Brighton & Hove City Council

Health Overview & Scrutiny Committee

Title:	**Health Overview & Scrutiny Committee**
Date:	**28 February 2018**
Time:	**4.00pm**
Venue	**Hove Town Hall, Council Chamber - Hove Town Hall**
Members:	**Councillors:** K Norman (Chair), Allen, Bennett, Bewick, Deane, Gilbey, Greenbaum, Morris, A Norman and Wealls **Co-opted Members:** Zac Capewell (Youth Council), Caroline Ridley (Community Sector Representative), Fran McCabe (Healthwatch), Colin Vincent (Older People's Council)
Contact:	**Giles Rossington** Senior Policy, Partnerships & Scrutiny Officer 01273 295514 giles.rossington@brighton-hove.gov.uk

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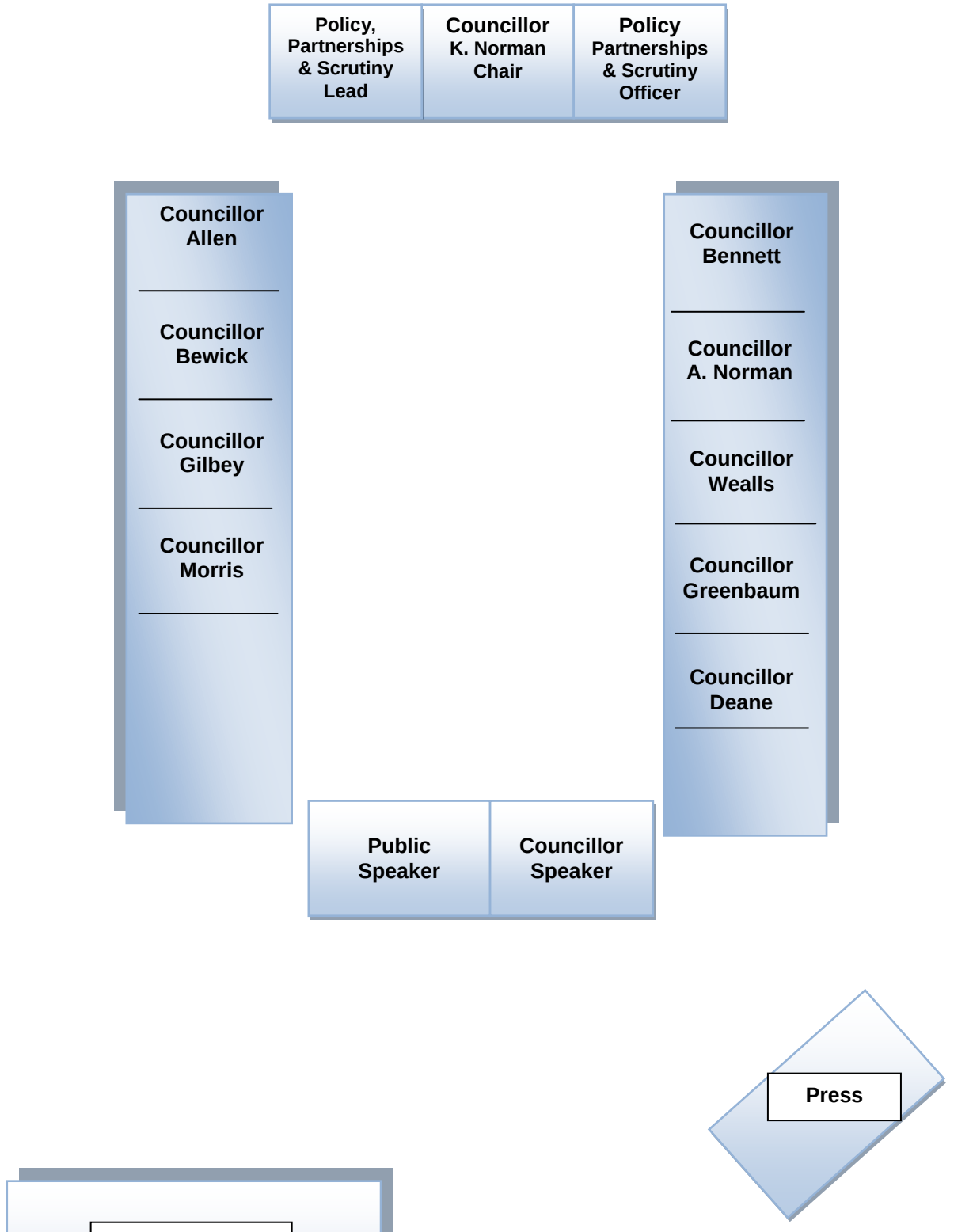
Democratic Services: Health Overview & Scrutiny Committee



AGENDA

PART ONE **Page**

36 PROCEDURAL BUSINESS

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

(b) **Declarations of Interest:**

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

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

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

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

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

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

37 MINUTES **1 - 18**

To consider the minutes of the last meeting held on the 06 December 2017.

38 CHAIRS COMMUNICATIONS

39 PUBLIC INVOLVEMENT 19 - 20

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

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

40 MEMBER INVOLVEMENT

To consider the following matters raised by councillors:

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

41 PATIENT TRANSPORT SERVICES (PTS) HEALTHWATCH REPORT 21 - 42

Healthwatch Brighton & Hove will present their report on performance of the new Sussex PTS provider, Southern Central Ambulance Service NHS Foundation Trust (SCAS) (copy attached)

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

42 PATIENT TRANSPORT SERVICES (PTS): FEBRUARY 2018 UPDATE 43 - 48

Update on Patient Transport Services performance from High Weald Lewes Havens CCG (copy attached)

Contact Officer: *Nuala Friedman*
Ward Affected: *All Wards*

43 CLINICALLY EFFECTIVE COMMISSIONING (CEC): FEBRUARY 2018 UPDATE 49 - 54

Brighton & Hove CCG will present an update on the Clinically Effective commissioning initiative (copy attached).

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

OVERVIEW & SCRUTINY COMMITTEE

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For further details and general enquiries about this meeting contact Giles Rossington, (01273 295514, email giles.rossington@brighton-hove.gov.uk) or email democratic.services@brighton-hove.gov.uk

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Date of Publication - Tuesday, 20 February 2018

BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00pm 6 DECEMBER 2017

HOVE TOWN HALL, COUNCIL CHAMBER - HOVE TOWN HALL

MINUTES

Present: Councillor K Norman (Chair)

Also in attendance: Councillor Allen, Bennett, Bewick, Deane, Gilbey, Greenbaum, Morris, A Norman and Wealls

Other Members present: Zac Capewll (Youth Council), Colin Vincent (Older People's Council), Fran McCabe (Healthwatch), Jo Ivens (Community & Voluntary Sector)

PART ONE

24 APOLOGIES AND DECLARATIONS OF INTEREST

24.1 Jo Ivens attended the meeting as substitute for Caroline Ridley, Community & Voluntary Sector co-optee.

24.2 There were no declarations of interest.

24.3 It was agreed that the press & public be not excluded from the meeting.

25 MINUTES

25.1 Cllr Allen queried whether additional information on the social care precept had been circulated to members as promised at point 18.5 in the September 2017 HOSC minutes. It was confirmed that this had taken place.

25.2 In response to a question from Cllr Allen relating to point 18.8 in the minutes, the scrutiny support officer confirmed that the Executive Director for Health and Adult Social Care had been briefed at the HOSC pre-meeting that his presentation to the HOSC should not focus on financial performance.

25.3 RESOLVED – that the minutes of the 06 September 2017 HOSC meeting be approved as an accurate record.

26 CHAIRS COMMUNICATIONS

26.1 The Chair welcomed everyone to the meeting and informed members that he would be taking item 32 NHS 111 tender as the first substantive item of business.

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27 PUBLIC INVOLVEMENT

27.1 Public Question from Linda Miller

27.1(a) The following question was asked by Ms Linda Miller:

"What data is HOSC keeping?

Do you have accurate data for:

- A&E waiting times?
- 62-day target of being seen for cancer?
- 18-week target for surgery?
- How many hospital beds per 1000 in Brighton and Hove?
- How many beds per 1000 for mental health patients?
- The current population of Brighton and Hove?
- How much was the CCG budget for 2016-17? How much is the budget for 2017-18?

The CCG, via their Big Conversation events, claim to be improving A&E, cancer care and mental health. We need to know that accurate records are being kept, that every 3 months this data will be compared with the previous period, and whether the services are improving or getting worse will be published.

If the Health Overview and Scrutiny Committee isn't keeping accurate records how will we know if things are improving or getting worse? How will HOSC hold the CCG to account?"

27.1(b) The Chair responded: "Thank you for your question. The HOSC does not itself gather and record data, but it works closely with NHS bodies to understand and monitor performance. For example, Sussex HOSCs meet regularly with Brighton & Sussex University Hospitals Trust to examine the trust's quality and performance and improvement data. This includes data on A&E waiting times, cancer targets and the 18 week referral to treatment target.

The HOSC holds similar meetings with Sussex Partnership Trust and with South East Coast Ambulance Trust. The minutes from these meetings are included for information in the HOSC papers. Performance data is also regularly published in the trust board papers which are available on their websites. The CCG publishes extensive financial data, including annual budget figures on its website."

Additional written information was also provided in response to this question:

What data is HOSC keeping?

Do you have accurate data for:

A&E waiting times?

62-day target of being seen for cancer?

18-week target for surgery?

The performance datasets referred to (A&E, cancer care and planned care) are published nationally on a monthly/quarterly basis (available here: NHS Stats). This is supplemented by additional local data sets, audits etc. The data sets are subject to regular scrutiny challenge and validation using the CCG governance structure, system AE delivery and planned care and cancer boards. Regular reporting and challenge is also done by NHSE England. (And as detailed in the verbal response to the question, Sussex HOSCs regularly meet with provide trusts to challenge performance and quality data.)

How many hospital beds per 1000 in Brighton and Hove?

How many beds per 1000 for mental health patients?

There is no simple way of determining this as people are free to choose where to access NHS services: some of the hospital beds in Brighton & Hove will currently be occupied by people who do not live in the city; and some local residents will be in hospital beds outside the city.

In addition, hospitals offer differing mixes of 'standard' and specialist services. Specialist hospital beds will typically draw on a regional rather than a local catchment.

Furthermore, NHS trusts may use their resources in specific ways which mean that Brighton & Hove patients requiring certain services are treated outside the city whilst non-residents are treated here. For example Brighton & Sussex University Hospitals Trust operates services across the Royal Sussex County Hospital and the Princess Royal Hospital, Hayward's Heath. Some services are provided jointly for the populations of Brighton & Hove and Mid Sussex at only one location.

By way of context, provider bed numbers can be accessed via links below:
BSUH
https://www.bsuh.nhs.uk/wp-content/uploads/sites/5/2016/08/BSUH-Quality-Account-2015-16.pdf The trust has a total of 1,069 beds spread across various core services: • 484 Medical beds (438 Inpatient, 46 day case) • 360 Surgical beds (338 Inpatient, 22 day case) • 105 Children's beds (79 Inpatient, 26 day case) • 79 Maternity beds (79 Inpatient, 0 day case) • 41 Critical Care beds (41 Inpatient, 0 case) • 25 A&E beds

SPFT https://www.cqc.org.uk/sites/default/files/new_reports/AAAC1746.pdf the trust has 657 beds.

A crude ratio of hospital beds to population could be calculated by dividing the total number of beds by the local population. However, this figure would not be accurate, for the reasons outlined above. Moreover, it would not be a useful way of comparing local facilities with those in other areas, because a meaningful comparison would need to take account of patient flow and of the specific ratio of acute/specialist beds in each area.

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The current population of Brighton and Hove?

This is estimated at 273,000

How much was the CCG budget for 2016-17? How much is the budget for 2017-18?

CCG Annual Report 16/17: 367M and 413.59M for 17/18

The CCG, via their Big Conversation events, claim to be improving A&E, cancer care and mental health. We need to know that accurate records are being kept, that every 3 months this data will be compared with the previous period, and whether the services are improving or getting worse will be published.

Performance data is regularly reported to the CCG Governing Body https://www.brightonandhoveccg.nhs.uk/publications/our-governing-body/governing-body-papers

27.1(c) Ms Miller asked a supplementary question querying what the HOSC does with NHS performance data to hold local NHS bodies to account. The Chair agreed to provide a written answer to this question. The following response was subsequently forwarded to Ms Miller:

What does the HOSC do with performance data to hold the NHS to account?
Brighton & Hove HOSC works closely with neighbouring HOSCs to hold NHS providers across the region to account for their performance. Given the very limited resources available to health scrutiny, HOSCs prioritise the NHS trusts whose performance gives most cause for concern: i.e. trusts that have been rates as *Requires Improvement* or *Inadequate* by the Care Quality Commission (CQC).

Brighton & Hove, East Sussex and West Sussex HOSCs meet regularly with Brighton & Sussex University Hospitals Trust (BSUH) to discuss trust quality improvement and performance data.
Brighton & Hove, East Sussex, West Sussex, Surrey, Kent and Medway HOSCs meet regularly with South Coast Ambulance NHS Foundation Trust (SECAmb) to discuss quality improvement and performance.

Minutes from both of these meetings are regularly included in HOSC papers.

Brighton & Hove, West Sussex and East Sussex HOSCs also meet regularly with Sussex Partnership NHS Foundation Trust (SPFT) to discuss trust development plans. Performance is discussed at these meetings when there is a specific concern. However, SPFT is rated as *Good* by the CQC so there is less concern about its performance at the current time.

Brighton & Hove, West Sussex, East Sussex, Surrey, Kent and Medway HOSC Chairs also meet regularly with NHS England, NHS Improvement and the Care Quality

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Commission to discuss emerging issues of quality and performance across the South East region.

It should however be noted that the principle accountabilities of NHS providers are to their commissioners (CCGs) and their regulators (NHSi and the CQC). Whilst HOSCs do have a role to play in performance, particularly in terms of alerting the regulators to instances of poor performance which they may be unaware of, this role is a limited one

27.2 Public Question from Christopher Tredgold

27.2(a) The following question was asked by Dr Tredgold:

"At the last HOSC meeting it was stated that the eight Brighton and Hove GP practices that had by then closed were mostly small ones and that it was the total number of General Practitioners, rather than the number of practices, that was important.

I think both are important. Patients, especially as they get older, don't want to travel a long distance to see their GP.

As for total numbers, the CCG has told me that Brighton and Hove have only 1 Full Time Equivalent GP per 2300 patients against a national average of 1 per 1800/1900.

I would like to know if and how this shortage impacts on the quality of care GP in Brighton and Hove is providing and how that is measured?"

27.2(b) The Chair responded: "Thank you for your question. As we have an item on GP sustainability on today's agenda, and as information provided by the CCG for this item explicitly addresses the issue of local GP to patient ratios, I will be sure to ask about how this low level of GPs impacts upon patient care. I am sure that other members will bear your question in mind also."

27.3 Public Question from Tony Graham

27.3(a) Mr Graham asked the following question:

"In the Council's Policy, Resources & Growth Committee Minutes (from 12th Oct 17, Agenda Item 48, Section 6.15) reference is made to Health & Social Care Integration Plans supporting... *'all our key principles; Public accountability, Citizen focussed, Increasing equality and Active citizenship (sic)'.* Later on, Appendix 3 of this Agenda Item referring to the 'Cross Party Health and Social Care Integration Working Group' includes the following:
"Papers and minutes of each meeting will be issued within seven days before subsequent meetings and will be confidential; Members will decide at the end of the meeting those items which may be discussed more widely."

In the light of the Council's key principles, will HOSC commit to securing the removal of the confidentiality requirement drawn up for the Cross Party Health and Social Care Integration Working Group? If not, please will HOSC explain why exactly such secrecy is seen as necessary?"

27.3(b) The Chair replied: "Thank you for your question. The council is committed to transparency and operates a committee system which ensures that as many decisions as possible are taken in public.

However, neither the council nor any other public body could reasonably commit to holding every planning, scoping and preparatory meeting in public or making the notes of those meetings publicly available. In the early stages of a project it is particularly important that information can be shared and ideas developed in an informal and confidential space.

As health and social care integration progresses there will be regular reports in public, as there have been to date – to wit the reports to Policy, Resources & Growth Committee in July and in October 2017."

27.3(c) Mr Graham asked a supplementary question: "Do Councillor Members of HOSC have a red line in relation to the possible development of an Accountable Care Organisation for this area? (I ask this where such an ACO is envisaged as having one or more commercial organisations as key players with capitation-set budgets, and where they are without meaningful democratic accountability to the electorate.) As the question was addressed to individual members, it was forwarded to them to respond to individually if they so chose.

27.4 Public Question from Valerie Mainstone

27.4(a) Ms Mainstone asked the following question:

"Will the Health Overview and Scrutiny Committee please scrutinise the Patient Transport Service with all possible speed?
My personal experiences (which have been circulated to members separately) demonstrate that PTS is close to breakdown, and that its management is lamentable. Valuable human and material resources are being wasted at huge public expense every day, while PTS staff and patients are completely frustrated."

27.4(b) The Chair responded: "Thank you for your question. Your original question included lots of information about the problems you have encountered with the patient transport service. This has been circulated to members, and I'm sure everyone shares my concerns about your experiences.

However, the HOSC is barred from considering individual cases or complaints, so we haven't included this information in the papers for today's meeting.

We do have concerns about PTS services and were already planning to have a report on patient transport at the next HOSC meeting. I have also asked Healthwatch to present their findings on PTS at this meeting."

27.4(c) Ms Mainstone noted that she was concerned with the time taken to scrutinise patient transport services. Fran McCabe told members that the Healthwatch report on PTS will be published before the next HOSC meeting and will be available on the Healthwatch website.

28 MEMBER INVOLVEMENT

28(b) Written Questions from Members

28.1 Cllr Greenbaum asked the following question:

"Having noted the CCG's response to HOSC questions about STP project costs (point 13.1 in the minutes to the 06 September 2017 HOSC meeting), I would like to know more about these costs. Specifically:

- How do these costs compare with those of comparably-sized STPs?
- What specifically have the contracts been awarded for, i.e. what was the brief?
- And are the consultants' reports publicly available?"

28.2 The Chair responded: "Thank you for your question. I'm sure that we have all noted the STP expenditure on consultants and would be interested to know more about what has been delivered for the money. I will therefore pass your questions on to the CCG. The answers will be circulated to members and included in the papers of the next HOSC meeting."

28.3 A response was subsequently received from the CCG and is included here (additional information is on p15):

How do these costs compare with those of comparably-sized STPs?

Comparative costs of STP's are not routinely available and given the wide variation in geographic size, population base, relative complexity of health systems covered and differing pace of development within each STP, any direct comparison would be difficult.

· What specifically have the contracts been awarded for, i.e. what was the brief?

The **attached spreadsheet** gives details of the agreed deliverables and description for the contracts. (This spreadsheet is attached to the February 2018 HOSC paper for information.)

· And are the consultants' reports publicly available?"

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STP Programme Board meeting agendas, papers and minutes are linked below on the Brighton and Hove CCG web page. The deliverables from the consultants' reports informed and contributed to the reports presented to the Programme Board. In some cases reports are published in full.

https://www.brightonandhoveccg.nhs.uk/publications/plans-priorities-and-progress/plans/sustainability-and-transformation-partnership

29 MENTAL HEALTH: UPDATE FROM SUSSEX PARTNERSHIP NHS FOUNDATION TRUST (SPFT)

29.1 This item was introduced by Samantha Allen, SPFT Chief Executive, and by John Child, SPFT Service Director, Brighton & Hove.

29.2 Sam Allen told members that she has now been in post for around 10 months. This has been a very busy time, with the development of the STP mental health work-stream and of the trust's clinical Strategy. There is a clear need to change the way that mental health services are delivered, in order to meet rising demand and ensure that there are no gaps in services. There needs to be an increased focus on crisis services and also on prevention and early intervention, particularly for younger people experiencing mental health problems. There are also severe pressures on acute beds, in part due to delayed transfers of care as suitable supported accommodation may not be available.

29.3 Changes to the rules governing Section 136 (the section of the mental health act that allows the police to detain people who may be suffering mental health episodes for assessment) mean that people now have to receive assessments in 24 hours (previously 72) and that people should no longer be detained in police custody whilst waiting for assessment. These are necessary changes, but they present a challenge to services.

29.4 John Child told the committee that plans to improve city dementia services by providing single-sex acute facilities were progressing, with the refurbished ward due to be opened at Mill View in the new year. HOSC members would be welcome to attend the ward opening.

29.5 Cllr Allen commented that he was disappointed that the report was so general. It would have been helpful if there was a greater focus on Brighton & Hove. This was echoed by other members. Ms Allen responded that the trust's brief had been to give a general overview of service developments, which the report does provide. If members require more detailed briefing on specific service areas, the trust will be happy to provide this.

29.6 In response to a question from Cllr Allen about a lack of mention about mental health services for younger people in the STP mental health report, Ms Allen assured members that the STP plans do focus on youth services. The trust would be happy to discuss detailed plans for Child & Adolescent Mental Health Services with the HOSC.

29.7 In answer to a question from Cllr Deane on funding for preventative/early intervention services, Ms Allen told members that there was very strong evidence for the effectiveness of

early intervention (e.g. the Early Intervention in Psychosis initiative), so it should be possible to develop strong business cases for funding. Mental health is a Government priority and there has already been significant investment locally (for example in perinatal mental health care).

29.8 In response to a question from Cllr Deane on mental healthcare in the penal system, Ms Allen confirmed that SPFT provides services to HMP Lewes and Ford. The trust is also one of the national pilot areas for a criminal justice liaison service which seeks to divert people with mental health problems from prison.

29.9 In response to a question from Cllr Bewick about demographic data, Ms Allen told members that the trust publishes performance data at local level. This can be shared with the HOSC. Mr Child added that the statistics about mortality of people with severe and enduring mental health conditions were particularly stark and clearly needed to be addressed.

30 BRIGHTON & HOVE CARING TOGETHER, CCG ALLIANCE AND NHS & SOCIAL CARE INTEGRATION UPDATE

30.1 This item was introduced by Dr David Supple, Chair of Brighton & Hove CCG; and by Rob Persey, BHCC Executive Director, Health & Adult Social Care.

CCG Alliance

30.2 Dr Supple explained that the alliance represents the coalescing of four Sussex CCGs (Brighton & Hove, High Weald Lewes Havens, Horsham & Mid Sussex, and Crawley), which will formally take place in January 2018. CCGs are coming together in this way across the country and it seems likely that those that do not jump will end up being pushed into closer working arrangements. The changes make sense in terms of realising efficiencies via unified back-office teams and scaled-up commissioning; and also in terms of the creation of a local Accountable Care System (ACS). The move will also ease workforce pressures as the new model should hopefully prove easier to recruit to.

30.3 Cllr Allen commented that, whilst he could see how the alliance could potentially save money by commissioning on a larger scale, the savings are nothing like those required to be made locally in order to meet national NHS targets. The CCG needs to start talking frankly about the kinds of service changes that will be required to meet these targets. Dr Supple agreed that there are difficult decisions to be made – for example, via the Clinically Effective Commissioning initiative. To date decisions have been limited to changing thresholds for referral or intervention, rather than decommissioning services.

30.4 In response to a question from Fran McCabe on who will be in charge of the alliance, Dr Supple told members that Adam Doyle will be the Accountable Officer across the four CCGs. A Managing Director for the south of the patch will provide additional managerial grip. Governance arrangements are a work in progress, and will be further developed in the coming months. However, individual CCGs will remain the accountable bodies.

30.5 In answer to a question from Ms McCabe on Accountable Care Organisations (ACO) and Accountable Care Systems (ACS), Dr Supple told the committees that ACOs are organisations that provide a wide range of health and care services for a defined population. ACOs are potentially incentivised to focus on prevention and early

intervention given the likely longer term financial benefits of this approach. The use of this model should significantly reduce commissioning and contracting costs. An ACS is a way of existing organisations working together to achieve similar outcomes. It is much quicker to set up than an ACO. Rob Persey noted that there has been no real local discussion of ACS to date and it is important that this happens so that we can reach agreement on what we mean locally by an ACS.

Brighton & Hove Caring Together (Cato) and Integration

30.6 Rob Persey explained that the local population is growing and is living longer, but unfortunately many people are living longer in poor rather than good health, with the prevalence of long Term Conditions (LTC) increasing. Services need to work differently to reduce and better manage demand. Prevention and early intervention will be key.

30.7 Dr Supple added that the NHS was not set up to deal with this level of LTC and will need to adapt to manage these new demands. Cato is intended to drive this change. There are five care programmes which each have a number of work-streams. These are currently being discussed with providers, with a report to the January 2018 Cato Programme Board outlining the next steps.

30.8 Integration of local NHS and social care services is an integral part of this. This will enable NHS commissioners to better influence the broader determinants of poor health such as housing. The council and the CCG will also work much more closely together to understand and utilise local date. The announcement of the CCG alliance complicates, but does not threaten to de-rail integration plans. Governance arrangements for the shadow year (April 18-19) leave the CCG and the council as separate organisations, and there is no pre-determined view on the ultimate governance model.

30.9 Commenting on the governance chart in the papers, Cllr Allen noted that an arrow was missing from HOSC to Full Council representing potential referrals. Mr Persey agreed that this should be included.

30.10 Jo Ivens asked whether the CCG and the council are sighted on the Early Action Commission work undertaken by Lambeth and Southwark councils. Mr Persey answered that they are aware of this work; the Public Health team is also working on a Prevention Framework.

30.11 In answer to a question from Colin Vincent on whether any areas had already integrated, Mr Persey told members that the furthest advanced area was probably Manchester. However, no area is there yet and there is no single template for integration. There is emerging best practice and we are using this to plan our approach.

31 GP SUSTAINABILITY: DECEMBER HOSC UPDATE

31.1 This item was introduced by Dr David Supple, Chair of Brighton & Hove CCG. Dr Supple outlined the state of local GP services, noting that there were issues with workforce, estates, the partnership model, and patient-mix in terms of the increasing prevalence of Long Term Conditions (LTC).

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31.2 However, it is not the case that all city GP practices are struggling. At a rough estimate, approximately 10 practices are reasonably comfortable/stable, another 10 are struggling, and the remainder are somewhere in the middle.

31.3 The CCG is working hard to support struggling practices, with a variety if interventions. In general, problems concern working conditions rather than practice income.

31.4 Dr Supple explained the graph on GP/patient ratios which were included in the papers, noting that there is some uncertainty about the figures as not all practices necessarily report this date and there is ambiguity about how the figure of whole time equivalent (wte) workers is calculated. Also, the graph does not take into account clinician skills-mix: a practice that has a relatively high GP/patient ratio may also have practice nurses, pharmacists etc. delivering high quality and timely services to patients. However, notwithstanding this, the figures are a clear cause for concern. Brighton & Hove Caring Together (Cato) will seek to address this problem, creating a more attractive environment for primary care, for example by instituting an emergency/LTC split which could see specific GPs providing continuity of care by working consistently with patients with LTCs whilst urgent calls are diverted to a more generic GP service.

31.5 The CCG is also beginning to amass better quality data about GPs – for example, around likely GP retirement dates. In addition, a local federation of GPs is being formed and this will be able to provide support to prospective GPs. For instance, the federation may be able to hold the leases to GP practices, reducing the risk to partners and allowing more GPs to opt for salaried employment. A federation may also be able to directly employ and support some staff (e.g. practice nurses) to work across several practices. It can be difficult for small practices to recruit to these roles since workers tend to prefer larger practices because they provide more opportunities for career progress. A federation could potentially also be in a position to step in and take over a practice in an emergency.

31.6 Cllr Greenbaum welcomed the report, but expressed concerns about CCG capacity to manage GP services, particularly in light of the CCG alliance plans. Dr Supple responded that the alliance should not result in there being fewer staff to commission services, but that the CCG is aware of this risk.

31.7 Fran McCabe also welcomed the paper, but wondered whether there was an issue of patient expectations exceeding the capacity of services. Dr Supple replied that patient expectations need to be taken seriously. For instance, if there is a genuine desire for extended opening times then this needs to be picked up.

31.8 RESOLVED – that the report be noted.

32 NHS 111 TENDER FOR NEW CONTRACT

32.1 This item was presented by Colin Simmons, 111 Programme Director.

32.2 Mr Simmons told members that recent developments include:

- Healthwatch has been engaged to contact hard to reach groups
- Soft market-testing events have now taken place

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- Services for callers requiring face-to-face contact have been revised so that 111 operatives can directly book appointments in the future with the new service

32.3 Procurement will begin in January 2018, with the contract award in July/August and a commencement date of April 2019. The major risks identified include: digital, clinical governance and workforce. Health Education England is involved in discussions about the clinical workforce.

32.4 In response to questions from Cllr Wealls on the depth of the provider market and on break-clauses, members were told that the market appears robust: 10 providers attended the soft marketing events. The contract will provide break-clauses for both sides; this is standard in NHS contracting.

32.5 In answer to a question from Jo Ivens about social value, the committee was told that social value is an important factor in the contract, particularly in terms of sign-posting to community and voluntary sector services.

32.6 In response to a query from Colin Vincent about private sector involvement in the contract, it was confirmed that bids would be welcome from private sector organisations and from public/private partnerships.

32.7 In answer to questions from Cllr Morris on the CCGs involved in the contract and on the clinical pilots, members were told that the new contract would be with the seven Sussex CCGs. The clinical pilots have focused on getting maximum value from the one year extension of the current contract with SECAmb.

32.8 In response to a question from Cllr Morris on performance data, Mr Simmons told the committee that performance data for the current contract is not broken down into individual localities, but the data can show which GP surgeries the patients are from as part of the information collated on the call.

32.9 Following a question from Cllr Greenbaum on the fall-back position if no suitable bidders come forward, Mr Simmons agreed to provide an update to the HOSC around Easter 2019 when it should be clear if this situation pertains.

32.10 RESOLVED – that the report be noted.

33 HEALTHWATCH ANNUAL REPORT

33.1 This item was introduced by David Liley, Healthwatch Brighton & Hove Chief Executive.

33.2 Mr Liley told members that 2016/17 had been a very difficult year for local NHS services and this was reflected in the Healthwatch annual report. However, things have subsequently improved in a number of areas.

33.3 2016/17 saw Healthwatch Brighton & Hove significantly raise its game. For example, Healthwatch was instrumental in influencing the CQC inspection report of Brighton & Sussex University Hospitals Trust which placed the trust in special measures. Healthwatch also played a significant role in holding Patient Transport Services (PTS) to account, interviewing many service users (particularly of renal services) and using this

insight to put pressure on service commissioners to deal with the problems with the PTS contract.

33.4 Cllr Deane welcomed the report and asked a question about Royal Sussex County Hospital (RSCH) outpatient services which are criticised in the Healthwatch annual report. Mr Liley responded by saying that services were in a parlous state in 2016/17, but have improved significantly in subsequent months. Healthwatch has been heavily involved in this process, particularly in terms of the redesign of the Patient Experience Panel. Mr Liley offered to circulate information on this work.

33.5 The Chair thanked Mr Liley for his report and for all the work that Healthwatch has undertaken in recent months.

34 FOR INFORMATION: UPDATE ON HOSC WORKING GROUPS

34.1 Fran McCabe noted that new categories have been introduced for ambulance response times and this ought to be explored at the SECAmb Quality Improvement Working Group. This was supported by members, as was Ms McCabe's suggestion that actions on falls should also be closely monitored.

34.2 The Chair announced that there would be a planning meeting of the STP working group on 14 December.

35 OSC DRAFT WORK PLAN/SCRUTINY UPDATE

35.1 Colin Vincent suggested that the issue of Delayed Transfers of Care should be added to the work programme. This was agreed by members.

The meeting concluded at Time Not Specified

Signed Chair

Dated this day of

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Quo Immus Ltd

Acute Services Modelling

Deliverable	Description
System capacity, configuration and financial modelling	Complete a reconciliation and testing of BSUHTs overall clinical strategy and use of 3Ts planned new build, including an assessment of all of the regional specialist work and local DGH work currently being referred to, and planned for BSUHT from its catchment areas. Identify whether or not BSUHT will have enough capacity in the new hospital to deliver this activity.
	Complete a review of the specialist activity being undertaken, within the footprint, at sites/providers other than BSUHT, the appropriateness of this activity and options for sustainable provision going forward.
	If BSUHT is unable to accommodate this referred activity what options can be considered across the STP footprint or wider to respond to this.
	Modelling the out-of-hospital and acute service provision across the STP footprint (this includes in relation to both physical and mental health): Identifying the potential number of patients that are currently supported in acute hospitals setting but could in the future be supported in out-of-hospital settings. Specifying solutions, cost of future service delivery, cost of transformation vs. current costs
	Assessing how changes in population demographics over the next 5 and 10 years will impact on the number of patients that could be supported in out-of-hospital settings and the number of patients that need to be supported in acute hospital settings
	Model the cost of supporting patients in the out-of-hospital setting who are currently cared for in acute hospital settings and compare this to the current cost of provision
	Identify potential models for acute service delivery across the STP footprint taking into consideration workforce, finance and geography.
	Model the potential net cost reductions associated with the options identified for acute infrastructure reduction detailed within the potential models and identify outline capital requirement
	Take account of workforce availability to ensure the deliverability of service options, including efforts to implement the transformation
Support to the development of the Programme Management Office (PMO)	Development of the PMO: short-term support), using an appropriate methodology (e.g. Managing Successful Programmes / Prince2 Lite)
Support for individual work streams	Flexible arrangements to call down support to align to work streams (where possible our intent is to use staff from within our organisations to support work streams but we recognise there may be some areas where we do not have the necessary capability or capacity), including support for clinical.

Carnal Farrar

Acute Services Modelling

Strategic financial framework and local care plans	The realistic baseline position for commissioners covering activity and finance, building on the October STP submission and the acute work to date. A population segmentation model based on the demographic characteristics of the population, the burden of disease, and the spend by POD for each CCG.
	A prioritised set of opportunities from a commissioner point of view, based on targeting specific segments of the population and application of impact assumptions based on analysis of local care patterns, benchmarks and a literature review of effective interventions;
	Reinvestment assumptions based on a combination of a “top-down” logic model that links the expected impact from opportunities to areas of intervention and likely reinvestment requirements and a “bottom-up” quantification of activity implications for new care models
	The expected financial impact for commissioners, including the expected recurrent benefits, recurrent costs and recurrent net benefits, phased over time.
Local care toolkit	Population segmentation model for each place that captures size, activity and spend
	Prioritisation of segments of the population to address

	Identification of changes in the local care models for the prioritised segments of the population
	Delivery requirements i.e. who does what, where and how
	Expected impact on activity and finance as a result of plans
	Expected reinvestment levels based on “logic model” and on activity based modelling
	Enabling requirements including changes in information, payment and governance
	A plan that sets out the activity and finance baseline and the implications of the plan, whether the gap will be closed and how recurrent and non-recurrent investment have been considered.

Carnal Farrar
Mental Health Modelling

Deliverable	Description
Case for change and baseline analysis	A PowerPoint set of materials that capture the case for change in mental health including the current state of provision and outcomes in mental health, informed by interviews, the analysis of data, literature review and a survey and workshop including service users and carers
	Establishing the baseline position of spending on mental health by area across each CCG and in comparison to complexity of the population and outcomes
	An assessment of performance against clinical standards across the pathway
	A population segmentation which maps resource consumption by condition.
Develop the mental health strategic framework	Future requirements in activity and spend modelled based on demographic and non-demographic change and meeting the 5-year forward view requirements
	Quantification of a set of opportunities to improve mental health delivery and cost effectiveness, with impact on activity and spend
	A financial bridge analysis of the net impact on spending on mental health
	A revised set of Trust priorities and their implications, thereby determining the strategic direction of SPFT and refresh of SPFT clinical strategy will be refreshed.
Development of a delivery roadmap	A confirmed set of short, medium and long-term priorities for the Trust and the STP, which have clinical, service user, carer, executive and financial input
	A set of initiatives to deliver these priorities
	A high-level delivery plan with critical delivery milestones identified
	Identification of the capital investments to be prioritised
	Proposed governance arrangements
	Recommended resourcing

2020 Delivery
Finance Group Support

Deliverable	Description
Handover	Use one-to-one sessions with key individuals for in-depth handover and Q&A
	Provide a written guide to the model illustrating the layout, methodology and assumptions Ensure transfer of all model files to a client server
	Hold two half-day workshops in the first two weeks of the internal team’s time (i.e. 19th Feb to 2nd Mar) to work through the detail of the model, and augment the team’s desk based review of the key documents and issues (note – we assume these staff may not be available full time during this two-week period but should be at least 60%)
	Provide “shadowing” opportunities when carrying out key tasks, particularly focussed on the model

Modelling and reporting	Refreshing the assumptions around impact of the STP programme workstreams and place-based plans
	Working with places to understand their revised activity and CCG spend projection to 20/21 following the work on non-elective acute activity interventions and 17/18 activity reconciliation
	Using the most recent view of projected activity to model required provider capacity and costs
	Updating the STP model to calculate a revised Do Something projection through to 20/21 for each organisation, place and for the STP in aggregate
	Developing the Strategic Financial Framework to include: i. The place-based financial risk framework ii. A standard interface between place-based activity and finance models and the STP model iii. The structure of the latest savings opportunities from STP workstre
Support to places and Developing the Finance Group as catalyst for transformation	Targeted delivery planning support
	OD-style workshops between the Place-based Finance Leads and Finance Group Chair and Deputy Chair cogvering:
	i. The standard nature and extent of the role of the place-based finance leads ii. The governance in place to support delivery of financial plans, contrasting between places and with best practice iii. The detail of delivery plans in place and capacity/capabilities to develop them
18/19 contractual planning	Development of system-wide financial submissions through a simple aggregation of the partner organisations' plans
	Using the revised Strategic Financial Framework to highlight variances in planning assumptions between organisations during the planning process
	Performing an analysis of the refreshed Operating Plans after a draft submission

HOSC Public Qs 28 Feb 2018

Public Q from Linda Miller

I am sure the members of the Health Overview and Scrutiny Committee are aware of the level of public concern about ACOs:

- the Judicial Review challenging their legality https://www.crowdjustice.com/case/jr4nhs-round3/, which has the support of Professor Stephen Hawking who said: "I am concerned that accountable care organisations are an attack on the fundamental principles of the NHS".
- the concern within the Conservative Party with the chair of the Health Select Committee, Sarah Wollaston, asking Jeremy Hunt to take note of public concern and pause the introduction of ACOs.
- and the policy of both the Labour Party and the Green Party to oppose the introduction of ACOs.

ACOs will be non-NHS bodies which will hold the contract for allocating resources for health and adult social care provision for the population in each area.

They can include private companies which will make money and can introduce charging. They will be allowed to sub-contract services. Each ACO will be able to decide on the boundary of what care is free and what has to be paid for. They will be given multi-billion pound budgets in contracts that may last 10 or 15 years.

ACOs will have control over the allocation of NHS money – but their accountability for spending it and their obligations to the public will be under commercial contract not statutes.

ACOs will fundamentally change the NHS and are being brought in without parliamentary scrutiny or public debate.

I would like to ask the members of this Health Overview and Scrutiny Committee if they agree the Council should:

- Pause the process of Brighton and Hove being part of any Accountable Care System or Organisation (or possibly re-named Integrated Care System),

- Conduct an Impact Assessment of the proposed cuts and changes to services,

- Publish the results and hold a Public Consultation.

Public Question from Valerie Mainstone

"Last Summer, a deputation of breast feeding mothers presented a petition against the cutting of a breast feeding support worker post in Hangleton and North Portslade. This was the Ward sixth from bottom in the 'league table' of breastfeeding in Wards across the city. The cut went ahead, and I understand that a Peer Support Group has consequently closed, for lack of professional supervision. Can the HOSC confirm the loss of this Peer Support Group, and say where Hangleton and North Portslade now stands in the 'league table' for breastfeeding per Ward?"

HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 41 Brighton & Hove City Council

Subject:		**Patient Transport Services (PTS): Healthwatch Report**
Date of Meeting:		**28 February 2018**
Report of:		**Executive Lead, Strategy, Governance & Law**
Contact Officer:	**Name:**	**Giles Rossington** **Tel: 01273 295514**
	Email:	**Giles.rossington@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 Healthwatch Brighton & Hove has been working to understand how Patient Transport Services (PTS) are being delivered now that PTS is provided by South Central Ambulance Services NHS Foundation Trust (SCAS) rather than by Coperforma.

1.2 The Healthwatch report on PTS under SCAS is included as **Appendix 1** to this report.

2. RECOMMENDATIONS:

2.1 That members note the information provided.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 The contract for PTS (non-emergency transport for NHS patients) was awarded to Coperforma in April 2016 after the previous provider, SECAmb (South East Coast Ambulance NHS Foundation Trust) announced that it did not wish to continue its PTS contract.

3.2 There were significant problems with Coperforma's performance from the outset of the contract and it eventually withdraw from PTS provision in Sussex, being replaced by an NHS body, SCAS in April 2017.

3.3 Healthwatch Brighton & Hove was instrumental in bringing the failings of PTS under Coperforma to the public's attention, undertaking extensive surveys of patient experience with the service. More recently, Healthwatch has been doing similar work to look at the quality of PTS services provided by SCAS (see **Appendix 1**).

3.4 In scrutinising this issue, members may wish to consider the following points:

- The Healthwatch report notes that customer satisfaction with PTS is significantly lower in Brighton & Hove than in the rest of Sussex. Members may wish to ascertain why this is and what steps commissioners and providers have taken to improve things.
- Customer satisfaction is clearly better now than it was under Coperforma, but significant numbers of service users still report problems with the service (e.g. vehicles arriving late). Members may want to know what commissioners consider an acceptable level of service to be and what steps are being taken to achieve this.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 None to this report for information.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 This report has been written with input from Healthwatch Brighton & Hove.

6. CONCLUSION

6.1 Members are asked to note the Healthwatch report on PTS.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 None to this information report.

Legal Implications:

7.2 There are no legal implications to this report.

Lawyer Consulted: Elizabeth Culbert; Date: 15/01/18

Equalities Implications:

7.3 None directly

Sustainability Implications:

7.4 None directly

Any Other Significant Implications:

7.5 None identified

SUPPORTING DOCUMENTATION

Appendices:

1. Healthwatch Brighton & Hove PTS report

Documents in Members' Rooms

None

Background Documents

None

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Non-emergency patient transport

Healthwatch Brighton and Hove review for HOSC, February 2018

Contents:

David Liley CEO, Healthwatch Brighton and Hove

Alan Boyd, Project Coordinator, Healthwatch Brighton and Hove

29/1/2018

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1. Executive summary

- Healthwatch patient reviews indicate that patient satisfaction with PTS services has improved by 10%, up from 75% in May 2017 to 85% by December across Sussex, and up 17% from 67% to 84% for Brighton and Hove patients.

- This improved patient satisfaction should not however be taken automatically as an endorsement of PTS as a high performing or high quality service.

- Three issues of concern to patients have remained unresolved since Healthwatch started to closely monitor patient experience of PTS in 2016:
  - Unreliable service for renal patients on Saturdays
  - Transport meeting mobility needs e.g. wheelchairs and stretchers
  - Inconsistent pick up and drop off arrangements and failure to keep patients advised of changes.

- Current PTS performance is not satisfactory [December 2017 – 17/18 year to date]:
  - Pre-Planned Discharges 60 mins performance was 73.5% against a threshold of 75% and a target of 80%
  - There has been a downward trend in the 60 min performance indicator since September 2017 and has fallen by 11% from April 2017 to December 2017.
  - Pre-Planned Discharges 90 min performance was 83.6% there is no target as this is a 'service indicator'
  - Downward tread also for the 90min service indicator since September 2017, with a fall of 7.5% from April 2017 to December 2017.
  - Unplanned Discharges within 120 min performance was 75.5% against a threshold of 85% and a target of 90%.
  - Downward tread for the 120 min service delivery indicator from July 2018, with a fall of 8% from April 2017 to December 2017.

To provide a balanced picture we have been asked to point out that the SCAS performance for non renal outbound and inbound journeys are achieving their key performance indicators [KPI's]

- The PTS contract allows what seem to be generous allowances for late journeys. However SCAS the service providers and the NHS Commissioners have asked us to point out that their Specialist Advisor has told them that the KPI's are 'realistic'

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- The impact of PTS failures on individual patients can be severe:

  - A 94yr old man left waiting to be taken home for 3 hrs in the Renal Reception area following dialysis.
  - A paraplegic woman who frequently arrived home late after her dialysis which meant that her carer had already left, meaning she had to remain in her wheelchair all night.
  - Renal patients arriving late lose their slot for dialysis – 3 patients told us about 1.5hr delays before dialysis resulting in an 8-10 treatment day

SCAS and the NHS Commissioners have asked us to qualify these personal experiences with the following statement:

"The contract covers all journeys across the whole of Sussex, not just for renal patients, and resources are planned against all of the bookings we receive. Also, some issues are outside of our control:

- ✓ on the day activity
- ✓ aborted journeys
- ✓ waiting more than 15 minutes for a patient to be ready"

- In line with increasing overall patient satisfaction many patients made complimentary comments about the service. Some patients expressing their gratitude to staff for their kindness and sensitivity:
  - They're good. They collect me early and collect me on time to go home which is usually on time
  - Always on time as a I have a regular driver
  - Medi4 are very good
  - I've only used the service for 3 months and it's been good during that time
  - The drivers are very good
  - When SCAS took over initially I wasn't always picked up, there was lots of waiting around. But now I have a regular driver and it's good. How it is now so lovely. My driver calls me to tell me he's on his way.

- Patient satisfaction with PTS tends to be lower in the Royal Sussex County Hospital [RSCH] for renal patients. There are currently issues with:

  - Eligibility for PTS when renal patients are attending for more than one intervention i.e. an outpatient appointment. SCAS and the NHS Commissioners have asked us to clarify that "Renal Patients do not have automatic eligibility for PTS for other NHS appointments". Healthwatch understands that but perhaps patients do not.

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- Whether some people use PTS because parking is not easily available at RSCH – clearly this is an issue for the hospital not the PTS providers but it is an issue on which Healthwatch and patients expect the different parts of the system to work jointly

2. What are Patient Transport Services?

The Patient Transport Service is a Sussex-wide service jointly commissioned by the seven Sussex CCGs. As with all jointly-commissioned services, one CCG acts as lead commissioner and in the case of the PTS, the lead CCG is High Weald Lewes Havens (HWLH) CCG. All decisions, however, are jointly made by all the CCGs.

The PTS service provides transport for people who are unable to use public or other transport due to their medical condition, patients may also be eligible due to mobility, visual impairment, mental health and learning disability needs and include those who are:

- attending hospital outpatient clinics
- being admitted to or discharged from hospital wards
- needing life-saving treatments such as radiotherapy, chemotherapy or renal dialysis or DVT treatment

Coverage for Sussex includes patients who live in the following catchment areas:

- Brighton & Hove CCG
- Coastal West Sussex CCG
- Hastings & Rother CCG
- High Weald Lewes Havens CCG
- Crawley CCG
- Horsham & Mid Sussex CCG
- Eastbourne, Hailsham & Seaford CCG.

The total cost of the PTS contract is £62 million over five years which represents 0.5% of the total Sussex NHS commissioning budget.

3. A brief history of Patient Transport Services

In 2011, the then Primary Care Trusts (PCTs) across Sussex commissioned a new Patient Transport Service (PTS), awarding the transport function to South East Coast Ambulance Service (SECAmb). Lead responsibility for commissioning the service was latterly inherited by High Weald Lewes Havens CCG. In 2014, the service underwent a further review by the seven joint Sussex Clinical

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Commissioning Groups (CCGs) after SECAmb gave notice in March 2014 that it wished to discontinue providing the service. At this time a new Managed Service Provider (MSP) model was introduced to run the service which included a separate Booking Hub; a single point of access to PTS which applies Eligibility Criteria and managed bookings. The MSP delivered patient transport via multiple sub-contractual arrangements. Although a full commissioning process was undertaken, only one contractor submitted an invitation tender: Coperforma; who were awarded the contract from April 2016.

Whilst the service under SECAmb was far from perfect, patients largely received a satisfactory service. From the moment Coperfroma took over, a near total collapse of the service occurred, with patients bearing the brunt of this failure. These events led to urgent remedial action being taken by HWLH CCG, including several independent reviews. These highlighted failures in the service, the commissioning process, the transition process and Coperforma's planning and ability to run the service. A further provider was subsequently awarded the PTS contract in April 2017: South Central Ambulance Service (SCAS), took over as a 'step in' provider with 3 months mobilisation and taking on the existing transport providers from Coperforma.

4. Healthwatch Brighton and Hove concerns and involvement

The failure of Coperforma to deliver the service and the early termination of its contract, will deliver a cost the NHS which has not yet been shared publically [1].

The Brighton and Hove Health and Wellbeing Board was promised an open and clear public explanation of the finances involved in PTS contract issues. That does not yet seem to have been provided.

From 2016, Healthwatch Brighton and Hove (HWBH) were aware of patient concerns about the PTS service, which it raised at the Brighton and Hove City Council's Health Overview and Scrutiny Committee, and the Health and Wellbeing Board. HWBH undertook its own independent review of the service in 2016, followed in 2017 by two further reviews undertaken by the three Healthwatch teams across Sussex.

[1] http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2018-01-19/123750/
http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2018-01-08/121520/

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In almost every review, recommendations have been made to address the following failures:

- **Improve the service for renal patients, particularly over the weekend period (notably Saturdays where the reliability of the service dips)**
- **Provide patients with additional support with their mobility where needed** (reports of transport not being suitable for wheelchair users) – SCAS have asked Healthwatch to provide specific details they stated "all bookings are made by patients/healthcare providers so we (SCAS) provide the vehicle and equipment based on the booking". Healthwatch Brighton and Hove will endeavour to assist SCAS to identify patients for whom this is a particular issue. Once again it seems to Healthwatch that one part of the NHS is pointing the finger and blaming another part of the system when things go wrong for patients
- **Deliver a consistent service for patients with more timely pick-up and take home times; and better information concerning collection times.** SACS commented: "Outbound performance for renal and non-renal patients is generally good though we recognise that for some the experience is poor and could be improved"

All three Healthwatch have made a number of other recommendations, but the above fundamental issues still do not seem to have been fully addressed.

Healthwatch notes with concern the underperformance of the PTS service on some performance indicators, with downward trends, as quoted above

PTS continues to be a service that needs to improve and meet patient expectations. There are signs that this is starting to happen, but more is needed; and Healthwatch has identified a number of areas which the provider and CCG's could easily focus on. In addition, the latest review of PTS undertaken in November/December 2017[2] raised concerns regarding eligibility for PTS, and how this may be impacting performance. For example are people using PTS because of difficulties parking a RSCH? Are the CCG's satisfied with the systems and scrutiny in place around eligibility.

Related to the above, Healthwatch is also interested in what impact aborted journeys has on the providers' ability to run PTS. It would also be helpful to understand how many daily cancellations / aborted journeys occur and plans to improve performance. SCAS have told Healthwatch that they collate and report information on aborted journeys and that NHS Commissioners have asked them to identify any scope for reducing aborted journeys.

[2] Draft report due shortly

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The following pages contain a timeline of important dates and activities for PTS, and a summary of the 3 Healthwatch reviews undertaken in 2016 and 2017.

5. Timeline of important dates and activities

January 2018	Questions are to be asked in Parliament after MPs, councillors and unions demanded a formal investigation into Coperforma.
May/June 2017	Healthwatch report on PTS is published[3]. A joint review was undertaken by Healthwatch teams in Brighton and Hove, East Sussex and West Sussex who visited health services across the regions; speaking to patients, carers and staff about their experiences of PTS. This reported high satisfaction levels (75%); but also highlighted a number of concerns. A number of recommendations were made: several of these were first raised in 2016.
April 2017	South Central Ambulance Service NHS Foundation Trust (SCAS) takes over the contract for PTS.
January 2017	High Weald Lewes Havens Clinical Commissioning Group (on behalf of all Sussex CCGs) published its report "Learning the lessons from the procurement and mobilisation of the new Patient Transport Service in Sussex".[4] This acknowledged the failures within the service, and accepted the recommendations and findings from various independent reviews of PTS plus the outcomes of 'lessons learned' events (see September 2016 below).
November 2016	A CQC report is published that requires significant improvements to patient transport services in Sussex[5]. The report listed 11 areas for improvement including: • robust systems are needed for handling complaints • robust systems are needed to monitor and improve safety • vehicles and equipment must be appropriate for safe transportation of patients, including wheelchair users. • Patients must receive timely transport services

[3] https://www.healthwatchbrightonandhove.co.uk/wp-content/uploads/2015/02/Healthwatch-Sussex-PTS-Report-Sept-2017.pdf
[4] www.highwealdleweshavensccg.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=446080
[5] http://www.cqc.org.uk/news/releases/cqc-requires-significant-improvements-patient-transport-services-sussex

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	• CQC must be notified of safeguarding incidents and incidents Also this month, in a media statement from Michael Clayton, Chief Executive, Coperforma Ltd (8 November 2016), he stated that Coperforma "*not been 'stripped' of the contract but what is best described as a 'friendly divorce' was agreed, importantly with 'no fault' attached to either Coperforma or the commissioners.*"[6]
October 2016	Coperforma wrote to the CCG's seeking a managed exit from the PTS contract on economic grounds which was accepted by the CCGs. The CCGs announced that South Central Ambulance Service NHS Foundation Trust (SCAS) would take over the entire service for the remainder of the 5-yr contract term. Towards the end of 2016/early 2017 Coperforma's performance did improve, although the improvements were not consistent across the whole of Sussex and some patients continued to experience problems.
September 2016	A report[7] is published by Healthwatch Brighton and Hove examining the experiences of renal patients, their carers and staff about PTS during April to September 2016. This finds an almost complete collapse of the service immediate after April 2016. A number of recommendations are made (see below).
August 2016	A number of issues are identified between Coperforma and some of its subcontractors, which raised concerns for commissioners about the broader sustainability of the service. Also this month, SECAmb loses the contract to provide non-emergency patient transport service (PTS) serving Surrey and the South East. The contract was awarded to SCAS for 5 years.
June 2016	An independent review was conducted by TIAA Ltd[8], one of the leading providers of assurance services to the public sector. All of

[6] https://www.facebook.com/Coperforma-Ltd-431694170225824/
[7] https://www.healthwatchbrightonandhove.co.uk/wp-content/uploads/2015/02/Users%E2%80%99-perspectives-on-the-Patient-Transport-Service-April-September-2016.pdf
[8] https://www.huwmerriman.org.uk/sites/www.huwmerriman.org.uk/files/2016-08/Sussex%20CCGs-Patient%20Transport%20Service-f.pdf

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	the reviews recommendations were later accepted by the CCG. See summary section 2 of this report for its main findings which include: • no evidence Coperforma had adequately stress-tested it's systems • a lack of preparation for a tight handover of staff from the old provider • a failure to alert the CCG to problems putting patients' details into its databases • For its part, the CCG which "hired" Coperforma to run the service was found not have a "plan B" for when things went wrong. • In future, the report advised that big healthcare contracts should be implemented in stages, rather than all at once.
May 2016	A CCG report places SECAmb into "special measures"[9] The emergency operations centre and patient transport services were individually rated as "requires improvement" (**NB** in May, SECAmb advised that patient satisfaction survey results were consistently above 90% cent.[10]
April 2016	Coperforma started to deliver PTS, taking over from SECAmb. SECAmb continued to provide emergency ambulances only. Immediate problems experienced in April, where transport for hundreds of patients was delayed. Coperforma partly blamed this on a poor transition between them and SECAmb[11]. A level 3 Serious Incident was raised by HWLH CCG[12]. An independent review was conducted by the Patient Safety Group[13] following a level 3 Serious Incident (SI) raised by High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG). This highlighted: • Lengthy delays in being picked up and taken home • Poor Saturday service • Difficulties getting through to the control centre

[9] http://www.cqc.org.uk/sites/default/files/new_reports/AAAF5030.pdf
[10] http://www.secamb.nhs.uk/about_us/news/2016/sussex_pts_statement.aspx
[11] http://www.secamb.nhs.uk/about_us/news/2016/sussex_pts_statement.aspx
[12] A level 3 investigation is defined as 'Required where the integrity of the investigation is likely to be challenged or where it will be difficult for an organisation to conduct an objective investigation internally due to the size of organisation or the capacity/capability of the available individuals and/or number of organisations involved
[13] http://www.highwealdleweshavensccg.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=449157

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During 2015	The PTS contract was put out to tender but only one, Coperforma, submitted a bid at the invitation to tender (ITT) stage.
During 2014	The seven Sussex Clinical Commissioning Groups (CCGs) designed and commissioned a new Patient Transport Service (PTS) after South East Coast Ambulance Services gave notice in March 2014 that it wished to discontinue providing the service after March 2015. A new Managed Service Provider (MSP) model was introduced to run the service which included a separate Booking Hub; a single point of access to PTS which applies Eligibility Criteria and managed bookings. The MSP delivered patient transport via multiple sub-contractual arrangements.
June 2012.	NHS Surrey and Surrey County Council awarded SECAmb the PTS contract.
2012	HWLH CCG inherited pan-Sussex responsibility for PTS from B&H PCT.
2011	Primary Care Trusts (PCTs) across Sussex commissioned a new Patient Transport Service (PTS). The transport function was awarded to the South East Coast Ambulance Service (SECAmb). The Patient Transport Bureau (PTB) was established to apply the Sussex PTS Eligibility Criteria and book transport for eligible patients

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6. Healthwatch Patient surveys/reviews

Date of first Healthwatch review	April – September 2016
Service provider	Coperforma

Reason for review:

Early in September 2016, Healthwatch Brighton and Hove was approached by a patient who was attending the Renal Outpatient Department at the Royal Sussex County Hospital (RSCH). The patient voiced serious concerns about PTS, operated by Coperforma. As a result of that encounter, Healthwatch decided to undertake a review of the PTS by interviewing patients at the Renal Outpatient Department who used the service.

Prior to September 2016 Healthwatch had already raised serious concerns about the performance of Coperforma. Earlier in the summer we had carried out an extensive service review in eight Outpatient Department clinics at the RSCH where people required patient transport. During that review we heard stories of transport not arriving to take patients to radiotherapy; patients being unable to make contact with the Coperforma control centre to check arrangements; and people with complex needs, e.g. requiring a bariatric ambulance, having appointments repeatedly cancelled. Healthwatch raised these issues at a number of forums including Brighton and Hove City Council's Health Overview and Scrutiny Committee and the Health and Wellbeing Board.

The data below relates to Brighton and Hove only.

Key results

- 50 patients at the Renal Outpatient Department, RSCH, who had used PTS, were interviewed in September 2016. Patients were asked questions evaluating the service across three different time periods: (i) before April 2016 (pre-Coperforma); (ii) April to July (Coperforma); and (iii) August and September (Coperforma).
- Patients reported that the service performed extremely poorly in the initial months (April-July 2016) when Coperforma took over, citing a virtual collapse of the service with frequent delays and 'no shows'.
- Patients reported some improvements in overall performance after August 2016. Nevertheless most people still noted ongoing issues particularly with the Saturday service.

B&H results were:

- Satisfaction levels dropped from a high under SECAmb of 67% (pre-April 2016), to 8% between April-July once the service was taken over by Coperforma.
- Satisfaction levels increased after August 2016, but remained at just 42%.
- 56% of patients interviewed reported suffering anxiety and stress as a result

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of failures in transport services.
- 14% experienced longer treatment days as a result of failures in PTS.
- 8% reported their treatment sessions had been shortened as a result of failures in PTS.
- 18% specifically provided adverse comments about Saturday services.

Suggested actions for the Trust to take

- Urgent and immediate action is required by service providers and commissioners to correct persistent deficits in service.
- SCAS should develop a clear and creditable action plan to recover the PTS.
- An independent review should consider the commissioning process that awarded the PTS contract to Coperforma with a view to learning lessons and improving future commissioning.
- A full and transparent investigation of the financial implications of the service failure should be undertaken with the results made public.
- Robust and simple complaints procedures are needed to resolve problems as they arise.
- There should be dedicated PTS performance standards for renal patients, with performance reports publically and prominently available.
- Improve the service for renal patients over the weekend period (notably Saturdays where the reliability of the service dips)
- Provide patients with additional support with their mobility where needed (reports of transport not being suitable for wheelchair users)
- Clear standards for call centre performance, vehicles, drivers and punctuality should be made explicit to people receiving the service.
- Drivers should receive proper training to know how to deal with patients.
- There needs to be better use of technology to give patients and their family greater certainty about when their transport will arrive.

Key statistics

Patient satisfaction levels (%) throughout 2016

Pre April 2016 - SECAmb	April-July - Coperforma	Post August - Coperforma
67%	8%	42%

Friends and family test

Likely	44%
Neither likely nor unlikely	18%
Unlikely	38%

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Date of second Healthwatch review	May - June 2017
Service provider	SCAS

Reason for review:

This review was commissioned by the lead commissioner, NHS High Weald Lewes Havens (HWLH) CCG. It was undertaken by Healthwatch in Brighton and Hove, East Sussex and West Sussex who visited health services across the regions; speaking to patients, carers and staff who used PTS.

The performance of the previous provider (Coperforma) was poor. This review was intended to gather evidence and insight on the quality of the new service provider (SCAS) who took over the running of the contract in April 2017. This was therefore an 'early stage review' of the new service provider. The evidence was provided to the CCG in 2017; with the final report published in September.

Key results

- 218 local people were interviewed. 71% were regular users.
- 75% of patients were satisfied with the quality of non-emergency PTS they received, including 44% who were very satisfied.
- 82% of patients said they arrived on time for their appointments.
- 42% found the process of booking transport easy to do and a positive experience.
- Journey experiences were overwhelmingly positive and people said that found vehicles to be clean and tidy, and in 95% of cases suitable for their needs. In a small number of cases vehicles were unsuitable for taking wheelchairs.
- There were regional variances in levels of satisfaction, notably in Brighton.
- Renal patients were less satisfied with the service than non-renal patients.

B&H results were:

- Lower overall satisfaction levels at 67% (75% overall)
- The % of B&H patients who would recommend the service to friends was similar to the regional average (77% and 74% respectively)
- The % of B&H patients who arrived on time for their appointment was similar to the regional average (79% and 82% respectively)
- Much lower levels of B&H patients were taken home on time than the regional average (58% and 69% respectively)
- Staff provided HWBH with their feedback, and this showed frustration with the reliability of the service and the impact it had on patient care, and staff time.

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Suggested actions for the Trust to take

Key recommendations were:

- Improve experiences for patients (and staff) accessing the contact centre to remove lengthy delays; and introduce a dedicated line for staff – we understand from SCAS that they have in place on line and phone options for patients, they expect that most health provider bookings will be made on line and there would be an additional cost in providing a dedicated phone line as suggested by Healthwatch
- As reported following the 2016 review, improve the service for renal patients over the weekend period (notably Saturdays where the reliability of the service dips
- As reported following the 2016 review, provide patients with additional support with their mobility where needed
- Provide further training for dispatch staff to help them understand the local geography and assist them with scheduling drivers' journey's
- Identify ways to improve the reliability of the service for renal patients and deliver greater consistency in 'pick-up' and 'take home' times.

Key statistics

Satisfaction levels

	All regions	B&H
Very satisfied	44%	32%
Satisfied	31%	35%
Neither satisfied nor dissatisfied	12%	20%
Dissatisfied	7%	8%
Very dissatisfied	5%	5%

Friends and family test

Extremely likely	43%	33%
Likely	34%	41%
Neither likely nor unlikely	11%	14%
Unlikely	5%	6%
Very unlikely	0%	0%

Arriving on time

Yes	82%	79%
No	18%	21%

Taken home on time

Yes	69%	58%
No	31%	42%

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Date of third Healthwatch review	**November - December 2017**
Service provider:	**SCAS**

Reason for review:

This was the second review of the service as commissioned by the lead commissioner, NHS High Weald Lewes Havens (HWLH) CCG. It was again undertaken by Healthwatch in Brighton and Hove, East Sussex and West Sussex who again visited health services across the regions. This review was intended to see how the service had changed over the last six months since the previous review in May. Healthwatch team again spoke to users of the service, their family members and carers, and hospital staff

At the time of writing, the final Healthwatch Sussex wide report into PTS was not available. Therefore the interim data below relates to Brighton and Hove only.

Key results

- The total number of surveys completed this time by Healthwatch Brighton and Hove was 122. This was 17 more than in May/June.
- 60% (approx) of all surveys came from renal patients, which is a similar percentage to the May/June report (63%).
- As before HWBH gathered views from hospital staff where these were offered

B&H results were:

- More than half of patients, 60% (approx), reported the service had improved in the last 6 months.
- The vast majority of patients reported being satisfied with the service, and the overall percentage had increased by 17% (up from 67% to 84%)
- The vast majority of patients said they would recommend the service to family or friends, and the overall percentage had increased by 2% (to 76%). However, an additional 7% of patients reported that they would not recommend the service (13% overall).
- Renal patients were less likely than non-renal patients to be 'very satisfied' or 'satisfied' with the service.
- Renal patients were considerably less likely than non-renal patients to be 'very likely' or 'likely' to recommend the service.
- Hospital staff who spoke to us said the service was about the same as the last time Healthwatch Brighton and Hove reviewed it in May/June.

Suggested actions for the Trust to take

1. Focus efforts on improving pick-up times (i.e. timelier collection to take patients home from the hospital). As reported following the 2016 and earlier 2017 reviews there is a continuing need to improve Saturday performance levels for renal patients.
2. As reported following the 2016 and earlier 2017 reviews, PTS must ensure

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that all transport is suitable for those requiring stretchers and wheelchairs to avoid long waits to be taken home.

3. As reported following the May/June, greater focus needs to be on ensuring services run better for renal patients in particular. For example, SCAS should aim to provide all regular users of PTS with a regular/nominated, local driver(s). SCAS has advised us they do this 'where feasible' We also recommend that patients are clustered geographically, SCAS have advised us that this might lead to people being in transport longer than at present.
4. SCAS must ensure the system is capable of identifying vulnerable patients i.e. those with caring needs, the elderly and those with multiple needs so that the service can respond in a timelier manner to any delays experienced by these individuals.
5. SCAS should better promote the SCAS mobile phone app ('View My Journey) so that patients can track their vehicles.
6. As reported following the 2016 and earlier 2017 reviews SCAS should provide timelier updates to patients concerning arrival timings i.e. a 20 minute advance warning by text or phone.
7. SCAS should provide a system that allows hospital staff to track where vehicles are to save them having to call control to find out. SCAS have advised us this is available via their online booking portal which raises the question of staff awareness and training
8. As previously reported following the May/June review, SCAS should provide a dedicated staff contact number so that staff can liaise with control/dispatch in a timelier manner.
9. As previously reported following the May/June review, further training for dispatch staff is needed to help them understand the local geography and assist them with scheduling drivers' journey's.
10. SCAS should clarify how eligibility for PTS is continually assessed. (Are the CCG satisfied with the systems and scrutiny in place around eligibility, and what it says in the commission etc and how does it satisfy itself that the system is being used appropriately and fairly?)
11. SCAS should clarify policies: (i) where patients need to attend hospital for more than one appointment/department; and (ii) driver wait times.

Key statistics

How has the service improved over the last 6 months?

Worse	Same	Better	*Total*
5	32	55	92

Satisfaction levels

Very satisfied	Satisfied	Neutral	Dissatisfied	Very dissatisfied	*Total*

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44	58	12	4	3	*121*

Changes in satisfaction levels for Brighton and Hove

	B&H June/July 2017	B&H Nov/Dec 2017
Very satisfied	32%	38%
Satisfied	35%	49%
Neither satisfied nor dissatisfied	20%	8%
Dissatisfied	8%	3%
Very dissatisfied	5%	2%

Friends and family test

Very likely	likely	Neutral	Unlikely	Very unlikely	*Total*
49	44	12	10	6	*121*

Changes in friends and family test for Brighton and Hove

	B&H June/July 2017	B&H Nov/Dec 2017
Very likely	33%	40%
Likely	41%	36%
Neither likely nor unlikely	14%	7%
Unlikely	6%	11%
Very unlikely	0%	5%

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

Subject:		**Patient Transport Services (PTS) Update**
Date of Meeting:		**28 February 2018**
Report of:		**Executive Lead Strategy, Governance & Law**
Contact Officer:	**Name:**	**Nuala Friedman** **Tel: 01273 290352**
	Email:	**nuala.friedman@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 This report presents the latest update on Patient Transport Services (PTS).

1.2 The performance of Coperforma, the previous provider of PTS (April 2016 to April 2017), caused considerable concern to patients, the public and organisations across Sussex. From 1st April 2017, Non-Emergency Patient Transport Services (NEPTS) in Sussex have been provided by South Central Ambulance Service NHS Foundation Trust (SCAS).

2. RECOMMENDATIONS:

2.1 That HOSC members note the content of this update report; and determine whether additional scrutiny of this contract is required.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 Coperforma began providing PTS in April 2016. The previous provider had been South East Coast Ambulance NHS Foundation Trust (SECAmb). There were significant problems with services from the outset, and after a number of months of operation Coperforma announced that it was withdrawing from the contract. Starting in April 2017, lead commissioners in High Weald Lewes Havens CCG awarded a new contract to South Central Ambulance Service NHS Foundation Trust (SCAS).

3.2 In January 2017, on behalf of all Sussex Clinical Commissioning Groups, High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG) released a report "*Learning the lessons from the procurement and mobilisation of the new Patient Transport Service in Sussex."*

This report, titled *'TIAA PTS Lessons Learnt Report January 2017'* can be viewed here, under 'Documents':
http://www.highwealdleweshavensccg.nhs.uk/our-programmes/patient-transport-services/

3.3 In September 2017, Healthwatch released their report on PTS, written following Healthwatch *Brighton and Hove, Healthwatch East Sussex and Healthwatch West Sussex* visited health services in Bexhill, Brighton and Hove, Crawley, Eastbourne, Hastings, Haywards Heath, Polegate and Worthing, gathering feedback from 218 patients.

This report can be viewed here (same as above link) under 'Documents' ('*Healthwatch Report September 2017*'): http://www.highwealdleweshavensccg.nhs.uk/our-programmes/patient-transport-services/

3.4 Healthwatch are continuing to consult with patients via a number of methods (social media, real time feedback and face to face across various services) and will bring their latest information to the February 2019 HOSC meeting.

3.5 Current performance information provided by High Weald Lewes Havens CCG is included as **Appendix 1** to this report. Commissioners have also submitted the following comments on this data:

Overview for the current situation is as follows;

Performance levels on the contract as per attachment [i.e. **Appendix 1**] are considered as generally satisfactory with gradual improvements being made from the initial few months. There are clearly improvements which need further focus; however transferring over to SCAS has provided a number of benefits to both patients and the commissioners. Some of these are as follows:

- Consistent and satisfactory operational performance
- Excellent governance processes
- Dedicated and strong management of NEPTS in Sussex
- Consistent financial improvements
- Wide ranging support services beyond the operational delivery
- SCAS have positive relations with staff and the unions
- A robust framework for engagement and governance of private providers
- Significantly reduced complaints from patients
- The capacity to support large scale initiatives which we are currently undertaking
- Financially secure
- An inspected good CQC rating.

There are however areas which need more focus that you would expect from a contract this size and the complexities that they faced. Some of these are as follows:

- Some KPIs need further improvement to achieve target levels
- Patient engagement has not seen the focus that we would have hoped and expected.

The CCG are pleased in the way the contract has developed during 2017/18 and are looking forward to further improvements and initiatives in the next financial year.

4 ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 This report is to note so there are no alternative options to consider.

5 COMMUNITY ENGAGEMENT & CONSULTATION

5.1 None in relation to this update report.

6. CONCLUSION

6.1 This is an update report.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 There are no financial implications to this update report.

Legal Implications:

7.2 There are no legal implications arising from this report.

Lawyer Consulted: Elizabeth Culbert Date: 10.01.2018

Equalities Implications:

7.3 None for this update report.

Sustainability Implications:

7.4 None for this update report.

Any Other Significant Implications:

7.5 None for this update report.

SUPPORTING DOCUMENTATION

Appendices:

1. Information from High Weald Lewes Havens CCG on current PTS performance

SCAS Patient Transport Services
Key Performance Indicators
Dashboard 2017 - 2018

KPI	Parameter	Threshold	Target	Values	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
KPI 1	Calls Answered within 60 seconds	85%	90%	No. Calls answered	11,107	11,464	10,072	10,708	11,804	10,013	10,454	9,818	7,863			
				KPI Achieved	8,064	9,147	9,182	8,510	8,974	7,027	7,959	7,715	5,900			
				KPI Performance	**72.60%**	**79.79%**	**91.16%**	**79.47%**	**76.03%**	**70.18%**	**76.13%**	**78.58%**	**75.03%**			
KPI 2	Provider to contact all patients within 24 hours of planned pickup to confirm booking (excluding regular renal/chemo patients who chose to 'opt out')	85%	90%	No. Journeys	4,208	5,837	5,887	5,463	6,070	6,096	6,258	6,487	5,159			
				KPI Achieved	541	587	486	428	469	851	880	1,815	2,659			
				KPI Performance	**12.86%**	**10.06%**	**8.26%**	**7.43%**	**7.73%**	**13.96%**	**14.06%**	**27.98%**	**51.56%**			
KPI 3	Non-Renal Inbound Journeys to arrive between 75 and 0 minutes early	75%	80%	No. Journeys	3,722	5,256	5,474	5,213	5,427	5,795	5,955	6,138	4,737			
				KPI Achieved	2,687	3,849	4,310	4,132	4,252	4,534	4,671	4,876	3,837			
				KPI Performance	**72.19%**	**73.23%**	**78.74%**	**79.26%**	**78.35%**	**78.24%**	**78.38%**	**79.44%**	**81.00%**			
KPI 4	Renal Inbound Journeys to arrive between 45 and 0 minutes early	75%	90%	No. Journeys	2,240	3,291	3,252	3,254	3,345	3,253	3,311	3,314	3,334			
				KPI Achieved	1,357	2,050	2,262	2,301	2,311	2,247	2,265	2,322	2,280			
				KPI Performance	**60.58%**	**62.29%**	**69.56%**	**70.71%**	**69.09%**	**69.07%**	**68.41%**	**70.17%**	**68.39%**			
KPI 5	Renal Outbound Journeys to collect within 30 minutes	80%	85%	No. Journeys	2,176	3,097	3,188	3,185	3,346	3,264	3,294	3,322	3,315			
				KPI Achieved	1,619	2,340	2,568	2,666	2,737	2,683	2,657	2,703	2,811			
				KPI Performance	**74.40%**	**75.56%**	**80.55%**	**83.70%**	**81.86%**	**82.20%**	**80.66%**	**81.37%**	**84.80%**			
KPI 5a	Renal Outbound Journeys to collect within 60 minutes			No. Journeys	2,176	3,097	3,188	3,185	3,346	3,264	3,294	3,322	3,315			
				Target Achieved	1,922	2,774	2,992	3,017	3,130	3,070	3,051	3,099	3,122			
				Target Performance	**88.33%**	**89.57%**	**93.85%**	**94.73%**	**93.54%**	**94.06%**	**92.62%**	**93.29%**	**94.18%**			
KPI 6	Non-Renal Outbound Journeys (excluding discharges) to collect within 60 minutes	75%	80%	No. Journeys	3,503	4,860	5,147	4,835	5,059	5,315	5,499	5,659	4,392			
				KPI Achieved	3,098	4,355	4,694	4,502	4,628	4,871	4,972	5,162	4,011			
				KPI Performance	**88.44%**	**89.61%**	**91.20%**	**93.11%**	**91.48%**	**91.65%**	**90.41%**	**91.22%**	**91.33%**			

KPI	Parameter	Threshold	Target	Values	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
KPI 7	Pre-Planned Ward Discharges to be collected within 60 minutes	75%	80%	No. Journeys	573	636	696	666	675	704	716	783	697			
				KPI Achieved	369	437	459	536	502	530	503	549	444			
				KPI Performance	**64.40%**	**68.71%**	**65.95%**	**80.48%**	**74.37%**	**75.28%**	**70.25%**	**70.11%**	**63.20%**			
KPI 7a	Pre-Planned Ward Discharges to be collected within 90 minutes			No. Journeys	573	636	696	666	675	704	716	783	697			
				Target Achieved	419	492	526	608	566	600	575	642	529			
				Target Performance	**73.12%**	**77.36%**	**75.57%**	**91.29%**	**83.85%**	**85.23%**	**80.31%**	**81.99%**	**75.90%**			
KPI 8	Unplanned Ward and A&E Discharges to be collected within 120 minutes	85%	90%	No. Journeys	2,795	3,096	3,049	2,696	2,788	2,871	2,940	2,943	2,867			
				KPI Achieved	2,122	2,350	2,327	2,155	2,145	2,136	2,062	2,138	2,027			
				KPI Performance	**75.92%**	**75.90%**	**76.32%**	**79.93%**	**76.94%**	**74.40%**	**70.14%**	**72.65%**	**70.20%**			

Notes

KPI1 - Sussex is still operating a dedicated call centre however have agreed a virtual call centre for 2018/19. This will improve performance for 2018-19 and reduce costs

KPI 2 - There is a technical issue in the reporting of this performance which is currently being worked on. The reduced performance is a reporting issue and had no impact on patients.

KPI 5a - This is for comparison purposes only and does not form part of the contracted KPI's.

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

Subject:		**Clinically Effective Commissioning (CEC): February 2018 Update**
Date of Meeting:		**28 February 2018**
Report of:		**Executive Lead, Strategy, Governance & Law**
Contact Officer:	**Name:**	**Giles Rossington** **Tel: 01273 295514**
	Email:	**Giles.rossington@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 Clinically Effective Commissioning (CEC) is a regional NHS initiative which aims to improve the effectiveness and value for money of healthcare services by ensuring that commissioning decisions across the region are consistent; that they reflect best clinical practice; are in line with the evidence; and that they represent the most sensible use of limited resources.

1.2 Sussex and East Surrey CCGs have identified a number of procedures that are not a priority for funding. These are procedures where there is limited evidence in terms of improving patients' health. The CCGs, with clinicians across the health economies, have considered evidence in terms of clinical effectiveness and outcomes in line with research and guidance. They have also balanced the cost of such procedures against the overall health benefit gained to come up with updated and aligned policies.

1.3 The HOSC received an initial report on CEC at its September 2017 meeting. This is an update on progress since then.

2. RECOMMENDATIONS:

2.1 That members note the information included in this report; and

2.2 Decide whether they wish to further scrutinise any elements of the CEC programme (e.g. tranche 3 as detailed at 3.4 below).

3. CONTEXT/ BACKGROUND INFORMATION (information provided by B&H CCG)

3.1 CEC is an initiative which brings together clinicians and commissioners across the STP footprint to ensure that a range of at least 39 key procedures are delivered to the same thresholds and standards; that all treatments are clinically

effective and accord with published evidence and clinical best practice; and that treatments on offer represent the most sensible use of finite NHS resources.

3.2 Although CEC planning has been undertaken across several CCG areas, any decisions to change services arising from CEC will be taken by individual CCGs.

3.3 Treatments being evaluated by CEC have been divided into three tranches. The **first tranche** of treatments have already been considered by CCGs and any changes signed-off by CCG Governing Bodies. The focus here has been existing policies with the aim of updating and standardising them across all STP CCGs in line with the latest evidence and guidance i.e. policies that were already in place across the CCGs but with different thresholds. The aim was to bring all the CCGs' current policies into alignment based on the clinical evidence available.

3.4 Ensuring consistency of approach ensures fairness across multiple CCGs, and the changes to the policies are not significant enough to have a major impact on patients. Lay members, as part of the CCG's health policy committee, and representatives from the voluntary sector on the Committee for Investment and Disinvestment, were consulted through the process; and Equality Impact Assessments were carried out for each policy to ensure robust process was followed and that no group was disproportionately affected by the changes.

3.5 Tranche 1 treatments are:

1. Reduction mammoplasty
2. Augmentation/ Mammoplasty
3. Rhinoplasty/ Septorinoplasty
4. Asymptomatic gallstones
5. Circumcision
6. (Adeno)Tonsillectomy
7. Blepharoplasty (surgery on the upper & lower lid)
8. Chalazion
9. Female sterilisation
10. Trigger Finger
11. Hallux valgus/ Bunions- surgical treatment of

3.6 **Tranche 2** treatments are being considered and signed-off by individual CCGs. This consists of Procedures for which there is considerable variation in existing policies or where there is a lack of policies. Currently the policies are being formally reviewed by the CCG's Health Policy Committee (HPC) and then the Committee for Investment and Disinvestment (CIDC). An Equality Impact Assessment has been carried out for each updated policy and scrutiny of the results of these is done by the HPC and CIDC. Again, this process is focused on updating the policies in line with clinical evidence and guidance, in order to align practice across CCGs.

3.7 The CCG has undertaken patient and public engagement under the Big Health and Care Conversation specifically around Clinical Effective Commissioning, and will be carrying out further engagement along with the other Sussex CCGs in the months ahead. However, it is again the CCGs' view is that these plans do not reach the trigger that would require consultation.

3.8 **Tranche 2** treatments are:

12. Minor Skin Lesions (Treatment of)
13. Excision of Haemorrhoid
14. Hernia Treatments
15. Varicose veins
16. Carpal tunnel syndrome (surgical treatment of)
17. Ganglia (Excision of ganglia)
18. Dupuyutrens contracture
19. Arthroscopy/ Knee washout (in patients with knee osteoarthritis)
20. Penile Implants
21. Vasectomy
22. Grommets in older children (12 and above) and adults (ventilation tubes) (Insertion of)
23. Grommets in children under 12 (ventilation tubes) (Insertion of)
24. Bone anchored hearing aid – unilateral
25. Correction of brow Ptosis*
26. Female genital prolapse/stress incontinence (assessment of)
27. Hysterectomy for heavy menstrual bleeding
28. Uterine fibroids (minimally invasive surgery for)
29. Discectomy for lumbar disc prolapse (elective)
30. Epidural injections for lumbar back pain
31. Therapeutic facet joint injections/medial branch blocks
32. Acupuncture for Non- Specific Low Back Pain (LBP)
33. Obstructive sleep apnoea in adults

3.9 **Tranche 3** (some of which may be considered under tranche 2): work on this has yet to be completed regarding review of the evidence and engagement in relation to the proposed changes to policies. If CCGs update these policies and are proposing significant changes, the CCG provides the assurance that this will be proactively discussed with the HOSC at future meetings. The tranche 3 treatments are:

34. Fertility preservation techniques
35. IVF
36. Cataract surgery
37. Hip replacement surgery (primary)
38. Knee replacement surgery (primary)
39. Bariatric surgery

3.6 It is important to note that CEC is not necessarily considering whether to cease providing any of the above treatments: the discussion will be about updating the policies in line with the evidence and whether thresholds for treatment need to be altered to account for best practice/ emerging evidence of efficacy.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 None to this report for information.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 CCGs have a legal duty to engage with patients, carers and the public when planning and/or commissioning services. There is a duty also to engage when changing a service. The level of engagement required is related to the significance of the change. The CCG is developing how it plans to engage going forward regarding more significant changes to policies incorporating learning from a 'Difficult Decisions' workshop held and discussions at the HPC on 27th November 2017.

5.2 Lay members sit on the Health Policy Committee and Voluntary sector representatives are members of the Committee for Investment and Disinvestment. Equality Impact Assessments have been conducted for all policies being reviewed.

6. CONCLUSION

6.1 Members are asked to note the update on CEC and also to decide whether they wish to further scrutinise elements of the CEC programme (e.g. potential plans to change tranche 3 services which may have a significant local impact).

6.2 As noted in the report above, the CCG's position to date is that none of the changes so far identified by CEC are significant enough to require public consultation or to require formal consultation with HOSCs (under legislation local HOSCs must be consulted at any early stage of all NHS plans to make substantial variations to service: SVIS). However, HOSCs may still chose to scrutinise NHS change plans under general scrutiny powers even where these plans do not amount to a SVIS.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 None to this report for information

Legal Implications:

7.2 There are no legal implications to this report

Lawyer Consulted: Elizabeth Culbert; Date: 16/01/18

Equalities Implications (information provided by B&H CCG):

The EIA process assesses for any actual or potential discrimination against protected characteristic groups, and whether any groups are likely to be treated less favourably than others in respect of the relevant clinical care. Equality Impact Assessments (EIAs) are completed for each policy; these are rapid EIAs, which indicate whether further equality assessments might need to be carried out.

In addition there is an established mechanism for dealing with requests from patients when there isn't a commissioned service available and they have a rare disease or illness and/or are clinically exceptional. This process is managed through the Individual Funding Request (IFR) process. More information on this process can be found at https://www.gp.brightonandhoveccg.nhs.uk/individual-funding-requests-information-clinicians

Sustainability Implications:

7.3 None identified.

Any Other Significant Implications:

7.4 None identified.

Documents in Members' Rooms

None

Background Documents

None