme, but potentially also other regional initiatives.

3.7 Officers from these HOSCs drew up JHOSC Terms of Reference and Ways of Working which were agreed by HOSC Chairs and presented to each of the HOSCs. East Sussex County Council, West Sussex County Council and Surrey County Council have subsequently agreed to join a JHOSC and have signed-up to the Terms of Reference and Ways of Working.

3.8 A report was presented at the October 2018 Brighton & Hove HOSC meeting asking members to agree to join a JHOSC and to approve the suggested Terms of Reference and Ways of Working. However, this was deferred until January

2019. The current report re-presents the recommendations of the October 2018 report.

3.9 At the October 2018 meeting, members expressed concern or sought additional clarity about a number of aspects of the JHOSC planning. These concerns are addressed below:

- **Is BH HOSC required to join the JHOSC?** The JHOSC is currently voluntary and membership is optional. However, as soon as NHS bodies publish plans for SViS that affect more than one local authority area, the JHOSC will be mandatory and BH HOSC will have to join. The officer recommendation is that we join the voluntary JHOSC now, so as to best represent local interests in JHOSC planning. However, there is no legal requirement to do so at the current time as NHS bodies have not yet formally announced any SViS plans.

- **Can we delay establishing a JHOSC until after the 2019 local elections?** The establishment of a JHOSC has already been agreed by the other STP area HOSCs, and it seems likely that they will choose to begin to plan together in early 2019, at an officer and/or a member level, whether or not Brighton & Hove HOSCs agrees to join at this point. As there is no requirement to join anything other than a mandatory HOSC, Brighton & Hove HOSC could delay joining a JHOSC as long as the JHOSC remains voluntary (i.e. until the NHS formally announces specific SViS plans). Equally, the HOSC could agree to join the voluntary JHOSC but could decline to appoint members until after the May 19 elections on the basis that there is little sense in making appointments in early 2019 when it is unclear what the post-May composition of the HOSC will be. However, if a mandatory HOSC was required before May 2019, this position would have to be re-considered. Whether or not a mandatory HOSC is required within this time period will depend entirely on when NHS organisations release detailed SViS plans.

- **Can co-optees be included on the JHOSC?** In the plans presented to the HOSC in October 2018 there were no co-optee places on the JHOSC. The HOSC Chair subsequently discussed this issue with his counterparts and it was agreed that each HOSC should nominate one non-voting co-optee to sit on the JHOSC. There is no realistic prospect of gaining more co-optee seats as the one co-optee per HOSC provision has now been formally adopted by all the other HOSCs. In addition, some HOSCs only have one non-voting co-optee, and are therefore not in a position to appoint further co-optees.

- **What provision is there for local interests to be reflected at the JHOSC?** There is no alternative to a JHOSC (once mandated). However, the constituent members of a JHOSC can agree that the power of referral to the Secretary of State be retained by individual local authorities rather than delegated to the JHOSC. Brighton & Hove lobbied for, and was successful in getting, agreement that power of referral be retained by local authorities.

- **What about public involvement in the JHOSC?** There is nothing in the JHOSC Terms of Reference or Ways of Working that either specifically encourages or specifically discourages public involvement in the JHOSC process. If Brighton & Hove JHOSC members wanted to argue for particular public involvement measures, they would be free to do so provided they were members of the

JHOSC. However, it is probably worth noting that none of the other HOSCs in the JHOSC have public engagement mechanisms that mirror those of Brighton & Hove HOSC (i.e. provision for public questions, deputations or petitions). There may therefore be a limited opportunity here. However, there is nothing to stop Brighton & Hove HOSC from agreeing that its representatives would seek to get answers to questions presented to the HOSC by local residents, or agreeing any other mechanism whereby local people could influence BH HOSC contributions to the JHOSC.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 It is recommended that Brighton & Hove HOSC agrees to join the JHOSC. However, the JHOSC is currently voluntary and membership is consequently optional. The HOSC could decline to join anything other than a mandatory JHOSC, although this would mean that there would be no one to represent local interests in JHOSC planning.

4.2 Alternatively, the HOSC could agree to join the JHOSC, but could decline to appoint members to a voluntary JHOSC until post-May, with local interests represented in the interim by the Chair. This position would only hold for a voluntary JHOSC: Brighton & Hove would have to nominate members to a mandatory JHOSC (or risk being directed to do so by the Secretary of State).

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 None for this internal planning report.

6. CONCLUSION

6.1 It is recommended that members agree to join the voluntary JHOSC so as to maximise local influence in JHOSC planning.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 None to this internal planning report.

Legal Implications:

7.2 While the Health Overview & Scrutiny Committee has a key role in reviewing these proposals and considering whether to recommend their approval, only Full Council may make a decision on behalf of BHCC to establish a Joint Health & Overview Scrutiny Committee and to approve its composition and terms of reference.

The legal implications of these proposals, including the statutory framework which gives rise to them, are contained in the body of this Report. Section 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013/218 (made under section 244 of the National Health Service Act 2006) is of particular relevance as it requires a joint committee to be established in the circumstances specified in this Report.
Lawyer Consulted: Victoria Simpson Date: 14/01/2019

Equalities Implications:

7.3 None identified

Sustainability Implications:

7.4 None identified

Any Other Significant Implications:

7.2 None identified

SUPPORTING DOCUMENTATION

Appendices:

1 JHOSC: Essential Points
2 JHOSC Terms of Reference
3 JHOSC Ways of Working

Documents in Members' Rooms

None

Background Documents

None

Appendix 1: JHOSC Essential Points

Establishment of a Joint Health Overview and Scrutiny Committee (JHOSC) for Brighton & Hove City Council, East Sussex County Council, Surrey County Council and West Sussex County Council

Background

Under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, local authorities may establish a joint health overview and scrutiny committee (JHOSC) to undertake health scrutiny functions on their behalf, and must establish a joint health overview and scrutiny committee to respond to consultation on proposals for substantial variation in health services (SViS) affecting more than one local authority area.

Discussions between the Sussex and Surrey HOSC and HASC Chairmen has concluded that the best way forward is the formation of a Standing JHOSC, with responsibility for responding to consultations on substantial service change affecting multiple local authorities across the area.

Establishing a standing JHOSC to scrutinise all cross-boundary SVIS plans means that we do not need to undertake a separate decision- making process each time a consultation requiring the establishment of a Joint Health Overview and Scrutiny Committee is initiated, enabling local authorities to respond more rapidly and saving officer and member time. The draft terms of reference and rules of procedure are attached. Points to note are:

- There will be three members of the Committee for each local authority represented, appointed in accordance with local procedures. As the JHOSC is a statutory local authority joint committee, each constituent local authority must ensure that its JHOSC nominees reflect the political make-up of their Full Council. Local authorities are also encouraged to nominate substitutes to attend when their primary representatives are unable to.
- The Committee will have the power to establish sub-committees, and much of the work in relation to specific consultation will be undertaken in these sub-committees. The members of a sub-committee may be members of the main committee, but constituent local authorities may also nominate another representative to serve on a specific sub- committee.
- Where a consultation affects some, but not all, of the constituent areas voting membership of the relevant sub-committee will be restricted to the authorities directly affected. Thus, for example, the sub-committee responding to consultation on the Sussex-wide Clinically Effective Commissioning initiative (CEC) would not include Surrey County Council as a voting member.
- There is no minimum frequency of meetings of the Committee, and when there are no current consultations there will be no need for the committee to meet.
- The life of the Committee will be for a maximum of four years. Constituent

areas will nominate members annually, and there will be an annual election for the Chair and Vice-Chair of the Committee. In some circumstances a constituent authority may need to change its membership mid-year (for example following local elections).

- Constituent local authorities will not delegate to the JHOSC their statutory powers to refer SViS to the Secretary of State for Health. Instead, each local authority will retain this power and will make an individual decision to refer, with reference to the evidenced recommendation of the JHOSC or its sub-committee.

Appendix Two

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

TERMS OF REFERENCE

1.1 The Sussex and Surrey Joint Health Overview and Scrutiny Committee is established by the Local Authorities of **Brighton & Hove City Council, East Sussex County Council, Surrey County Council** and **West Sussex County Council (constituent areas)** in accordance with s.245 of the NHS Act 2006 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

1.2 It will be a standing Joint Overview and Scrutiny Committee or a sub-committee thereof which will undertake scrutiny activity in response to a particular reconfiguration proposal or strategic issue affecting some, or all of the constituent areas.

1.3 The length of time a specific matter / proposal will be scrutinised for will be determined by the Joint Committee or Sub Committee.

1.4 The purpose of the Standing Joint Committee is to act as a full committee or commission sub-committees to consider the following matters and carry out detailed scrutiny work as below:

(a) To engage with Providers and Commissioners on strategic sector wide *proposals* in respect of the *configuration* of health services affecting some or all of the area of Brighton & Hove, East Sussex, Surrey or West Sussex (constituent area).

(b) Scrutinise and respond to the consultation process (including stakeholder engagement) and final decision in respect of any reconfiguration proposals affecting some, or all of the constituent areas.

(c) Scrutinise in particular, the adequacy of any consultation process in respect of any reconfiguration proposals (including content or time allowed) and provide reasons for any view reached.

(d) Consider whether the proposal is in the best interests of the health service across the affected area.

(e) Consider as part of its scrutiny work, the potential impact of proposed options on residents of the reconfiguration area, whether proposals will deliver sustainable service change and the impact on any existing or potential health inequalities.

(f) Assess the degree to which any proposals scrutinised will deliver sustainable service improvement and deliver improved patient outcomes.

(g) Agree whether to recommend to its constituent areas that the local authorities individually use their statutory powers of referral to refer either the consultation or the final decision in respect of any proposal for reconfiguration to the Secretary of State for Health.

(h) As appropriate, review the formal response of the NHS to the Committee's consultation response.

1.5. The Joint Committee will consist of three Councillors nominated by each of the constituent areas and appointed in accordance with local procedure rules, and with regard to the requirement for nominees to statutory joint committees to be proportionate to the political make-up of the constituent authority. Each Council can appoint named substitutes in line with their local practices.

1.6 Appointments to the Joint Committee will be made annually by each constituent area with in-year changes in membership confirmed by the relevant authority as soon as they know.

1.7 The life of the Joint Committee will be for a maximum of four years.

1.8 The JHOSC is being established to scrutinise NHS change plans that affect two or more councils within the Sussex and East Surrey STP footprint. In the event of the footprint changing so that one of the constituent JHOSC bodies is no longer part of the footprint, that council is free to resign from the JHOSC. Should the JHOSC Chairman or Vice Chairman represent such a council, the JHOSC will elect replacements.

1.9 For each specific piece of scrutiny work undertaken relating to consultations on reconfiguration or substantial variation proposals affecting all or some of the constituent areas, the Joint Committee will either choose to act as a full Committee or can agree to commission a sub-committee to undertake the detailed work and define its terms of reference and timescales. This will provide for flexibility and best use of resource by the Joint Committee.

1.10 In determining how a matter will be scrutinised, the Joint Committee can choose to retain decision-making power or delegate it to a sub-committee.

1.11 The overall size of each sub-committee will be determined by the main Committee and must include a minimum of 1 representative per affected constituent area.

1.12 Where a proposal for reconfiguration or substantial variation covers some but not all of the constituent areas, in establishing a sub-committee, formal membership will only include those affected constituent areas. Non affected constituent areas will be able to nominate members who can act as 'observers' but will be non-voting.

1.13 The Committee and any sub-Committees will form and hold public meetings, unless the public is excluded by resolution under section 100a (4) Local Government Act 1972 / 2000, in accordance with a timetable agreed upon by all constituent areas and subject to the statutory public meeting notice period.

1.14 The JHOSC will be responsible for determining whether any specific NHS change plan which impacts on two or more of the

JHOSC members constitutes a Substantial Variation in Service (SViS) such that it requires formal consultation with the JHOSC.

Appendix 3

BRIGHTON & HOVE, EAST SUSSEX, SURREY & WEST SUSSEX JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (JHOSC)

RULES OF PROCEDURE

1. Membership of Committee and Sub-Committees

1.1 Brighton & Hove City Council, East Sussex County Council, Surrey County Council and West Sussex County Council will each nominate three Councillors to the JHOSC, appointed in accordance with local procedure rules and with the relevant statutory regulations.

1.2 Appointments will reconfirmed annually by each relevant authority.

1.3 Individual authorities may change appointees in accordance with the rules for the original nomination.

1.4 Individual authorities will be strongly encouraged to nominate substitutes in accordance with local practice.

1.5 In commissioning Sub-Committees, membership will be confirmed by the JHOSC and can be drawn from the main Committee or to enable use of local expertise and skill, from other non-Executive members of an affected constituent area (excluding Health & Wellbeing Board members).

1.6 The membership of a sub-committee will include at least one member from each affected constituent areas. An affected constituent area is a council area where the proposals will impact on residents. Non affected areas can appoint 'observer' members to sub-committees but they will be non-voting.

1.7 The JHOSC, may as appropriate review its membership to include authorities outside the JHOSC boundaries where those authorities are equally affected by a SViS. Members of such local authorities may be appointed to serve as members of relevant sub-committees.

2. Chairman

2.1 The JHOSC will elect the Chairman and Vice Chairman at the first formal meeting. A vote will be taken (by show of hands) and the results will be collated by the supporting Officer.

2.2 The appointments of Chairman and Vice Chairman will be reconfirmed annually.

2.3 Where a sub-committee is commissioned, at its first meeting a Chairman and Vice-Chairman will be appointed for the life of the sub-committee.

3. Substitutions

3.1 Named substitutes may attend Committee meetings and sub-committee meetings in lieu of nominated members. Continuity of attendance is strongly encouraged.

3.2 It will be the responsibility of individual committee members and their local authorities to arrange substitutions and to ensure the supporting officer is informed of any changes prior to the meeting.

3.3 Where a named substitute is attending the meeting, it will be the responsibility of the nominated member to brief them in advance of the meeting.

4. Quorum

4.1 The quorum of a meeting of the JHOSC will be the presence of one member from any three of the four participating constituent areas.

4.2 The quorum of a meeting of a Sub Committee of the JHOSC will be the presence of members representing two or more constituent areas.

5. Voting

5.1 Members of the JHOSC and its sub Committees should endeavour to reach a consensus of views and produce a single final report, agreed by consensus and reflecting the views of all the local authority committees involved.

5.2 In the event that a vote is required, each member present will have one vote. In the event of there being an equality of votes the Chairman of the JHOSC or its sub-committee will have the casting vote.

6. JHOSC Role, Powers and Function

6.1 The JHOSC will have the same statutory scrutiny powers as an individual health overview and scrutiny committee that is:

- accessing information requested
- requiring members, officers or partners to attend and answer questions.

However, the power to refer to the Secretary of State for Health will be retained by the constituent areas rather than being delegated to the JHOSC. Should the JHOSC believe that there is a case for referral, it will make an evidenced recommendation to refer to its constituent areas.

6.2 The JHOSC can choose to recommend to constituent areas that they refer to the Secretary of State for Health for a particular scrutiny matter or delegate this function to an established sub-committee.

7. Support

7.1 The lead governance and administrative support for the JHOSC will be shared by constituent areas.

7.2 The lead scrutiny support for sub-committees will be provided by constituent areas on a per issue basis to be agreed by the sub-committee.

7.3 Meetings of the JHOSC and its sub-committees will be rotated between participating areas.

7.4 The host constituent area for each meeting of the JHOSC will be responsible for arranging appropriate meeting rooms and ensuring that refreshments are available.

7.5 Each constituent area will identify a key point of contact for all arrangements and Statutory Scrutiny Officers will be kept abreast of arrangements for the JHOSC.

7.6 All costs of the JHOSCs will need to be met from within existing HOSC budgets: there is no additional funding for the JHOSC. Any decision to apply to the constituent areas for additional funding would need to be unanimously agreed by the JHOSC.

Joint Sussex HOSC Working Group: BSUH

Date: Wednesday 31st October 2018
Time: 9.30am to 1.30pm
Room 181 Hove Town Hall

Attending

Name	From
Ben Stevens	Deputy Chief Delivery & Strategy Officer, BSUH
Nicola Ranger	Chief Nurse, BSUH
Cllr Ken Norman	Chair, B&H HOSC
Cllr Louisa Greenbaum	Member, B&H HOSC
Cllr Colin Belsey	Chairman, ESCC HOSC
Cllr Johanna Howell	Member, ESCC HOSC
Harvey Winder	Officer, ESCC
Cllr Edward Belsey	Co-opted Member, WS HASC
Dr James Walsh	Vice-Chairman, WS HASC
Cllr Bryan Turner	Chairman, WS HASC
Helena Cox	Officer, WSCC
Nuala Friedman	Officer, B&H

1	**Notes of the last meeting 04.04.18**
	The notes were agreed.
2	**Media update**
	NR used the opportunity to update the group on recent press coverage involving the Trust and TB. The Trust had approximately 60 TB cases per year. A patient treated in December 2016 was diagnosed with TB, subsequently a nurse also tested positive for TB in January 2018. Both had a specific strain (Beijing) which had responded to medication. The cases had been declared to PH England and RIDDOR. The Trust had undertaken work to ensure that 341 patients and 1600 staff were tested, those who had an inflammatory response have been treated successful with medication. Not all who have been contacted have taken up the blood test, so secondary letters will be sent. The Trust was consulting with a hospital in Birmingham who had experienced similar issues. Pathways had been altered so those presenting with specific symptoms would be treated in isolation rather than on the respiratory ward. Staff communications would continue emphasising that the strain is completely treatable.
3	**Update on CQC / Quality**
	24/25/26 September – CQC inspection in all domains **16/17 October – 'Well-Led' inspection** Large team of over 50 inspectors split across the two sites In April 2016 the Trust had gone into special measures and could not come out without a well-led inspection. A previously divisional structure had made it difficult to collaborate which had been changed to improve communications. CQC visited: critical care, A&E, medicine and surgery.

	Each division had prepared an overview of where they were before and where they thought they were now, what has been implemented, challenges, what still needed to be done etc**.** **ACTION: It was agreed that the overview documents would be shared electronically with members of the group** The incident where a patient had accidentally drunk cleaning fluid from a water jug had resulted in stricter protocols including the removal of green drinking jugs and swipe card access to cleaning cupboards. COSHH compliance was checked and was described as exemplary. Initial feedback on engagement of staff was also very positive. The Trusts Equality Action Plan had also impressed the CQC. Well-led review report was due in January 2019. The management team were hopeful that BSUH would come out of special measures. Positives: CQC was impressed with the preparation. Core inspection could probably not have gone better. Other positive comments included improvements in cleanliness, staff keen to showcase positive things they have done. Compliments also on the culture and the work being done on the equality action plan. Members asked what was considered as areas of possible weakness: NR highlighted the following areas of paediatrics at PRH, Cancer performance, A&E small for the level of activity and was not included in the 3Ts project; bed shortage on the County site. **ACTION: It was agreed that members of the group would visit the County site to see the development of the 3Ts project.**
4	**Update on Performance**
	Members highlighted their frustration that more up to date reports had not been made available for the meeting. NR gave an assurance that this would not happen in future. NR provided updates to the July 2018 Board reports which had been circulated: • Mortality overview – lot of work had been done on evaluating deaths, with a clear process that the Trust could share with members. • Key issue was falls but the Trust was performing well on prevention of falls nationally. • Infection Control and CDifficile - Protocol for use of side-rooms, limited number so staff had to prioritise the use of these depending on diagnosis. • Monthly audits including what patients present with, falls. High number of patients coming into hospital with tissue damage, working with partners to try and work with causes and reduce. Members asked if the Trust held data relating to the numbers of patients with dementia who fall. In response members were informed that this was often the case but not always. Demographic is actually younger than Eastbourne or Worthing. • Family & Friends test (national NHS test) - Only 11% of patients responded to this previously but since April 2018 this has been automated and the Trust are now above national average of response rate at 38%. As a result the recommendation rate has decreased as the Trust was asking higher numbers. Getting some good data on this. Feedback is at 90%, nationally it is 88%. Only slightly lower in post-

	natal ward. Good response rate for outpatients. The Trust had commissioned an outside company to managing and review the data. • Admittance of people with Stroke – 88% seen within 4 hours, improvement since last report. Some figures have dipped. <u>Points from June performance</u> A&E there were 2 numbers reported: 1. system as a whole including walk in centres, and 2. just BSUH performance. BSUH was 85% against the 95% target of patients being seen within 4 hours In June the Trust were above trajectory, so 3 or 4 months of improvement. May and June PRH achieved above the standard. Through July, August and September there had been an increase in 8.2% of patients attending, plus an increase in acuity of patients coming through, so this has meant a dip in performance of around 3%. Heat wave would have contributed to these figures. <u>In response to a question relating to areas of growth,</u> mental health presentations were going up, which brought challenges to the system as patients were waiting longer for follow on care. This can be a challenge for staff to manage these patients in crisis. The number of people with eating disorders was also increasing. A change in the law meant that the Police could not detain someone until assessed by a mental health team. Difficulty in providing separate units as combination of mental health and physical health is necessary. Higher attendances at walk in centres, particularly around the heat wave during the summer months. This also contributed to higher attendances from people residing in care homes due to dehydration. DTOC (Delayed Transfers of Care) numbers were high with an increase of 8% over the summer, so a summit meeting had been arranged to help with acute trusts and local authorities discuss delayed transfers of care and a suite of actions had been agreed, subsequently the Trust was close to reaching the 3.5% target. Contributory issues include staffing in domiciliary care. <u>Elected Performance – update on main constitutional standards</u> Standard to meet is 92% seen within 18 weeks. Currently the Trust was meeting the performance from March 2018. 52 week wait: this had been high for years but had been reduced to 1 (a patient who chose to wait). <u>Cancer Performance</u> 62 day standard for referral to treatment: figures are in arrears - September report has July data. 71% against target of 81%. This was a national issue and improvement plans were in place so the Trust was hoping to see improvements in coming months. Patients referred from a screening programme – performance low. This was due to resourcing issues but the number of patients was low (18). Improvements were already being made.
5	**Update on New Build**
	Expected to be completed in 2020 / 2021. Services provided from the Barry Building would move when stage 1 was completed. Work was underway to finalise stage 2. The

	position of A&E was to be decided. As previously noted, members expressed an interest in visiting the new build in the New Year. Heli deck - Build works coming to conclusion, next phase would be licences and it would then come into use. Agreed hours of operation are 7am to 7pm. Helicopter currently lands at East Brighton Park and ambulance transfer to Hospital. BSUH could provide figures of numbers of helicopters landing in park to members if requested.
6	**Winter planning**
	In terms of winter planning there was a bed deficit on the county site and 3Ts would not be complete until early 2021. 18 beds would be added to the outpatient site in early 2019. The county site had a high occupancy rate which was frequently above 90% but the Trust was working hard to mitigate issues in the meantime. There was an overarching system plan of support for winter months.
7	**Financial update**
	Financial targets - total at month 6 was delivered as expected. Although the Trust was in deficit, it was out of financial special measures, this had meant that interest rates available to the Trust had dropped. There was a robust SIT plan. Members were informed that the necessary assurances financial plan were in place.
8	**AOB**
	The following points were noted in response to member questions: *Staffing* – BSUH was in top quartile in UK for staffing levels, with around 300 staff vacancies currently. *A&E handovers* – this continued to be an issue but there had been improvement in the last 2/3 months as work continued with partners. There was a discussion regarding services being contracted by private companies at a local level and the impact that this had had. There was a drop in orthopaedics. *Where does BSUH stand with the newly modified CCGs in STP?* - There needed to be closer working and a need to collaborate better. This was challenging as a system as organisations were still regulated individually.
9	**Date and focus of next meeting**
	ACTION: NF to contact the Trust for dates from mid to late January 2019 for a tour and presentation at the County site and for a further meeting at Hove Town Hall in April 2019. **ACTION: NR** would confirm when the CQC report would be available – this was expected to be by mid-January 2019. **ACTION: NF** to get the up to date Board reports and circulate to members.

Meeting between Sussex Health Scrutiny Committees and Sussex Partnership NHS Foundation Trust (SPFT)

11 September 2018, 3.30pm, Trust Headquarters, Swandean, Worthing, BN13 3EP

For reference – Attendees

Sussex Partnership NHS Foundation Trust (SPFT):

Sam Allen, Chief Executive; Simone Button, Chief Operating Officer; Dan Charlton, Director of Communications; Dr Rick Fraser, Chief Medical Officer; Dom Ford, Director of Corporate Affairs

Brighton & Hove Health and Wellbeing Overview & Scrutiny Committee: Cllr Ken Norman (Chair), Giles Rossington (Scrutiny Officer) and Nuala Friedman (Scrutiny Officer)

East Sussex Health Overview & Scrutiny Committee: Cllr Colin Belsey (Chair), Cllr Bob Bowdler (Vice-Chair), and Harvey Winder (Scrutiny Officer)

West Sussex Health & Adult Social Care Select Committee: Mr Bryan Turner (Chairman), Dr James Walsh (Vice-Chair), and Katherine De La Mora (Scrutiny Officer)

1. Apologies

1.1 The following apologies were received:

- Councillor Sarah Osborne
- Diane Hall, Chief Nurse
- Sally Flint, Chief Finance Officer and Deputy Chief Executive

2. Minutes

2.1 The minutes of the previous meeting were agreed.

2.2 The Board requested that the following information be provided by email:

- Serious Incident figures from the SPFT Board reports
- A link to the suicide prevention video produced by Sussex Partnership NHS Foundation Trust (SPFT)

3. Disclosures of Interest

3.1 Mr Bryan Turner declared a personal interest as a locum Pharmacist.

4. Sustainability and Transformation Partnership Mental Health Programme Board

4.1 Sam Allen (SA) provided an updated on the progress of the Sussex and East Surrey Sustainability and Transformation Partnership (STP) Mental Health Programme Board.

4.2 SA explained that the Mental Health Programme Board had been established in the time since last meeting of this working group. Its purpose is to agree and oversee a combined delivery programme for mental health across the STP and help to ensure strategies of individual members, such as SPFT's clinical strategy, align with it.

4.3 Mr Bryan Turner (BT) asked what progress has been made on the 12 priorities of the Mental Health workstream. SA explained that the trust had been developing a delivery plan for the 12 workstreams but the workstreams are at different stages of progression. The priority at the moment is to develop a business case for the 24/7 Crisis Response Team, which the SPFT Governing Board is expected to confirm shortly.

4.4 Dr James Walsh (JW) asked what is being done to improve Children and Adolescent Mental Health Services (CAMHS). SA explained that there is a detailed plan to improve CAMHS through the STP that is overseen by the STP children's programme board. CAMHS is a jointly commissioned service between the NHS and local authorities and there is a local authority representative on the board.

4.5 Simone Button (SB) explained that delays in receiving CAMHS treatment is a national issue caused by an increasing level of demand for the service and insufficient capacity within the secondary mental health care sector. This means that there needs to be greater capacity in primary and community care to treat children and adolescents with mental health issues before they need to seek specialist care. The Government White Paper 'Health in Mind' set out the importance of mental health support in schools to help people develop resilience at a young age, and pilots are currently underway for this service. Working within the STP collaboratively with partner organisations with a combined children and adolescents pathway will also help to improve the service using the available resources. SA added that locally the CAMHS neural pathway development services for autism need to be developed as a key priority in order to reduce the back log following a spike in referrals. The CCGs recognise that more resources are required for the service.

4.6 It was RESOLVED to:

1) note the report;

2) request that members of the working group are included on the stakeholder briefing distribution list for the STP Mental Health Programme Board; and

3) circulate the CAMHS improvement plan.

5. Mental health in the Long Term Plan for the NHS

5.1 SA introduced this item on a consultation response by SPFT to NHS England's proposed 10-year plan.

5.2 SA said that despite the upcoming £20bn Government settlement for the NHS, SPFT's local authority partners are continuing to have to make cuts to services that will increase demand on the NHS and so lessen the impact of the additional funding, for example, proposals to cut housing related support in West Sussex and the reduction in many discretionary preventative Adult Social Care services in East Sussex.

5.3 BT clarified that the process of engagement on whether to terminate the contracts with the voluntary sector to provide housing related support during 19/20 is due to

commence at the end of September and the decision taken in December. He understood that the entire budget might not necessarily be cut but that it would need to be decided within the context of a deteriorating financial position of West Sussex County Council – with £25-50m savings needed in 19/20 to offset rising demand in Adult and Children's social care.

5.4 BT agreed with the comment in the penultimate paragraph of the Trust's response to NHS England that the commissioner-provider model was no longer viable for healthcare, particularly in the context of the role-out of Integrated Care Services. He believed the money spent supporting a commissioner-provider model could be better spent on improving services. SA responded that the trust, despite being a provider, is doing more commissioning of services that were previously the role of NHS England and this is helping to remove some of the transactional costs that don't add financial value to the process.

5.5 It was RESOLVED to note the report.

6. West Sussex service redesign

6.1 SB introduced an item on the ongoing redesign of inpatient mental health services in West Sussex.

6.2 SB explained that the preferred option has been scaled down from the one that was presented to the West Sussex HASC previously following a detailed options appraisal. SB said that one of the key clinical drivers for the reconfiguration is moving patients out of poor accommodation, which means that the preferred option would include the closure of the Harold Kidd unit in Chichester, which cannot be brought up to specification. One of the non-preferred options it to include a new build unit but the capital cost would make this option difficult to achieve. The proposals will mean that there are single gender wards for all patients and all dementia beds will now be sited at Swandean.

6.3 SB explained that the proposals would result in a reduction of 8 beds, comprising 6 working age and 2 older people, which is considered achievable. However, there is a review of required bed numbers due to be reported to the trust's board that could determine that bed numbers should not be reduced, which could be difficult to accommodate given that the Harold Kidd unit is no longer fit for purpose.

6.4 SB confirmed that the trust is working with the CCGs in partnership and is currently undertaking options appraisals, for example, analysing West Sussex travel data. It is expected that the consultation could begin in the new year and include transport and travel solutions.

6.5 JW asked how many of the inpatient beds are used by patients outside of West Sussex. SB responded that when the proposals were originally drawn up there were 12 more beds than were needed to meet demand. This is currently not the case as more patients from elsewhere in Sussex and East Surrey are using the current service, but the Trust is confident the situation will shift back, for example, the number of East Surrey patients has reduced from 13 to 9 and is expected to fall to zero within the next two years.

6.6 BT asked whether the requirement in the preferred option to agree with Sussex Community NHS Foundation Trust (SCFT) to provide a new ward at Salvington Lodge was feasible. SB said that SCFT currently has the lease on the upstairs floor of Salvington Lodge and uses half of the floor space but has mothballed the other half, which could be used as a

single sex female dementia patient ward. A shared arrangement with SCFT will also have the added benefit of their staff being able to assist with the physical needs of the dementia patients.

6.7 It was RESOLVED to note the report.

7. East Sussex Service redesign

7.1 SB introduced an item on the ongoing redesign of inpatient mental health services in East Sussex.

7.2 SB explained that plans in East Sussex are some way behind those in West Sussex due in part to the fact that all existing inpatient accommodation is in a poor state and the plans will require identifying a new site. SB said that the trust was currently at the feasibility study stage but that further developments would be made in identifying a suitable site by the end of the year.

7.3 Councillor Colin Belsey (CB) asked whether the new site would be a new building. SB confirmed that no new site has been identified yet but some possible options involve new builds and other involve converting existing buildings.

7.4 BT asked whether the funding for a new build or major conversion is in SPFT's capital budget. SA explained that the trust, as an NHS foundation trust, has always self-funded its capital programme in the past, allowing it to progress at its own pace. However, the combination of more challenging financial times and a complex business case would mean that borrowing could be needed for a new inpatient building, requiring the trust to satisfy the financial requirements of the lender. SA added that feasibility studies for all options would be carried out before any decisions on borrowing would be made, including the possibility of sharing costs with NHS partner organisations. CB added that local authorities can borrow at a low cost and partnering with them may be a better idea than with a private lender. SA noted that there was precedent for this.

7.5 SA said that work continued to separate the large Woodlands ward at Conquest Hospital into two single gender inpatient working-age wards.

7.6 It was RESOLVED to:

1) note the report;

2) request a visit to the Woodlands ward.

8. Clinical Strategy

8.1 This item was deferred.

9. Operational Pressures

9.1 SB introduced a report about the operational pressures facing the Trust. She explained that adult mental health community teams are under pressure at the moment due to an increase in referrals and reduced capacity to deal with them in a timely way. This has led to some breaches in waiting time targets. SB explained that the clinical strategy and STP mental health workstream include plans to work with GP practices to ensure that they are making appropriate referrals to community teams and other specialist mental health care. It is currently the case that common mental health disorders that could be better dealt with in a

primary care setting are being referred to specialist teams, which is the equivalent of someone with high blood pressure being referred to a cardiologist.

9.2 SB said that there had been extreme pressure on inpatient beds, with 10 patients put in out of area placements in private beds. The first weekend of September saw a situation where there were no beds available in the whole of England. SB explained that this issue is nationwide but must also be addressed as far as possible within the local health and care system, for example, working with local authorities to reduce Delayed Transfer of Care (DTOC) as much as the acute and local authority sector have managed to do over the previous year. This task is made more challenging, however, by the fact that many mental health patients have very complex needs that make it hard to find appropriate accommodation for. This leads to a number of patients classified as 'stranded' and 'super-stranded' who have been ready for discharge for 50 + and 100+ days respectively. This is an issue because their condition can often deteriorate again.

9.3 SB said that the trust is still in business continuity and is ramping up activities to get to 0 patients in accommodation outside of the trust (ECRs) by the end of September. She said that the 24/7 crisis teams will be an important tool in supporting a reduction here through timely community assessments of patients who would otherwise need to be placed in inpatient care, where it is appropriate to do so.

9.4 SB explained that since the use of police cells was abolished as an options for s.136 suites at the end of last year, no patients have been detained in such a way. However, this has been achieved with no extra resource and at a time when the number of people from out of area who need to be sectioned and placed into an s.136 suite has continued to increase. This has placed the system under further pressure.

9.5 JW asked whether having a bed occupancy rate of 102% is unsafe. SA explained that 85% occupancy rate is the gold standard and SPFT has run at 100% for several years due to the persistent problem of DTOC. If it was not for DTOC numbers, SA said that the trust would be confident it could reduce occupancy levels beneath 100%. Reducing DTOC, however, relies on the availability of nursing homes and supported accommodation that is not currently available in sufficient numbers. Therefore, the issue is not a lack of beds but lack of services outside of an inpatient setting to discharge patients to.

9.6 JW asked about the vacancy rate at the trust. SB explained that the vacancy rate was 6% and was going down, although some hotspots remained. This has led to £4m less being spent on agency staff this year, aided by an increase in bank staff. Turnover rate of staff was, at 16 %, improving and good compared to other trusts, but she acknowledged that more can be done. The trust recruited 150 nurses last year and many more are beginning training now. RF said that there were 26 locum doctors last year and this has been reduced to 13 this year. Developments to improve retention rates included an academy preceptorship for new nurses allowing them to join the trust for 1 year to help them consolidate training and develop new skills, hopefully encouraging them to stay. Other improvements included ensuring staff appraisals and development plans are completed; 40 nurses beginning in the apprenticeship academy; nurse associate programme to train up nurses in-house; visiting universities to entice trainees; the recruitment of the first three doctor's assistants; and golden handshakes to staff. DC added that the trust was working with the media to raise awareness of the potential career opportunities, for example, a Channel 5 documentary about working in the trust.

9.7 It was RESOLVED to note the report.

10. Suicide rates

10.1 RF introduced a report about suicide rates in Sussex. He said that around 1/3 of people who commit suicide had no contact with any organisations, 1/3 had contact with their GP, and 1/3 were in contact with mental health services before they committed suicide. It is the biggest killer in men under 40 and the ratio of men to women who commit suicide is 3 to 1. The rate of suicide in Sussex is 10.1 people per/100 000; 7.5 in W Sussex; 11.8 in E Sussex (due to Beachy Head); and 15/100 000 in Brighton & Hove, which is in the top 10 highest in the country.

10.2 RF said that there are many reasons why Sussex has a high suicide rate, including high substance misuse rates; housing and relationship issues and social isolation. The rate has started to reduce from 7.13 in 10,000 in contact with SPFT from 11.1. This amounted to 89 patients during 2017 (including 20 homeless people in Brighton), and for 2018 it is currently trending below this figure, but is still a real issue.

10.3 RF explained that SPFT recently held a 'Say Hello' event in East Sussex to help train people to know to speak with those who may look in distress when out and about; around 50 people attended. Cllr Bob Bowdler (BB) attended the event and believed it had been very useful. He recommended that the trust invite walking groups to future events such as the Eastbourne Park Run.

10.4 JW asked what is done for armed forces veterans. SA said that armed forces personnel referred to SPFT can be fast tracked to a specialist assessment in London. The trust is also working to employ veterans and reservists where possible.

10.5 BT asked why one third of people who commit suicide are not known to authorities. RF explained that substance misuse and homelessness were often reasons for people not seeking help. He also said that risk assessments are important because often people who commit suicide may have been judged as low risk but who then commit suicide when something bad happens to them.

10.6 RF explained that the Towards Zero Suicides programme has been launched across the STP and aims to link together all organisations and communities to make suicide everyone's issue. It includes awareness training, training of GPs, and training of SPFT staff (who currently have inconsistent training). It also aims to ensure that when things don't go right, people learn something meaningful from the tragedy to make changes in the future. The programme also involves tangible changes such as around pharmacy dispensing, ligature work in inpatient settings, and ensuring collaborative care plans are produced when a patient is discharged so that signs of depression are not missed.

10.7 Councillor Ken Norman (KN) asked how Brighton's demographics compared to those in other cities. SA explained second highest homeless rate in the country, is one of the drug capitals of the country; and has a number of people travelling to escape from their current situation. All of these factors lend themselves to a high suicide rate. These factors are enduring as the city has had a high suicide rate since Victorian times.

10.8 BT asked whether it is known how many suicides are accidental. RF said that it is difficult to know as whilst a number drug overdoses are accidental, such as in people

restarting heroin use after a period in prison, around 25% of people who commit suicide have are drug users.

10.9 The report was noted.

11. Next meeting date

11.1 All Members agreed to review the purpose and frequency of the meeting before arranging another meeting. They also requested that all future meetings be held in the morning.

Date of Meeting	Issue/Meeting Description	Reason for Item	Presenters	Notes
06 February 2019	HOSC/HWB HASC Performance Improvement Group	Regular Meeting	TBC	All HOSC members inc. co-optees invited. Not a meeting in public. Cat Harwood-Smith (BHCC) coordinates. Informal joint HOSC/HWB meeting to monitor HASC performance
Spring 19 (date TBC)	SPFT Quality & Performance Working Group	Joint Meeting with East Sussex HOSC and West Sussex HASC	SPFT Executive Leadership	Not a meeting in public. Ongoing informal meeting of Sussex HOSCs to monitor SPFT quality improvement and performance. Minutes published as part of HOSC papers.
Spring 19 (date TBC)	BSUH Quality & Performance Working Group	Joint Meeting with East Sussex HOSC and West Sussex HASC	Chief Nurse and Chief Operating Officer BSUH	Not a meeting in public. Ongoing informal meeting of Sussex HOSCs to monitor BSUH quality improvement and performance. Minutes published as part of HOSC papers.
Spring 19 (date TBC)	HOSC Chairs' Meeting with STP Chair	Regular Meeting	Bob Alexander (STP Chair)	Not a meeting in public. Sussex and East Surrey HOSC Chairs informal meeting with STP leadership
Spring 19 (date TBC)	Regional HOSC Chairs' Meeting	Regular Meeting	NHS England/CQC/NHS Improvement	Not a meeting in public. South East Coast HOSC Chairs' meeting with regional NHS leaders
20 March 2019 HOSC MEETING	Updates from HOSC Working Groups	Standing Item	For information only	Minutes of HOSC working groups for information
	Cancer	HOSC request	Becky Woodiwiss (Public Health)	
	Young People Mental Health	Youth Council request	TBC	
	Healthwatch	Healthwatch BH	David Liley, HW CE	

Date of Meeting	Issue/Meeting Description	Reason for Item	Presenters	Notes
	Brighton & Hove Annual Report	request		
	BSUH CQC inspection report	Request from HOSC	BSUH	To update members on the recent CQC inspection report and the action planning in response

COUNCILLOR KEN NORMAN

Brighton & Hove City Council
c/o Hove Town Hall
Norton Road
Hove
BN3 3BQ

Date: 19/11/2018

Our Ref: 001

Your Ref:

Dr David Supple
Chair of Brighton & Hove Clinical Commissioning Group

Dear David,

At the October 2018 Brighton & Hove Health Overview & Scrutiny Committee (HOSC) meeting, the committee discussed recent developments in the Clinically Effective Commissioning (CEC) initiative.

At the meeting members expressed concerns about various aspects of CEC. In particular, there was a focus on the CCGs' decision to unilaterally determine that planned changes to tranches 0, 1 and 2 are not Substantial Variations in Service (SViS) requiring formal consultation with the HOSC.

It is the committee's view that the HOSC should have been involved in determining whether the planned changes constituted SViS. This would accord with statutory guidance: *"[NHS bodies] will need to discuss any proposals for service change with the overview and scrutiny committee at an early stage, in order to agree whether or not the proposal is considered substantial"* (Health Scrutiny Statutory Guidance: point 10.1.2.Department of Health, 2003).

In consequence, I would like to request that the HOSC be provided with the following:

- a brief rationale for each of the CEC service changes;
- information on the process for determining that the procedures in tranches 0, 1 and 2 of CEC did not constitute SViS;
- Information (assuming this is readily available) on how often each CEC procedure is currently performed; and how frequently commissioners expect it to be performed after the changes are implemented;
- Details of how equalities issues were taken into account in relation to each CEC decision.

I assume that the above information is not confidential and can be published in HOSC papers etc. Given the fact that CEC is Sussex-wide, I also think it would be

Telephone 01273 291182
Email: ken.norman@brighton-hove.gov.uk

Conservative Members for Withdean Ward

helpful if the information provided to the HOSC could be copied to West Sussex HASC and East Sussex HOSC.

Finally, I would like your assurance that the HOSC will be informally consulted at an early stage when CCGs seek to determine whether tranche 3 CEC procedures constitute sViS.

Yours sincerely

Cllr Ken Norman
Chair, Brighton & Hove Health Overview & Scrutiny Committee

NHS
Commissioning Alliance
Brighton and Hove CCG
Crawley CCG
East Surrey CCG
High Weald Lewes Havens CCG
Horsham and Mid Sussex CCG

Councillor Ken Norman
Chair of Brighton and Hove Health Overview
& Scrutiny Committee

By Email

Hove Town Hall
Norton Road
Hove
BN3 4AH

Tel: 01273 238787

Email: david.supple@nhs.net
Website: www.brightonandhoveccg.nhs.uk

07 January 2019

Dear Cllr Ken Norman,

The Clinically Effective Commissioning (CEC) is a Sussex STP NHS Initiative, which aims to improve the effectiveness and value for money of healthcare services by ensuring that commissioning decisions across the STP are consistent, reflect best practice, are in line with the latest clinical evidence and represent the most effective use of limited resources.

The aim of the programme is to bring a uniform systematic approach to policy review and implementation across all the CCGs in the STP to remove unwarranted variation and apply sound clinical decision making within mutually agreed policies. This ensures equity of access, improved clinical outcomes, better patient experience and efficient demand and capacity management across the system.

To enable this to happen, all Sussex CCGs have come together as part of the CEC Programme and agreed to take a single approach to identifying, developing and agreeing areas of focus.

Specifically, you have asked us to provide responses to a number of specific questions relating to the CEC Programme, which I am setting out below:

- **a brief rationale** for each of the CEC service changes
    - Rationale: The CCGs have designated a number of procedures as low priority for NHS funding. The CCGs with the clinicians across our health economies, have considered evidence of clinical effectiveness and experience, information on current activity, resources, costs and provision in order to formulate the policies.

- **information on the process** for determining that the procedures in tranches 0, 1 and 2 of CEC did not constitute SViS;

- The policies in Tranches 0-2 are based on clinical evidence reviews, which the CCGs have commissioned. The policies are aligning Sussex CCG to NICE guidance or the latest best practice and on that basis, we do not believe the policies constitute substantial variations of service. We do however recognise the areas of work which we will be considered going forward as part of the emerging Tranche 3 of policies, are more likely to fall into the category of SViS,
- Therefore, for the past 3 months, the CEC Programme leadership have been working with constituent CCGs to review and, where necessary, strengthen existing CEC processes and ensure meaningful engagement. To this effect, the CEC leadership has met a number of time with the chairs of Sussex and Surrey HOSC/HASC to discuss how the HOSC/HASC will be involved in the revised processes when decisions around statutory consultation requirements need to be made. To respond to this, Sussex HOSCs have initiated a process to establish a Joint HOSC from March 2019, to ensure that the CEC programme is considered once only across Sussex. We welcome this initiative.
- The draft processes are also currently being discussed with the Sussex HealthWatch organisation. We are keen to ensure that patient and public engagement in all policy development is timely and meaningful and informs CCG decision makers of patient and public views before decisions are made. We hope to have concluded these discussions by January 2019.
- In parallel, earlier this month, NHS England has published a number of policies, which clearly set out expectation of interventions, which Commissioners will not be funding, from 1st April 2019. We have started work to understand what these national policies mean in terms of our local Tranches 0 to 2 and we will be looking to adopt the national policies once the impact has been assessed.

- **Information on how often each CEC procedure is currently performed and how frequently commissioners expect it to be performed after the changes are implemented**
  - Firstly and most importantly, the way planned care activity data is counted and coded, may not allow for the specific identification of procedures which CCGs have identified as part of the CEC programme as not being evidence based and therefore not fundable. Secondly, please note that even if a specific procedure is included into the CEC programme it does not mean that a specific patient does not receive an alternative treatment.

- **Details of how equalities issues were taken into account** in relation to each CEC decision.
  - All revised or proposed new policies had undergone an Equality Impact Assessment; this assesses any actual or potential discrimination against protected characteristic groups, and whether any groups are likely to be treated less favourably than others in respect of relevant clinical care. EIAs will were reported to Brighton Health Policy Committee. Attached for your information

This information is not confidential and can be viewed by members of the public on the CCG's website links below.

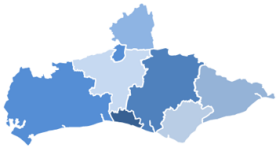
https://www.brightonandhoveccg.nhs.uk/low-priority-procedures-lpps

As requested, I have copied this to both colleagues from East Sussex HOSC and West Sussex HASC into the response.

Kind regards,

Dr David Supple
Clinical Chair
Brighton and Hove Clinical Commissioning Group

Cc: Helena Cox - Helena.cox@westsussex.gov.uk
Harvey Winder - Harvey.winder@eastsussex.gov.uk



Sussex and East Surrey Commissioners

NHS

Hove Town Hall
Norton Road
Hove
BN3 3BQ

Tel: 01273 238700

4 January 2019

Dear colleague

New Chief Executive Officer appointed for Sussex and East Surrey Clinical Commissioning Groups

We are pleased to be writing to let you know that we have formally appointed Adam Doyle as the new Chief Executive Officer for the Clinical Commissioning Groups across Sussex and East Surrey.

Adam has been working across the eight organisations as Accountable Officer on an interim basis for the last three months and his leadership role has now been made substantive following a robust interview process. The job title has changed to a CEO as this better reflects the significant leadership responsibilities that the position holds. The appointment is fully supported by all the CCG Governing Bodies and has been endorsed by NHS England.

It was always the intention to make the shared leadership role permanent and we are delighted that Adam has agreed to take up the post. Since Adam began overseeing all eight CCGs we have already seen a number of benefits to how we have worked. Our relationships with providers and regulators has improved, there has been greater strategic oversight that has allowed for more consistency in how we work, and we have been able to manage risks, issues and large pieces of work in a more robust and collaborative way.

Three of our CCGs – Crawley, East Surrey and Horsham and Mid Sussex – had their legal directions for quality of leadership lifted by NHS England last November, just ten months after Adam had taken over the leadership of the organisations. During this time, all three organisations have been working with Brighton and Hove CCG and High Weald Lewes Havens CCG to collectively achieve greater control on their finances and are now in a much stronger position to meet their financial commitment. Additionally, Coastal West Sussex CCG have made significant improvements since Adam took over in April last year, particularly around the governance and staff morale, and are now on a stronger financial footing.

We believe having Adam as the single CEO, our organisations will be able to build

on the progress we have already been making and be in a stronger position to address the challenges we collectively face. As CCG Chairs, we are committed to ensuring that local services are commissioned in a way that best meets the needs of the populations we serve and are sustainable and affordable for the future. We believe this can be best achieved by working together as CCGs in a more collaborative way. The appointment of a single CEO provides the opportunity to take this forward in earnest and begin to look at how we can work more effectively for our patients and populations at both regional and local level.

We hope you welcome this appointment positively and we would like to thank you for your ongoing support.

Kind regards

Dr David Supple
Clinical Chair for Brighton and Hove CCG

Gill Galliano
Interim Lay Chair for Coastal West Sussex CCG

Dr Laura Hill
Clinical Chair for Crawley CCG

Dr Elango Vijaykumar
Clinical Chair for East Surrey CCG

Dr Martin Writer
Clinical Chair of Eastbourne, Hailsham and Seaford CCG

Dr David Warden
Clinical Chair of Hastings and Rother CCG

Dr Elizabeth Gill
Clinical Chair for High Weald Lewes Havens CCG

Dr Minesh Patel
Clinical Chair for Horsham and Mid Sussex CCG