Overview & Scrutiny

Title:	**Health Overview & Scrutiny Committee**
Date:	**9 February 2011**
Time:	**4.00pm**
Venue	**Banqueting Suite, Hove Town Hall**
Members:	**Councillors:** Peltzer Dunn (Chairman), Allen (Deputy Chairman), Barnett, Bennett, Deane, Harmer-Strange, Marsh, Rufus, Brown (Non-Voting Co-Optee) and Hazelgrove (Non-Voting Co-Optee)
Contact:	**Giles Rossington** **Senior Scrutiny Officer** 29-1038 Giles.rossington@brighton-hove.gov.uk

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AGENDA

Part One	Page
47. PROCEDURAL BUSINESS	**1 - 2**
(copy attached)	
48. MINUTES OF THE PREVIOUS MEETING	**3 - 8**
Draft minutes of the meeting held on 08 December 2010 (copy attached)	
49. CHAIRMAN'S COMMUNICATIONS	
50. PUBLIC QUESTIONS	
No public questions have been received	
51. NOTICES OF MOTION REFERRED FROM COUNCIL	
No Notices of Motion have been received	
52. WRITTEN QUESTIONS FROM COUNCILLORS	
No questions have been received	
53. PATIENT EXPERIENCE/PATIENT OUTCOMES	**9 - 20**
Presentations by Sussex Community Trust and Sussex Partnership NHS Foundation Trust on measuring and assessing patient experience and focusing on quality outcomes for patients (papers attached).	
Dr Richard Ford, Executive Director of Strategic Development, and Andy Porter, Deputy Director, Social Inclusion, will present for the Sussex Partnership NHS Foundation Trust.	
Karen Hutchinson, Group Director, will present for Sussex Community Trust.	
54. GP SERVICES	**21 - 34**
Information provided by NHS Brighton & Hove on city GP practice performance. Kathy Felton, NHS Brighton & Hove, and Dr Christa Beesley, a city GP, will be present to answer members' questions (copy attached)	

55. RE-COMMISSIONING OF LOCAL MENTAL HEALTH ACCESS SERVICES

Letter to the HOSC Chairman on plans to make changes to the commissioning of local mental health 'access' services (copy attached).

Geraldine Hoban, Deputy Director of Commissioning, NHS Brighton & Hove, will be present to answer members' questions.

56. BRIGHTON & SUSSEX UNIVERSITY HOSPITALS TRUST (BSUHT): FOUNDATION TRUST APPLICATION

Presentation on the progress of BSUHT's foundation trust application (verbal)

57. HEALTH AND SOCIAL CARE BILL 2011 **35 - 50**

Report of the Strategic Director, Resources: update providing information on the Health and Social Care Bill command paper and on the NHS Operating Framework 2011-12 (copy attached)

58. LETTER FROM THE CHIEF EXECUTIVE, NHS BRIGHTON & HOVE **51 - 52**

Letter to the HOSC Chairman explaining arrangements for the 'clustering' of Sussex PCTs and the appointment of a single Sussex PCT Chief Executive (copy attached)

59. 2009/2010 HOSC WORK PROGRAMME **53 - 60**

(copy attached)

60. ITEMS TO GO FORWARD TO CABINET OR THE RELEVANT CABINET MEMBER MEETING

To consider items to be submitted to the next available Cabinet or Cabinet Member meeting

61. ITEMS TO GO FORWARD TO COUNCIL

To consider items to be submitted to the next Council meeting for information

The City Council actively welcomes members of the public and the press to attend its meetings and holds as many of its meetings as possible in public. Provision is also made on the agendas for public questions to committees and details of how questions can be raised can be found on the website and/or on agendas for the meetings.

The closing date for receipt of public questions and deputations for the next meeting is 12 noon on the fifth working day before the meeting.

Agendas and minutes are published on the council's website www.brighton-hove.gov.uk. Agendas are available to view five working days prior to the meeting date.

Meeting papers can be provided, on request, in large print, in Braille, on audio tape or on disc, or translated into any other language as requested.

For further details and general enquiries about this meeting contact Giles Rossington, 01273 29-1038, email giles.rossington@brighton-hove.gov.uk) or email scrutiny@brighton-hove.gov.uk

Date of Publication - Tuesday, 1 February 2011

Agenda Item 47

To consider the following Procedural Business:

A. Declaration of Substitutes

Where a Member of the Commitee is unable to attend a meeting for whatever reason, a substitute Member (who is not a Cabinet Member) may attend and speak and vote in their place for that meeting. Substitutes are not allowed on Scrutiny Select Committees or Scrutiny Panels.

The substitute Member shall be a Member of the Council drawn from the same political group as the Member who is unable to attend the meeting, and must not already be a Member of the Committee. The substitute Member must declare themselves as a substitute, and be minuted as such, at the beginning of the meeting or as soon as they arrive.

B. Declarations of Interest

(1) To seek declarations of any personal or personal & prejudicial interests under Part 2 of the Code of Conduct for Members in relation to matters on the Agenda. Members who do declare such interests are required to clearly describe the nature of the interest.

(2) A Member of the Overview and Scrutiny Commission, an Overview and Scrutiny Committee or a Select Committee has a prejudicial interest in any business at a meeting of that Committee where –
(a) that business relates to a decision made (whether implemented or not) or action taken by the Executive or another of the Council's committees, sub-committees, joint committees or joint sub-committees; and
(b) at the time the decision was made or action was taken the Member was
(i) a Member of the Executive or that committee, sub-committee, joint committee or joint sub-committee and
(ii) was present when the decision was made or action taken.

(3) If the interest is a prejudicial interest, the Code requires the Member concerned:
- (a) to leave the room or chamber where the meeting takes place while the item in respect of which the declaration is made is under consideration. [There are three exceptions to this rule which are set out at paragraph (4) below].
- (b) not to exercise executive functions in relation to that business and

(c) not to seek improperly to influence a decision about that business.

(4) The circumstances in which a Member who has declared a prejudicial interest is permitted to remain while the item in respect of which the interest has been declared is under consideration are:

(a) for the purpose of making representations, answering questions or giving evidence relating to the item, provided that the public are also allowed to attend the meeting for the same purpose, whether under a statutory right or otherwise, BUT the Member must leave immediately after he/she has made the representations, answered the questions, or given the evidence;

(b) if the Member has obtained a dispensation from the Standards Committee; or

(c) if the Member is the Leader or a Cabinet Member and has been required to attend before an Overview and Scrutiny Committee or Sub-Committee to answer questions.

C. Declaration of Party Whip

To seek declarations of the existence and nature of any party whip in relation to any matter on the Agenda as set out at paragraph 8 of the Overview and Scrutiny Ways of Working.

D. 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 2 of the Agenda states in its heading the category under which the information disclosed in the report is confidential 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.

Agenda item 48

BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00PM 8 DECEMBER 2010

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillors Peltzer Dunn (Chairman); Allen (Deputy Chairman), Barnett, Deane, Harmer-Strange, Davis and Randall

Co-opted Members: Hazelgrove (Older People's Council) (Non-Voting Co-Optee)

PART ONE

33. PROCEDURAL BUSINESS

33A Declarations of Substitutes

33.1 Councillor Davis was present as substitute for Councillor Marsh.

33.2 Councillor Randall was present as substitute for Councillor Rufus.

33.3 Apologies were received from Councillor Jayne Bennett.

33B Declarations of Interest

33.4 There were none.

33C Declarations of Party Whip

33.5 There were none.

33D Exclusion of Press and Public

33.6 In accordance with section 100A(4) of the Local Government Act 1972, it was considered whether the press and public should be excluded from the meeting during the consideration of any items contained in the agenda, having regard to the nature of the business to be transacted and the nature of the proceedings and the likelihood as to whether, if members of the press and public were present, there would be disclosure to them of confidential or exempt information as defined in section 100I (1) of the said Act.

33.7 RESOLVED – That the Press and Public be not excluded from the meeting.

34. MINUTES OF THE PREVIOUS MEETING

34.1 RESOLVED – That the minutes of the meeting held on 29 September 2010 be approved and signed by the Chairman.

35. CHAIRMAN'S COMMUNICATIONS

35.1 There were none.

36. PUBLIC QUESTIONS

36.1 There were none.

37. NOTICES OF MOTION REFERRED FROM COUNCIL

37.1 There were none.

38. WRITTEN QUESTIONS FROM COUNCILLORS

38.1 There were none.

39. PRESENTATION BY THE STRATEGIC DIRECTOR, PEOPLE

39.1 Terry Parkin, Strategic Director, People, addressed the committee.

39.2 In response to a question from Cllr Randall concerning the imminent transfer of Public Health responsibilities from Primary Care Trusts to Local Authorities, Mr Parkin told members that this represented a real opportunity to improve public health services, particularly in terms of increasing engagement with city organisations such as sports clubs.

39.3 The Chairman thanked Mr Parkin for his attendance and asked that he update the committee in six months time.

40. SOUTH EAST COAST AMBULANCE SERVICE NHS TRUST (SECAMB): UPDATE

40.1 This item was introduced by Geraint Davies, Director of Business Development, South East Coast Ambulance Service (SECamb); and by Geoff Catling, SECamb Director of Technical Services and Logistics.

40.2 In response to a question from Cllr Barnett on cleaning of ambulances, Mr Catling told members that there was a rigorous daily cleaning regime, backed up by monthly swab

tests. The trust was confident that this cleaning regime was robust, as all swab tests were negative.

40.3 In answer to a query from Cllr Randall about the use of paramedic motorcycles, the committee was informed that only one motorcycle was currently in use in the Brighton & Hove area, and this only during the summer months. In general, motorcycles were seen as too dangerous for paramedic staff to use, and were being phased out.

40.4 In response to a question from Cllr Harmer-Strange as to why SECamb's 'make ready' initiative had been introduced in the East of the trust's operational area, Mr Davies told members that this decision had been dictated by logistical concerns: SECamb owned suitable sites for large depots in the East of its patch, but not in the West.

40.5 In response to a question from Cllr Harmer-Strange regarding the potential for co-location with other emergency services, Mr Catling told the committee that such co-locations were always considered as an option if they made sense in terms of patient safety. However, it was relatively rare that such a co-location did make sense. There was generally more value in co-locating ambulance services with health centres, and SECamb had been involved in very successful projects of this type in Lancing and Whitstable.

40.6 Mr Davies extended an invitation to HOSC members to come and see one of SECamb's operational 'make ready' depots, and trusted that members would support the trust in obtaining the best possible site for a Brighton depot, perhaps ideally at Patcham Court Farm.

40.7 The Chairman thanked Mr Davies and Mr Catling for their contributions.

41. PATIENT EXPERIENCE

41.1 This item was introduced by Martin Campbell, Head of Engagement, NHS Brighton & Hove; Sherree Fagge, Chief Nurse, Brighton & Sussex University Hospitals Trust (BSUHT); and Peter Flavell, Patient Experience Manager, BSUHT.

41.2 In response to a question from Jack Hazelgrove as to why there were so few GP practice patient groups in the city, Mr Campbell informed the committee that, to date, there had been little incentive for GPs to work with patient groups. However, this would become much more important with the introduction of GP commissioning, as GP consortia will assume some of the public engagement responsibilities of PCTs). Both Mr Campbell and Amanda Fadero, Chief Executive, NHS Brighton & Hove, assured members that local GPs were extremely enthusiastic about developing their engagement role.

41.3 In answer to a query from the Chairman as to whether the national GP patient survey contacted people registered with a GP or only those patients who had actually accessed GP services in the past year, Ms Fadero told the committee that it was likely that the survey was for any registered patients.

41.4 In response to a question from Cllr Barnett as to whether in-patients responded candidly to surveys (i.e. whether they were willing to criticise aspects of their care whilst

continuing to receive care), Mr Flavell told members that his experience was that patients were willing to make robust comments. A key factor here was to ensure that trusts collected 'real-time' information and responded promptly to it, so that patients could actually see that there comments were being taken seriously.

41.5 In answer to a question from the Chairman regarding processes for feeding-back information to patients who had responded to surveys, Mr Flavell told members that effective feed-back mechanisms were still being developed, but that they might well take the form of ward-specific "You said – We did" notice boards.

41.6 Robert Brown told members that the LINk had developed an excellent working relationship with BSUHT and was supportive of the trust's engagement with patients. However, there was still an issue with some patients understanding what they were entitled to – particularly so with patients suffering confusion (e.g. dementia). Ms Fagge responded that the trust was aware of this issue and was actively looking for better ways to reach out to confused patients – e.g. through the "sit and see" initiative.

41.7 The Chairman thanked Mr Campbell, Mr Flavell and Ms Fagge for their contributions.

42. BRIGHTON & HOVE LINK: 6 MONTHLY UPDATE

42.1 This item was introduced by Robert Brown, BHLINk Steering Group Chairman. Mr Brown detailed the LINk's recent activity in areas including medicine wastage, hospital discharge, mental health, dentistry and hospital car parking.

42.2 Mr Brown told members that the LINk was in the process of referring a recommendation top HOSC that the free swimming scheme for city residents over 65 be continued.

42.3 In response to a question from Cllr Deane about the LINk's recent 'Dragon's Den' event, Mr Brown told members that this was a one-off event, held because the LINk had under-spent its last year's budget and had spare cash to use.

42.4 The Chairman expressed the committee's gratitude to the LINk for the excellent work it had done and thanked Mr Brown for his contribution.

43. DEPARTMENT OF HEALTH WHITE PAPER CONSULTATIONS: "GREATER CHOICE AND CONTROL" AND "AN INFORMATION REVOLUTION"

43.1 Members discussed whether the committee should formally respond to these Department of Health consultations.

43.2 RESOLVED – That the report should be noted, but that there should be no formal HOSC response to the Department of Health consultations on 'choice' and 'information'.

44. NHS BRIGHTON & HOVE ANNUAL OPERATING PLAN 2011/12: REPORT BACK FROM THE HOSC WORKING GROUP

44.1 Members discussed the findings of the HOSC working group set up to examine NHS Brighton & Hove's Annual Operating Plan for 2010-11.

44.2 Both the members who sat on the working group and the Chief Executive of NHS Brighton & Hove agreed that the process had been a useful one. It was agreed that the working group should meet again early in the new year to look at the final draft of the AOP.

44.3 Cllr Allen asked the Chief Executive of NHS Brighton & Hove to convey the working group's thanks to the PCT officers who engaged directly with the working group.

44.4 RESOLVED – That the report be noted; another meeting of the working group be convened in 2011 to examine the final draft of the AOP; and the HOSC work programme (amended to include recommendations for work programme items made by the HOSC working group) be agreed by members.

45. ITEMS TO GO FORWARD TO CABINET OR THE RELEVANT CABINET MEMBER MEETING

45.1 There were none.

46. ITEMS TO GO FORWARD TO COUNCIL

46.1 There were none.

The meeting concluded at 6pm

Signed Chair

Dated this day of

Patient Experience Report December 2010

By Andy Porter, Deputy Director Social Inclusion

1.0 Context and Background

Self reported patient experience is an important part of the way we measure the quality of our services, as well as being built into the evaluation frameworks of commissioners and monitoring bodies.

This report summarises the key areas of work undertaken in relation to measuring patient experience to date in 2010/11 and looks ahead to initiatives planned for the future.

Reporting from the Complaints and PALS service is not included and will be reported separately.

2.0 National Patient Survey

2.1 Community survey 2010

The results of the 2010 Community survey have already been reported to the Board and to the Council of Governors. An Action plan has been developed to address the main areas for development in relation to the survey results (Appendix1) and this has been shared with CQC. Whilst some of the actions are ongoing the majority are set for completion by the end of December 2010 to ensure immediate progress has been achieved prior to the start of the 2011 survey. Ongoing actions recognize that it is our two major initiatives – Better By Design and Better By Experience that will lead to sustainable long term service improvement. Short term Actions include:

- A range of actions to improve the CPA process
- A range of actions to improve service user involvement in decisions re: medication
- Poster campaigns with regard to both of the above
- A review of the Mental Healthline service including a service user evaluation survey.

2.2 Community survey 2011

CQC have announced that the Community survey will be repeated in 2011 and we have commissioned Quality Health to undertake the survey on our behalf. A sample of approximately 900 adults aged 16 and over, who have used our community mental health services between July and September 2010, will receive the questionnaires during the three months from January to March 2011.

2.3 Inpatient survey 2010

The 2009 National Patient Survey focussed on inpatient services but in 2010 the survey returned to a focus on community services as above. Along with the majority of other of mental health trusts we decided to commission a further inpatient survey in 2010. This was undertaken by Quality Health using the same question set and sample size as in the previous year.

Initial results have now been received and show considerable improvement in comparison to our 2009 results.

- For 27 questions our score is 3% or more higher than in 2009. (Higher)
- For 11 questions our score is within 3% of the 2009 score. (About the same)
- For 8 questions our score is 3% or more lower than 2009. (Lower)

It is encouraging that we have shown consistent improvement for the majority of questions relating to the ward environment, hospital staff, and care and treatment. For example:

- 50% of respondents said that they always felt safe on the ward compared to 42% in 2009
- 52% said the ward was very clean compared to 42% in 2009
- 72% said that the psychiatrist(s) always treated them with dignity and respect compared to 62% in 2009.
- 64% said that nurses always treated them with dignity and respect compared to 54% in 2009.
- 36% were definitely involved as much as they wanted to be in decisions about their care compared to 27% in 2009.

Areas needing improvement were in relation to activities on the wards during the day; having rights under the Mental Health Act fully explained; and delayed discharge. Performance in relation to having an out of hours phone number had improved but was still lower than the national average.

It is also possible to make a national comparison. Quality Health undertook the survey in 2010 with 33 out of the 58 mental health trusts nationally – and in comparison to these 33 organisations we performed as follows:

- For 12 questions we scored 3% or more above the national average (Higher)
- For 23 questions we scored within 3% of the national average (About the same)
- For 11 questions we scored 3% or more lower than the national average. (Lower)

Results have been shared with inpatient services and we are awaiting a more detailed analysis from Quality Health due at the end of this month.

3.0 Mental Healthline service user evaluation

The Sussex Mental Healthline was established in December 2009 building on the West Sussex Mental Healthline service that had operated since 1994. The aims of the Sussex Healthline are to:

- Offer a service to anyone concerned about their own mental health or that of relatives or friends
- Encourage callers to make choices about the way their own mental health needs are met
- Provide immediate support to people expressing distress

The service is run by Sussex Partnership and staffed by a team of trained operators. These offer supportive listening in order to help callers identify and clarify their immediate problems and to explore ways of coping or suggest alternative avenues of help.

The service operates 24 hours a day to West Sussex callers and from 17.00 to 9.00 Monday to Friday and 24 hours at weekends and Bank holidays to Brighton, Hove and East Sussex callers.

To support a wider review of the Mental Healthline service after 12 months of operation the customer experience team undertook a telephone survey this year. The survey was undertaken during October and November 2010, using a sample of 54 people who had called the Healthline during that period and had consented to a telephone interview. 34 questionnaires were completed. The majority of the other 20 people could not be contacted. The full report will be available as a part of the planned review of the service.

Overall the evaluation indicated the following:

- The highest number of callers were from West Sussex (35%).
- 76% of callers were aged between 21 and 60 years. There were no callers aged under 21.
- 74% were female.
- The majority of callers used the line frequently: 37% once a day and 18% more than once a day. Most called the line in the evening (36%) or at night (26%).
- Most people contacted the line for emotional support and 28% were seeking help during a crisis or in relation to the prevention of self harm or overdose
- 76% of respondents said that they got the help they needed.
- 73% said that they sometimes got an engaged tone. A smaller number (15%) said they usually got an engaged tone. 94% tried again if the line was engaged.

- 32% said they would ring the Samaritans if they could not get through, and 23% would ring the Crisis team, Accident and Emergency or 999.
- 97% said they were always or usually spoken to in a polite and respectful manner
- 85% said the operators skills were good or excellent
- 79% said they always or usually felt better after speaking to someone on the line.
- 59% said the time taken to deal with the call was always or usually appropriate. For 28% the response to this question was never or sometimes.
- 92% of respondents identified themselves as having a disability including a significant number with multiple disabilities – e.g. both mental and physical health problems
- 94% of respondents identified themselves as White British – indicating an under representation of BME people using the line
- 94% of respondents identified as heterosexual or not disclosed – indicating an under representation of LGBT people using the line

The data from the evaluation will help to inform a service review that is currently being undertaken.

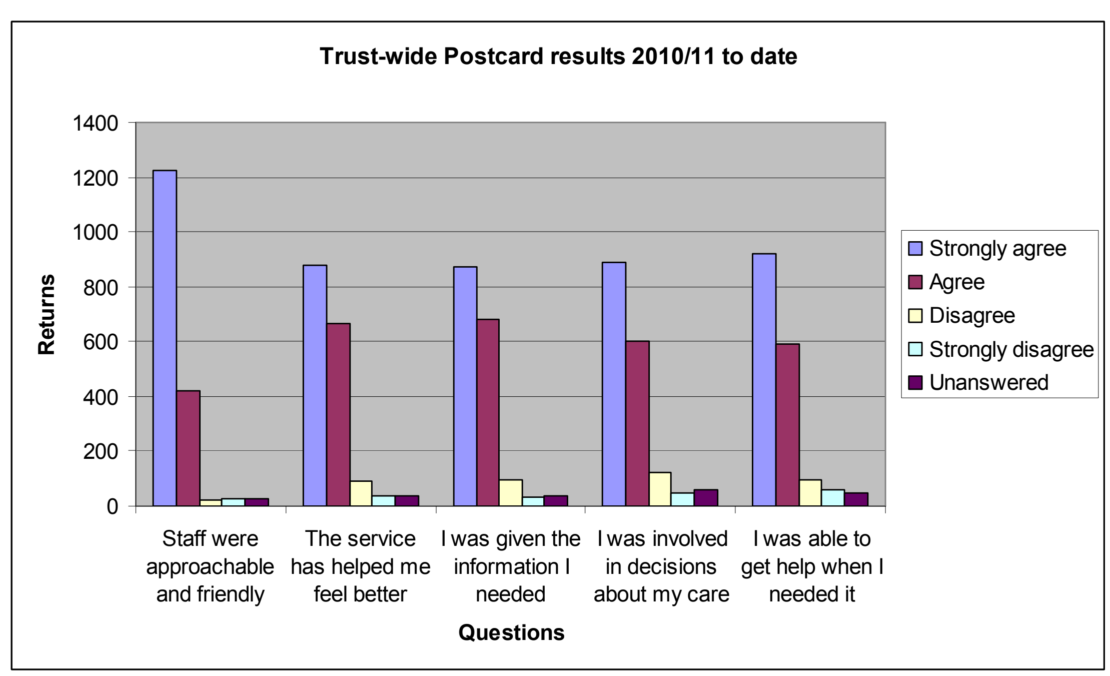
4. Postcards and Patient Experience Trackers

4.1 Your Views Matter Postcard Project

The postcard monitoring initiative was launched in October 2009. The project is based around feedback postcards which are given out at reviews and on discharge from a service. The cards are colour coded by care group and also coded to indicate locality.

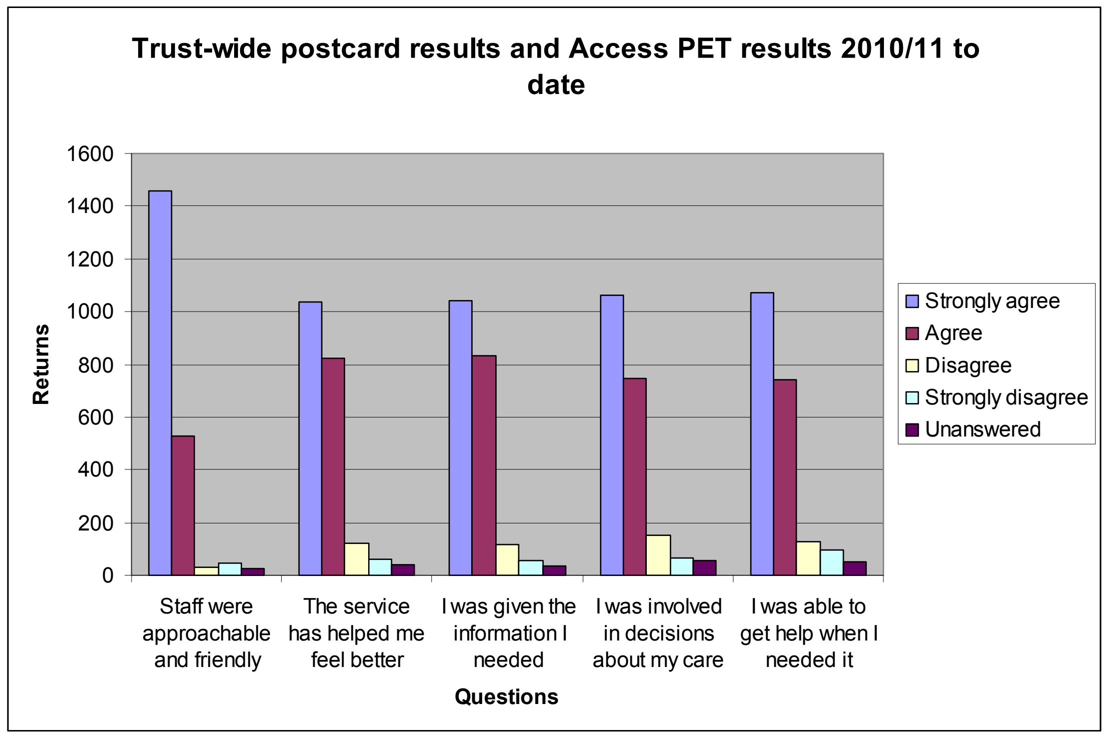
In 2010/11 to date 1,728 postcards have been returned, with a positive response rate (combined strongly agree and agree answers) of 90%. The performance target for this financial year is 2,444 cards with a performance target of 80% positive response rate agreed with commissioners.

The Trust-wide postcard responses for the year to date are shown below.



The results are broken down by care group and locality and are reported on a quarterly basis to commissioners and are also publicly reported on the Trust website. A monthly update is provided to the Board in the Risk, Quality and Safety Board report.

The postcard results have been supplemented by the Access Patient Experience Tracker (PET) results, as these PETs ask the same questions as the postcards. The total combined number of responses for 2010/11 to date is 2,083, with a positive response rate of 90%. The results are shown below.

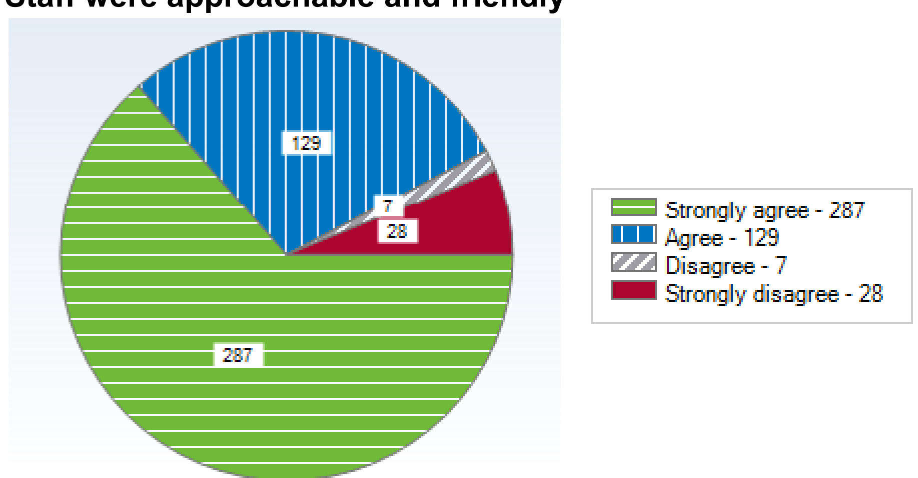


4.2 Patient Experience Tracker Project

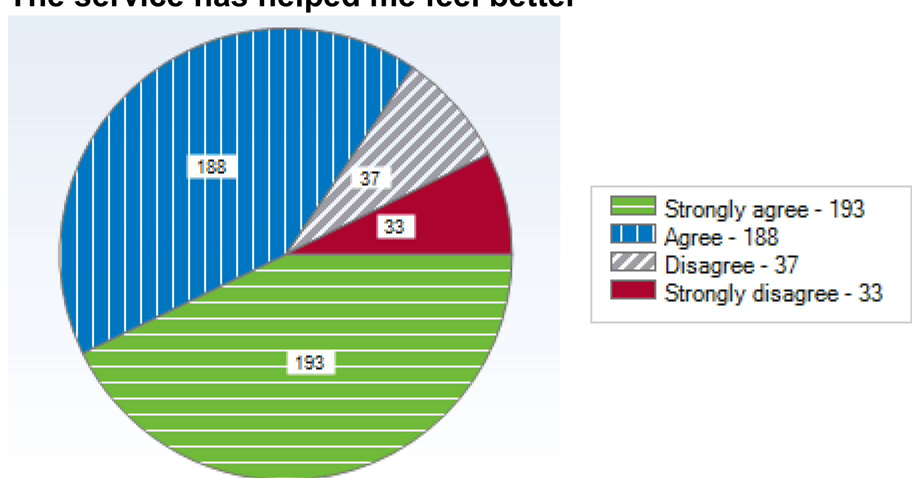
The Patient Experience Tracker (PET) project was launched in August 2009. PETs are electronic handheld devices for collecting patient experience feedback at the point of delivery of services, to collect 'at the moment' feedback to specific questions for respective care groups. The PETs have been used either as handheld devices, which are handed to the patient to complete (used in this way for community visits or on inpatient wards), or as fixed devices on stands in reception/high footfall areas in community settings. The most recent results are shown below.

4.2.1 Three PETs were used in the Brighton & Hove area Access teams and generated 451 responses.

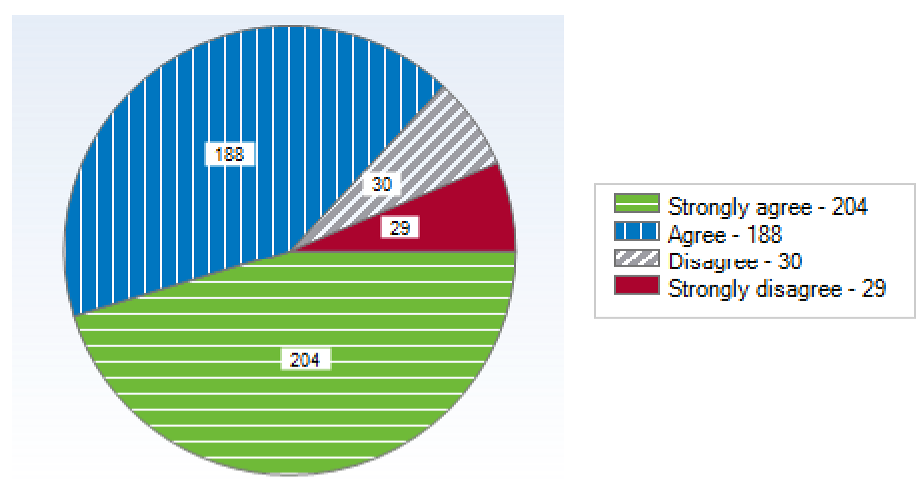
Staff were approachable and friendly



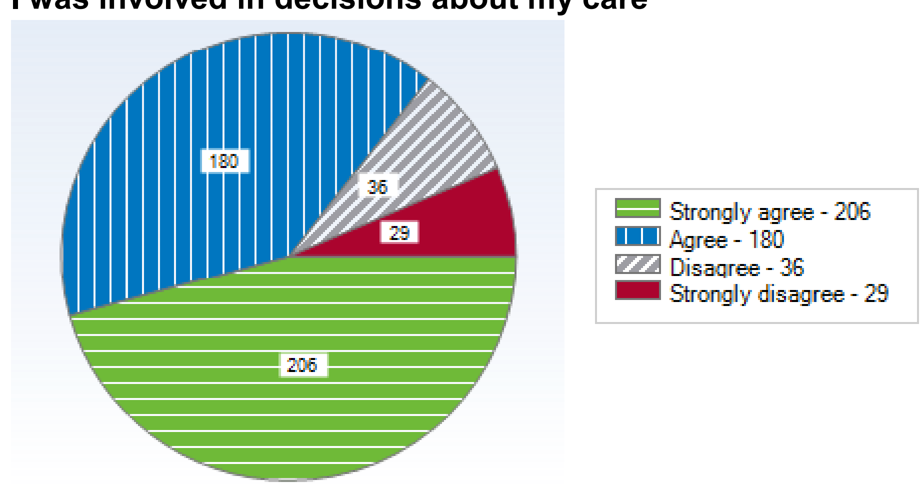
The service has helped me feel better



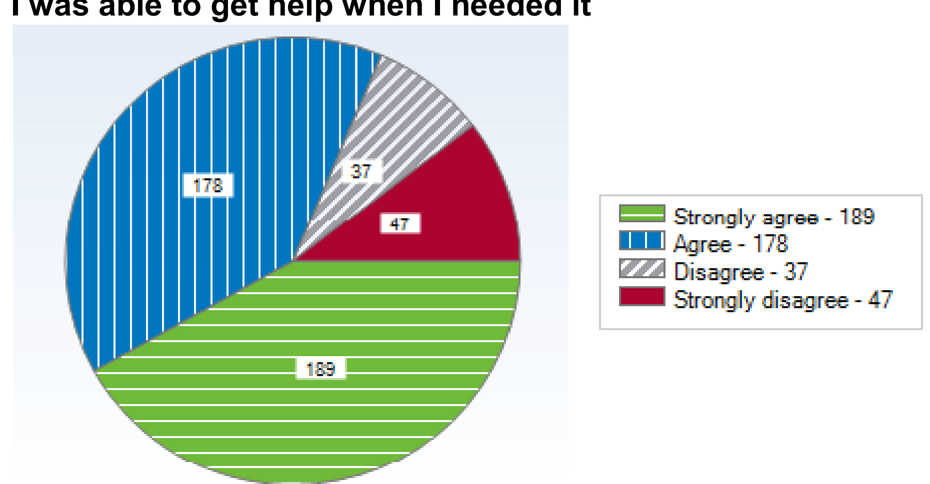
I was given the information I needed



I was involved in decisions about my care

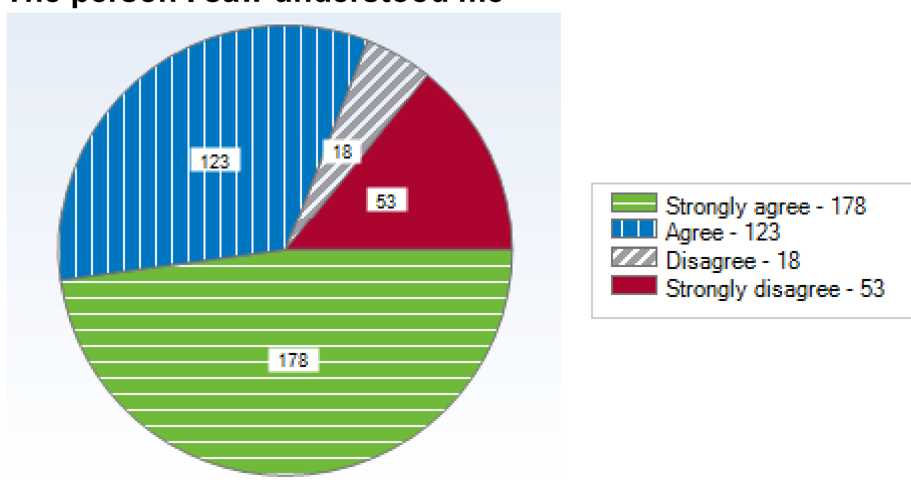


I was able to get help when I needed it

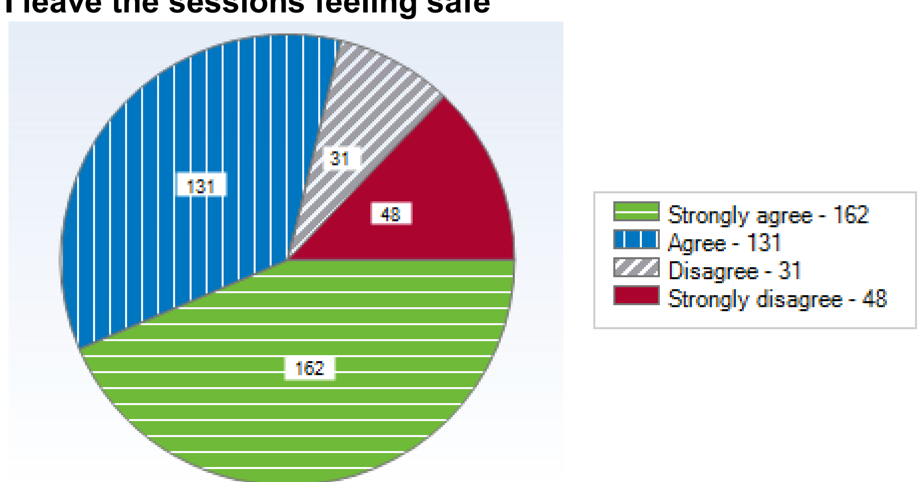


4.2.2 Three PETs were used in CAMHS teams across the Trust and generated 372 responses.

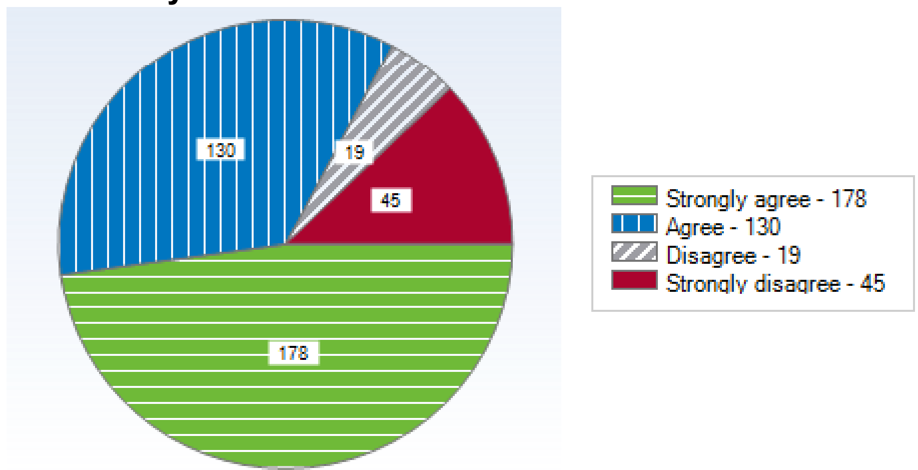
The person I saw understood me



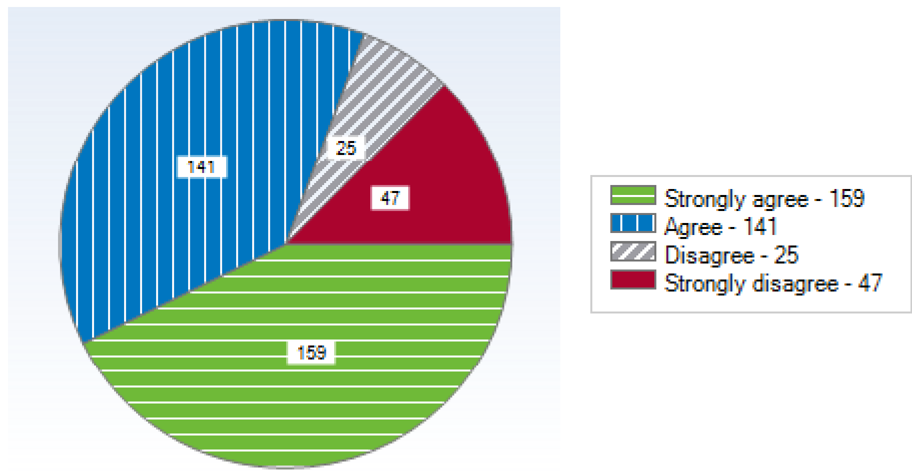
I leave the sessions feeling safe



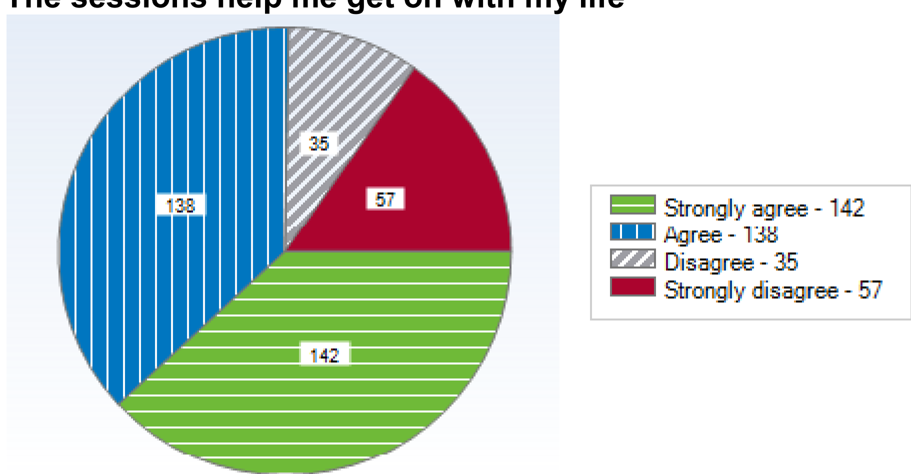
I have a say in what is discussed in the sessions I attend



The sessions are useful to me



The sessions help me get on with my life



Our 12 month contract with Dr Foster Intelligence expired on 30th November 2010. The project generated a total of 1,855 responses across ten different Trust settings. The preferred supplier for a second 12-month pilot starting in 2011 has been identified following a tender and interview process in November, and we will be developing a new reporting system in 2011 linked to Better By Experience.

5. Better By Experience

The Better By Experience programme (BBE) aims to improve the experience of service users and staff through the development and implementation of clear organisational commitments relating to staff behaviour and attitude and to organisational culture.

The BBE programme identifies 4 stages in its implementation: listening; co-creating; aligning; going live.

5.1 Listening and Co-creating:

The first two stages have been undertaken between August and October 2010. This involved a number of activities:

- In Your Shoes workshops with staff, service users and carers which enabled people to identify both positives and negatives about their experience of the organisation
- Graffiti Boards for staff which enabled staff to express their hopes and aspirations about what kind of organisation we could be
- Values Into Action workshops with staff which received the feedback from the listening stage and worked to develop organisational commitments
- A series of additional workshops and presentations with Chief executives strategy group, the Leadership conference, and Foundation Trust governor and member meetings.

The work has been led by a steering group with Director level representation and supported by a Core group with key staff drawn from all areas of the trust.

A great deal of feedback has been received and developed to identify the standards around which the programme will be based in future. These are expressed as the 5 key commitments outlined below which will now be taken to the Executive Management Board in December and to the Trust Board in January 2011.

5.2 The Better By Experience Commitments

- **We welcome you**
- **We hear you**
- **We are hopeful for you**
- **We work with you**
- **We are helpful**

5.3 Improvements to support staff

Staff workshops also identified areas for immediate action that would improve staff experience. After workshop based discussions at the Chief executives strategy group the following 3 have been prioritised by the BBE steering group. These proposals will be further developed at the Leadership conference in January for implementation as a part of the programme Launch.

- Red tape review : staff will be invited to identify administrative procedures that they find cumbersome and to identify effective alternatives
- Quick guide to policies: easy to read summary guides will be developed for all key policies
- Improving your local environment: a scheme will be developed to encourage staff to take action to improve their working environment

5.4 Alignment

We are now moving into the alignment stage of the project.

BBE encompasses more than just a change in individual behaviour – although this is important. It also has to be a process of systemic change. As such BBE has to impact on all aspects of our organisational life to achieve a real change in our culture and to sustain that change. The commitments agreed need to become part of the

fabric of our organisational life. Alignment means embedding the BBE commitments and values into all of the work of the organisation.

The following workstreams are being developed in relation to this:

- Communication: plans are being developed for the launch of the new Commitments once Board agreement has been given. BBE will be a key element of the Leadership Conference in January. The development of a service standards handbook is being considered.
- Learning and development; plans are being developed to ensure inclusion of the BBE commitments in the Trust induction programme, and discussions are underway about what other training inputs will be needed.
- Business planning: the BBE commitments are being integrated into the Business plan for 2011/12
- Human resources; work is underway with HR to ensure that the BBE commitments are integrated into recruitment, induction, supervision and appraisal.
- Performance monitoring: the current customer experience monitoring tools such as the postcards and the patient experience trackers will be developed to ensure that customer experience is monitored in relation to the BBE commitments.
- Better By Design: the BBE commitments will also need to be integrated into the Better By Design programme at operational level.

6. Looking Ahead

Measuring and improving patient experience will continue to be a priority in 2011/12. The Better By Experience commitments will give us a new framework within which we can measure and evaluate patient experience across the Trust. We will be looking at ways of developing our current monitoring systems such as the PETS and the postcards to incorporate the Better by Experience standards and also to link what we measure to the priority areas emerging from national surveys. The BBE commitments have been co-created through staff, service user and carer involvement and put us on a sound footing for the work we have to do in the months ahead.

HOSC Paper
How Patient Experience of Primary Care Services is Monitored and used to Improve Services

1. Background

Patient experience is increasingly recognised at a fundamental element of the quality of healthcare services. Primary care staff are often the closest NHS staff to patients and are well placed to understand their health needs and concerns. Overall public satisfaction with primary care services remains high compared to other parts of the NHS[1] but there is huge variation in terms of patient experience at an individual practice level. As people exercise greater choice and control in their own lives and become accustomed to high quality and responsive services in the commercial sector, the public have similar expectations of their primary care services and they will need to adapt accordingly.

2. Purpose of the Paper

The purpose of the paper is to provide summary information on the following areas in relation to primary care services in Brighton and Hove:

- the key mechanisms for obtaining & monitoring patient feedback
- the key issues that patients raise
- how patient feedback is used to improve services

3. Background Information - Primary Care Services in Brighton and Hove

- **175 GP's** (equating to 140 Whole Time Equivalent (WTE)) work in 49 practices in Brighton and Hove across **55 surgery buildings**
- **15% of the population see a GP in any two week period**. (Royal College of General Practitioners (2007)[2]
- **Each full time GP has on average 2,100 patients**
- **The average patient visits their GP practice about 5 times a year** with at least 78% of the population consulting their GP once a year or more[3].
- **The highest users of Primary care services are older people aged 75+**[4]
- **Most health needs (86%) are managed in primary care**[5]

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[1] The 2008 Healthcare Commission survey found that 93% of people agreed that their GP always treated them with dignity and respect Healthcare Commission (2008) National survey of local health services 2008
[2] http://www.gpcurriculum.co.uk/rcgp/12_facts.htm
[3] The Information Centre (2008) Trends in Consultation Rates in General Practice 1995 to 2007
[4] The Information Centre (2008) Trends in Consultation Rates in General Practice 1995 to 2007

4. Sources of Information on Patient Experience

There are a variety of means of measuring patient experience with primary care services:

4.1 The GP Patient Survey

This comprehensive national survey is run on a quarterly basis. It asks patients about a range of issues, such as how easy or difficult it is for patients to make an appointment at their surgery, satisfaction with opening hours and the quality of care received from their GP and practice nurses. It is sent to over 5 and a half million people each year across the country and provides patients with the chance to have their say about their GP practice[6]. The response rate to the survey between October 2009 and September 2010, was 37%.

4.2 Practice's own surveys

Practices sometimes find it helpful to design a simply survey to measure satisfaction with particular changes that have been made to services or to help inform what changes could be made. Examples of individual practice surveys include:

- Carers survey regarding the quality of end-of life care for palliative care patients.
- Patient travel surveys regarding potential re-location of GP surgery premises

4.3 NHS Choices

On the NHS Choices web-site[7] there is a tool to allow patients to leave feedback on GP services. Patients are asked a series of questions covering topics including how easy it was to get through on the phone, whether they could get an appointment and if they were treated with dignity and respect. There is also be space to leave additional comments and GP practices can post responses to individual comments.

It provides GP practices with an opportunity to see patients' views on what they are doing well and what needs to be improved. However, there are limitations to the tool in that feedback is from a self-selecting population and older users who are the highest users of GP services may be less likely to post feedback using an on-line tool.

4.4 Review of Complaints

Reviewing key themes from patient complaints can be an important means of make improvements to services. The Quality and Outcomes Framework

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[5] http://www.gpcurriculum.co.uk/rcgp/12_facts.htm

[6] A copy of the GP patients survey is available at the attached link: http://www.gp-patient.co.uk/download/Questionnaires/Y5Q4%20GP%20Patient%20Survey%20questionnaire.pdf

[7] The NHS web-site that provides information on health conditions and services

(QOF) specifically incentivises GP Practices to undertake an annual review of patient complaints.

5. What are the Key Themes from Patient Feedback

Different users of primary care services want different things and the challenge is for surgeries to be responsive to a range of different demands and design services effectively around the needs of the patients. A particular challenge for primary care is to delivery services that allow convenience and accessibility as well as continuity of care. Examples of different users of primary health care include:

- "Convenience" users want to see a doctor when and there they want. They tend to be younger more mobile people without long-term conditions so continuity of care is not of overriding importance.

- "Mainstream" users that make up the majority of users of primary care services. They access both the "sickness" as well as the preventative primary health care services. Often these users want to plan their lives in advance around caring and work commitments.

- "High-impact" users who need integrated and well managed care of long term conditions that improve quality of life and help avoid admission to hospital[8].

Full details of the GP patient survey results are published on line.[9]
Key themes that have emerged from patient feedback for Brighton and Hove:

- **Overall satisfaction with care is high.** The latest GP survey results (July to September 2010) shows:

  - Overall satisfaction with GP services in Brighton and Hove at **88.1%.** (Slightly below the national average of **89.8%)**

  - 93% of patients in Brighton and Hove found receptionists helpful (in line with the national average of **93%**)

  - 94% have confidence and trust in their doctor

  - 81% would recommend their surgery to a friend.

- **Access to GP services still remains an issue.** Patient survey data for Brighton and Hove residents for the period July 2009 to June 2010 shows:

[8] Categorisation devised by CBI (2007) Just What the Patient Ordered: Better GP Services
[9] http://www.gp-patient.co.uk/results/

- **22**% of patients do not find it easy to get through on the phone (in line with the national average of **22%**)

- **18% of patients who had tried to see a doctor fairly quickly in the last six months were not able to do so.** (This compares with a national figure of **20%**). The main reason for this was that there not any appointments available.

- **25% of patients who had tried to book ahead for an appointments in the last six months were not able to do so**. (this compares with the national average of **26%**).

- Results at an individual practice level in Brighton and Hove varies significantly - ranging from 63% who couldn't book an appointment to 2%). This shown in graphical form in Appendix A.

- **Services are not always available at times when patients want.**
  - **10%** of patients in Brighton on not satisfied with opening hours (compared with **7%** nationally). The most requested additional hours that patients want services available are on a Saturday
  - Satisfaction with opening hours varies at a practice level and this is shown graphically in Appendix B.

6. How is Patient Feedback Used to Improve Services

Improvements to services come about when primary care services respond to patient feedback. Increasingly as more information is put in to the public domain about the quality and performance of primary care services, patients can use this information to exercise their choice of GP. In reality patients are only exercising this choice in terms of changing GP practice to a limited extent, but the publication of information in itself is beginning to be a powerful lever for General Practice to improve the quality of their services.

What are the PCT doing to support practices:

- The PCT has produced a **Balanced Scorecard** for every GP Practice in Brighton and Hove. It measures the quality and performance of GP Practice across 60 indicators including 12 indicators based on patient experience. A simplified version of the scorecard is being developed that will be put in the public domain in April 2011. An example scorecard is contained in Appendix C. The scorecard results vary by practice and a graph summarising scores by geographical area is contained in Appendix D.

- **Access and Responsiveness Local Enhanced Service**. In 2010-11 the PCT has made available pump priming funding to support GP practices to involve their patients in improving the access and responsiveness of their

services. Examples of work that has been undertaken by practices include:

- Developing additional means of obtaining patient feedback to inform the development of services specific to the individual practice population, for example the development of patient groups and practice surveys.
- Improvements to services that have been made include:
  - Installation of new phone systems to improve access to appointments.
  - Improvements to privacy arrangements within the surgery for example installing background music in the reception area so that conversations can not be overheard.
  - Improvements to surgery buildings such as re-design of reception area.

7. The Future

Moving forward more information in the public domain in a format that is accessible and easily understood could help patients exercise choice. The PCT has encouraged practices to be more pro-active in terms of obtaining and using feedback from patients (e.g. through the Access and Responsiveness programme of work) but there is wide variation in approach at an individual practice level.

The 2010 White Paper: *Equity and Excellence: Liberating the NHS* proposes that from 2013 most commissioning of local health services will be undertaken by GP's. The thinking behind this new model is that GP's are closer to the patients and therefore services should develop in a more responsive way. Within Brighton and Hove GP's have organised themselves into three localities for the purpose of commissioning. It is expected that these locality groups will provide a forum for promoting quality improvement as well as reviewing and benchmarking practice performance. Given the variation in patient experience at a practice level these locality groups provide an opportunity for peer review and challenge as well as the sharing of good practice that could help improve the patient experience.

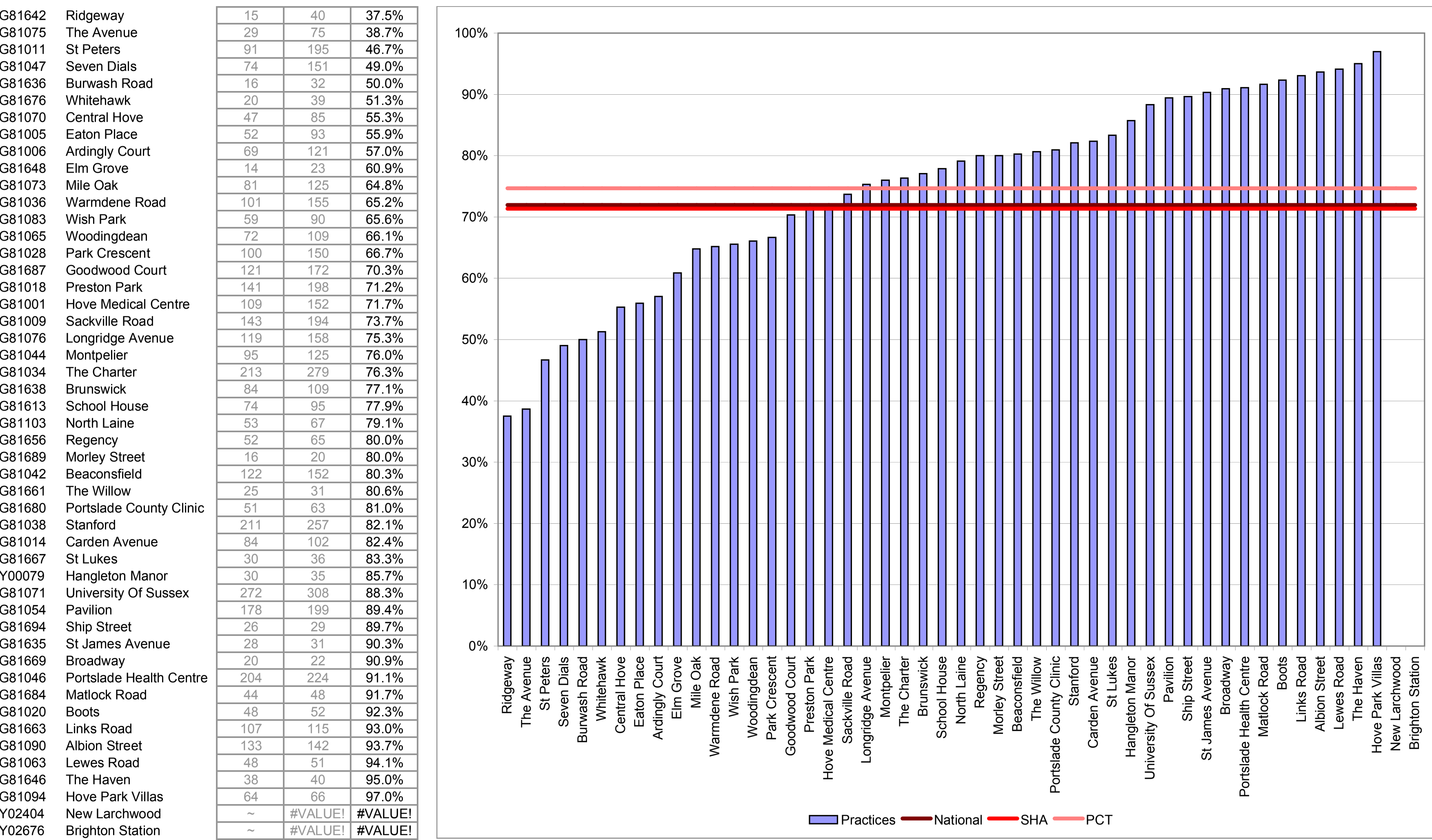
Appendices

Appendix A	**Ability to Book Ahead for an Appointment – By Practice**
Appendix B	**Satisfaction with Opening Hours – By Practice**
Appendix C	**Example Scorecard**
Appendix D	**Scores by Practice and Locality**

Able to book ahead for an appointment with a doctor

< Select indicator from drop-down

Code	Practice	N	D	%
	National	640,662	890,471	71.9%
	SHA	54,340	76,165	71.3%
	PCT	3,831	5,129	74.7%
G81642	Ridgeway	15	40	37.5%
G81075	The Avenue	29	75	38.7%
G81011	St Peters	91	195	46.7%
G81047	Seven Dials	74	151	49.0%
G81636	Burwash Road	16	32	50.0%
G81676	Whitehawk	20	39	51.3%
G81070	Central Hove	47	85	55.3%
G81005	Eaton Place	52	93	55.9%
G81006	Ardingly Court	69	121	57.0%
G81648	Elm Grove	14	23	60.9%
G81073	Mile Oak	81	125	64.8%
G81036	Warmdene Road	101	155	65.2%
G81083	Wish Park	59	90	65.6%
G81065	Woodingdean	72	109	66.1%
G81028	Park Crescent	100	150	66.7%
G81687	Goodwood Court	121	172	70.3%
G81018	Preston Park	141	198	71.2%
G81001	Hove Medical Centre	109	152	71.7%
G81009	Sackville Road	143	194	73.7%
G81076	Longridge Avenue	119	158	75.3%
G81044	Montpelier	95	125	76.0%
G81034	The Charter	213	279	76.3%
G81638	Brunswick	84	109	77.1%
G81613	School House	74	95	77.9%
G81103	North Laine	53	67	79.1%
G81656	Regency	52	65	80.0%
G81689	Morley Street	16	20	80.0%
G81042	Beaconsfield	122	152	80.3%
G81661	The Willow	25	31	80.6%
G81680	Portslade County Clinic	51	63	81.0%
G81038	Stanford	211	257	82.1%
G81014	Carden Avenue	84	102	82.4%
G81667	St Lukes	30	36	83.3%
Y00079	Hangleton Manor	30	35	85.7%
G81071	University Of Sussex	272	308	88.3%
G81054	Pavilion	178	199	89.4%
G81694	Ship Street	26	29	89.7%
G81635	St James Avenue	28	31	90.3%
G81669	Broadway	20	22	90.9%
G81046	Portslade Health Centre	204	224	91.1%
G81684	Matlock Road	44	48	91.7%
G81020	Boots	48	52	92.3%
G81663	Links Road	107	115	93.0%
G81090	Albion Street	133	142	93.7%
G81063	Lewes Road	48	51	94.1%
G81646	The Haven	38	40	95.0%
G81094	Hove Park Villas	64	66	97.0%
Y02404	New Larchwood	~	#VALUE!	#VALUE!
Y02676	Brighton Station	~	#VALUE!	#VALUE!



Satisfaction with opening hours

< Select indicator from drop-down

		N	D	%
	National	1,582,023	1,933,277	81.8%
	SHA	129,544	161,393	80.3%
	PCT	8,501	10,892	78.0%
G81083	Wish Park	126	201	62.7%
G81613	School House	135	215	62.8%
G81001	Hove Medical Centre	233	351	66.4%
G81076	Longridge Avenue	233	342	68.1%
G81005	Eaton Place	178	260	68.5%
G81642	Ridgeway	63	92	68.5%
G81661	The Willow	50	72	69.4%
G81669	Broadway	56	79	70.9%
G81014	Carden Avenue	140	197	71.1%
G81070	Central Hove	127	178	71.3%
G81636	Burwash Road	54	75	72.0%
G81006	Ardingly Court	160	222	72.1%
G81065	Woodingdean	149	206	72.3%
G81648	Elm Grove	51	70	72.9%
G81047	Seven Dials	247	339	72.9%
Y00079	Hangleton Manor	57	78	73.1%
G81075	The Avenue	167	228	73.2%
G81676	Whitehawk	65	87	74.7%
G81036	Warmdene Road	236	315	74.9%
G81044	Montpelier	177	236	75.0%
G81009	Sackville Road	300	398	75.4%
G81694	Ship Street	53	70	75.7%
G81656	Regency	113	149	75.8%
G81071	University Of Sussex	393	516	76.2%
G81635	St James Avenue	57	74	77.0%
G81103	North Laine	141	183	77.0%
G81028	Park Crescent	273	353	77.3%
G81018	Preston Park	295	377	78.2%
G81054	Pavilion	310	387	80.1%
G81638	Brunswick	194	240	80.8%
G81094	Hove Park Villas	117	144	81.3%
G81680	Portslade County Clinic	97	119	81.5%
G81038	Stanford	498	607	82.0%
G81020	Boots	79	96	82.3%
G81090	Albion Street	228	274	83.2%
G81046	Portslade Health Centre	375	447	83.9%
G81073	Mile Oak	210	250	84.0%
G81042	Beaconsfield	302	357	84.6%
G81667	St Lukes	70	82	85.4%
G81034	The Charter	486	566	85.9%
G81011	St Peters	346	398	86.9%
G81689	Morley Street	27	31	87.1%
G81684	Matlock Road	82	94	87.2%
G81687	Goodwood Court	347	388	89.4%
G81646	The Haven	92	102	90.2%
G81063	Lewes Road	113	125	90.4%
G81663	Links Road	181	198	91.4%
Y02676	Brighton Station	13	14	92.9%
Y02404	New Larchwood	#VALUE!	#VALUE!	#VALUE!

100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0%

Practices National SHA PCT

GP Scorecard 2010/11, [Practice Name]

Overall Band: B (78 out of 114, 68.4%) [Locality] [Code]

1 Contractual Requirements & Premises

	Indicator	A	B	C	Score	Band	Rank	Previous		Locality		PCT		National	
1.1	Compliance with GMS Contractual and Statutory Requirements	Fully compliant		Not fully compliant	Fully compliant	A	N/A	Fully compliant	=	N/A		41		N/A	
1.2	Business Continuity Plan (BCP)	Approved BCP		No approved BCP	Approved BCP	A	N/A	N/A		N/A		47		N/A	
1.3	Compliance with GMS minimum premises standards	Fully compliant	<10 changes needed	≥10 changes needed	16	A	=37	N/A		N/A		N/A		N/A	

2 Priority Standards & Services

	Indicator	A	B	C	Score	Band	Rank	Previous		Locality		PCT		National	
2.1	Electronic Patient Records (EPR)	Using EPR	Working towards EPR	Not using EPR	Using EPR	A	N/A	N/A		N/A		N/A		N/A	
2.2	Information Governance Toolkit	Submitted, all ≥ level 2	Submitted, not all ≥ level 2	Not submitted	Submitted, not all ≥ level 2	B	N/A	N/A		N/A		N/A		N/A	
2.3	Priority Enhanced Services	≥ 90%	60% to 90%	< 60%	78.6%	B	=19	78.6%	=	74.6%	▲	76.5%	▲	N/A	
2.4	PBC locality agreement	Signed up		Not signed up	Signed up	A	N/A	N/A		N/A		48		N/A	

3 Access

	Indicator	A	B	C	Score	Band	Rank	Previous		Locality		PCT		National	
3.1	Ease of access to building	≥ National (97.3%)	Top 50% of those below	Bottom 50% of those below	98.2%	A	19	97.8%	▲	96.8%	▲	97.0%	▲	97.3%	▲
3.2	Telephone access [1]	≥ National (75.8%)	Top 50% of those below	Bottom 50% of those below	45.0%	C	48	55.7%	▼	69.7%	▼	75.0%	▼	75.8%	▼
3.3	GP appointment within 2 days [1]	≥ National (79.8%)	Top 50% of those below	Bottom 50% of those below	77.3%	B	40	81.5%	▼	83.4%	▼	81.9%	▼	79.8%	▼
3.4	GP appointment 2+ days [1]	≥ National (73.4%)	Top 50% of those below	Bottom 50% of those below	69.9%	B	36	52.6%	▲	75.3%	▼	74.4%	▼	73.4%	▼
3.5	Satisfaction with opening hours [1]	≥ National (83.6%)	Top 50% of those below	Bottom 50% of those below	77.0%	B	33	77.3%	▼	79.7%	▼	79.2%	▼	83.6%	▼
3.6	Ability to see preferred GP [1]	≥ National (74.7%)	Top 50% of those below	Bottom 50% of those below	74.1%	B	31	79.0%	▼	76.3%	▼	78.0%	▼	74.7%	▼
3.7	Extended hours [1]	Providing		Not providing	Providing	A	N/A	N/A		N/A		33		N/A	

4 Patient Experience

	Indicator	A	B	C	Score	Band	Rank	Previous		Locality		PCT		National	
4.1	Cleanliness of building	≥ National (98.6%)	Top 50% of those below	Bottom 50% of those below	99.1%	A	32	99.1%	▼	99.2%	▼	98.6%	▲	98.6%	▲
4.2	Helpfulness of reception staff	≥ National (93%)	Top 50% of those below	Bottom 50% of those below	90.1%	C	41	91.1%	▼	93.1%	▼	92.6%	▼	93.0%	▼
4.3	Experience with doctor	≥ National (95.4%)	Top 50% of those below	Bottom 50% of those below	95.9%	A	20	96.6%	▼	94.9%	▲	94.6%	▲	95.4%	▲
4.4	Experience with practice nurse	≥ National (97.6%)	Top 50% of those below	Bottom 50% of those below	95.8%	C	40	98.2%	▼	96.3%	▼	96.8%	▼	97.6%	▼
4.5	Patients told they have a care plan	≥ ONS cluster (12.5%)	Top 50% of those below	Bottom 50% of those below	8.5%	B	27	N/A		8.8%	▼	9.5%	▼	11.9%	▼
4.6	Overall satisfaction with care [1]	≥ National (90%)	Top 50% of those below	Bottom 50% of those below	89.1%	B	33	91.3%	▼	89.5%	▼	88.5%	▲	90.0%	▼

5 QOF

Part 1: General

	Indicator	A	B	C	Score	Band	Rank	Previous		Locality		PCT		National	
5.1	Overall QOF score [2]	≥ National (93.7%)	Top 50% of those below	Bottom 50% of those below	95.7%	A	14	95.6%	▲	87.4%	▲	89.3%	▲	93.7%	▲
5.2	Patient Experience domain score	≥ National (71.5%)	Top 50% of those below	Bottom 50% of those below	53.0%	C	41	70.2%	▼	70.5%	▼	72.0%	▼	71.5%	▼
5.3	Additional Services domain score	≥ National (95.3%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	88.4%	▲	88.3%	▲	95.3%	▲
5.4	Overall exception reporting rate	≤ National (5.4%)	Bottom 50% of those above	Top 50% of those above	6.6%	B	22	6.9%	▼	6.9%	▼	7.2%	▼	5.4%	▲

Part 2: Clinical Domain

	Indicator	A	B	C	Score	Band	Rank	Previous		Locality		PCT		National	
5.5	Overall Clinical domain score [2]	≥ National (95.9%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	89.0%	▲	92.1%	▲	95.9%	▲
5.6	Asthma	≥ National (98.1%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	90.4%	▲	93.6%	▲	98.1%	▲
5.7	Chronic Kidney Disease	≥ National (94.7%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	88.5%	▲	92.0%	▲	94.7%	▲
5.8	COPD	≥ National (95.8%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	80.0%	▲	87.8%	▲	95.8%	▲
5.9	Dementia	≥ National (97.5%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	81.1%	▲	92.3%	▲	97.5%	▲
5.10	Depression	≥ National (81.7%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	69.5%	▲	68.6%	▲	81.7%	▲

GP Scorecard 2010/11, [Practice Name]

Overall Band: B (78 out of 114, 68.4%) — **[Locality] [Code]**

No.	Indicator	A	B	C	Score	Band	Rank	Previous		Locality		PCT		National	
5.11	Diabetes	≥ National (95.2%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	90.1%	▲	93.2%	▲	95.2%	▲
5.12	Hypertension	≥ National (98.9%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	96.2%	▲	96.8%	▲	98.9%	▲
5.13	Learning Disabilities	≥ National (98.6%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	93.8%	▲	98.0%	▲	98.6%	▲
5.14	Mental Health	≥ National (94.5%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	86.5%	▲	89.4%	▲	94.5%	▲
5.15	Obesity	≥ National (100%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	100.0%	=	100.0%	=	100.0%	▲
5.16	Palliative Care	≥ National (89.3%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	75.0%	▲	83.7%	▲	89.3%	▲
5.17	Smoking	≥ National (99%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	93.6%	▲	96.1%	▲	99.0%	▲
	Part 3: Organisational Domain														
5.18	Overall Organisational domain score [2]	≥ National (99%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	93.6%	▲	96.1%	▲		
5.19	Records and Information	≥ National (95.8%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	92.4%	▲	87.7%	▲		
5.20	Information for Patients	≥ National (98.6%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	95.8%	▲	93.9%	▲		
5.21	Education and Training	≥ National (95.9%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	83.0%	▲	84.8%	▲		
5.22	Practice Management	≥ National (97.9%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	84.0%	▲	89.4%	▲		
5.23	Medicines Management	≥ National (97.2%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	89.4%	▲	88.4%	▲		

6 Public Health

No.	Indicator	A	B	C	Score	Band	Rank	Previous		Locality		PCT		National	
6.1	Cervical screening (National Screening Programme)	≥ 80%	75% to 80%	< 75%	81.8%	A	5	80.8%	▲	74.5%	▲	75.8%	▲	N/A	
6.2	Cervical screening (QOF CS1)	≥ 80%	75% to 80%	< 75%	82.9%	A	23	83.1%	▼	83.6%	▼	83.0%	▼	N/A	
6.3	Childhood imms: DTaP/IPV/Hib 1 yr olds [1]	≥ 95%	≥ PCT (91.6%)	< PCT (91.6%)	87.9%	C	=38	N/A		89.5%	▼	91.6%	▼	N/A	
6.4	Childhood imms: MMR for 2 yr olds (1st dose) [1]	≥ 90%	≥ PCT (86.5%)	< PCT (86.5%)	85.9%	C	31	83.9%	▲	85.4%	▲	86.5%	▼	N/A	
6.5	Childhood imms: MMR for 5 yr olds (2nd dose) [1]	≥ 90%	≥ PCT (77.2%)	< PCT (77.2%)	82.2%	B	19	N/A		77.7%	▲	77.2%	▲	N/A	
6.6	Childhood imms: pre-school booster for 5 yr olds [1]	≥ 90%	≥ PCT (80.6%)	< PCT (80.6%)	87.1%	B	17	72.0%	▲	81.5%	▲	80.6%	▲	N/A	
6.7	Flu imms, 65+	≥ 70%	≥ PCT (68.1%)	< PCT (68.1%)	73.2%	A	12	76.8%	▼	68.0%	▲	68.1%	▲	72.4%	▲
6.8	Pneumococcal imms, 65+	≥ 80%	≥ PCT (69.8%)	< PCT (69.8%)	77.0%	B	11	47.0%	▲	71.2%	▲	69.8%	▲	N/A	
6.9	Smoking status recording (QOF Records 23)	Top quartile (≥ 84.5%)	Middle quartiles	Bottom quartile (< 75.9%)	90.8%	A	4	90.5%	▲	82.2%	▲	80.9%	▲	89.4%	▲
6.10	Smoking status recording (Omnibus) [1]	≥ 90%	70% to 90%	< 70%	76.2%	B	5	72.5%	▲	67.2%	▲	66.3%	▲	N/A	
6.11	Hypertension management [1]	≥ 75%	70% to 75%	< 70%	73.3%	B	24	74.7%	▼	72.1%	▲	71.7%	▲	N/A	
6.12	Chlamydia screening, 15-24 yr olds	≥ 50%	25% to 50%	< 25%	2.5%	C	25	N/A		5.3%	▼	4.3%	▼	N/A	

7 Prescribing

No.	Indicator	A	B	C	Score	Band	Rank	Previous		Locality		PCT		National	
7.1	Renin-angiotensins	≥ 74%		< 74%	70.3%	C	30	60.8%	▲	70.6%	▼	70.7%	▼	N/A	
7.2	High risk antibiotics	≤ 25%		> 25%	16.7%	A	16	18.8%	▼	19.7%	▼	19.8%	▼	N/A	
7.3	Low cost PPIs	≥ 91%		< 91%	89.6%	C	27	83.7%	▲	88.6%	▲	89.4%	▲	N/A	
7.4	Statin prescribing	≥ 75%		< 75%	70.1%	C	45	71.0%	▼	77.5%	▼	79.7%	▼	N/A	
7.5	Seretide 250 evohaler	≤ 25%		> 25%	48.7%	C	44	N/A		34.4%	▲	30.7%	▲	N/A	

1 Indicators to which the PCT is held to account; mostly Vital Signs, but also 6.10, for which we submit data via the Omnibus return
2 These indicators do not count towards a practice's overall or banding

2010/11 GP scorecard score - by locality
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Central
East
West

HEALTH OVERVIEW AND SCRUTINY COMMITTEE	Agenda Item 57 Brighton & Hove City Council

Subject:		**Health and Social Care Bill and NHS Operating Framework 2011-12: Update**		
Date of Meeting:		**09 February 2011**		
Report of:		**The Strategic Director, Resources**		
Contact Officer:	Name:	Giles Rossington	Tel:	29-1038
	E-mail:	Giles.rossington@brighton-hove.gov.uk		
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 This report provides a basic summary of recent developments in national healthcare policy, specifically in terms of the publication of the NHS Operating Framework 2011-12 and the Health and Social Care Bill 'command paper': "Liberating the NHS – Legislative Framework and Next Steps". (More detailed information on these documents is included as **Appendices 1** and **2** to this report.)

1.2 Subsequent to the compilation of this report, the Health and Social Care Bill was published. However, the measures included in the Bill do not differ significantly from those outlined in the command paper (it would have been surprising had they done so), and therefore the briefing is still relevant.

1.3 Full texts of both the Annual Operating Framework and the Health and Social Care Bill command paper can be found on the Department of Health website.

2. RECOMMENDATIONS:

2.1 That members:

(1) Note the content of this update.

3. BACKGROUND INFORMATION

3.1 In 2010 The Government released a white paper, “Equity and Excellence”, detailing its plans to improve NHS healthcare. Published alongside the white paper were a series of consultation documents focusing on various aspects of the Government’s plans. These consultations have now ended, the Department of Health (DH) has considered the submissions received, and, in some instances, the Government has amended its policies. In December 2010 the DH published “Liberating the NHS – Legislative Framework and Next Steps” which set out the Government’s revised plans for health and social care. This was followed in January 2011 by the Health and Social Care Bill which is currently progressing through parliament.

3.2 A précis of the command paper is included as **Appendix 1** to this report.

3.3 In December 2010 the Department of Health also published the 2011-12 NHS Annual Operating Framework. This document outlines the national NHS priorities for the coming year, and details significant changes to NHS management structures, tariff regimes, quality initiatives etc.

3.4 A précis of the Annual Operating Framework is included as **Appendix 2** to this report.

4. CONSULTATION

4.1 None

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 None to this report for information

Legal Implications:

5.2 None to this report for information

Equalities Implications:

5.3 None to this report for information

Sustainability Implications:

5.4 None to this report for information

Crime & Disorder Implications:

5.5 None to this report for information

Risk and Opportunity Management Implications:

5.6 None to this report for information

Corporate / Citywide Implications:

5.7 None to this report for information

SUPPORTING DOCUMENTATION

Appendices:

1. Additional information on “Liberating the NHS – Legislative Framework and Next Steps”;

2. Additional information on the NHS Annual Operating Framework 2011-12

Documents in Members’ Rooms:

None

Background Documents:

1. “Equity and Excellence”: DH White Paper (2010)

2. NHS Annual Operating Framework 2011-12 (2010)

3. “Liberating the NHS – Legislative Framework and Next Steps”: DH command paper (2010)

4. The Health and Social Care Bill (2011)

Appendix 1

Additional Information on the Health and Social Care 'Command' Paper – Liberating the NHS: Next Steps and Legislative Framework

The recently published Health and Social Care command paper sets out the Government's legislative intentions for health (the Health and Social Care Bill will be presented to parliament in early 2011). In large part, these are a reiteration of the plans detailed in the white paper "Equity and Excellence". However, following a series of consultations on aspects of the white paper proposals, the Government has made some significant changes to its plans for NHS reform. Rather than re-brief members on the entire contents of Equity and Excellence, this paper focuses on those elements of the white paper plans which have been significantly amended.

The DH identifies the most significant amendments to its plans as being:

1 A longer transition period for provider reforms

In the white paper the Government proposed that all NHS trusts would become self-governing NHS Foundation Trusts by 2013. This deadline has now been extended until 2014, although the command paper reiterates the Government's commitment to all trusts becoming FTs (the Government plans to revoke NHS trust legislation by 2014, so that it will no longer be possible for organisations to exist as NHS trusts). This extension recognises the difficulty of transition to FT status, particularly given the current financial climate. The DH anticipates that a relatively small number of provider trusts will struggle to attain FT status within any time-scale, and sets out measures to support these trusts.

With the abolition of Strategic Health Authorities, Monitor (the FT regulator) was expected to take over performance management of any remaining NHS trusts in 2013. However this role will now be undertaken by a specialist organisation with particular skills in managing financial turnaround plans.

2 Strengthening the role of Health and Wellbeing Boards (HWBs)

Although the white paper introduced the concept of HWBs - partnership bodies bringing together social care, public health, patient representative bodies and GP commissioners– it was unclear on what HWBs would look like, whether they would be compulsory, or what their powers and duties would be. The command paper confirms that HWBs will be mandatory, with responsibility for the local Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy (JHWS). GP commissioners will be required to take an active role in HWBs (as will local authority Directors of

Public Health, Adult Social Care and Children's Social Care). There will be places on each HWB for representatives of Healthwatch and for local Councillors. HWBs will be piloted via a number of early adopters in 2011-12 prior to being formally launched in 2013. (Subsequent guidance makes it apparent that all upper tier authorities will be expected to begin preparing for HWBs in 2011-12.)

3 Moving more quickly to GP commissioning consortia via pathfinder initiatives

In the command paper the Government reiterates its commitment to move to a system of GP commissioning. Indeed, the timetable has now been tightened, with pathfinder consortia already being launched. This change to the timetable seems partly to be a reaction to professional enthusiasm for GP commissioning, partly because there are concerns about the sustainability of many PCTs as staff leave to take up other posts etc.

4 Creating a distinct identity for Healthwatch

The command paper confirms the Government's intentions to create a new patient and public representative organisation called Healthwatch. It also confirms that Healthwatch will be part of the Care Quality Commission (CQC), operating as a formal sub-committee of the CQC. There had been some debate as to whether Healthwatch should be an entirely free-standing independent body, but the Government feels that there is considerable value in aligning Healthwatch with the CQC – the statutory independent assessor of health and social care. Administration for local Healthwatch organisations will be contracted by local authorities as per the white paper.

5 Requiring all GP consortia to publish a constitution

GP consortia will be statutory organisations and will be required to publish a constitution, annual reports and commissioning plans. Consortia will not be required to have public/patient representatives on their boards, as had been mooted, although they are free to do so if they wish. The DH intends for there to be a clear distinction between GP consortia and their member GP practices.

6 Maternity services to be commissioned locally rather than nationally

The white paper had proposed that maternity services be commissioned by the NHS Commissioning Board rather than by local GP consortia. The rationale for this was that GPs had relatively little involvement in or understanding of maternity services. However, this was challenged by many

respondents to the white paper consultation, and the position has now been reversed, with maternity becoming a GP consortia responsibility.

7 Retaining HOSCs and extending their powers

The white paper had effectively proposed the abolition of HOSCs, by planning to transfer their statutory powers to HWBs. This was challenged, both on the basis that HOSCs had made a valuable contribution to scrutiny of the NHS, and on the basis that the proposals would leave HWBs (or at any rate some HWB members) responsible for both executive decisions and scrutiny functions. The command paper therefore states that statutory health scrutiny powers will not be transferred to HWBs.

However, there are some changes to scrutiny arrangements proposed:

- Although health scrutiny powers may not be transferred to HWBs, they can be exercised by any other designated local authority body – i.e. not specifically a scrutiny committee as is currently the case.

- HOSCs currently have the statutory power to oblige NHS trusts and commissioners to report to them. The Health Bill will extend this power to cover all organisations which commission or provide NHS-funded services – this includes independent sector providers, GP practices etc. There is as yet no detail about these powers, and it should perhaps be noted that the current HOSC powers to compel attendance are actually relatively minimal: NHS organisations engage positively with HOSCs largely because they choose to rather than because of any statutory compulsion. It seems reasonable to anticipate that relationship building will continue to be more useful than statutory levers in terms of scrutinising commissioners and providers.

- It had originally been the Government's intention to involve Healthwatch directly in the scrutiny of health reconfiguration plans via the scrutiny functions of HWBs. Although HWBs will no longer exercise these functions, the Government is still committed to involving Healthwatch in scrutiny and expects HOSCs to develop strong partnership relationships with local Healthwatch organisations.

8 Phase in the transfer of complaints advocacy to Healthwatch

The white paper plans to transfer responsibility for complaints advocacy to Healthwatch have been slightly revised, with these services moving across to local authorities in 2013 rather than 2012 (when Healthwatch will 'go live'). This is in recognition of the specialist nature of these services and the need to plan carefully for them.

9 Give GP consortia a stronger role in determining local primary care policy

The white paper proposed that primary care services (e.g. GPs, dentists and community pharmacists) should be commissioned by the NHS Commissioning Board. Doing so removes the obvious clash of interests which would arise should GP commissioners be allowed to commission their own services. This position still stands; however, the Government has revised its plans slightly to give GP consortia a bigger role in improving quality amongst their constituent practices. The Health and Social Care Bill will therefore introduce a specific duty for GP consortia to support the NHSCB in improving the quality of primary medical care services.

10 Adding an explicit duty for NHS arms-length bodies to co-operate

The white paper adumbrated major plans to change NHS command structures, with the current Foundation Trust regulator, Monitor, becoming the NHS economic regulator, and the NHS Commissioning Board assuming a range of duties currently undertaken by the DH or SHAs. Some respondents to the white paper consultation expressed concerns that a situation could develop where these independent organisations ended up communicating with each other via quasi-judicial means – e.g. that Monitor would set the tariff price for various procedures and the NHSCB would then appeal against the tariff being set to high. To avoid this situation, the Bill will introduce a duty for Monitor and the NHSCB to informally co-operate on tariff-setting, only resorting to the formal resolution mechanisms when there is no possibility of reaching a mutually agreeable position.

Appendix 2

Additional Information on the NHS Annual Operating Framework 2011-12

The NHS Annual Operating Framework (AOF) sets out the main national priorities for the NHS in the coming year, as well as detailing planned changes to NHS managerial structures, payment regimes, staff terms and conditions, quality initiatives etc. 2011-12 is likely to be a particularly significant year in terms of NHS structures, as a radical Health and Social Care Bill (due to be presented to parliament in early 2011) will seek to make significant changes to the way in which the NHS operates. In addition, the requirement to find around £20 billion in 'efficiency' savings in the next four years presents the NHS with very major financial challenges.

1 Organisations

1(a) NHS Commissioning Board/SHAs

The forthcoming Health and Social Care Bill will propose introducing a national NHS Commissioning Board (NHSCB). Essentially, the NHSCB will take over many of the current strategic/monitoring functions of Strategic Health Authorities (SHAs), whilst also directly commissioning services which are unsuitable for localised commissioning by GP consortia, such as primary care (where there would be an obvious clash of interests for GP commissioners), specialised care (i.e. low volume treatments provided on a regional or national basis), and aspects of prison/military care. The NHSCB will be launched in shadow form in 2011, but will not become operational until April 2012. In the meantime, SHAs will continue to exercise authority over regional health planning, quality assurance etc.

1(b) PCTs

Primary Care Trusts (PCTs) will remain in existence until at least April 2013, but the DH expects there to be a significant reduction and/or transfer of staff (i.e. into GP consortia, local authorities, the NHSCB) before this date. This is likely to mean that the current system of 152 discrete PCTs will quickly become unsustainable, and the DH consequently expects PCTs to form regional or sub-regional 'clusters' by June 2011. Clusters will each be managed by a single executive team.

1(c) Health and Wellbeing Boards

Health and Wellbeing Boards (HWBs) will bring together GP commissioners and local authorities to plan local health and social care strategies. In formal terms, HWBs will be responsible for the local Joint Strategic Needs Assessment (JSNA) and for the local Joint Health and Wellbeing Strategy (JHWS). HWBs will need to be in place by April 2012, and 2011 will see a network of 'early adopters' piloted in parallel with some of the pathfinder GP consortia. The Health and Social Care Bill is expected to define a minimum membership for HWBs, with localities free to add to this core if they choose. The minimum representation will be: local GP consortium representative,

Director of Public Health, Director of Adult Social Care, Director of Children's Social Care, local authority elected member, Healthwatch representative.

1(d) Foundation Trusts

The AOF confirms that all NHS trusts must become Foundation Trusts by 2014.

2 Commissioning Community Services

By April 2011 all PCTs must have separated their commissioning activities from any 'provider arm' community services (this is not directly relevant to Brighton & Hove, as NHS Brighton & Hove has never provided services directly).

During 2011-12 PCTs are expected to promote the "Any Willing Provider" policy, encouraging a range of providers to participate in community healthcare services. Particular attention should be provided to encouraging social enterprises and the voluntary and community sectors.

3 Pay and Reward

The AOF confirms that there will be a general pay freeze for NHS staff from 2011-13. The DH is also actively negotiating with unions over plans to freeze pay increments across the same period, with savings used to mitigate the impact of redundancies.

4 Transparency and Accountability

The NHS will begin publishing an Outcomes Framework in 2011. This will set out the NHS plans for service improvement in terms of specific outcomes measures, and will become the main tool to measure improvements within NHS-funded healthcare.

Patient experience and feedback will also be prioritised, with PCTs and GP commissioners encouraged to engage with patients and use patient-recorded information to inform commissioning decisions.

5 Choice

From April 2011, patients will be offered a greater degree of choice in their treatment, including a wider choice of diagnostic options and the choice of a named consultant-led team to carry out procedures. People with long term conditions should also be offered more involvement in the management of their conditions.

"Any Willing Provider" – e.g. the ability for patients to choose any healthcare provider willing to operate within NHS tariffs and at NHS quality – will be phased in, starting with community care.

Patients will be able to choose to register with any GP practice (providing it has spaces on its list) from April 2012.

6 QUIPP

The current commitment to finding £15-20 billion savings via the QUIPP programme is reiterated in the AOF, but the time-frame has been relaxed somewhat – savings must now be found over four rather than three years.

7 Key New Commitments

The AOF makes a number of commitments to improve particular aspects of NHS services. These include:

7(a) **Health Visitor Services** - increasing the number of health visitors and changing the way in which they are utilised.

7(b) **Family Nurse Partnerships** - providing dedicated support for teenage mothers and their families via expanding the current family nurse initiative.

7(c) **Cancer Drugs Fund** - £200 million p.a. to help buy cancer treatments recommended by doctors.

7(d) **Military and Veterans' Health** – ensuring that good quality services are available, particularly in terms of prosthetics and mental health. Also ensuring that NHS organisations support staff with commitments as reservists.

7(e) **Autism** – ensuring that the NHS acts in accordance with the 2009 Autism Act guidance (to be published in 2011).

7(f) **Dementia** – improving services, particularly in terms of: early diagnosis and intervention, better care in general hospitals, care homes, and reduced use of antipsychotic medications. Better co-ordination between health and social care via S75 agreements.

7(g) **Support for Carers** – better support, particularly in terms of: early identification of carers, supporting carers to fulfil their educational and employment potential, personalised support for carers, looking after carers' physical and mental wellbeing.

7(h) **Maintaining Quality Improvements** – ensuring that achievements in reducing waiting times (e.g. 4 hour wait for A&E, 18 week wait for planned treatment) are not lost as the NHS moves from a process target culture to one focused on outcomes.

7(i) **A&E Services** – general improvement across a range of indicators.

7(j) **Ambulance Services** – general improvement across a range of indicators.

7(k) **Mixed Sex Accommodation** – working to implement the programme to eliminate mixed sex accommodation in hospitals.

7(l) **End of Life Care** – continuing to implement the End of Life Care strategy.

7(m) **Cancer Care** – working to improve access to diagnostics and to improve the efficacy of radiotherapy; better data collection re: survival rates.

7(n) **Stroke** – implementing the stroke strategy, particularly in terms of improving prevention; acute care at the point of admittance (i.e. ensuring that those patients who would benefit from thrombolysis receive it); long term care/re-ablement.

7(o) **Mental Health** – better integration of mental and general health services; improved early intervention in MH (with targeting of 'at risk' groups such as offenders); reducing hospital admissions and length of stay via improved community services; (subject to consultation) introducing "Any Willing Provider" to MH services; expanding the "Improving Access to Psychological Therapies" programme.

7(p) **Safeguarding Children** – implementation of the Munro Review (to be published spring 2011.

7(q) **Dentistry** – working to improve access to dental services and to develop children's services.

8 Areas for Improvement

The AOF identifies a number of areas in which NHS services urgently need to be improved. these include:

8(a) **Healthcare for Learning Disabled People** – improving services, with particular focus on: staff making reasonable adjustments for LD patients, involving LD people in making decisions about their care; providing annual health checks for LD people.

8(b) **Children and Young People's Health** – with particular attention to transition services; CAMHS; palliative care; disabled children; children in care and families with multiple problems.

8(c) **Diabetes** – better screening; improved patient information; better management of diabetes in-patient services.

8(d) **Sharing Non-Confidential Information to Tackle Violence** – initiative for A&E services to collect and share data on violent incidents resulting

in hospital attendance with local Community Safety Partnerships. (This is essentially a national roll-out of the 'Cardiff' pilot on reducing alcohol-related harm. The recently completed BHCC intelligent commissioning pilot on alcohol also recommended adopting this initiative.)

8(e) **Violence Against Women and Girls** – ensuring that the NHS has effective systems for identifying women and girls who have experienced violence or abuse (e.g. domestic abuse) when they present for healthcare treatments and that appropriate pathways are in place to guarantee that they receive the help they need.

8(f) **Regional Trauma Networks** – implementing regional trauma networks (locally the Royal Sussex County Hospital is to become the SE region trauma centre as part of the '3T' programme)

8(g) **Respiratory Disease** – particular focus on earlier diagnosis of COPD (chronic obstructive pulmonary disease).

9 Other Areas of Importance

The AOF also identifies other areas as being of importance. These include:

- managing the transfer of public health responsibilities from PCTs to local authorities;
- improving pharmacy services; improving emergency preparedness and resilience;
- promoting physical activity for children and adults; better screening for major illnesses (heart disease, diabetes, stroke, kidney disease);
- better abdominal aortic aneurysm screening;
- and a focus on improving care for and reducing the incidence of fragility fractures (particularly in older women).

10 Finance

GP consortia will not inherit historic PCT debt - i.e. debt incurred prior to 2011-12. However, consortia will be responsible for debts accrued after this date, and so will be expected to work with PCTs to minimise the risk of budget deficits during the transition period.

There will be a 45% reduction in the costs of NHS management (i.e. PCTs and SHAs) by 2014-15. At the same time as these reductions are being implemented, PCTs and SHAs will need to realise reductions in order to fund the establishment of GP consortia managerial/administrative and commissioning support (which will eventually be funded at a rate of £25-35 per head of population).

Capital funding for NHS projects has been reduced, although not drastically so. Urgent maintenance spending should be prioritised, as should short term capital investment likely to realise significant medium term savings.

11 Social Care

There is approximately £1 billion in the NHS budget to be passed over to local authority social care services. Some of this funding is specifically for re-ablement, but the bulk can be spent on general social care investment. Spending plans must be jointly agreed by PCTs and local authorities.

12 Tariff

The AOF announces a number of changes to the NHS tariff system. Some of the more noteworthy include:

- A reduction in tariff price of 1.5% for 2011-12 (e.g. providers working to tariff will be paid 1.5% less than in 2010-11).

- In 2011-12, hospitals will not be reimbursed for the costs of treatment for patients who have emergency re-admissions within 30 days of being discharged following an elective admission. This measure is designed to incentivise acute providers to ensure that they do not discharge patients inappropriately. Payment for re-admissions within 30 days following other discharges (i.e. discharges after unplanned admissions) is to be negotiated locally, with the intention of reducing re-admissions by 25%.

- In 2011-12 the DH will pilot initiatives to increase specific tariffs to include payment for a period of re-ablement following hospital discharge.

- Extension of tariff scheme to include elements of treatment for long term conditions, community services, mental health care etc.

- Continuation of 30% marginal tariff rate initiative for emergency admissions above agreed baseline (i.e. hospitals are only paid 30% of tariff for every emergency admission beyond an agreed annual baseline rate). This initiative is intended to encourage acute providers to manage emergency admissions effectively.

- ‘Never-events’ (e.g. catastrophic failures in care which should never have been allowed to happen) will no longer be reimbursed by commissioners.

- In 2011-12, and for the first time, providers will be able to offer services to commissioners at less than the published tariff rate. This is potentially significant, as tariffs were introduced, in part, to ensure that competition within the NHS internal market was focused on quality rather than price. Currently, providers in the tariff-controlled market (i.e. mainly planned hospital care) cannot offer their services at anything

other than the tariff rate - the fear presumably being that price competition would drive down quality.

The bar on price competition may also have had the effect (although perhaps not the intention) of limiting the penetration of core NHS markets by the independent sector. New entrants into any market will typically struggle to gain business based on their reputation for quality, as they have no local reputation to rely upon, in contrast to existing providers. Therefore unless the existing provision is clearly sub-standard or lacks the capacity to cope with demand, new entrants to the market need to compete on price. By barring price competition, the tariff system has effectively discouraged the independent sector from competing with existing NHS providers – given the costs associated with establishing health infrastructure, relatively few providers are likely to gamble that commissioners will refer into their services if they have no levers to ensure they can compete with existing providers.

It is unclear whether the radical implications of this change in the tariff rules were intended – this is a measure published in the 'small print' of the AOF rather than a headline initiative. Nonetheless, it has created considerable interest.

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1 February 2011

Cluster PCT leadership arrangements

Many of you will be aware that as the NHS Operating Framework for 2011/12 and Sir David Nicholson's latest letter to the NHS about transition from the current NHS system to the new ways of working signalled, we are now moving towards a cluster arrangement for primary care trusts across our region.

The purpose of this is to build in resilience for the next couple of years, focusing on securing great quality, financial and other performance outcomes. We also need to build commissioning expertise and support for emerging general practice commissioning consortia, and accelerate effective joint arrangements with local authorities system as quickly as possible.

In practice the cluster arrangement means there will be a single primary care trust (PCT) chief executive and just one primary care trust executive team for each county in the South East Coast region (which covers Sussex, Kent and Surrey).

Following a robust process, we are pleased to let you know that Amanda Fadero has been appointed to lead the cluster in Sussex as the designate Chief Executive and accountable officer for all the constituent county PCTs in this area (ie NHS Brighton and Hove, NHS West Sussex, NHS East Sussex Downs and Weald, and NHS Hastings and Rother).

We are also pleased to let you know that Ann Sutton has been appointed as the designate Chief Executive for Kent (encompassing NHS Eastern and Coastal Kent, NHS West Kent, and NHS Medway).

You may be aware that NHS Surrey operates as a single PCT across the county and therefore already matches the county cluster arrangement. The recently appointed PCT

Interim Chair: Denise Stokoe
Chief Executive: Amanda Fadero

NHS Brighton and Hove is the working name of
Brighton and Hove City Teaching Primary Care Trust.

chief executive, Anne Walker, is confirmed as the chief executive to lead Surrey through the transition period.

Feedback from the appointments panel (which comprised the Strategic Health Authority chief executive and deputy chief executive, primary care trust chairs, local authority, NHS trust and GP leaders from the region) was that they believed they were 'spoilt for choice' in terms of impressive, able and committed existing chief executives from each of our PCTs.

We would like to take this opportunity to pay tribute to the sterling leadership John Wilderspin has given in West Sussex and Mike Wood has given in East Sussex over recent years. We are confident that the new leadership arrangements will build on the successes and foundations they have put in place, as well as continuing to make improvements in Brighton and Hove, in delivering the next phase of better health and care for our residents across Sussex.

The precise date of handing over accountable officer responsibilities is yet to be agreed, but will be in place by 1 April 2011. Amanda is now considering the cluster executive team arrangements. Importantly, we will also be working with the strategic health authority to develop simple but effective governance arrangements and to determine the board governance approach for Chairs and Non Executive Directors. Our aim is to create the environment for success for patients, citizens and staff as we head towards the reformed health and social care system to local needs and priorities.

We will of course keep you updated with progress on this over the coming weeks, and look forward to continuing to work with you to deliver better health and care for the people of Sussex.

Yours faithfully

Norman Robson
Chair
NHS West Sussex

Denise Stokoe
Chair
NHS Brighton and Hove

Charles Everett
Chair
NHS East Sussex Downs and Weald and NHS Hastings and Rother

Interim Chair: Denise Stokoe
Chief Executive: Amanda Fadero

NHS Brighton and Hove is the working name of
Brighton and Hove City Teaching Primary Care Trust.

HOSC Work Programme 2009/2011

Issue	Date to be considered	Referred/Requested By?	Reason for Referral	Progress and Date	Notes
Dental Services	02 December 2009	HOSC (March 09)	Update requested re: outstanding performance issues	Report 02 Dec 09	Further update required in 6/12 months
Mental Health – commissioning and provision	02 December 2009	SPFT/NHSBH	Brief HOSC members on major reconfiguration of Sussex MH services – presentation by SPFT; paper from NHSBH	Report 02 Dec 09	SPFT will bring their options for consultation back to a later meeting (Jan 2010)
Health Inequalities	02 December 2009	Audit Committee	Referred from Sep 09 Audit Committee	Report 02 Dec 09	Referred to OSC
NHS Brighton & Hove Strategic Commissioning Plan	02 December 2009	NHS BH	Update of PCT's commissioning intentions	Report 02 Dec 09	

Issue	Date to be considered	Referred By?	Reason for Referral	Progress and Date	Notes
LINk Update	27 January 2010	HOSC	Regular HOSC item		Postponed from 02 Dec at request of LINk
Annual Health Check Report Back	02 December 2009	HOSC	Report for information on 08/09 Healthcare Commission performance scores for local NHS trusts	Report 02 Dec 09	
3T Progress Report/Transfer of RSCH acute services to community settings	27 January 2010	BSUHT/Cllrs Mitchell and Turton	Update on progress re: the redevelopment of the RSCH site		Item to include the issue of transferring acute services into community settings
Immunisation/Vaccination	10 March 2010	Cllr Kitcat	Report on city vaccination rates compared to national/regional rates	Moved from Jan 2010	
Breast Cancer Screening	10 March 2010	HOSC	Update on screening services (following recent underperformance)	Moved from Jan 2010	
South Downs Health Trust Integration with West (and East) Sussex Community Services	27 January 2010	SDH	Update on plans to integrate SDH with community provider arms of WSPCT and (potentially) ES PCTs		

Issue	**Date to be considered**	**Referred By?**	**Reason for Referral**	**Progress and Date**	**Notes**
Better By Design	27 January 2010	SPFT	SPFT presenting reconfiguration options to HOSC		Public consultation delayed until summer
Alcohol Related Hospital Admissions	10 March 2010	HOSC	Examine red LAA indicator with view to setting up an ad hoc panel	Referred to OSC	Agreed by OSC – Select Committee to be formed
Car Park Charges at NHS trusts	10 March 2010	Cllr Peltzer Dunn	Examine local (acute) trust policy for visitor car parking at hospital sites		
BSUHT emergency planning	2010	Cllr McCaffery	Examine BSUH planning for acute care in emergencies	July 14 2010	
Sussex Orthopaedic Treatment Centre Update	2010	HOSC	Update on SOTC performance (as some performance issues remained unresolved following last meeting in Nov 08)	July 14 2010	
Transfers of Care	2010	Cllr McCaffery	Examine delays in transferring patients out of acute care	Septemb er 2010	

Issue	Date to be considered	Referred By?	Reason for Referral	Progress and Date	Notes
Swine Flu	2010	HOSC/Cllr McCaffery	Determine lessons to be learnt from swine flu pandemic, including maintaining acute care provision in an outbreak	post May 2010	
Fit For the Future	2010	Joint HOSC	Final results of the Joint HOSC on reconfiguration of West Sussex acute care	post May 2010	
Ad Hoc Panel on GP-Led Health Centre	July 2010	HOSC	12 monthly update on the GP-Led Health Centre (to incorporate report on how the PCT ensures the commercial competitiveness of local health care providers)	July 2010	
Older People in Hospital	Sep 2010	Cllrs McCaffery and Barnett	Report on acute care provision for older people	Septemb er 2010	Report on nutrition at RSCH (LINk and BSUHT)
Older People's Mental Health Care	Sep 2010	Cllr Barnett	Report on nursing (EMI) provision for older people	Septemb er 2010	Covered by select Committee on Dementia? (report for information to Sep 10 HOSC)

Issue	Date to be considered	Referred By?	Reason for Referral	Progress and Date	Notes
Patient Experience/Measuring Outcomes	Dec 2010	BSUHT/NHS BH	Report on how NHS organisations are increasingly focusing on patient experience, and on measuring outcomes rather than processes	Report covering PCT and BSUHT at Dec meeting; other trusts and GPs to come to subsequent meetings	
Community Mental Health Services	Dec 2010	Cllr Meadows	Examine how the NHS policy of providing MH services in the community whenever possible impacts upon other services (e.g. police, housing, ASC) and how any costs/risks are shared by partners		Examined by ASCHOSC

Issue	Date to be considered	Referred By?	Reason for Referral	Progress and Date	Notes
Health Visitors, Midwives and Breast Feeding	Dec 2010	Cllr McCaffery	Examine breast feeding uptake and effectiveness of the integration of pre, peri and post natal services	Postponed until 2011 as BSUHT currently recruiting a new Head of Midwifery	
DoH consultations on 'patient choice' and 'information'	Dec 2010	SHA/DoH	Briefing for members on current white paper consultations		
South East Coast Ambulance Service: update	Dec 2010	SECamb	Update from SECamb on recent activities/future plans		
BHLINk 6 monthly update	Dec 2010	HOSC	Regular update from BHLINk and LINk host contract manager		
GP services	Feb 2011	HOSC working group on AOP	Variations in performance across the city and development of specialisms across the city GP 'pool'		
Dental Care	April 2011	HOSC working group on AOP	General performance and provision for children with special needs and their siblings		
Mental Health	April 2011	HOSC working group on AOP	Waiting times for psychological therapies; suicide; dementia		