Health Overview & Scrutiny Committee

Title:	**Health Overview & Scrutiny Committee**
Date:	**16 October 2019**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall**
Members:	**Councillors:** Deane (Chair), Barnett, Druitt, Evans, Grimshaw, Hills, Lewry, McNair, O'Quinn, Powell **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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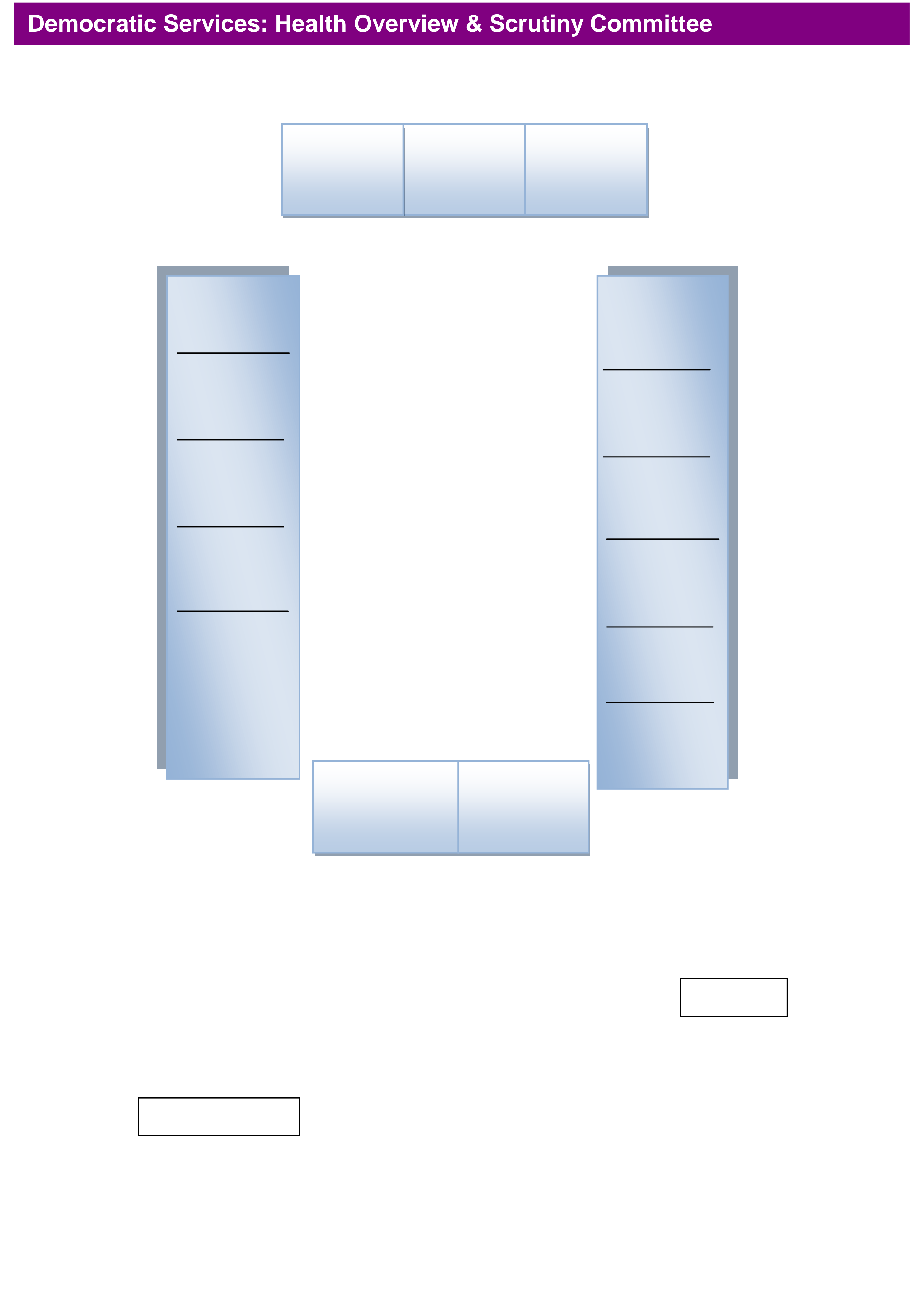
Democratic Services: Health Overview & Scrutiny Committee

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Ward Affected: *All Wards*

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Report of the Executive Lead, Strategy, Governance & Law (copy attached)

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

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Date of Publication - Tuesday, 8 October 2019

BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00pm 17 JULY 2019

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Deane (Chair)

Also in attendance: Councillor Barnett, Druitt, Evans, Grimshaw, Hills, Lewry, McNair, O'Quinn and Powell

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

PART ONE

1 APOLOGIES AND DECLARATIONS OF INTEREST

1.1 Apologies were received from Caroline Ridley (community sector representative) and from the Youth Council.

1.2 There were no substitutes.

1.3 There were no declarations of interest.

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

2 MINUTES

2.1 The minute of the 20 March 2019 HOSC meeting was noted.

3 CHAIRS COMMUNICATIONS

3.1 The Chair welcomed members and thanked everyone for agreeing to change the scheduled date of the meeting.

4 PUBLIC INVOLVEMENT

4.1 There were no public questions.

5 MEMBER INVOLVEMENT

5.1 There were no member questions.

6 POSSABILITY PEOPLE DISABILITY ADVICE CENTRE FUNDING

6.1 Geraldine Des Moulins, Chief Officer of Possability People, addressed the committee. Ashley Scarff, Director of Partnerships and Commissioning Integration, and Dr David Supple, Chair, of Brighton & Hove CCG, were present to respond to members' questions.

6.2 Ms Des Moulins told members that Possability People:

- have challenged the CCG's decision to cease funding the Disability Advice Centre (DAC), but have not to date received a full response;
- have also challenged the Equality Impact Assessment (EIA) process which underpinned the CCG's decision;
- Are unhappy with the mitigations offered in the EIA, particularly since they contend that there was no comprehensive attempt to check that alternative providers were willing and able to take on DAC clients;
- Contend that the EIA was seemingly written after the funding decision had been taken (whereas it should have been used to inform the decision);
- Argue that there is a clear evidence base for the health benefits of the DAC (including its role in reducing healthcare spend, particularly in terms of mental health services);
- Wanted the HOSC to scrutinise the CCG's decision-making process in terms of whether it accorded with Public Sector equalities duties.

6.3 In response to a question from Cllr Druitt on the EIA, Ms Des Moulins told members that Possability People have asked the CCG to clarify when the EIA was completed but have not yet received a response.

6.4 In answer to a query from Cllr Hills on alternative service provision, Ms Des Moulins informed the committee that she had spoken to alternative providers. There are some excellent services in the city, but all providers are struggling with capacity, particularly given the impact of Universal Credit. The DAC is the only specialist advice service for people with disabilities and some of the alternatives are not fully accessible.

6.5 In response to a question from Cllr Powell on numbers of people using the DAC, the committee was told that there were more than 4000 contacts in 2017/18. The number of contacts has been steadily rising in recent years. This service will not easily be replaced and there will be a real impact on people's lives if they do not have rapid access to advice. This can lead to a loss of benefits and the danger that people's problems may spiral out of control.

6.6 In answer to a question from Cllr Powell about engagement with the CCG, Ms Des Moulins told members that the short notice of closure meant that there had been no opportunity to put a case to the CCG or to prepare properly to wind-down the service.

6.7 Dr Supple told the committee that the CCG was required to use NHS funding wisely and to fulfil the NHS mandate. The CCG is required to meet its annual Control Total, and in a very constrained financial environment, this entails making very difficult decisions. The

CCG has reviewed all its non-mandated commissioning and has subsequently reduced some funding. Ultimately, money invested in advice services is money that cannot be spent on treatment. Whilst there is a case to be made for investing more in long-term prevention, the NHS financial system does not currently work to facilitate this.

6.7 In response to a question from Cllr Grimshaw on the equalities impact of the decision, Dr Supple told members that the CCG did pay due regard to equalities; there are alternative advice services in the city. Ashley Scarff added that the CCG used its EIA to explore mitigatory measures prior to making a decision. This process was time-consuming, hence in part the 'late' notification of the decision. Cllr Grimshaw noted that whilst there are other advice services in the city, the DAC offers the only dedicated service for people with disabilities.

6.8 Fran McCabe noted that Healthwatch Brighton & Hove had recently published a report on Personal Independence Payment (PIP) assessments. People's health problems can be exacerbated by the PIP process, and the DAC provides vital support to mitigate this. The fact that the decision to cease funding the DAC was made is indicative of how poorly integrated the city health and care system is. The decision also seems odd given the high prevalence of long term health conditions in Brighton & Hove (according to the city Joint Strategic Needs Assessment: JSNA). Dr Supple noted that the CCG did take JSNA data into account when making its decision. The NHS is faced with making a number of unpalatable decisions and remains committed to learning from all decisions in terms of ensuring that all mitigatory steps have been taken.

6.9 In response to a request from Cllr Powell, Dr Supple agreed to circulate the relevant EIA.

6.10 In answer to a query from Cllr Powell on consultation, Mr Scarff told members that there had been no formal consultation process; formal public consultation would not be required when a contract is not renewed.

6.11 In answer to a question from Cllr Powell on accessibility, Dr Supple told members that the CCG had not visited all the alternative provider sites to check their accessibility.

6.12 In response to a query from Cllr Hills on the timing of the announcement of the decision, Mr Scarff told members that the CCG had spent all available time exploring possible alternatives to ceasing funding.

6.13 In answer to a question from Cllr Hills on what it would take for the CCG to rethink its decision, Dr Supple responded that the CCG would reflect on the views expressed by HOSC members. Mr Scarff added that the CCG will monitor the impact of the decision, but that the CCG is bound to apply its resources to meet mandated requirements and to meet its control totals.

6.14 Cllr Druitt noted that the CCG announced its decision to cease funding the DAC after the city council had set its budget for the coming year. This meant that it was not possible for the council to plug the funding gap had it wished to do so. In the circumstances, the least the CCG should reasonably do would be to maintain funding this year until alternative arrangements can be made. Dr Supple responded by saying that there has been a historical lack of alignment between CCG and BHCC budget-

setting processes which is being addressed. Mr Scarff added that there was a lesson to be learnt about terminology: the CCG believed it had been clear that the contract was being reviewed and that there was no certainty of ongoing funding and about risks to services at an early stage, but in hindsight could perhaps have spoken more bluntly to ensure this was fully understood.

6.15 In response to a question from Cllr McNair on the criteria for making savings, Mr Scarff told members that there are significant financial challenges and the CCG is mandated to prioritise clinical services.

6.16 There was discussion of the CCG's funding. Dr Supple explained that in 2018/2019 the CCG was required to generate a surplus in order to meet its nationally-set control total but that this surplus was not available for commissioning.

6.17 Members discussed further action and Cllrs Hills suggested that the Chair write a letter to the Chair of the CCG setting out member concerns. It was unanimously agreed that the Chair should write to the CCG further expressing member concerns about the DAC decision and asking the CCG to reconsider its stance. (A copy of the letter sent by the Chair and a copy of the CCG's response are included in the October 2019 HOSC papers for information.)

6.18 RESOLVED – that the report be noted.

7 DEVELOPMENT OF AN URGENT TREATMENT CENTRE (UTC) AT THE ROYAL SUSSEX COUNTY HOSPITAL

7.1 This item was introduced by Ashley Scarff, Director of Partnerships and Commissioning Integration at Brighton & Hove CCG.

7.2 In response to a question from Cllr O'Quinn on waiting times, Mr Scarff told members that waiting times remain a problem for the local health and care system, but that the Urgent Treatment Centre (UTC) should help 'stream' patients to the most appropriate treatment settings, relieving some of the pressure on A&E.

7.3 In answer to a question from Fran McCabe on staffing for the UTC, Mr Scarff told the committee that this would be closely watched. The UTC has the same staffing model as the current Urgent Care Centre (UCC) which offers very similar services. The current prediction is that there will be the same volume of activity as experienced by the UCC, but a potentially different patient case-mix. Co-location with A&E helps with staffing as additional capacity is generally available close to hand.

7.4 In response to a query from Ms McCabe as to how booked and un-booked patients would be managed, Mr Scarff responded that this will be refined during the planning for implementation between now and when the UTC opens, once the UTC is in operation patient feedback can be collated. Walk-in patients will be able to in effect book an appointment on arrival at the UTC so neither booked nor walk-in patients are advantaged or disadvantaged over one another, they will be streamed on clinical need.

7.5 In answer to a question from Ms McCabe about the possible relaxation of national NHS A&E targets, Mr Scarff confirmed that the targets are being reviewed, but there is as yet no information on what changes may or may not be made.

7.6 In response to a question on media from Cllr McNair, Mr Scarff affirmed that there would be local and regional press campaigns to explain how UTCs function.

7.7 In answer to a question from Cllr McNair about the Brighton Station Walk-In Centre (WIC), Mr Scarff told members that the WIC is a valuable asset, but one that could probably be better used. The WIC is being reviewed and any change plans will be presented to the HOSC in due course.

7.8 In response to a query from Cllr Powell on the accessibility of the UTC, Mr Scarff confirmed that it will be fully accessible, offering the same access and interpretation services as the UCC currently does.

7.9 In answer to a question from Cllr Powell on how well staff have been prepared for the UTC, Mr Scarff responded that the existing pool of UCC staff should have ample time to prepare before the 01 December UTC launch.

7.10 In response to a query from Cllr Grimshaw about people with urgent mental health issues, Mr Scarff told the committee that people calling 111 may be advised to go directly to dedicated mental health services. Alternatively they might be directed to A&E or the UTC; either would suitable as the on-site mental health liaison team will cover both services.

7.11 In response to a question from Colin Vincent on whether more diagnostics capacity would be required at the UTC, Mr Scarff responded that it was anticipated that demand would be similar to that currently managed at the UCC.

7.12 In answer to a question from Cllr Druitt on readiness, Mr Scarff told members that 21 of the 27 UTC requirements have been met to date. The remaining requirements relate to the booking system and are on schedule to be met prior to opening.

7.13 In response to a query from Cllr Powell on scheme costs, Mr Scarff responded that these would not be significant as the current UCC provides almost all UTC services. There may be some minor capital spend required.

7.14 In answer to a question from Cllr Powell on staff involvement, Mr Scarff responded that there would be no change to staff rotas in moving from the UCC to the UTC. There has consequently been no formal consultation with staff, but there has been engagement.

7.15 RESOLVED – that the report be noted and that the committee agrees that the plans to develop a UTC do not constitute a substantial variation in services.

8 DEVELOPMENT OF A COMMUNITY HEALTH HUB AT THE BRIGHTON GENERAL HOSPITAL SITE: UPDATE

8.1 This item was presented by Peter Prentice, Strategic Director Estates & Facilities, and Geoff Braterman, Head of Health Planning, from Sussex Community NHS Foundation Trust (SCFT).

8.2 In answer to a question from Cllr Druitt on where services would move to in the development, Mr Braterman told the committee that all patient services would be retained on the Brighton General Hospital (BGH) site, which the exception of some Brighton & Sussex University services which will be returned to the Royal Sussex County Hospital once the development of that site has been completed.

8.3 In response to a query from Cllr Druitt on the impact of Brexit, Mr Braterman told members that this was far from certain, but that there is a robust project risk assessment process that seeks to control project risks (e.g. of increased materials cost) as far as is possible. The BGH scheme is pushing ahead irrespective of Brexit, with SCFT using its own capital to progress things where necessary.

8.4 In response to a question from Cllr Hills as to whether the development of a Community Health Hub (CHH) is separate from the development of housing on the site, Mr Prentice explained that the land sale will fund the CHH. SCFT is agnostic about the form of the land sale, but it needs to generate sufficient revenue to fund the CHH. SCFT is not seeking an additional profit from the land sale and is not simply seeking to sell to the highest bidder. Mr Braterman added that the current healthcare facilities on site are far from adequate, for example in terms of disability access, and that the CHH is urgently needed. The only way to fund the CHH is via some form of land sale.

8.5 In answer to a query from Cllr McNair as to whether the BGH site was the best place for a CHH, Mr Braterman told members that a site was needed in the east of the city; Hove polyclinic already serves the west. The BGH site is perhaps not ideally located given the hilly terrain, but it is the best option available.

8.6 Cllr Evans asked a question about whether the BGH plans and/or the re-siting of the ambulance station at the BGH site potentially constitute a substantial variation in service (SViS) requiring formal consultation with the HOSC. The scrutiny support officer responded that advice was that the plans to develop a CHH should not be considered as SViS because they represent an unambiguous service improvement; there is little obvious scope for members to engage with the plans to improve clinical services, and the housing element of the scheme is not within the HOSC's statutory remit.

In terms of the ambulance station, South East Coast NHS Ambulance Trust (SECAmb) is undertaking a reconfiguration of ambulance services across Sussex, which includes the development of a new station at Falmer. The BGH site is consequently surplus to requirement. Both SECAmb's plans and SCFT's plans to develop the CHH have been previously considered by the HOSC.

8.7 RESOLVED – that the report be noted.

9 PRIMARY AND URGENT CARE SERVICES IN HOVE AND PORTSLADE

9.1 This item was introduced by Dr David Supple, Chair of Brighton & Hove CCG.

9.2 Dr Supple told the committee that the local healthcare system was moving to become a more unified service with less emphasis on distinctions between primary and acute/urgent care. Primary (GP) services in Hove & Portslade have been vulnerable, due in part to the relatively high number of smaller practices operating in the area. However, the situation has improved overall with 3 large, stable practices but nevertheless at least 2 smaller practices remain vulnerable and are receiving CCG support.

9.3 Hove & Portslade residents do not present in disproportionate numbers at either the city Urgent Care Centre or at A&E. This suggests that primary services in the west of the city are functioning as well as elsewhere – if they were markedly poorer or offered worse access, this would likely be reflected in higher than average attendance at emergency care.

9.4 It is hoped that the Primary Care Network (PCN) programme will improve experiences of primary care across the city. It is however very early days and PCNs vary considerably in terms of 'capability'; some will require significant support while relationships are established and historical challenges overcome. The model for improvement is based on better network of existing services rather than adding additional capacity in the form of new buildings at this stage.

9.5 In response to a question from Cllr McNair on how future-proof capacity planning is, given the amount of new housing scheduled for the area, members were told that Hove & Portslade is very unlikely to ever need an acute hospital, given the proximity of the Royal Sussex. At some point additional Primary Care capacity may be required; Hove Polyclinic has some potential to expand, particularly in terms of offering more out of hour provision. We may also see more of the existing GP practices jointly relocating to new, future-proofed premises.

9.6 In answer to a query from Cllr Barnett about the potential to open facilities at the Toad Hole Valley development, Dr Supple reiterated that the favoured initial direction of travel was to better network existing services via PCNs rather than to build new facilities. Although informal discussions have taken place around relocation of smaller teams to a single site, local GP practices have not expressed enthusiasm for moving to this development given its geographical disadvantages.

9.7 RESOLVED – that the report be noted.

10 HOSC DRAFT WORK PLAN

10.1 This was briefly discussed.

The meeting concluded at Time Not Specified

Signed Chair

Dated this day of

Councillor Lizzie Deane

Brighton & Hove City Council
King's House
Grand Avenue
Hove BN3 2LS

Dr David Supple
Chair
Brighton & Hove Clinical Commissioning Group

Dear David,

I first of all would like to thank you and Ashley very much indeed for attending the HOSC meeting on 17th July, and for answering so many questions on behalf of the CCG on the subject of funding for the Disability Advice Centre at Possability People. I do appreciate that this was a difficult and passionate debate.

The feelings expressed at the meeting last week were both unanimous and clear, that the Disability Advice Centre plays a crucial role for the city, in that it is the only fully accessible centre offering a service that is only available elsewhere in a fragmented and piecemeal fashion. The alternatives put forward are in centres not fully accessible to all, or to which only certain groups can attend, such as disabled older persons, disabled LGBT persons, etc. which does not best serve the needs of a particularly disadvantaged and vulnerable sector of society.

Concern was expressed that due process had not been fully observed, with Possability People left with very little notice to accommodate the consequences of the decision, delays in the Equality Impact Assessment, and lack of an adequate Priority Action Plan and, more crucially, no consultation conducted with service users.

I am writing to you today to formally ask that the CCG reverse its decision with regard to funding, and reinstate the £29,000 annual grant.

Whilst the view of the CCG is that the services provided by the DAC are not directly health related, there is a cogent argument that it has direct links to physical, mental and emotional well-being. As this, in turn, has direct financial savings implications to the NHS in terms of prevention, to do so would not only be humane in the immediate term, but would also be cost effective in the long term.

On behalf of Possability People, members of HOSC and those with disabilities across the city, I urge you to reconsider.

Yours Sincerely

Cllr Lizzie Deane
Chair, Brighton & Hove Health Overview & Scrutiny Committee

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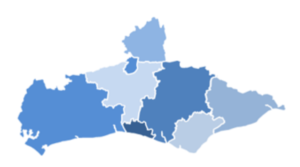
Green Member for St Peter's & North Laine Ward



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13 August 2019

Dear Cllr Deane

Re: Funding of the Disability Advice Centre

Thank you for your letter of 29 July 2019 on behalf of the Brighton and Hove HOSC, following the Health Overview and Scrutiny Committee (HOSC) meeting on 17 July 2019.

There are some issues which, given the nature of discussions at HOSC and reflected in your letter, that we would like to clarify:

- Notice of non-renewal of funding for welfare benefits advice service
- Equality Impact Assessment
- Key principles of the use of NHS funding
- Wording of your letter.

Notice of non-renewal of funding for welfare benefits advice service

The Local Authority and CCG commissioners met with Possability People on 12 December 2018 to discuss the funding of the Disability Advice Centre (DAC). At this meeting, the Local Authority confirmed a 10% cut in its funding for 2019/20, and the CCG confirmed that we were unable, at that point, to guarantee funding beyond the end of the contract in March 2019. Following the meeting, an email was sent to Possability People on 21 December 2018 to inform them that the contract was being reviewed and that there was no certainty of ongoing CCG funding.

Given that the contract was due to end in March 2019 and that Possability People had been

given no certainty about continued funding, it would be reasonable to have expected the organisation to fulfil their own legal requirements regarding management of staff and taking necessary measures to ensure the contract end was handled appropriately.

Equality and Health Impact Assessment (EHIA)

An EHIA was completed in early January 2019 and this informed discussion at the CCG's Local Management Team in January and February 2019, prior to, and directly informing, the CCG's final decision-making process. The EHIA was again reviewed in the light of further comments and signed off by the CCG's Equality and Diversity Lead prior to sharing with Possability People and other parties in early April 2019.

The EHIA recognised that there are a variety of services in the city, and nationally, which could provide support and advice to people seeking help with benefits. We did not contact these organisations to assess their capacity and we acknowledge that this is something we could have followed up on; however, this does not change the reasoning for the decision not to renew funding for the DAC contact.

The EHIA included a Prioritised Action Plan, which centred on ensuring information about the range of services was made available. Again, we have acknowledged that we could have been more proactive in ensuring these actions were followed up.

With regard to service user engagement, we had already been provided with user feedback through the DAC contract review process, and we were satisfied that those using the service considered it valuable and that it impacted positively in a number of ways, including being able to access benefits. We could indeed have carried out further engagement with service users; however, this would not have changed our decision given the reasons, as outlined, for taking it.

Key principles of the use of NHS funding

The CCG recognises that the DAC provided a service that was very much valued by its users and the wider community; however, the key principle on which the CCG's decision was made was the need to prioritise limited NHS funding, and to deliver standards enshrined in the NHS Constitution. In addition, as a CCG much of our funding is nationally determined – such as our spend on primary care and mental health services – which means that funding outside this is limited and must be prioritised.

The CCG has a legal responsibility to ensure that the funds allocated to meet the health needs of the local population are used to the best effect; this involves constant assessment of how we use these funds, which includes consistent review of our contracts to ensure we are meeting required our legal duties, NHS Constitution standards and agreed outcomes.

Wording of your letter

We are sorry that you feel that this decision is not "*humane*". We make all of our decisions with consideration of the best interests of our population and of course with regard to the stewardship of public money.

We note that your letter is also written "on behalf of Possability People"; this response to your letter is addressed to you as Chair of the HOSC. We feel that it would be much healthier for the relationship between the CCG and HOSC, and will protect against any potential conflicts of interest, for any future discussions and correspondence between us to be carried out in an objective and impartial way.

Conclusion

In summary, and as was discussed at HOSC, the NHS locally has to make decisions on how best to deploy the limited financial resources to best meet the health needs of the whole population of Brighton and Hove within the policy and financial frameworks that are set for the NHS nationally. This requires us to constantly make decisions about where investment needs to be made that will have the largest positive impact on, and make the greatest difference to, people's lives.

We have, though, made decisions on this matter under the authority we have as a CCG and, in the absence of tangible evidence that has not previously been considered, that decision will stand.

Regardless of this, as partners committed to the wider Brighton and Hove Health and Wellbeing Strategy, we would welcome alternative solutions to further support people with welfare and benefits advice needs and will work with partners to that end. For example, we are now engaging with the Department for Work and Pensions in exploring local opportunities for partnerships with NHS and GP surgeries to raise awareness of health journeys, disabilities and benefits within the social prescribing service model.

Yours sincerely

Dr David Supple
Clinical Chair
Brighton and Hove Clinical Commissioning Group
Central Sussex and East Surrey Commissioners

HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 17 Brighton & Hove City Council

Subject:		**Winter Planning for Health and Social Care**	
Date of Meeting:		**16 October 2019**	
Report of:		**Executive Lead Officer for Strategy, Governance & Law (Monitoring Officer)**	
Contact Officer:	**Name:**	**Giles Rossington**	**Tel: 01273 295514**
	Email:	**giles.rossington@brighton-hove.gov.uk**	
Ward(s) affected:		**(All Wards);**	

FOR GENERAL RELEASE

Glossary:

- Local A&E Delivery Board (LAEDB) – partnership body that coordinates urgent care across the city, including planning for seasonal pressures
- Sustainability & Transformation Partnership (STP): NHS regional planning footprint
- SES: Sussex & East Surrey (area covered by local STP)
- BSUH – Brighton & Sussex University Hospitals Trust: NHS trust responsible for Royal Sussex County Hospital
- SECAmb – South East Coast Ambulance NHS Foundation Trust: NHS trust responsible for local emergency ambulance services
- Sussex Resilience Forum – local partnership that coordinates emergency planning
- CQUIN (Commissioning for Quality and Innovation) – NHS system that males part of NHS provider income conditional on delivering locally agreed performance targets
- LLOS (long length of stay) – NHS metric that records all patients spending more than 20 days in an in-patient bed
- 111 – urgent but non-emergency NHS phone service
- Discharge to Assess (D2A): initiative that entails undertaking care assessments of individuals *after* they are discharged from hospital to their own homes

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 There is a consistent surge in the use health and care services in the winter months, creating additional pressure on a system already struggling to meet

demand. This report seeks to provide HOSC members with assurance that partners have robust, evidence-based plans in place to cope with winter 2019/20.

1.2 **Appendix 2** includes information on local winter planning supplied by Brighton & Hove CCG.

2. RECOMMENDATIONS:

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

3. CONTEXT/ BACKGROUND INFORMATION

3.1 There is a consistent increase in demand for health and care services during winter months. This has several causes: cooler and wetter weather can worsen certain medical conditions, particularly respiratory problems. There is also an increase in trips and falls in the winter, potentially as a result of extreme weather, but mainly because the colder conditions can act to exacerbate health problems experienced by frail older people. In addition, winter is the season for flu and norovirus.

3.2 All local health and social care systems are expected to agree a plan for the winter period (01 December 2019 to 31 March 2020). The plan covers the whole health and social care system, from preventing unnecessary admission to hospital through to supporting timely discharge home, ensuring that access to services and patient safety is maintained.

3.3 The plan provides system assurance that service capacity across the health and social care system will be sufficient to meet forecast levels of demand and is able to respond quickly and effectively when there are exceptional surges in demand that require a rapid system response.

3.4 Winter planning is the responsibility of the local A&E Delivery Board (LAEDB) a partnership body bringing together a wide range of organisations (the Brighton & Hove LAEDB Terms of Reference/membership are included for information as **Appendix 1**).

3.5 **Plan Objectives.** The LAEDB-set winter planning objectives are:

- To maintain patient safety and service quality at all times;
- To ensure that acute hospital bed occupancy is maintained at a level that ensures that patients who require admission to a hospital bed are able to be admitted in a timely way, thereby avoiding the risk of overcrowding in A&E and delays to ambulances being able to handover patients and respond to 999 calls;
- To ensure that community health services are maximised, e.g. improving length of stay and utilisation and increasing the number of patients who can be safely discharged home. Effective use of community services during the winter period will support timely discharge from hospital and avoidance of unnecessary admission to an acute hospital bed;

- To ensure the delivery of agreed improvement plans in respect of national NHS access standards including the 4 hour A&E standard, the 18 week referral to treatment standard and cancer waiting times standards;
- To deliver the national ambition to reduce the number of patients in an acute hospital bed with a long length of stay by 40% by March 2020 – It is well evidenced that patients with a long length of stay in acute hospital settings are at high risk of de-conditioning.
- To ensure system Delayed Transfer of Care (DTOC) are no greater than 3.5% of acute hospital beds.
- To proactively prevent and manage infection control outbreaks issues such as influenza and norovirus

3.6 **Using learning from last year**

3.5.1 Last Winter was very challenging for the Brighton & Hove system, but the system was able to maintain a focus on patient safety. There are a number of lessons that have been identified that informed the development of the plan for this winter.

3.5.2 A 2019 LGA (Local Government Association)/NHS peer review of local 'hospital to home' services identified a number of opportunities to strengthen partnership working; all system partners are committed to this. An example of this learning is the development of a whole system approach to capacity and demand planning for winter which will significantly strengthen planning.

3.5.4 However it is recognised that the system remains a challenged system and there is an improvement journey that needs to be continued to deliver the best possible services to the residents of Brighton & Hove. It is also important that the system effectively supports staff during the challenging winter period

3.5.5 The slides attached (**Appendix 2**) give the detail of mitigations developed in response to learning from previous performance.

3.6 **Management of the winter plan.** The Local monthly A&E Delivery Board will be the lead body managing delivery over the winter period. There will also be weekly face to face meetings of the senior system leadership at the Operational Command Group to support delivery and the option of daily escalation calls if necessary.

3.7 **HOSC involvement**

3.7.1 The local health and care system's ability to cope with seasonal demand surges is a key factor in delivering high quality services that meet national targets and local aspirations. The HOSC has a role in seeking assurance that system partners are working effectively together to plan for winter. HOSC members may particularly wish to consider the following:

- Are there sufficient city acute hospital beds to cope with forecast demand over the winter?
- Is the system doing all it can to reduce acute attendances by offering community/primary alternatives?

- Can the local system cope with the forecast demand for urgent care without a negative impact on elective care (e.g. having to cancel planned operations because beds are needed for emergency care)?
- Is the system doing all that can be done in terms of having a coordinated approach to hospital discharge (e.g. efficient use of step down beds and residential care beds)?

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 Not relevant to this report which is to note.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 This report has been prepared with input from Brighton & Hove CCG.

6. CONCLUSION

6.1 Members are asked to note local system preparations for increased demand for health and care services over the winter.

6.2 If members are not assured that local winter planning is robust, they may want to further scrutinise issues or make recommendations to the responsible bodies (LAEDB, Health & Wellbeing Board)

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 Not relevant to this report for information

Legal Implications:

7.2 There are no legal implications to this report

Lawyer Consulted: Elizabeth Culbert; 01/10/2019

Equalities Implications:

7.3 This plan shows that partners are working together to ensure that a strategic approach to the reduction of excess winter deaths (EWDs) is taken across the local health and social care economy. The winter plan can help to reduce health inequalities, and as part of the planning all partners should consider how they might target high-risk groups and address the wider determinants of health.

Sustainability Implications:

7.3 None identified

Any Other Significant Implications:

7.4 None identified

SUPPORTING DOCUMENTATION

Appendices:

1. Terms of Reference/membership of the Local A&E Delivery Board (LAEDB)

2. slides on winter planning for Brighton & Hove provided by BH CCG

Documents in Members' Rooms
None

Background Documents
None

Commissioning Alliance
(South Place)
Brighton and Hove CCG
High Weald Lewes Havens CCG

Appendix 1

Brighton & Sussex University Hospitals Local Accident & Emergency Delivery Board

Terms of Reference

Authority

The Brighton & Sussex University Hospitals Local Accident and Delivery Board is being configured in response to the NHS England/NHS Improvement 16-17 “Strengthening financial performance and accountability” guidance issued 21st July 2016, and the CCG’s obligation to transform the System Resilience Group (SRG) into a board to focus solely on Urgent & Emergency Care

Purpose of the meeting

The Board is **accountable** for setting the strategic direction and delivery of the local health economy Urgent & Emergency Care, **to deliver and sustain the responsibilities around Urgent & Emergency Care deliverables** and therefore improve and maintain the quality of care for patients and the public.

The Board will be the forum where all the partners across the health and social care system come together to undertake the regular planning of service delivery. This group will sign off implementation plans, regularly review the system improvement plan, address escalated issues and risks which cannot be resolved at an operational level. The board will make decisions, provide rigorous oversight of system pressures and enable collaborative approaches to solving them

Membership

LAEDB will be chaired by the Chief Operating Officer of Brighton & Sussex University Hospitals with the Director of Integrated Urgent Care, Brighton & Hove CCG as the Deputy Chair. The board will comprise each of senior members of the partner organisations within the BSUH system.

The membership of BSUH LAEDB will include executive level from the following organisations:

- Brighton and Hove CCG
- Horsham and Mid Sussex CCG
- High Weald Lewes Havens CCG
- Brighton and Sussex University Hospitals NHS Foundation Trust
- Sussex Community NHS Foundation Trust
- Sussex Partnership NHS Foundation Trust
- South East Coast Ambulance NHS Foundation Trust
- Brighton and Hove City Council
- West Sussex County Council
- East Sussex County Council
- Integrated Care 24
- East Sussex Healthcare NHS Trust community provision
- Independent sector care home representative
- Healthwatch
- NHS England (specialist)
- NHS Improvement
- Primary care provider representation

In attendance:

NHS England South (South East) representative
NHS Improvement (South East) representative
Other directors and senior officers will be invited to attend the LAEDB as appropriate dependent on the issues being discussed.

Attendance and quorum

Unless on annual leave, all members will attend the BSUH LAEDB meeting.

The meeting will be deemed as quorum when over 50% of the members attend including the chair and or deputy chair

Frequency of meetings

Meetings will take place monthly. Agenda items from members should be sent to the chair and the PA at least 10 working days prior to the meeting. Papers, agenda and all other communication for the meeting will be circulated at least 5 working days before the meeting. Members should ensure that they provide relevant papers to enable this in a timely manner

Scope

The Delivery Board will span the Brighton and Sussex University Hospitals (BSUH) NHS Trust local health economy. The **Board will set the strategy, agree the whole system delivery plan and oversee its implementation.**

- Ensure that Urgent & Emergency Care national deliverables and the NHS long-term plan objectives are achieved
- Reducing and managing non-elective attendances
- Accident and Emergency streaming at the front door – to ambulatory and primary care
- NHS 111 - increasing the number of call transferred for clinical advice
- Ambulance Response Programme
- Improved flow e.g. implement SAFER to enhance patient flow
- Discharge e.g. implementing “Discharge to Assess” and “Trusted Assessor” type models
- Other best practice as identified e.g. Emergency Care Improvement Support Team (ECIST)

Specific duties and responsibilities

Strategic planning

- To set the strategic vision, identify and set goals for the local health economy
- To identify local priorities and funding
- To sign off and oversee the implementation of the delivery plan

Delivery

- Oversee and drive through delivery of the strategy by addressing risks and issues in a timely manner
- Develop and manage the process to ensure delivery of the NHS constitutional standards

Roles and Responsibilities

The Board will:

- Maintain an immediate focus on improving AE performance against the national 95% 4 hour standard including delivery of the agreed improvement trajectory
- Deliver the national A&E improvement plan locally with particular attention on Delayed Transfers of Care and super-stranded patients
- Where possible, provide executive/senior clinical and strategic leadership
- Develop comprehensive whole system operational resilience and capacity plan fulfilling national planning requirements and ensuring good system working. Plans should be aligned with the strategic direction established by the STP and the Urgent & Emergency Care Network
- Oversee the use of non-recurrent funds and marginal tariff and resilience funding
- Determine service needs on a geographical footprint, initiate the local changes needed and address the issues that have previously hindered whole system improvements
- Hold each other to account for the delivery of agreed work programmes to improve resilience across local systems
- Ensure appropriate integration and links with other related governance structures
- Be supported by a robust governance structure enabling the Delivery Board to be assured on delivery of work programmes without needing to stray into operational management
- Be supported by a Patient Safety Group that provides whole system oversight of patient's safety issues such as handover delays etc.
- Provide rigorous and on-going analytical review of the drivers of system pressures, so that solutions to these pressures may be developed with a collaborative approach
- Work across boundaries to improve patient experience and clinical outcomes, by establishing partnerships and better working relationships between all health and social care organisations
- Develop and agree new ways of working that are transformational in line with national and international best practice guidelines; learning from national vanguards and NHS England five year forward view, and the NHS Long Term Plan
- Ensure system wide participation in the planning and operations for local ambulance services and for NHS 111 services

Ways of working

BSUH LAEDB takes place at Hove Town Hall, CCG offices, unless otherwise stated.

The Chair will be responsible for the compilation of an agenda. All members of the Group will be contacted in advance and invited to raise items to be placed on the agenda.
The Group is accountable for agreeing the whole system plan and priorities, for ensuring implementation within and across organisations. The Board will receive recommendations for decision and escalation reports which require agreement at a system wide level.
Members are therefore expected to be able to make decisions on behalf of their organisation and are asked to nominate named deputies who are able to do so.

To ensure progress and delivery at pace the expectation is that there would be consistency of attendees and only by exception will the agreed deputy attend on behalf of the representative. For those who are unable to attend comments and completed/status updates on assigned actions and papers should be sent to the chair's PA at least 5 working days before the meeting.

The board is expected to be outcome focused with meetings reflecting progress and delivery of its objectives. To enable this if members are not able to attend they are expected to review the papers and work with the deputy attending on their behalf to ensure that their views feed into the meeting. Decisions made at the board meeting will be reached by consensus and will move all approved items to delivery.

Conflicts of Interest will be managed in line with the CCG's conflict of interest policy: **http://www.brightonandhoveccg.nhs.uk/sites/btnccg/files/files/BH%20CCG%20Conflict%20of%20Interests%20%28v1%205%20Aug%202015%29.pdf** . A register of interest will be maintained by the delivery board and regularly updated.

All individuals must state at the meeting if an interest potentially conflicts with an item of business and have completed the necessary declaration form. The Chair (or their nominated deputy) will determine any action to be taken, with respect to the declared interest.

Sub-committees

The BSUH LAEDB is reported to directly from the LAEDB Delivery Working Group (previously known as CUCORG). This is the operational arm of the BSUH LAEDB and will focus on progressing all pertinent operational matters arising from LAEDB in agreement with the LAEDB members and in line with the System Improvement Plan

Administrative support

The Brighton & Hove CCG Urgent Care & Resilience Team will be responsible for compiling papers, taking notes and dissemination of all relevant subsequent material for the LAEDB meeting.

Accountability and reporting arrangements

BSUH LAEDB will report directly to the Aligned Incentive Contract (AIC) Joint Management Board by the chair for Performance and Transformational content. Individual members are expected to report in line with their respective organisational structure.

Issues from the LAEDB meetings will as appropriate be cascaded by all members of the LAEDB to their teams.

Monitoring effectiveness and compliance with terms of reference

The LAEDB will develop a work plan with specific objectives which will be reviewed regularly and formally on an annual basis

Review of Terms of Reference

These terms of reference will be formally reviewed by the LAEDB in April of each year, and may be amended by the LAEDB at any time to reflect changes in circumstances which may arise.

Terms of Reference drafted:	01/07/2019
Date approved:	23/05/2019
Approved by:	Brighton Sussex University Hospitals Local Accident & Emergency Delivery Board
Next review date:	23/04/2020

HOSC– Winter Planning
to support the Health and Care system

Introduction

- Planning for the winter period is a national requirement for local preparation for additional demands and pressure on the health and social care system expected during the winter period (01 December 2019 to 31 March 2020).
- The plan covers the whole health and social care system from preventing unnecessary admission to hospital through to supporting timely discharge home ensuring that access to services and patient safety is maintained.
- The plan provides system assurance that service capacity across the health and social care system will be sufficient to meet forecast levels of demand and is able to respond quickly and effectively when there are exceptional surges in demand that require a rapid system response.
- The plan is being developed by the local system Local A&E delivery board (LAEDB), which has representation from all local system health and social care providers and commissioners (see Appendix 1 LAEDB Terms of Reference).
- The plan for winter builds on learning from previous years as part of a continual improvement process
- The final version of plan will be approved by the LAEDB at the end of September following assurance review by NHS England. The plan will also be considered for assurance by the B&H CCG Governing Body in September and individual providers will assure their own plans though their respective boards.
- Whilst the winter plan covers the broader system that Brighton and Sussex University Hospitals NHS Trust serve the focus of this report is specifically on the Brighton and Hove element of the plan.
- We are bringing this update to the HOSC for information

Brighton & Hove City Council

Winter Plan 2019/20 Objectives

- To maintain patient and staff safety and service quality at all times;
- To ensure that acute hospital bed occupancy is maintained at a level that ensures that patients who require admission to a hospital bed are able to be admitted in a timely way, thereby avoiding the risk of overcrowding in A&E and delays to ambulances being able to handover patients and respond to 999 calls;
- To ensure that community health services are maximised, e.g. improving length of stay and utilisation and increasing the number of patients who can be safely discharged home in a timely manner with care support. Effective use of community services during the winter period will support timely discharge from hospital and avoidance of unnecessary admission to an acute hospital bed;
- To ensure the delivery of agreed improvement plans in respect of national NHS access standards including the 4 hour A&E standard, the 18 week referral to treatment standard and cancer waiting times standards;
- To deliver the national ambition to reduce the number of patients in an acute hospital bed with a long length of stay by 40% by March 2020 – It is well evidenced that patients with a long length of stay in acute hospital settings are at high risk of de-conditioning.
- To ensure system Delayed Transfer of Care are no greater than 3.5% of acute hospital beds.
- To proactively prevent and manage infection control outbreaks issues such as influenza and norovirus.

Brighton & Hove City Council

Winter Plan 2019/20 key elements

- ✓ System capacity and demand plan to address the expected increased demand
- ✓ Primary Care
- ✓ Community Services
- ✓ Acute Hospital plans
- ✓ Social Care
- ✓ Mental Health
- ✓ 999 and 111
- ✓ Infection Control and influenza vaccination
- ✓ Business Continuity
- ✓ Severe weather planning
- ✓ Winter Communications and Engagement
- ✓ Enhanced capacity requirements to meet the Christmas and New Year period 24th December - 7th January 2020
- ✓ System Pressure monitoring and escalation response
- ✓ Risks to delivery and mitigating actions

Brighton & Hove City Council

Learning from Last Winter

What went well:

- Following action taken collectively by health and social care partners delayed transfers of care from Brighton & Sussex University Hospital decreased from 6.4% to 3.5% ahead of the winter period and were sustained between 3.5% and 4.1% after winter.
- Support from other local health and social care systems in response to pressure in the local system.
- Maintenance of patient safety in A&E during periods of sustained demand pressure.
- Ability of system partners to rapidly support additional capacity in response to system pressure.
- Mobilisation of additional care home clinical support ward rounds across the city.
- Introduction of mental health street triage services in Brighton and Hove from early December.
- Increase in the number of paramedics following a recruitment drive by SECamb.
- Single winter communications plan across Sussex and East Surrey aligned to the national NHS campaign.
- Increased provision of rehabilitation beds and home care hours over the winter period.

Brighton & Hove City Council

Learning from Last Winter

What went well:

- Overall reductions in DToCs

BSUH Delayed Transfers of Care %

Percentage occupied beddays DToC

National Target

Brighton & Hove City Council

Learning from Last Winter

Area/Opportunity for Improvement		Action taken
The need for a whole system approach capacity and demand plan for winter	→	A whole system Capacity & Demand model is being developed
Improved utilisation of primary care, improved access	→	Direct booking digitally enabled via NHS 111 by Nov 19
Ambulance response times	→	Additional investment in SECAmb for 19-20
Ambulance handovers delays at RSCH	→	Agreed system ambulance handover improvement plan
Improvements to acute hospital flow	→	Increase in ambulatory same day emergency care and BSUH internal flow improvement programme
High number of patients in an acute bed with long length of stay (21 days+)	→	Long length of stay improvement programme
Limited community rehabilitation capacity	→	Commissioning additional capacity for 19-20 – Lindridge, Newhaven Downs
Levels of long term care home admission	→	Discharge to Assess (D2A) Improvement Programme
Care Home responsiveness in assessing new residents	→	Increased engagement with residential and nursing providers Care Matching task and finish group to maximise brokerage efficiency
Mental Health Capacity	→	SES STP MH Programme – Investment in Core 24, Crisis Response and Home Treatment Teams, Opening of new 24/7 Psychiatric Decision Unit.

Brighton & Hove City Council

National Influenza Plan 19-20

- Target uptake for eligible individuals:
  - 75%
  - 80% (front line staff)

- General Practice Directed Enhanced Service (named lead, registers, early planning, proactive communications and immunisation to ensure patients protected before flu starts circulating)

- Vaccines available from GP and community pharmacies

- GP to collaborate with community, care homes, nursing homes

- System approach to outbreak management

- Data collection process September 2019; collection November – February

- Public Health England has ultimate responsibility for the overall plan, with specific responsibilities resting with the CCG for certain elements

Sussex-Wide Influenza Plan 2019-20 - Summary

Target area	Planned Outcome	Comments/Progress
Primary Care	Implementation of the National Influenza Vaccination programme for over 65 years, Under 65 years with clinical risks, Pregnant Women and Children aged 2&3 years.	Briefing to all Primary Care Localities with the changes to the National 2019/20 Influenza programme during Aug/September 2019
Primary Care	NHSE Assurance of Primary Care Vaccination Suppliers to determine if delay in Supply of Vaccination due to WHO delay in manufacturing Vaccine.	A request has been sent to all GP Practices across SES CCGs requesting this information. To be returned to NHSE on 5th August.
Provider Trusts	Work with Provider Trusts in meeting the Clinical staff Influenza vaccination rates of 80% - national target	National Commissioning for Quality and Innovation (CQUIN) Target 2019/20 is 80% of Frontline staff require vaccination. Increase availability of Peer to Peer Influenza vaccination and education programmes
Provider Trusts	Review of provider Trusts to offer vaccinations at ante-natal appointments to Pregnant Women	Assurance Sought of Provider plans at Sussex and East Surrey CCG meeting in July 2019
Provider Trusts	Provider organisations to offer long stay patients Influenza vaccinations	Assurance Sought of Provider plans at Sussex and East Surrey CCG meeting in July 2019
Social Care/ Independent Providers	Increase in compliance with Influenza National Vaccination programmes for Social care and Independent Providers staff	Increase awareness of National Influenza Vaccination programme offer of free Influenza Vaccine.
Primary Care	Improve vaccination rates for all staff groups across primary care	
CCGs	Clinical Commissioning Groups to offer free Influenza vaccination for all staff	A standard approach to be adopted across all Sussex and East Surrey CCGs

Winter communications campaign

The winter comms strategy is to take a coordinated and consistent approach to communications and engagement, to help encourage behavioural changes in our population that will mitigate the winter pressures within the local health system.

Aims and Objectives

- To raise the awareness among the public of the alternative local services to A&E and explain when to use them.
- To ensure information is easily accessible through a range of channels and meet accessibility standards of the alternative services, such as, NHS111, GP Improved Access, Urgent Treatment Centres and bookable appointments into other primary and community services.
- To raise awareness among the public of when they should use GP services and what alternative Primary Care services are available to them.
- To raise awareness of NHS111 (phone and online) and Pharmacist and explain how they can help you this winter.
- To raise awareness of the benefits of self-management and to provide information that encourages and supports patients to self-care.
- To establish channels of feedback that will help to better inform why people access A&E and GP services, which can be used to shape and adapt services in the future.

Communications approach

The proactive communications plan has been developed to encourage the public to use A&E responsibly, to promote self-care and other NHS services and that may be better suited based on their condition.

- Aligned with national NHS Help Us Help You campaign - utilising those resources and collateral
- A stand alone flu campaign, designed and implemented in partnership with PHE colleagues
- Combines communications with robust engagement activity to ensure a set of honed key messages are reaching and are understood by the public

Brighton & Hove City Council

Winter communications campaign

Using insights

- Targeted campaign introduced for winter 2019/20 following lessons learnt 2018/19 and Healthwatch recommendations
- Use the CCGs insights and data to identify whom we needed to reach; this was based around our A&E figures.
- The patient insight showed that in Brighton and Hove a high percentage of people attending A&E (excluding the under 18's) over the winter months with a primary care need are:
  - 20-39 year olds
  - 40-59 year olds
  - Residents in Kemptown / Whitehawk / Moulsecoomb

Communications channels

- **Media Handling** - co-ordinated system wide across the Sussex and East Sussex STP
- **Communications channels** - Use of channels and distribution based on insights, including geographical targeted distribution of comms materials (Flyers, posters, and Z-Cards) and paid for advertising
- **Website and social media**

Engagement channels

- **Events/groups -** organise bespoke engagement events and established events and groups
- **Group discussions -** hold public group in a range of localities and at different times of the day.
- **Social Media -** run a number of social media initiatives throughout the campaign
- **Targeted engagement - subject -** carry out targeted work where we want to engage about key issues. This will comprise bespoke focus groups and online discussions/feedback.
- **Targeted engagement - people -** we will talk with specific groups and carry out targeted work in specific locations.
- **Attending existing meetings and forums -** existing meetings, forums and groups to discuss the key messages and gather feedback from those present.

Brighton & Hove City Council

Winter plan key risks and mitigations

Risk	Mitigations
System Flow	• Additional community and Newhaven confirmed to come online Sept/Oct 19 • Establish multi agency agreement on standard operating procedure and escalation process and triggers for all community pathways • LLOS action plan in place, multi system engagement secured, regularly reviewed
Challenge with timely access to domiciliary care	• Local authority engagement with homecare provider market • Care Matching task and finish group to maximise brokerage efficiency
Workforce challenges across the system	• Prebooking block contracts with agency and bank staff • STP wide and local winter communications plan • Flu vaccine uptake by staff • Upskilling workforce to ensure flexibility across multiple areas • Preplanning rota fill across providers
Mental Health patient flow pressures	• STP Mental Health Programme Investments 19-20 • STP Executive escalation related to housing and accommodation risk identified. • Development of SES Mental Health escalation plan, triggers and related actions.
Low uptake of flu vaccine	• National and local campaigns • CQUINs in place to support uptake locally
Increased attendances / admissions from at risk cohorts i.e. frail elderly, respiratory, homeless	• Multi system core care plan access • Forum to discuss and plan for high intensity users • Robust community planning for same day service access e.g. respiratory • Streaming away from A&E to ambulatory and frailty units where appropriate • Robust admission avoidance pathways and full access/utilisation of available pathways
Brexit	• Coordinated no deal Brexit contingency planning through Sussex Resilience Forum

LGA/NHS peer review recommendations/actions

Overarching objective 'Put the patient and the wider population needs first'

Recommendation/Finding	Action
There is a lack of trust, respect and confidence between partners	New weekly face to face system operational executive meeting focused on leading improved system collaboration and delivery
Staff need the collective vision of the Home First philosophy to work to	Discharge to Assess improvement programme
The system needs a Demand and Capacity Plan which is dynamic and future proofed	Underway and coordinated by senior Operational Executive Group
Managers and staff need to be empowered to lead and act - too many system calls	Review of system escalation, triggers and actions
The focus on complex DToCs is distracting focus from the real cause of poor patient flow	Long Length of stay improvement programme, simplified out of hospital pathways, improved front door service model for rapid assessment and discharge and an integrated approach to discharge
An agreed model of care was not articulated or shared	Simplification of discharge pathways

Next Steps

	Action
Aug/Sep	NHS Review and Assurance process
September	Winter Plan covering entire BSUH Footprint to Local Accident and Emergency Delivery Board (LAEDB)
September	Process of stress testing plan
September	Final Plan submitted to LAEDB for approval
September	CCG governing body review and approval
Throughout Winter	Close monitoring of winter plan throughout the winter by all partners (via LAEDB Monthly and Operational Executive Group weekly)

Brighton & Hove City Council

Conclusion

- Last Winter was very challenging for Brighton and Hove system but the system was able to maintain a focus on patient safety
- There are a number of lessons that have been identified that informed the development of the plan for this winter.
- The LGA/NHS peer review has identified a number of opportunities to strengthen partnership working, all system partners are committed to this
- The development of a whole system approach to capacity and demand planning for winter will significantly strengthen our plans
- However it is recognised that the system remains a challenged system and there is an improvement journey that needs to be continued to deliver the best possible services to the residents of Brighton & Hove
- It is also important that as a system we effectively support our staff during the challenging winter period

HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 18 Brighton & Hove City Council

Subject:		**Knoll House Resource Centre: Future Use**	
Date of Meeting:		**16 October 2019**	
Report of:		**Executive Director for Health & Adult Social Care**	
Contact Officer:	**Name:**	**Giles Rossington**	**Tel: 01273 295514**
	Email:	**giles.rossington@brighton-hove.gov.uk**	
Ward(s) affected:		**(All Wards);**	

FOR GENERAL RELEASE

Glossary:

- BHCC – Brighton & Hove City Council
- BSUH – Brighton & Sussex University Hospitals Trust
- CCG – Clinical Commissioning Group
- HASC - Health and Adult Social Care directorate, Brighton & Hove City Council
- HWBB – Health and Wellbeing Board
- SCFT – Sussex Community Foundation Trust
- KH – Knoll House
- CV – Craven Vale
- Integrated Care 24 (IC24) – social enterprise providing health services across SE England

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 This report summarises for the HOSC the recent background to the service remodelling that impacts upon the current use of Craven Vale and Knoll House. It explains the rationale underpinning the proposal to merge the revised service to operate from one site, which has BHCC cross-party and CCG support. Consultation with all staff working across both sites has now been completed and the future delivery will operate from Craven Vale.

1.2 This will release Knoll House for an alternative use. An initial desk top study has identified a number of potential uses for Knoll House, with the preferred use being retaining the site within Health and Adult Social Care and repurposing it to meet identified gaps in provision of services for adults with support needs.

1.3 A report with a recommendation that officers be charged with developing a business case for the future use of Knoll House was agreed by the HWB at its September 2019 meeting. The business case will be further considered at the January 2020 HWB meeting.

2. RECOMMENDATIONS:

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

3. CONTEXT/ BACKGROUND INFORMATION

3.1 Knoll House and Craven Vale are two council owned and operated residential homes. Both are registered with the Care Quality Commission to provide residential care. In recent years both KH and CV have supported older people requiring ongoing therapy and rehabilitation following their discharge from hospital to enable as many people as possible to get back to their home. SCFT provide both nursing and therapy staff commissioned by Brighton & Hove CCG.

3.2 Feedback from staff and population health data shows that the health and social care needs of our local population are changing, with more patients now leaving hospital with complex and greater nursing needs.

3.3 This is evidenced by the increase in people being transferred to Knoll House and Craven Vale requiring increased levels of support and specialist nursing care.

3.4 In 2016 the CCG and City Council ran a procurement process to identify appropriate providers to deliver this care as existing contracts were reaching their end, and commissioners are obligated by national and international law to undertake competitive procurement when awarding public service contracts. Unfortunately the procurement process outcomes were such that commissioners in the CCG and City Council were not able to identify appropriate providers who could supply the necessary level of high quality care with value for money for our residents.In place of this, the temporary arrangement was agreed that in addition to the care provided in NHS community wards run by SCFT, services would continue to be located in Knoll House and Craven Vale, run by the City Council and supported with healthcare provided by SCFT nursing and therapy and GP medical support provide by Integrated Care 24.

3.5 The arrangements described above have been in place since 2016 and have until recently been able to provide an excellent level of care and patient experience. However, there have been a number of recent factors that have necessitated a review of these arrangements:

- Emerging NHS and public health data showing that the health and care needs of our local population have increased over the last few years,
- A recent report from Healthwatch Brighton and Hove, published in February 2019, revealed that patient experience of discharge from the Royal Sussex County Hospital is being negatively impacted by delays in finding suitable community care resulting in them being stranded in hospital even if they are well enough to be discharged from an acute setting.
- The increasing health and care needs of patients was also noticed and reported by staff working at Craven Vale and Knoll House during the previous winter and a question was raised amongst local system health and care leaders as to the sustainability of the current residential, social care community beds model in Brighton and Hove.

- Further to this in April 2019, Sussex Community Foundation Trust confirmed it would not be able to continue to provide a sustainable and safe model of community nursing and therapy at Knoll House and Craven Vale and felt that nursing staff had been providing significantly higher levels of care than had been commissioned. It was felt that the model of care needed should be in a setting where there is nursing care 24/7, whereas at Knoll House and Craven Vale this is only provided from 8am to 8pm.

3.6 In April 2019 BHCC was informed by SCFT of their intention to reduce their nursing and therapy services to Knoll House and Craven Vale.

3.7 Following this notice and with full priority given to patient safety and our duty of care to staff, BHCC amended the registered admission criteria for Knoll House and Craven Vale.

3.8 The revised admission criteria resulted in a significant reduction in occupancy levels in both Craven Vale and Knoll House; both sites are regularly at 50% or less occupancy.

3.9 People requiring more intensive and specialist nursing care when following hospital discharge access this via other provision commissioned by Brighton and Hove Clinical Commissioning Group. The overall number of community beds provided for Brighton and Hove and surrounding area residents will increase from 161 to 174 and this change will also involve the CCG increasing its investment in community beds. The detail concerning bed numbers and level of care is as follows:

- Between September and December 2019 the CCG has agreed with health and care partners an investment to mobilise 42 community rehabilitation beds (sometimes referred to as 'step-down beds') in sites in the East and West of Brighton and Hove. This is in addition to 12 nursing home beds in the city which the CCG commissioned as part of supporting hospital discharges. These nursing home beds are supporting patients who are non-weight bearing or have a diagnosis of delirium.

- These additional beds replace the loss of capacity due to the limitations on accessing Knoll House and Craven Vale from hospital discharge, and account for the increase in community beds that are being provided to Brighton and Hove residents whilst we work in partnership to introduce more community services over the next two to three years.

- These 54 beds in the city are in addition to the existing community hospital beds provided by Sussex Community Foundation Trust at sites in Lewes, Uckfield and Crowborough. In summary this means in 2019 we will benefit from a growth in community beds for Brighton and Hove resident from 161 to 174, with an enhanced health and care model to support the changing health needs of our residents.

3.10 An initial demand study has indicated that supporting the revised operational pathway will require a total of 24 social care community beds. These will be used for planned and emergency respite and lower dependency hospital discharge.

Craven Vale, with its proximity to the RSCH site and existing capacity is the preferred site to operate from.

4 Future use of Knoll House

4.1 Officers have carried out an initial options appraisal exercise to consider the possible future uses of the Knoll House site.

4.2 The planning use for the site is currently C2, provision of residential accommodation and care to people in need of care, and planning permission would be required for any change of use.

4.3 The options appraisal initially considered the following three high level options:

A Disposal - The site could be sold for alternative use. This could include use as a nursing or residential home, conversion to flats or redevelopment for housing (subject to receiving planning permission).

B Hand the property back to estates to be retained as part of the corporate property portfolio. - The site could then be made available for consideration of future uses including potentially meeting other housing based needs within the city.

C Reuse the facility to provide mental health step-down supported accommodation or as mental health residential accommodation.

4.4 The option 3.3.3 was supported by HASC as both meeting an identified need in the city and supporting person-centred outcomes maximising future independence of people on a recovery journey from moderate and serious mental health issues.

4.5 Between the last two performance years 2017/18 and 2018/19 there was an 81% increase in admissions to long term residential care for younger adults with mental health needs indicating an urgent need for further development of alternative accommodation and support for this group .In 2018/19 50% of all long term care admissions for 18-64 year olds were for people with mental health support needs.

4.6 Best practice suggests that young people with mental health problems need support to maximise independence. Our aim is to deliver this, but to do this we need more supported and move-on accommodation as part of the pathway to independence. The Supported Accommodation option has been shown to be an effective model in improving people's outcomes and supporting longer term independence.

4.7 Having decided on investigating the feasibility of retaining the site, a further three possible uses were identified:

1. Functional mental health residential accommodation
2. High level supported step-down accommodation
3. Lower level supported accommodation to enable independent living.

4.8 These three options were explored at a high level that included estimation of revenue and capital costs and the potential benefits, risks and opportunities associated with each.

4.9 The full options paper was then discussed with the chair of the Health and Wellbeing Board and the lead member for Adult Social Care and it was agreed that, given evidence base and best practice the functional residential care would not be explored as the outcomes for the service users were not optimised and that the following options should be explored in more depth:

a) High level supported step-down accommodation

b) Lower level supported accommodation to enable independent living

4.10 The high level options appraisals are included as **Appendix 1**.

4.11 Part of the business planning and process will include engagement with local residents.

5 ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

5.1 Not relevant to this report to note.

6 COMMUNITY ENGAGEMENT & CONSULTATION

6.1 None in relation to this report

7 CONCLUSION

7.1 Members are asked to note plans to re-profile services currently provided from Knoll House and Craven Vale and to concentrate future operations at Craven Vale, with Knoll House re-purposed to meet other HASC needs.

8 FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

8.1 There is the potential for financial efficiencies to be obtained by improving the pathway for clients with mental health needs and supporting longer term independence. As per paragraph 4.5, the number of admissions for younger adults with mental health needs is increasing and the average cost of an accommodation placement in the independent sector is £820 per week.

The high level calculations for the options outlined shows that there is a range of costs and potential net savings. Detailed modelling would need to be carried out to ascertain the likely financial impacts from the implementation of the different options.

Finance Officer consulted: Sophie Warburton Date: 16/08/2019

Legal Implications:

8.2 The report highlights the need to review the use of Knoll House Resource Centre to improve performance and efficiency within Health and Adult Social Care. There are no legal implications arising immediately from this report. The business case may give rise to legal implications due to the level of capital expenditure and running costs, any building work or staff reorganisation that may be required in the adoption of identified options. These can be considered if and as they arise.

Lawyer Consulted: Sandra O'Brien *Date: 03/10/19*

Equalities Implications:

8.3 There will be equalities implications to consider for each of the options outlined above. An Assessment of equality impact will be completed to analyse areas of potential impact – and areas where negative impact might be mitigated. The findings of EIA will be reflected and articulated in the proposed business case and options appraisal that is brought back to Health and Wellbeing Board for approval in January 2020.

Sustainability Implications:

8.4 None identified

Any Other Significant Implications:

8.5 None identified

SUPPORTING DOCUMENTATION

Appendices:

1. High level options appraisal for the future use of Knoll House

Documents in Members' Rooms
None

Background Documents
None

Appendix 1

	Option 1	Option 2	Option 3
Description of the Option *A brief description including what is in and out of scope*	Mental Health residential accommodation (Capacity 20)	Mental Health High level step down supported accommodation (Capacity 20)	Mental Health Low Level supported accommodation (Capacity 18)
Non-Cashable Benefits *Benefits such as efficiency savings*	Provides local accommodation for many individuals currently placed out of area.	Increased local provision	Increased local provision
Costs and resources Include capital and revenue costs Include staffing requirements	Operating costs will ultimately depend on the client group targeted Assume staffing costs circa £800k p.a.* Running Costs £80k p.a	Unlikely to be any need for significant capital costs however operational costs would be relatively high. Staffing cost Est £636K p.a * Running Costs est £80k p.a Housing Benefit Income est £203k	The current accommodation at Knoll House would need to be remodelled in order to provide 18 self-contained flats. Estimated capital cost £1m to £1.3m. (Estates) Staffing costs for this model would be modest at approximately £180k p.a * Running costs est at £48k Housing Benefit income est £183k
Cashable Benefits *High level benefits that will deliver savings against a specific budget code*	Assuming clients move from low level support in external placements: Ongoing benefit £0.037m	Assuming clients move from high level support in external placements: Ongoing benefit £0.665m	Assuming clients move from medium level support in external placements: Ongoing benefit - £0.739m Year 1 – Loss of £0.261m to £0.561m
Risks and Opportunities *High Level Risks and opportunities associated with this option.*	Once the site is full there is unlikely to be much turnover of places. Risks associated with moving individuals with function mental health issues. e.g. Best Interest assessments / loss of familiar surroundings /	Could place a significant role in the mental health Pathway by providing support prior to move-on. (provided suitable next step options are available) Provision of additional Supported accommodate should help to reduce the number of individuals needing residential care.	Danger that individuals in this type of accommodation become resistant to any further move-on. Provision of additional Supported accommodate should help to reduce the number of individuals needing residential care.

Appendix 1

		Risks associated with moving individuals with function mental health issues. e.g. Best Interest assessments / loss of familiar surroundings / advocacy	

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

Subject:		**Procurement of a New NHS 111 Service**	
Date of Meeting:		**16 October 2019**	
Report of:		**Executive Lead for Strategy, Governance & Law (Monitoring Officer)**	
Contact Officer:	**Name:**	**Giles Rossington**	**Tel: 01273 295514**
	Email:	**giles.rossington@brighton-hove.gov.uk**	
Ward(s) affected:		**(All Wards);**	

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 This report provides an update on the progress of the re-procurement of NHS 111 services for Sussex and Kent.

1.2 Information provided by NHS commissioners is included as **Appendices 1 & 2** to this report.

2. RECOMMENDATIONS:

2.1 That the Committee notes the contents of this report.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 The NHS provides the public with advice and support for urgent, but non-emergency health issues via its NHS 111 telephone helpline. 111 was provided by South East Coast Ambulance NHS Trust (SECAmb), but the contract needed to be re-procured.

3.2 The HOSC received an initial report on plans to re-procure 111 at its 06 September 2017 meeting and has been monitoring the procurement process since then. This process has taken longer than anticipated as the initial Sussex-wide procurement was suspended when it became evident to commissioners that an opportunity had arisen to procure more cost effectively at larger scale (with Kent).

3.3 The new111 contract, jointly procured across Sussex and Kent, has now been awarded. The new contractor will be SECAmb, with elements of the service subcontracted to IC24, a social enterprise. More information on the contract award and the mobilisation of the new service has been provided by NHS commissioners and is included for information as **Appendix 1** to this report. The new service will begin operating on 01 April 2020. A mobilisation timeline is included as **Appendix 2**.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 Not relevant to this report for information

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 None undertaken

6. CONCLUSION

6.1 Members are asked to note the award of the new NHS 111 contract for Sussex and Kent to SECAmb.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 Not relevant to this report for information

Legal Implications:

7.2 There are no legal implications to this report

Lawyer Consulted: Elizabeth Culbert *Date: 01/08/2019*

Equalities Implications:

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

Sustainability Implications:

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

Any Other Significant Implications:

7.5 None identified

SUPPORTING DOCUMENTATION

Appendices:

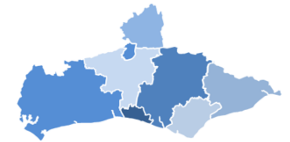
1. Information on the 111 tender and mobilisation provided by NHS commissioners
2. Mobilisation timeline

Documents in Members' Rooms

None

Background Documents

None



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- How the new service is an improvement over the existing service
- Assurance that the provider can successfully recruit to the new Clinical Assessment Service (CAS), and whether this will be in place from the beginning of the contract.
- How the 111 service will book patients into the UTCs, GP practices etc. and whether this will be available from April 2020.

NHS 111 and the new Clinical Assessment Service (CAS)

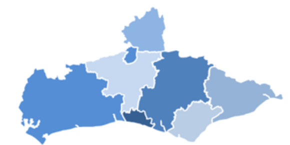
Background

A key component of our strategic networked model for Urgent Care is the new NHS111 Clinical Assessment service. This new and improved service will provide 24/7 access to clinical advice and treatment, available over the phone and online. This new service is required to support delivery of the following NHSE mandated Integrated Urgent Care Outcomes:

1. Data and Information can be shared between providers.
2. The NHS 111 and urgent multidisciplinary clinical services need to be jointly planned.
3. The Summary Care Record (SCR) is available in the Clinical Assessment Service (CAS) and elsewhere.
4. Care plans and special patient notes are visible to the Clinicians within the 111 / CAS IUC and in any downstream location of care.
5. Appointments can be made to in-hours and to extended access primary care services - offering services in the evening and at weekends.
6. There is joint governance across Urgent and Emergency Care.
7. Suitable calls are transferred to a Clinical Assessment Service comprising GPs and other health care and social care professionals
8. The delivery of the workforce blueprint which has been developed to ensure that there is a sustainable and optimal call centre workforce with the right skills, behaviours and competencies for the 111 / CAS.

Sussex CCGs, stopped the initial NHS111/CAS procurement process in June 2018 recognising that our strategic model for urgent care was evolving and further work was required to ensure that the new service fully meets our needs. As the work to review this took place it was agreed to align the Sussex procurement with Kent. The transformation teams in both areas reviewed the options to either procure separately or together. The team undertook financial modelling and this showed there were efficiencies of approximately £2 million that could then be re-invested into the service. Lessons were reviewed on other procurements and for this type of service a larger area is preferable as this offers greater resilience, better staff utilisation and better efficiencies for digital over a larger area.

A 12 month interim contract was negotiated with current providers of the NHS111 and GP Out of Hours Services (SECAmb and IC24) to start to deliver the IUC outcomes and to allow time



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Clinical Commissioning Groups

to re-procure a new service. The GP Out of Hours (OoH) Home Visiting service(s), which was originally part of the NHS111-CAS contract was removed and is being commissioned separately as a pan-Sussex service. This is following an open tender procurement process with service mobilisation by April 2020.

The NHS111 and Clinical Assessment Service in Kent, Medway and Sussex (KMS) will provide:

- NHS 111 Telephony and call management provision;
- A Clinical Assessment Service (CAS) across all KMS CCGs, the CAS will accept all 'Speak to GP' and 'Speak to a clinician within the service' dispositions;
- Advice and support to Health Care Professionals and Care homes;
- Co-ordinated clinical governance across all providers within the umbrella of 'Integrated Urgent Care Service';
- Access to the most appropriate clinician or service for a patient's need;
- Access to a multi-disciplinary team enabling a robust "hear and treat" delivery of care thereby reducing pressure on Emergency Departments;
- The ability to directly book patients into services (e.g. extended access GP appointments, Urgent Treatment Centre appointments).

How the new service will offer an improved service and improved experience for patients

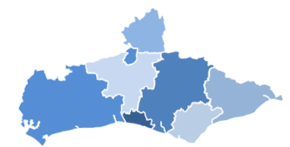
NHS 111 / CAS will provide a vital service to help people with urgent care needs to get assessment, clinical advice and treatment quickly, taking around 15 million calls a year. The service will be further enhanced by increasing clinical consultation for patients calling 111, so that more patients get the care and advice they need over the phone, and only those who genuinely need to attend A&E or use the ambulance service are advised to do this. All other patients will have their issue resolved over the phone if at all possible, or if not will be directed to appropriate primary care or community services, with an emphasis on strongly supporting patients in self-care.

If it is assessed that a patient needs to access another service, this will be directly arranged by the NHS111 CAS with the ability to directly book patients into primary care settings, such as Urgent Treatment Centres, Improved Access Hubs. The work on this roll out has started and is aimed to be delivered over the coming year. This means patients do not have to contact other services themselves to get the help they need if the CAS assesses with the patients that an appointment is needed. It also reduces the likelihood of long waits to access another service as an appointment time will be agreed and made.

Procurement

The participating 15 CCGs Governing Bodies approved the large-scale collaboration for the procurement and the development of a single specification and contract. This agreement included the delegation of authority with respect to contract award to be managed through the Kent, Medway and Sussex NHS111 & CAS Joint Committee.

This single contract is jointly funded by each participating CCG and is for a period of 5 years



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with up to a 24-month extension option

Route to award

The Kent Medway Sussex (KMS) Joint Committee met on the 9th July to review the evaluation of the bids received and were able to reach a unanimous decision to commence the procurement award process.

South East Coast Ambulance Service (SECAmb) NHS Foundation Trust were successful in their bid to deliver the new NHS111/Clinical Assessment Service (CAS) contract, in partnership with IC24 as sub-contractors for the service.

The final award of the contract was subject to further assurance processes being undertaken and conditions being met by the bidder.

There were 4 conditions that commissioners required the bidder to address prior to the contract award being formally announced (the other 3 will be delivered and managed as part of the mobilisation of the contract and monitored through formal delivery stage gates and decision points).

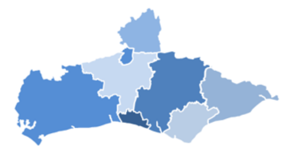
The KMS Joint Committee met again on 6 August 2019 and confirmed that sufficient progress had been made and assurance gained to allow the decision to be made public.

A robust procurement process has been followed, with Qualification Questions (PQQ) and then the Invitation To Tender, with the support of Arden & GEM CSU who ensured the process and procurement regulations were followed. The documents were evaluated by a total of 51 different evaluators from Kent, Medway and Sussex. These came from a mix of skills and roles including workforce, digital, commissioning, clinical (including mental health and pharmacy subject matter experts), public member / Healthwatch, communications, contracting and finance.

As commissioners, we have been encouraged by the level of partnership working that has obviously gone in to the bid by SECAmb and IC24. Moreover, it is encouraging to see how positively both parties have responded to the immediate conditions prior to the contract being formally awarded.

For the NHS111 / CAS procurement and mobilisation, the programme has also been required to go through a NHS England checkpoint process. NHSE have stated that the evidence required 'has been received and are pleased to note the clear governance and project management procedures in place" and have "received assurance from the CCGs that due process has been followed with their procurement partners so far in relation to this procurement".

The mobilisation window allowed for a provider to exit and a new provider to establish the service for NHS111/CAS. As incumbents, the providers are in essence retaining elements of the service, which significantly de-risks mobilisation and will encourage more investment by providers in the current interim service to bring forward the delivery of some of the benefits of



Sussex and East Surrey
Clinical Commissioning Groups

the CAS and we are working towards increasing this capability to support winter pressures.

Mobilisation and next steps

Mobilisation has started in early September, with Joint Mobilisation Committee oversight. The key elements of the mobilisation plan will focus on ensuring that we have the right staff and skill mix for the start of this new service. Digital will be key to ensure staff are able to track patients as they go through the service and also to be offering patients, where needed, an appointment. There will be a number of check points as part of the roll out to ensure the service delivers on time and that mitigations can be developed should they be necessary.

Suggested governance structure is:

KMS 111 & CAS Mobilisation & Assurance Structure

Key: Assurance | Oversight | Information | Delivery

Kent Medway Sussex

- ESOG
- KMS Joint Committee
- Governing Bodies

Sussex

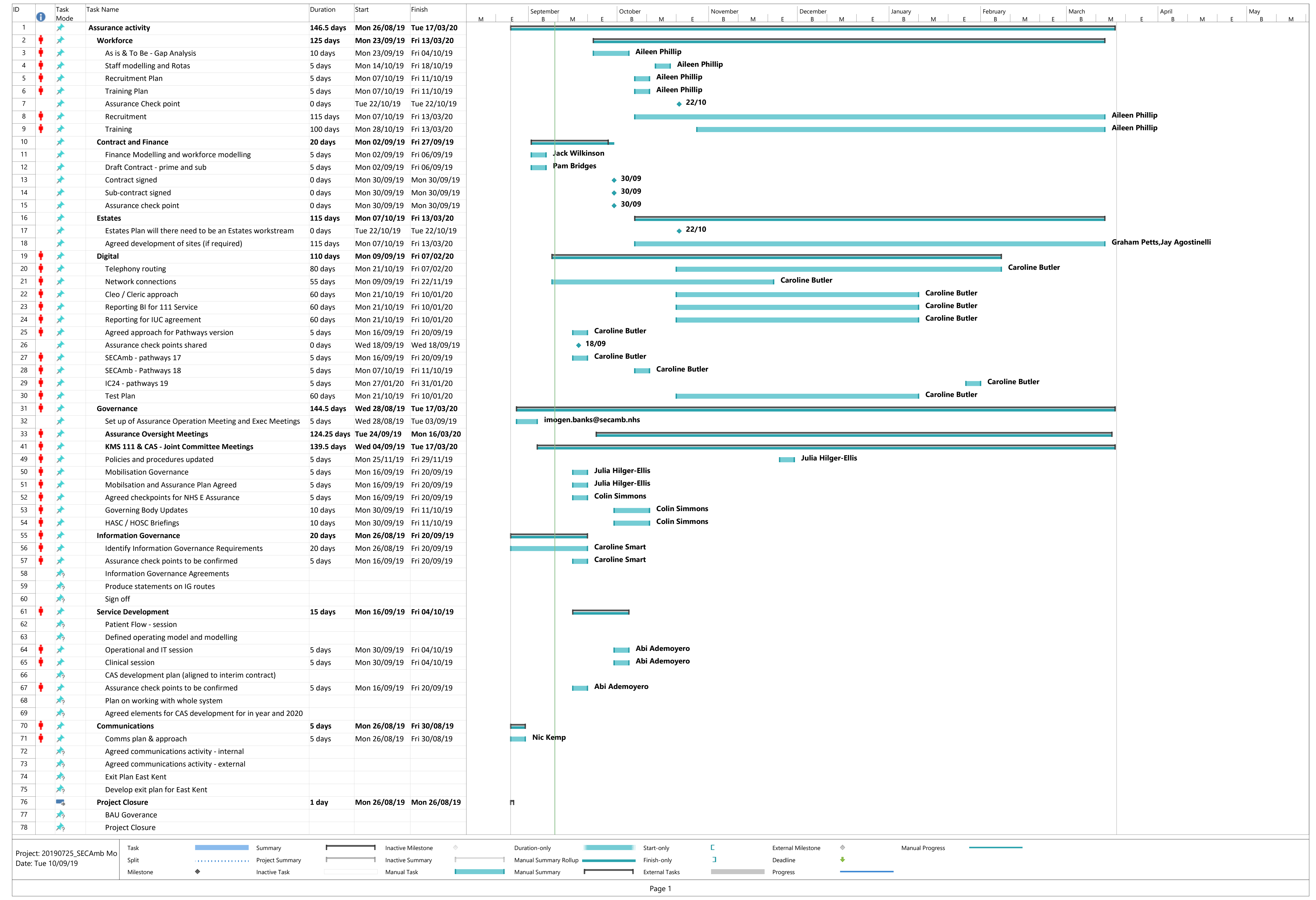
- Sussex NHS 111 / IUC Programme Board
- UEC Steering Group
- EMT
- STP Exec

Kent

Assurance Oversight Group – Meets monthly. Reports to KMS Joint Committee / SECAmb Board Steering Group / IC24 Board

Workstreams – reports in to Assurance Oversight Group – Programme Leads – Colin Simmons (Sussex) & Jacqui Sarakbi (Kent)

- Communication
- Recruitment & Workforce
- IT & Digital
- Estates
- Service Development
- Governance - Clinical, Quality & Risk
- Finance & Contracts – short term – until sign off of contract – End of Sept 2019
- Exit Strategy – East Kent
- Information Governance



ID	Task Name	Duration	Start	Finish
1	**Assurance activity**	**146.5 days**	**Mon 26/08/19**	**Tue 17/03/20**
2	**Workforce**	**125 days**	**Mon 23/09/19**	**Fri 13/03/20**
3	As is & To Be - Gap Analysis	10 days	Mon 23/09/19	Fri 04/10/19
4	Staff modelling and Rotas	5 days	Mon 14/10/19	Fri 18/10/19
5	Recruitment Plan	5 days	Mon 07/10/19	Fri 11/10/19
6	Training Plan	5 days	Mon 07/10/19	Fri 11/10/19
7	Assurance Check point	0 days	Tue 22/10/19	Tue 22/10/19
8	Recruitment	115 days	Mon 07/10/19	Fri 13/03/20
9	Training	100 days	Mon 28/10/19	Fri 13/03/20
10	**Contract and Finance**	**20 days**	**Mon 02/09/19**	**Fri 27/09/19**
11	Finance Modelling and workforce modelling	5 days	Mon 02/09/19	Fri 06/09/19
12	Draft Contract - prime and sub	5 days	Mon 02/09/19	Fri 06/09/19
13	Contract signed	0 days	Mon 30/09/19	Mon 30/09/19
14	Sub-contract signed	0 days	Mon 30/09/19	Mon 30/09/19
15	Assurance check point	0 days	Mon 30/09/19	Mon 30/09/19
16	**Estates**	**115 days**	**Mon 07/10/19**	**Fri 13/03/20**
17	Estates Plan will there need to be an Estates workstream	0 days	Tue 22/10/19	Tue 22/10/19
18	Agreed development of sites (if required)	115 days	Mon 07/10/19	Fri 13/03/20
19	**Digital**	**110 days**	**Mon 09/09/19**	**Fri 07/02/20**
20	Telephony routing	80 days	Mon 21/10/19	Fri 07/02/20
21	Network connections	55 days	Mon 09/09/19	Fri 22/11/19
22	Cleo / Cleric approach	60 days	Mon 21/10/19	Fri 10/01/20
23	Reporting BI for 111 Service	60 days	Mon 21/10/19	Fri 10/01/20
24	Reporting for IUC agreement	60 days	Mon 21/10/19	Fri 10/01/20
25	Agreed approach for Pathways version	5 days	Mon 16/09/19	Fri 20/09/19
26	Assurance check points shared	0 days	Wed 18/09/19	Wed 18/09/19
27	SECAmb - pathways 17	5 days	Mon 16/09/19	Fri 20/09/19
28	SECAmb - Pathways 18	5 days	Mon 07/10/19	Fri 11/10/19
29	IC24 - pathways 19	5 days	Mon 27/01/20	Fri 31/01/20
30	Test Plan	60 days	Mon 21/10/19	Fri 10/01/20
31	**Governance**	**144.5 days**	**Wed 28/08/19**	**Tue 17/03/20**
32	Set up of Assurance Operation Meeting and Exec Meetings	5 days	Wed 28/08/19	Tue 03/09/19
33	**Assurance Oversight Meetings**	**124.25 days**	**Tue 24/09/19**	**Mon 16/03/20**
41	**KMS 111 & CAS - Joint Committee Meetings**	**139.5 days**	**Wed 04/09/19**	**Tue 17/03/20**
49	Policies and procedures updated	5 days	Mon 25/11/19	Fri 29/11/19
50	Mobilisation Governance	5 days	Mon 16/09/19	Fri 20/09/19
51	Mobilsation and Assurance Plan Agreed	5 days	Mon 16/09/19	Fri 20/09/19
52	Agreed checkpoints for NHS E Assurance	5 days	Mon 16/09/19	Fri 20/09/19
53	Governing Body Updates	10 days	Mon 30/09/19	Fri 11/10/19
54	HASC / HOSC Briefings	10 days	Mon 30/09/19	Fri 11/10/19
55	**Information Governance**	**20 days**	**Mon 26/08/19**	**Fri 20/09/19**
56	Identify Information Governance Requirements	20 days	Mon 26/08/19	Fri 20/09/19
57	Assurance check points to be confirmed	5 days	Mon 16/09/19	Fri 20/09/19
58	Information Governance Agreements			
59	Produce statements on IG routes			
60	Sign off			
61	**Service Development**	**15 days**	**Mon 16/09/19**	**Fri 04/10/19**
62	Patient Flow - session			
63	Defined operating model and modelling			
64	Operational and IT session	5 days	Mon 30/09/19	Fri 04/10/19
65	Clinical session	5 days	Mon 30/09/19	Fri 04/10/19
66	CAS development plan (aligned to interim contract)			
67	Assurance check points to be confirmed	5 days	Mon 16/09/19	Fri 20/09/19
68	Plan on working with whole system			
69	Agreed elements for CAS development for in year and 2020			
70	**Communications**	**5 days**	**Mon 26/08/19**	**Fri 30/08/19**
71	Comms plan & approach	5 days	Mon 26/08/19	Fri 30/08/19
72	Agreed communications activity - internal			
73	Agreed communications activity - external			
74	Exit Plan East Kent			
75	Develop exit plan for East Kent			
76	**Project Closure**	**1 day**	**Mon 26/08/19**	**Mon 26/08/19**
77	BAU Goverance			
78	Project Closure			

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

Subject:		**Primary Care in Brighton & Hove**	
Date of Meeting:		**16 October 2019**	
Report of:		**Executive Lead for Strategy, Governance & Law (Monitoring Officer)**	
Contact Officer:	**Name:**	**Giles Rossington**	**Tel: 01273 295514**
	Email:	**giles.rossington@brighton-hove.gov.uk**	
Ward(s) affected:		**(All Wards);**	

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Glossary

- Primary Care – services provided by NHS GP practices (the term can also be used to include NHS dentistry and community pharmacies and opticians)
- CCG – Brighton & Hove Clinical Commissioning Group – NHS body responsible for the bulk of city healthcare commissioning
- PCN – Primary Care Networks – integrated primary health, community health and social care etc. networks serving populations of C 50,000.
- QOF – Quality Outcomes Framework. QOF is a voluntary reward and incentive programme that rewards GP practices in England for the quality of care they provide to their patients and helps standardise improvements in the delivery of primary care.
- NHS LTP – NHS Long Term Plan. The LTP is NHS England's strategic plan to sustain and improve NHS services

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 This report, requested by the HOSC Chair, provides an update on primary (GP) care in Brighton & Hove and outlines planning for the future development of services, including the establishment of Primary Care Networks (PCN) across the city.

1.2 Information provided by Brighton & Hove Clinical Commissioning Group (CCG) is attached as **Appendix 1** to this report.

2. RECOMMENDATIONS:

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

3. CONTEXT/ BACKGROUND INFORMATION

3.1 There are xx GP practices in Brighton & Hove providing primary healthcare services to local residents. Whilst GPs play a key role in delivering these services, so increasingly do nurses, pharmacists, paramedics and other clinicians.

3.2 GP practices are generally small, private businesses which contract with the NHS. CCGs are responsible for commissioning and managing these contracts.

3.3 When the HOSC has scrutinised GP services in past years, some issues have received particular attention. These include:

- **The ratio of patients to GPs.** This has historically been high in Brighton & Hove (i.e. more patients per GP than the England average). However, it is not simply the case that a low patient/GP ratio is good and a high one bad. For example, a practice featuring relatively few GPs could have practice nurses, pharmacists etc. providing an excellent level of care. Members have previously voiced concerns about the number of GPs in the city and the impact this may have on services, particularly in terms of patients getting appointments.

- **The geographical spread of GP practices.** As private businesses, GP practices have a degree of freedom in where they are based, and practices will not necessarily be evenly distributed across a geographical area. However, an uneven distribution of practices can mean that some communities have significantly worse access to primary care than others. This problem may be exacerbated if these communities also experience worse health outcomes – e.g. due to high levels of deprivation. HOSC members have previously expressed concerns about the east Brighton and Hangleton in terms of GP coverage.

- **GP practice sustainability.** Recent years have seen increasing pressures on GPs across England, with an unprecedented number of practices closing. Problems include the 'partner' model of practices, increasing workload and a lack of newly qualified doctors choosing to enter general practice. Small practices are particularly exposed to these pressures. Brighton & Hove has a high number of smaller practices, and there have been a number of closures in recent years. It should be noted that closures are not the same thing as mergers – i.e. where two practices choose to combine, often in new purpose-built premises. Mergers can create problems (e.g. the loss of coverage in a particular area), but they also enhance sustainability by providing greater economies of scale.

- **Quality.** There is no simple measure of the quality of GP practices. Individual practices are inspected and rated by the CQC. There is also an annual NHS patient survey that provides feedback about user perceptions of services. Practices can also be benchmarked within and across localities by looking at performance data – particularly in terms of QOF scores, although there are issues with using this data to make direct comparisons (e.g. QOF is voluntary and not all practices participate fully; some QOF measures may say more about the local demographic than the quality of GP services).

3.4 The NHS has significant plans to improve GP services, perhaps particularly in terms of the NHS LTP drive to establish Primary Care Networks (PCN). More details of this planning is included in the CCG's submission (**Appendix 1**).

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 Not relevant to this information report

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 None in relation to this report

6. CONCLUSION

6.1 Members are asked to note the CCG's update on city primary (GP) services.

6.2 Members may wish to consider the themes identified by previous scrutiny of city primary care

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 Not relevant to this report for information

Legal Implications:

7.2 There are no legal implications to this report

Lawyer Consulted: Elizabeth Culbert; Date: 01/10/2019

Equalities Implications:

7.3 Primary health services are disproportionately used by some protected groups – e.g. people with disabilities, older people. Poor quality or hard to access services may have a particular impact upon these groups.

Sustainability Implications:

7.4 Primary healthcare in Brighton & Hove has historically been delivered by a large number of small practices. The direction of travel is seemingly towards fewer, purpose-built surgeries. This may have implications for sustainable travel as patients are required to travel further for services and members may be interested in the steps taken to ensure that new surgery sites can be readily accessed by public transport.

Any Other Significant Implications:

7.5 None identified

SUPPORTING DOCUMENTATION

Appendices:

1. Information provided by Brighton & Hove CCG

Documents in Members' Rooms

None

Background Documents

None

Appendix 1

Primary care in Brighton and Hove

Increasing resilience in Primary care
HOSC has discussed the current pressures on Primary care in previous meetings; and how this is impacting on the potential for Primary care to meet the future needs of the Brighton population. The CCG will be working with the other Sussex CCGs to deliver a programme of work in 2019/2020, based on four key themes, to support practices as follows

- Practice Resilience –The adoption of a Sussex wide approach to use regional funds to target the most challenged areas to improve resilience; continue to provide dedicated CCG support to individual practices; and sharing good practice across the county to ensure practices learn from and support each other wherever possible.
- GP Retention Programme - Development of more wide ranging career opportunities outside traditional practice partner role; aimed at locum GPs and GPs expressing a desire to leave the profession; Development of GP with Special Interest (GPwSI) posts in mental health; Supporting the development of First Contact Practitioner roles for Multi-skeletal and Mental Health services; and the promotion of GP Fellowships which include more flexible arrangements tailored to the needs of the individual GP.
- Reception and clerical staff training – funding has been made available to provide training opportunities for all general practices in Care Navigation (helping patients find the right service for them); Workflow and Medical Terminology training; and enhanced reception and clerical staff training
- Online Consultation – the CCG will procure the right technology to allow practices the opportunity to offer patients online consultation appointments. This is addition to, and not replacing current face to face provision.

The above programme illustrates the support available to all practices in the city. The attached diagram describes the process by which the CCG works with a practice when they are considering closure and/or merger with another practice.

Primary Care Networks
The development of Primary care networks (PCNs) is intrinsic to the successful delivery of the NHS long-term plan. These are groups of general practices who agree to work together at scale to deliver a wider range of services to patients that are integrated with other health and social are providers; manage financial and estates pressures; which in turn will increase the likelihood of practices recruiting and retaining staff. The seven PCNs in Brighton were established on 1 July and are all delivering the national requirements. They are currently considering the

potential for employing a range of additional staff (for which funding has been made available), including first contact physiotherapy, additional appointments (extended access) and social prescribing. The CCG is supporting them in these discussions, including exploring the potential for alignment with the current CCG commissioning social prescribing contract held by Together Co (formerly Impetus).

Public Health colleagues in Brighton and Hove City Council are working with their East and West Sussex counterparts, and the CCG, to compile population Health packs to help PCNs make informed decisions regarding their priorities for development and strategic direction. PCNs are currently completing a self-assessment against the national NHSE maturity matrix; and respond to a prospectus detailing the national support offer.

The Director of Primary Care meets regularly with each PCN to discuss their plans and how CCGs can support them, and the wider CCG primary and Community Care team members are being repositioned as more externally focussed in order to directly support PCNs. This support offer includes funding legal support; hosting meetings; and the provision of a PCN accelerator fund which offers financial support to bring forward key elements of the Long Term Plan, support the desired integration of services, and reduce clinical variation across the Sussex Healthcare Partnership foot print.

Decision Flow Diagram for Support to Practices considering merger/closure

Practice informs CCG of specific support needs which may lead to contract termination and/or merger with another practice.

Practice meets with CCG to discuss options.

Intention to terminate/ merge reversed.

Continue to actively monitor Practice performance

Practice confirms intention to terminate its contract.

Is the Practice Area Covered by another practice?

Yes

Discuss practice merger with neighbouring practices.

No

Yes

Are nearby practices willing to extend their boundaries?

No

Procurement Process

Willing to merge?

No

Discuss List dispersal with neighbouring practices.

Practices have capacity to absorb additional patients?

No

Yes

Financial and other support (communications, Digital, etc.) agreed.

Managed Transfer of Patients

Item	Description	Referred By	Notes
16 October 2019 HOSC Meeting			
Presentation by Lola Banjoko	Presentation on Sussex CCGs on plans to reorganise commissioning countywide	HOSC	**Contacts:** Lola Banjoko
Winter planning	To receive assurance about partner (A&E deliver board) planning to meet winter surge pressures	HOSC HOSC has legal duty to scrutinise local NHS performance	**Contacts:** Katy Jackson (CCG) A follow-up item may be required (March 20)
NHS 111 Procurement	HOSC is monitoring the process of the procurement of a new NHS 111 call-centre service for Sussex & Kent	Sussex CCGs HOSC has legal duty to consult with NHS re: SViS plans	HOSC has been monitoring this procurement process since its inception. Current timetable: contracted awarded summer 19; mobilisation autumn 19 (and HOSC report-back) **Contacts:** Colin Simmons (CCGs)
Primary Care in Brighton & Hove	Update on primary care performance and capacity and CCG primary care planning (including the pathway to Primary Care Networks)	HOSC members Member concerns about aspects of city primary care (e.g. GP to patient ratios; access to GP services	Report from the CCG. **Contacts:** Ashley Scarff/David Supple (CCG)

		in some parts of the city). The NHS Long Term Plan requires local areas to introduce Primary Care Networks	
Additional Activity Autumn 2019			
22 Oct 2019 Performance Information Group (PIG) meeting (HOSC and HWB members' informal meeting to discuss performance, work planning etc.)			
Date TBC South East Coast Ambulance Trust (SECAmb): invitation to visit new ambulance station at Falmer **Contact:** Helen Wilshaw (SECAmb)			
Date TBC Sussex HOSC Chairs informal joint meeting with BSUH: quality, performance and forward planning			
Date TBC Sussex HOSC Chairs informal joint meeting with BSUH: quality, performance and forward planning			
Date TBC STP HOSC Chairs Meeting (meeting with STP leaders)			
22 January 2020 HOSC Meeting			
Healthwatch Report on Older Patient Experience of Discharge from RSCH	Monitor implementation of report action plan	Healthwatch BH HOSC has legal duty to scrutinise local NHS performance	At March 19 HOSC members considered HW report on hospital discharge and agreed to monitor implementation of joint CCG/BSUH/BHCC action plan (autumn 19?) **Contacts:** Grace Hanley (HASC) BSUH? CCG?

			David Liley (Healthwatch)
Clinically Effective Commissioning (tranche 3)	CEC is Sussex-wide programme to standardise commissioning and ensure it aligns with best clinical practice	Anticipated referral by CCG (summer 19?) HOSC has legal duty to consult with NHS re: SViS plans	CCGs have indicated that they anticipate that CEC tranche 3 will include cross-border SViS and will consequently require scrutiny by a joint HOSC (JHOSC) of B&H, East Sussex and West Sussex HOSCs. Although this will be for a JHOSC rather than HOSC, HOSC will need to determine how it wants to be updated. **Contacts:** Peter Kottlar, Wendy Hughes, Raheem Anwar (CCGs) Helena Cox (West Sussex HASC) Harvey Winder (East Sussex HOSC)
Establishment of a Joint HOSC (JHOSC)	BH HOSC is required to join a JHOSC to scrutinise NHS SViS plans that cut across HOSC boundaries	HOSC has legal duty to consult with NHS re: SViS plans	BH HOSC rejected (Jan 19) proposals to join a voluntary JHOSC, but will be required to join a mandatory JHOSC if and when NHS bodies announce cross-boundary SViS plans (e.g. re: CEC tranche 3) NB: HOSC will need to approve plans for JHOSC, but FC is final BHCC decision-maker
Additional Activity Winter 19/20			
17 Dec 2019 Performance Information Group (PIG) meeting (HOSC and HWB members' informal meeting to discuss performance, work planning etc.)			
Date TBC STP HOSC Chairs Meeting (meeting with STP leaders)			

Date TBC South East Coast HOSC Chairs Network (meeting with NHSE)			
18 March 2020 HOSC Meeting			
Cancer	Monitor local performance re: screening (bowel, cervical, breast) and treatment	HOSC HOSC has legal duty to scrutinise local NHS performance	CQC identifies local cancer performance as a concern and BH performance re: screening and re: treatment is poor. Report at March 19 HOSC – HOSC follow-up/monitoring? **Contacts:** Becky Woodiwiss (BHCC PH) Max Kammerling (NHS England) Ben Stevens/Oliver Phillips (BSUH) Lola Banjoko/Dr Alex Mancey-Barratt) CCG
Royal Sussex County Hospital (RSCH): Improving Outpatient Services	BSUH plans to improve OP services	Potential referral by BSUH? HOSC has legal duty to scrutinise local NHS performance	CQC rates OP services as requires improvement. Improvement planning discussed at March 19 HOSC – HOSC to follow-up and monitor improvement trajectory? **Contacts:** Oliver Phillips (BSUH) Ben Stevens (BSUH)
Hospital to Home Review: implementation of action plan	To oversee implementation of the action plan from the independent peer review of hospital discharge	HOSC has legal duty to scrutinise local NHS performance	**Contacts:** Barbara Deacon (BHCC) This is a follow-up to the (tentative) Hospital to Home Review item at Oct 19 HOSC

Young People Mental Health	Report on YP experiences of mental health services – to include input from Youth Council	Youth Council (deferred from 18/19 work plan at YC request as restructure meant that they were unable to engage with this) HOSC has legal duty to scrutinise local NHS performance	Aim to align with YP MH review – reporting to Sussex HWBs Jan 20 and to CYPS March 20 **Contacts:** Rob Scoble (Youth Council) Monica Brooks (CCG) Sarah Lofts (CCGs)
NHS 999	Report on 999 performance	Sussex Integrated Urgency Care Transformation Programme (NHS commissioning)	**Contacts:** Colin Simmons (CCGs)
Patient Transport Services (PTS)	Report on plans to tender PTS (end of contract)	Sussex Integrated Urgency Care Transformation Programme (NHS commissioning)	**Contacts:** Colin Simmons (CCGs) HOSCs will be watching this re-procurement closely given major problems with tender of previous PTS contract
Additional Activity Spring 2020			
04 Feb 2020 Performance Information Group (PIG) meeting (HOSC and HWB members' informal meeting to discuss performance, work planning etc.)			
Date TBC STP HOSC Chairs Meeting (meeting with STP leaders)			