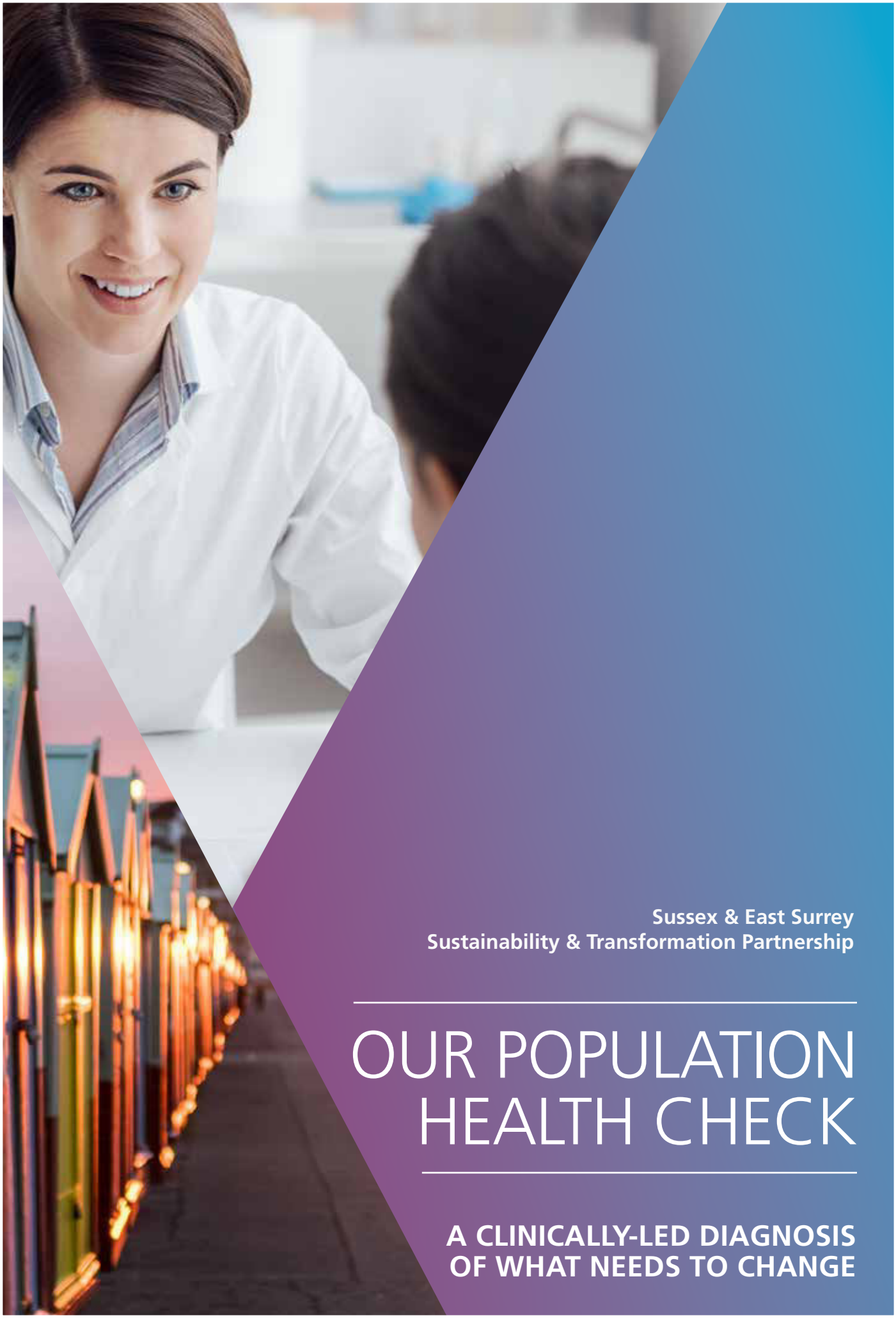

Sussex & East Surrey
Sustainability & Transformation Partnership

OUR POPULATION HEALTH CHECK

A CLINICALLY-LED DIAGNOSIS OF WHAT NEEDS TO CHANGE

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Introduction

“We have many great services and people, delivering great care. However, there is an urgency to address the gaps in the quality and responsiveness of some of our services. There has been an under-investment in prevention and self-care and not enough emphasis on wellbeing and care. Services are not operationally or financially sustainable in the current set-up, which is based on historic and isolated services, not built around what local people need now. In essence, there is less partnership working than we need between patients and clinicians and between services. Given our demography, we need to rely as much on technology-enabled care as on state funded clinical and domiciliary workforce. There just won’t be as many employees available in future as would be needed to provide current services to a larger population with more retired people and not many more working-age citizens. This Population Health Check represents a case for change and provides the evidence of the key issues and the priorities we will deliver together to ensure we offer sustainable services. Doing nothing is neither affordable nor sustainable”

Dr Minesh Patel and Mr Peter Larsen-Disney, Co- Chairs, Sussex and East Surrey STP Clinical and Professional Cabinet

Population Health Check

This Population Health Check has been developed and agreed by a STP group called the Clinical and Professional Cabinet, which consists of the most senior medical and nursing leaders across our partnership.

The STP is not one single separate plan. It is a way of making sure that the plans of all the partners across the area are joined up and working together.

WHAT IS THIS "POPULATION HEALTH CHECK"?
This document is a diagnostic analysis of the key issues we are facing in our local health systems today. This analysis provides the strong evidence base we need for the next phase, which will be an STP-wide Clinical Strategy.

The overall goal of the Population Health Check is to identify the challenges facing our population's health and our system's sustainability in order to develop a strategy, which will see people living with better health that is value focussed and patient centred.

WHY DO WE NEED AN STP POPULATION HEALTH CHECK WHEN WE ALREADY HAVE LOCAL PLANS?
Our STP is comprised of four 'places' responsible for locally driven community and integrated care with the aim of improving health outcomes for our communities and reducing avoidable illness and health and care expenditure. Each place is building a model that best responds to both the local health needs and context of the health and care organisations in the region, however many commonalities exist between them. Each place will oversee radical clinical transformation of Long Term Conditions, frailty, mental health, community, social care, general practice and urgent services to transform outcomes and quality.

The STP is not one single separate plan. It is a way of making sure that the plans of all the partners across the area are joined up and working together. It aims to ensure that no part of the health and care system operates in isolation. We know that what happens in GP surgeries, for example, impacts on social care, which also impacts on hospital wards, and so on. With services feeling the strain, working together will give our nurses, doctors and care staff the best chance of success.

The "added value" of an STP Population Health Check, which complements those Place Based Plans and delivers best value is:

- We will be consistent with our messages on increasing population health and well-being and the importance of delivering value for money.
- We are able to identify and work together on addressing unwarranted clinical variation to deliver value for money services across the system.
- We will work together to improve communication and collaboration across the system and between clinicians and the public to enable decision based on objective, best value evidence and conversations.
- We will support each other to manage the impact of the 3Ts development at Brighton and Sussex University Hospitals NHS Trust (BSUH), which will reduce bed capacity in the short term through collaborative redesigning our model of services to enable care closer to home (delivering the lowest level of effective care).
- We will provide STP-wide senior clinical support for local plans which may help the pace of change, with consistent messaging on delivering value based services.
- We will develop simpler collaborative commissioning, whilst maintaining local engagement and ownership, to make best use of limited resources and to integrate care for patients,
- We will share best practice and offer support on implementation of local transformation plans to deliver better value care at a faster pace,
- We will further develop the skills of clinical leadership, workforce development and resilience through learning from others outside our neighbouring systems,
- We will support consistent access to supportive mental health services to reduce costly reactive responses to crisis care.
- We will develop system-wide digital technology to support communication across the system,
- We will contribute to the strategic planning for the development of estates to ensure we are able to deliver care closer to home across the system.
- We will provide consistent key message to the public so that A&E is not the option chosen as the urgent care option but that the public understand the benefits of accessing alternative services in the community.

We are able to identify and work together on addressing unwarranted clinical variation to deliver value for money services across the system

THE SYSTEM WILL, THEREFORE, COME TOGETHER ON ISSUES WHICH MAKE SENSE TO DO TOGETHER.

Some of these initiatives, such as the STP Mental Health Strategy, are already underway and demonstrating significant improvements. However, it is crucial that the changes identified throughout are interconnected with the delivery of the STP Mental Health Case for Change, Mental Health Delivery Plan, Mental Health Workforce Plan and the identified Mental Health priority work streams and vice versa. This will then emphasise the importance of parity of esteem where mental health is valued equally with mental health. For example – some of the changes will impact and are interdependent with this overall STP Population Health Check e.g. impact of Improving Access to Psychological Therapies (IAPT) Long-term conditions developments on Diabetes, Musculoskeletal (MSK) and Cardiovascular, the life gap for people with severe mental illness and the high proportion of smokers having an severe mental illness. Also the mental health Crisis & Urgent Care workstream need to work closely with the Urgent and Emergency Care workstream.

HOW DO WE OFFER BEST VALUE?

We need to offer best value care to our patients. In July 2017, the South East Clinical Senate produced a briefing entitled 'Emphasising Quality, Delivering Value' (South East Clinical Senate 2017a), which recognises that:

- "The inexorable rise in demand for healthcare and growing pressures and constraints on the workforce and finance threaten the sustainability of the NHS. For clinicians across all disciplines, this means that we need to focus our combined resources on the care that delivers the greatest value.

- Value in healthcare is defined as the achievement of the best outcomes for individual patients and for the public within available resources. It also means doing less of things that add little or no value to patients.

- To achieve best value will require the development and use of standardised outcome measures that are more relevant to patients (such as the impact on their functional status and wellbeing), and their more active involvement through the process of shared decision making with well-informed patients. It also involves recognising unwarranted local variation in the delivery of high value care and addressing it.

- Value is not a financial term. It is a term that integrates high quality, safe and cost effective care that improves patient or population outcomes. It can be represented as follows:"

- Better Conversations' is a fundamental part of delivering the Five Year Forward View. The first principle within the 'New Care Models' to engage people and communities is that care and support is person-centred: personalised, coordinated, and empowering. Person-centred approaches has recently beenpublished by Skills for Health, Skills for Care and Health Education England as a core skills education and training framework for the health and care workforce.

The inexorable rise in demand for healthcare and growing pressures and constraints on the workforce and finance threaten the sustainability of the NHS.

$$\text{VALUE (of an intervention)} = \frac{\text{OUTCOME (health and social)}}{\text{RESOURCED REQUIRED (to deliver the coutcome)}}$$

- We need to begin focusing on assets and "what matters to people" rather than "what's the matter with" people.

We need to improve communication between services. The way that clinicians work together in providing care to individual patients, and how they communicate with each other, is vital to providing an integrated, coordinated, patient-centred approach, and for delivering the best experience of care and outcomes for patients. Phone calls and conventional letters have been the default means of communication for decades, whilst over time technological changes, increasing specialisation, the need for greater efficiency, changing organisational and professional boundaries, and changing patient expectations, have ceaselessly evolved. (SE Clinical Senate. 2017b)

WHAT DID WE FIND ARE THE KEY THEMES?

We found that:

- There are four main unhealthy behaviours of smoking, alcohol misuse, poor diet and lack of physical activity, as well as poor emotional and mental well-being, which are responsible for at least a third of ill health and are amenable to cost-effective preventative interventions. Focusing on prevention earlier in the life-course will accumulate greater benefits, but even in middle and older age groups, preventative approaches are cost-effective. Prevention requires prioritisation and investment across the system. This includes the need to treat symptoms early in primary

care to stop the development of a long-term condition. To date, across our STP, there has been an under-investment in prevention and self-care and not enough emphasis on wellbeing and care.

- There were 1,314 stillbirths in the South East between 2013-2015, equating to roughly 36 stillbirths per month. A large proportion of stillbirths are attributable to risk factors some of which are fully or partly avoidable, indicating an opportunity for rate reduction. Independent risk factors for stillbirth include: obesity, smoking, acquired medical disorders (diabetes) and disadvantaged populations.

- The STP covers a wide geographical area and many organisations, with a notable amount of variation in financial performance. For 2017/18, the combined net deficit (surpluses and deficits added together) for Clinical Commissioning Groups (CCGs) and Trusts in the footprint was £228.2m.

- There is significant expected growth in the population generally and an enormous growth in the 65+ and 85+ age groups. Significantly, this includes an increase in life expectancy for people in poor health. One in three over-65s and half of those over 80 will suffer a fall each year. In addition to the physical consequences, falls can have a damaging psychological impact, resulting in loss of confidence and independence, and increased isolation and depression. The Department of Health has stated that a falls prevention strategy could reduce the number of falls by 15-30%.

- Pressures on our GP services are critical causing issues with access for patients and staff stress. General Practice across the country is struggling to maintain services, and this situation is mirrored in Sussex and East Surrey. The population is getting older, many more people live with multiple chronic diseases, people are seeing their doctor more often and with more complex problems. General Practice has coped well so far, but we need to address these issues if we are not to face much bigger problems.

- We have significant workforce shortages across the system, in particular in GP surgeries, mental health and social care, with increasing demand.

- There have been many years of under-investment in estates, which has resulted in non-compliance, high backlog maintenance and an inefficient estate with high running costs. This hampers our ability to shift care closer to home.

The population is getting older, many more people live with multiple chronic diseases, people are seeing their doctor more often and with more complex problems.

- Bed capacity is expected to increase by 176 beds by 2023/24 at BSUH as a result of the 3Ts rebuild. However, in the meantime, there will be a detrimental impact on capacity which needs to be supported across the wider system.

- Care is often un-co-ordinated and duplicated leading to poor quality care with multiple hand-offs. The supportive systems are often difficult for the public to navigate, resulting in increased attendance to A&E.

- Communication between clinicians across organisations and between clinicians and patients requires improvement.

- We have a high level of mental illness and dementia, with the need to increase access to supportive services.

- Digital technology needs to better support integrated care, population health management and empower patients in managing their care. We have not been good at establishing systems for self-support which are cheap, cost effective and improve outcomes – (patient held records, patient educational materials /fora via online platforms for example) despite 90% of the population owning a smartphone / tablet or PC.

- We have unmet need at one end of the spectrum and unnecessary and/or non-evidenced treatments at the other with variably informed decision-making in the middle.

- There is variation across the trusts in delivering our constitutional standards (the standards everyone should expect) including Referral to Treatment Times (RTT), emergency admissions, Delayed Transfers of Care, bed occupancy, cancer waits and A&E 4-hour performance.

- Our data shows us we have significant unwarranted variation across the STP that are impacting on quality in many areas but particularly in MSK, Cardiovascular and Falls/Fragility Fractures. There is also evidence that we over treat patients in some specialties.

- Too many people are dying away from their usual place of residence or in a place that is not of their choosing.

- Doing nothing is neither affordable nor sustainable.

Digital technology needs to better support integrated care, population health management and empower patients in managing their care.

WHAT DO WE NEED TO CHANGE TO ADDRESS THESE KEY THEMES?
We concluded that:
We have not focussed enough on promoting the determinants of good health because:

- There remains considerable, and unacceptable, differences in life expectancy between areas across the STP and within local CCG / local authority areas. Service access, take up and outcomes need to be addressed for disadvantaged groups.

- There are four main unhealthy behaviours of smoking, alcohol misuse, poor diet and lack of physical activity, as well as poor emotional and mental well-being, which are responsible for at least a third of ill health and are amenable to cost-effective preventative interventions.

- Focusing on prevention earlier in the life-course will accumulate greater benefits, but even in middle and older age groups, preventative approaches are cost-effective. Prevention requires prioritisation and investment across the system. Prevention includes the reduction of falls in the elderly and healthy living to reduce still births.

In order to keep up with increasing demand, we need to collaboratively redesign our service models to bring care closer to home because:

- There is an imbalance of bed/un-bedded capacity and demand in acute, primary, community and social care.

- BSUH is undergoing a significant re-build programme through 3Ts, which will have an impact on bed capacity until it is completed.

- We want more people to die in their usual place of residence and place of choice.

- Bringing care closer to home, cannot be delivered without addressing the issue that the sustainability of primary care is significantly challenged across the system. Dedicated effort to address primary care challenges is crucial.

Our Urgent and Emergency Care services cannot keep up with demand because:

- Attendances to A&E and handover delays continue to put immense pressure on our services.

- Over a quarter of A&E attendances could be treated at another suitable location e.g. primary care.

- There are several points of contact for access to services, fragmented pathways and gaps in service availability (geographic and time of day), particularly around admissions avoidance and to support hospital discharges.

Our patients with mental health needs are not always able to access support when they need it because:

- There is a lack of a 24/7 crisis support.

- Capacity needs to be built in primary care, closer to home and thereby reduce presentations and referrals to physical and mental health secondary care.

- The prevalence of severe mental illness is 5% higher than nationally, affecting 25,000 individuals

- For dementia, prevalence is 25% higher than nationally, will increase further as the population ages, while the proportion of those with a diagnosis is 5% lower. A quarter of those patients with dementia who are fit to leave acute care wait over 50 days for discharge.

- There is an increasing problem of addiction and its impact on the individual and the system.

We do not have the workforce numbers and skills to meet current and future demands because:

- There is an imbalance in staffing capacity and demand across the whole health and social care system. This includes front line staff providing direct patient/client care, back office staff, and key services e.g. pathology and radiology.

- The average retirement age is 59 and we have 15 % of staff aged 55 years and over.

- The turnover rate for all registered nursing, midwifery and health visiting staff ranges from 13% - 20%.

- In social care there is a significant annual turnover of 26% for registered nurses.

- There are difficulties recruiting and retaining substantive mental health nurses and psychiatrists.

- In June 2017, the Sussex and East Surrey STP had a shortfall of GPs (Full-time equivilants) of 193.

There is an increasing problem of addiction and its impact on the individual and the system.

We need to enable our workforce to have conversations which enable patients to make the right decision about care

Our digital technology does not meet current and future needs because:

- There is a lack of ability and confidence to access shared information to support for Clinicians, professionals, patients and carers in:

(a) Direct Care and Self-Management,
(b) Population Health Management and Evaluation,
(c) Research and Innovation.

- Digital systems do not yet integrate effectively enough to support new models of care or meet expectations.

- There is a lack of health and care services digital maturity, partnerships and agility to take advantage of the opportunities of emerging technologies (e.g. Artificial Intelligence (AI), Precision Medicine, Internet of Things)

There is a lack of demand management to create the most efficient pathways because:

- There is a lack of working practice changes required to encourage 'channel shift.'

- There is a lack of standardised communication and engagement strategies to reduce demand on the system.

- Communication between clinicians across boundaries needs to be addressed as a priority.

Unwarranted clinical variation exists across the system leading to inequity in access to the good standards of care because

- There is unwarranted variation in referrals guidelines, treatment, medicines and Continuing Healthcare funding when we compare ourselves to our demographic peers.

- There is insufficient shared decision-making between patients and their healthcare professional. We need to enable our workforce to have conversations which enable patients to make the right decision about care, based on objective evidence and dialogue and containing expectations to value based care.

OUR POPULATION HEALTH CHECK

THE FOLLOWING CHART SUMMARISES THE KEY THEMES AND WHAT WE NEED TO CHANGE IN OUR SES STP

5 BEHAVIOURS
1. Smoking
2. Physical inactivity
3. Unhealthy diet
4. Excess alcohol
5. Social isoloation

LEADS TO

5 RISK FACTORS
1. Hypertension and breathing problems
2. Obesity and High Chloesterol
3. Hyperglycaemia
4. Frailty and falls
5. Anxiety and depression

LEADS TO

5 DISEASES
1. Cancer
2. Circulation and respiratory disease
3. Diabetes
4. Bone and joint conditions
5. Mental Health conditions

LEADS TO

75% OF DEATHS AND DISABILITY

5 IMPACTS ON PATIENTS AND SERVICES
1. There is an increase in life expectancy (increased demand), which includes an increase of people living longer in poor health (higher acuity).
2. The capacity in the NHS and social care cannot keep up with demand leading to delays and poor quality care.
3. Insufficient numbers of dying patients being cared for in their usual place of residence.
4. There is an increase in reactive, urgent care.
5. There is an increase in the cost of delivering services.

LEADS TO

5 STP PRIORITIES
1. STP workforce and capacity strategy.
2. Shared decision-making and patient activation.
3. Re-framing our cultural norms to make the right lifestyle choices easy to make.
4. Addressing unwarranted clinical variation.
5. Mental and physical health services and social services closer to home with good communication and co-ordination.

OUR POPULATION HEALTH CHECK HAS TRIANGULATED PREVIOUS ANALYSIS INTO A SINGLE CASE

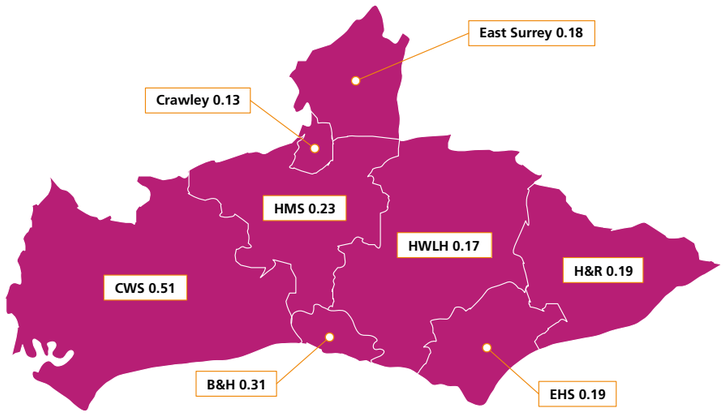
PRIORITY AREA	STP EXECUTIVE	STP CLINICAL AND PROFESSIONAL CABNIET	STP PLAN AND REFRESHED PLAN (11 KEY INTERVENTIONS)	EXISTING SYSTEM TARGETS/ MEASURES
Older people + disabilities/ Long-term conditions	11 interventions MSK Get It Right (GIRFT), Continuing Healthcare (CHC), Clinically Effective Commissioning, Medicines, Optimisation	Right: bone and joint, MSK unwarranted variation, Falls and Fagility fractures, end of life care, over treatment, medicalisation	Older people, dementia end of life care, re-ablement, falls reduction	Delayed transfers of care, dementia indicators (improvement and Assessment Framework (IAF), Urgent and Emergency Care GP access, Learning disabilities
Circulation and Respiratory (cardiovascular disease, coronary heart disease, cronic obstructive pulmonary disease (COPD), diabetes)	Clinically Effective Commissioning (CEC) / Procedures of limites clinical effectiveness (POLCE)	Rightcare 5:5:5 (prevention, detection, management / risk reduction) – Stable angina, Atrial Fibrillation (AF) / Hypertension and breathing problems / High Cholesterol, Hyperglycaemia, obesity, diabetic foot amputations). Shared decision-making and social activation	Adults with physical disability build knowledge and change behaviours	Quality and Outcomes Framework (QOF), RightCare, diabetes. Maternal smoking, obesity (IAF)
Cancer		5:5:5 (cancer risk factors; screening; early detection and treatment, survivorship)	Acute liaison, SEMI	2 week wait, 31 days, 62 days Screening, stage 1 and 2, diagnosed in A&E
Mental health	Mental health strategy	Mental health in relation to 5:5:5 (prevention, wellbeing, early intervention, social isolation, mental health and long-term conditions and dementia)	Acute liaison, SEMI	IAF, IAPT / dementia / acute crisis / CYP
Urgent and Emergency Care	Urgent and emergency care including 111, 3Ts	Capacity across the health and care system	Rapid response in community and acute services	A&E 4 hour waits
Co-ordinated and well communicated care	Digital Strategy Workforce strategy	Improving communication across primary and secondary care. Patient activation	Discharge planning Single point of access Specialist advice Integrated care	Recruitment and retention Agency spend
Maternity	Better Births	Supporting a good start in life		Still birth reduction

Our Population Health Check in context

There are 24 large organisations in our partnership – local authorities, providers and clinical commissioning groups. This STP recognises the very critical part played by so many other smaller but core health, care and wellbeing organisations across the STP.

Our footprint is home to 1.7 million people providing health and social care at a cost of £4bn. It cannot be under-estimated the importance of planning changes to care across the health and social care system so that changes are not made in isolation but in partnership, with the impact of changes being clear and mitigating any negative consequences together.

POPULATION SIZE BY LOCATION (M)



NHS Commissioners
Brighton & Hove CCG
Coastal West Sussex CCG
Crawley CCG
East Surrey CCG
Eastbourne Hailsham & Seaford CCG
Hastings & Rother CCG
High Weald Lewes Havens CCG
Horsham & Mid-Sussex CCG
Specialised Commissioning (NHS E South)
Total = 9

NHS Providers
Brighton & Sussex University Hospitals
East Sussex Healthcare
Queen Victoria Hospital
South East Coast Ambulance Service
Surrey & Borders Partnership
Surrey & Sussex Healthcare
Sussex Community
Sussex Partnership
Western Sussex Hospitals
GP Providers
Total = 9 (excluding GP Providers)

Non-NHS Providers
Brighton & Hove City Council
East Sussex County Council
Surrey County Council
West Sussex County Council
First Community Health and Care
IC 24
Total = 6

STP Total = 24

We must also acknowledge some of the many examples we have of great care across the health and social care services across our STP.

STPs are a way for the NHS to develop its own, locally appropriate proposals to improve health and care for patients. They are working in partnership with democratically elected local councils, drawing on the expertise of frontline NHS staff and on conversations about priorities with the communities they serve. Partnerships will be forums for shared decision making, supplementing the role of individual boards and organisations. Their immediate focus is on refining and implementing their sustainability and transformation plan so that patients can see practical benefits in their local health system. STPs do not replace new care models; instead they will allow the ability to build on their success, by providing a collaborative system of leadership and governance which will allow new care models to evolve and spread. (NHS England, 2018)

Although this document focusses on what we need to change, we must also acknowledge some of the many examples we have of great care across the health and social care services across our STP. For example:

- East Sussex Better Together: Health and Social Care Connect (HSCC) which offers both the public and professionals a single point of access for adult health and social care enquiries, assessments, services and referrals. Streamlining access frees GPs to see other patients rather than having to refer to several different services for a patient. It also supports faster access to the services for patients in their home.

- Central Sussex and East Surrey Commissioning Alliance (CSESCA) North: Integrated, patient-centred teams developing in Primary Care Homes. East Grinstead is a rapid test site for a Primary Care Home model: Key work-streams are addressing urgent 'on the day' primary care capacity with GPs working in the Minor Injury Units (MIUs).

- Central Sussex and East Surrey Commissioning Alliance (CSESCA) South: Dementia Golden Ticket in HWLH. The Golden Ticket delivers a holistic mix of services to address health and wellbeing, supporting people with dementia and their carers in every aspect of their lives. Evaluation of the project shows that it is already reducing GP visits and emergency admissions to hospital. People who said that they had previously felt isolated received support to live more independently.

- Coastal Care: Frailty pathway redesign. The Paramedic and Occupational Therapy team work together on the Falls Response vehicle, provided by Sussex Community NHS Foundation Trust, with the pilot being funded by Coastal West Sussex CCG. So far the conveyance rate for this vehicle in the first four weeks is 9.18% compared to 20.5% for the previous 5 weeks.

- Sussex Partnership NHS Foundation Trust (SPFT): Developing a single access point to ensure that people in crisis can access services 24 hours a day and a no 'wrong front door' approach with access points for other services. They have set up a front door staffed by peer workers, care navigators, carers, voluntary sector staff and mental health clinicians.

- South East Coast Ambulance Service NHS Foundation Trust (SECAmb): 999, Emergency Operations Centre and 111 Rotational Workforce: Working with HEE and commissioners, SECAmb is developing a number of rotational workforce positions. These are focussed on rotating staff out (e.g. Paramedic Practitioners in primary care) and rotating staff in from other organisations (e.g. midwives). This is allowing the Trust to test workforce and governance issues before beginning wider work on rotational workforce approaches such as mental health nurses and rotating SECAmb paramedics into hospice and urgent care centre settings.

- Sussex Community NHS Foundation Trust: Healthy Child Programme, which provides a range of health interventions and support, beginning in pregnancy and continuing through to the end of formal schooling.

- IC24: Developing the multi-professional urgent care workforce and strengthening the role of the GP as a clinical leader.

- Specialist Palliative Care: The adult and children's hospices and Specialist Palliative Care services serving the STP area are all supported by their local communities to provide holistic multi-professional care for those facing death and bereavement. Adults known to hospice services are less likely to die in hospital and have a higher chance of dying in their usual place of residence.

- Academic Health science Network: The Atrial Fibrillation (AF) project identified 580 individuals who were eligible for anticoagulation and would benefit from a change of treatment to reduce their risk of an AF-related stroke. By the end of May 2018, 219 individuals had had their medicines optimised by their GP practice. This has reduced the risk of AF-related strokes to such an extent that the equivalent of six AF-related strokes have been avoided, avoiding debilitating effects on individuals and their families and avoiding costs to state-funded health and social care of over £160,000.

Some residents living within our STP, are treated in Kent and Medway and Surrey and are also affected by their STP Cases for Change. Kent and

Adults known to hospice services are less likely to die in hospital and have a higher chance of dying in their usual place of residence.

People with mental ill health have poor outcomes and may not always be able to access services

Medway STP, Surrey Heartlands STP and Frimley STP have all identified the same issues in their Cases for Change in that:

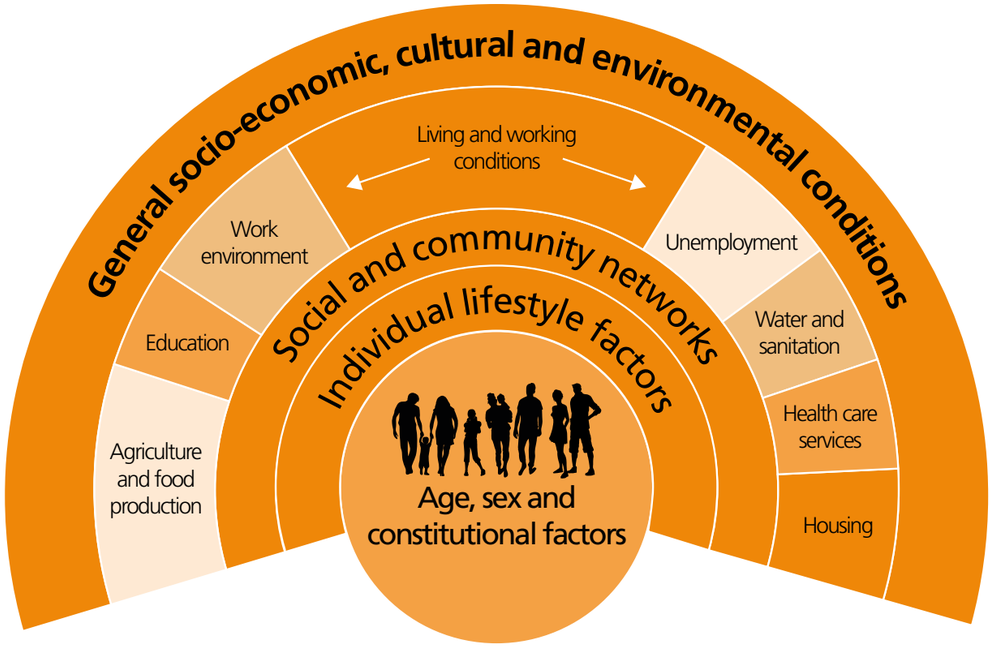
- There is not enough focus on maintaining independence and ill health prevention,
- There are challenges in primary care provision, which is extremely fragile in some areas,
- There are gaps in service and poor outcomes for those with long term health conditions,
- We do not support people with long-term conditions and needs to look after themselves as effectively as we should,
- Many people are in hospital who could be cared for elsewhere,
- There is a growth in demand from older, more complex patients,
- Planned care is not delivered as efficiently and effectively as it could be,
- There are particular challenges in the provision of cancer care,
- People with mental ill health have poor outcomes and may not always be able to access services,
- There are capacity issues,
- There is a lack of Digital integration and innovation,
- They have an unsustainable workforce model,
- They need to reduce clinical variation,
- Urgent and Emergency care needs to reduce.

In addition they have also identified the following which we have not identified in that some local hospitals find it difficult to deliver services for seriously ill people: some services are vulnerable and potentially unsustainable. There is a need to review their specialist acute model including mental health. Existing capacity needs to be redesigned to be used much more productively.

What we found (our evidence)

Our evidence: Our Population and Demographics

OUR APPROACH TO HEALTH AND WELLBEING INEQUALITIES



Ref: Determinants of Health, Dahlgren and Whitehead (1991)

Our approach reflects the responsibilities of the whole system in addressing health and well-being – NHS, councils, police, education, voluntary sector, communities and individuals. This well-being approach recognises that health is created by wider factors than health services. This approach requires a strategic commitment to building a culture in which individuals, organisations and communities work together to identify and pool their capacity, skills, knowledge, assets and resources

Ref: Adapted from Gonnering RS and Riley WJ (2018) Robert Wood Johnson and University of Wisconsin Population Health Institute

to improve health and wellbeing outcomes for all our residents. Such an approach requires a shift from a demand management approach to a whole system approach to prevention which addresses "the causes of the causes" as identified in Dahlgren and Whitehead model (1991) above. The "causes of the causes" recognises that if the causes of poor health are social, economic and environmental then the solutions need to be too – from social determinants to those of the built environment, and these solutions require concerted, sustained, partnership working.

CAUSES OF THE CAUSES

From Health in All Our Policies (Local Government Association 2016)

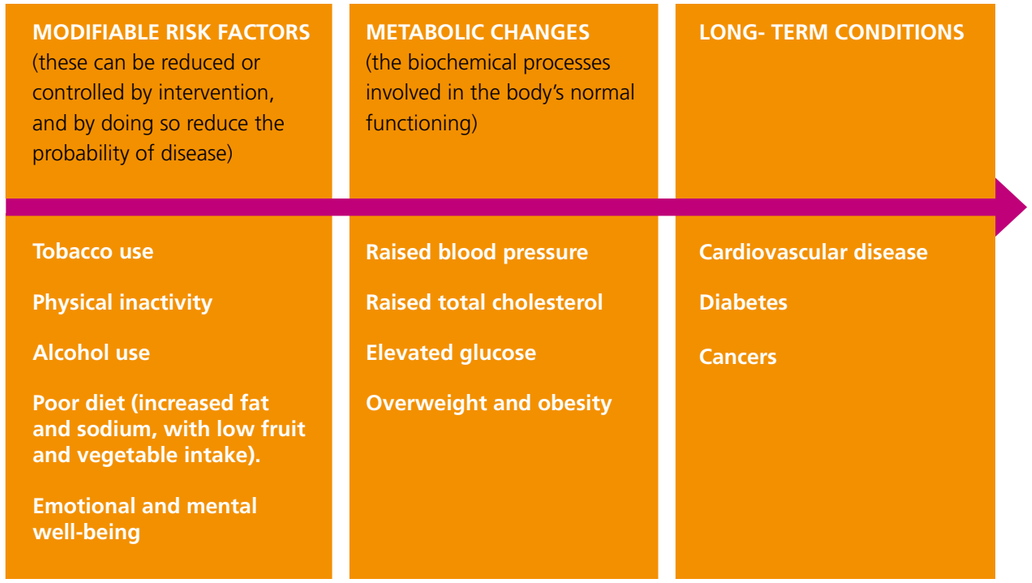
Our Joint Strategic Needs Assessment (JSNA) show our health priorities are largely the same as elsewhere – good mental health and wellbeing underpins success; poor physical health is linked to lifestyle behaviours, health inequalities result from social and income inequality; healthy futures are built on good employment and decent homes. However, there are extreme variations in terms of socioeconomic status, health outcomes, environment and economic prosperity. These are often masked by averages, meaning health outcomes can seem on a par with the rest of England, when for parts of Sussex and East Surrey the reality is significantly and enduringly worse.

There remain considerable, and unacceptable, differences in life expectancy between areas across Sussex and East Surrey and within local CCG / local authority areas. Service access, take up and outcomes need to be addressed for disadvantaged groups.

Four main unhealthy behaviours of smoking, alcohol misuse, poor diet and lack of physical activity, as well as poor emotional and mental well-being are responsible for at least a third of ill health and are amenable to cost-effective preventative interventions. Substance misuse, in all its forms, continues to present challenges across the STP area, and notably in the Hastings and Brighton and Hove areas.

Unhealthy behaviours of smoking, alcohol misuse, poor diet and lack of physical activity, as well as poor emotional and mental well-being are responsible for at least a third of ill health

MODIFIABLE RISK FACTORS AND LONG TERM CONDITIONS



LIFE COURSE APPROACH

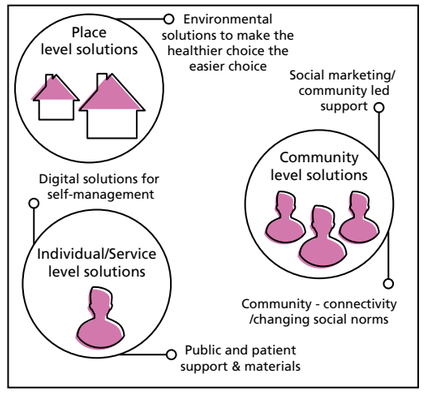
Starting well in life is important for every child. The first few years of life are critical for readiness to learn, educational achievement, income and economic status - strong predictors of future health and wellbeing. What happens during pregnancy and early years impacts on their risk of long term ill health such as obesity, substance misuse, risk of heart disease, dental decay and poor mental health. These differences are almost entirely explained by deprivation and inequalities. Public health interventions have an important part to play to stem the tide of long-term conditions and increasing costs. Focusing on prevention earlier in the life-course will accumulate greater benefits, but even in middle and older age, preventative approaches are cost-effective. Prevention requires prioritisation and investment across the system.

Self Care Continuum

Prevent
- Self care
- Daily Choices
- Lifestyle

Reduce
- Self-managed ailments
- Long terms conditions
- Actute conditions

Delay
- Compulsory psychiatric care
- Major trauma
- Residential care



Enablers:
- Asset based needs assessment
- Aligned Strategies
- Collaborative partnerships
- Systematic workforce development
- Embedding prevention into care pathways
- Systematic self care & digital support

A WHOLE SYSTEM APPROACH TO PUBLIC HEALTH

As well as individual service interventions, public health interventions to build stronger and more resilient communities and places which support people to maintain independence and manage their own health and wellbeing across the course of their lives, are an important components of a whole system approach to prevention across NHS, local authorities, voluntary sector, community groups and wider stakeholders.

Working together, we can achieve the cultural shift we need to sustain improvements for people wherever they live and create a focus on health rather than the treatment of illness. This is increasingly important if public services are to be sustainable in the future – all parts of the public sector face significant budget pressures and the NHS and local government are by no means exempt. Improving the public's health will help secure the future of these services and deliver longer, healthier lives for all our residents.

Improving the public's health will help secure the future of these services and deliver longer, healthier lives for all our residents.

CURRENT RESIDENT POPULATION AND PROJECTED TO 2030 (DATA ROUNDED TO NEAREST 100)

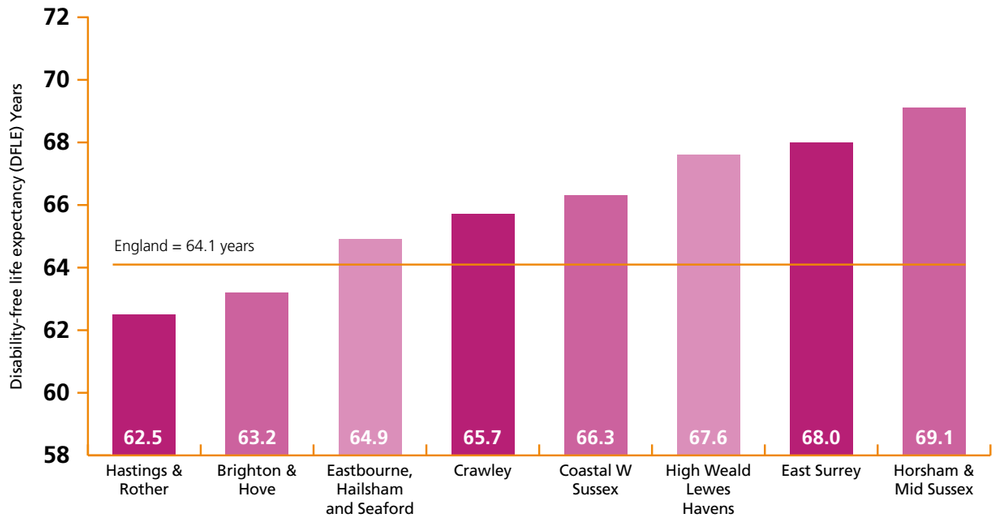
	2016 POPULATION	2030 PROJECTED	% CHANGE
OVERALL RESIDENT POPULATION			
ESBT	375,200	417,900	11.4%
Coastal	498,900	558,800	12.0%
CSESCA North	528,600	578,900	9.5%
CSESCA South	461,800	504,100	9.2%
0-19 YEARS			
ESBT	79,300	83,00	4.7%
Coastal	104,400	111,200	6.5%
CSESCA North	130,100	139,00	6.8%
CSESCA South	99,400	103,900	4.5%
65-84 YEARS			
ESBT	82,400	109,700	33.1%
Coastal	109,200	143,000	31.0%
CSESCA North	79,000	104,900	32.8%
CSESCA South	66,600	86,900	30.5%
85 AND OVER			
ESBT	16,000	22,200	38.8%
Coastal	20,200	28,500	41.1%
CSESCA North	14,500	20,600	42.1%
CSESCA South	11,700	15,500	32.5%

Sources: Aggregated CCG data provided by ONS. 2016 Population - ONS Mid-Year Estimate (Resident Population) 2016. 2030 Projected - ONS Population projections for clinical commissioning groups and NHS regions

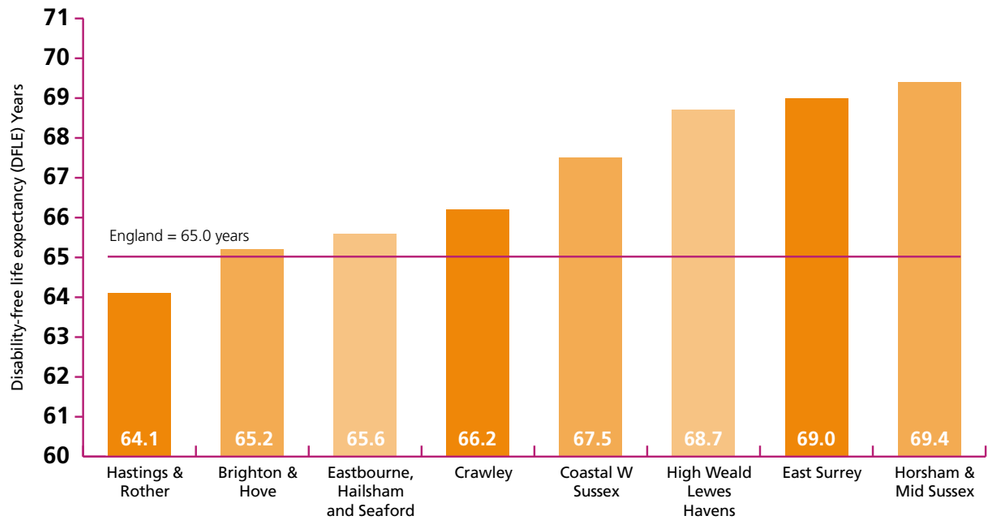
The resident population across the overall area is projected to increase between 2016 and 2030, from a projected 9.2% increase in the CSESCA South area to 12% in Coastal. The greatest increases are projected in the older age groups, notably amongst people aged 85 years or over. Growth in the child population is lower than overall change. The overall population increase, and the rise in the older age groups will impact the demand for health and social care services, with frailty and the number of people with one or more long-term health condition rising.

Disability Free Life Expectancy

MEN (2010 - 2012) *Source: ONS*



WOMEN (2010 - 2012) *Source: ONS*



Life expectancy varies considerably across the area; this reflects deprivation, with shorter life expectancies in the most deprived local authority areas.

In Hastings male disability-free life expectancy is over five years lower than that in Horsham and Mid Sussex, East Surrey and High Weald, Lewes and the Havens.

Hastings and Rother also has the lowest female disability-free life expectancy at 64.1 years compared with Horsham and Mid Sussex at 69.4 years.

DEPRIVATION - INDEX OF DEPRIVATION 2015

While overall the STP area is relatively affluent, there are some areas, notably along the coastal strip in Hastings, Brighton and Hove and Littlehampton, which rank within the most deprived areas in England; deprivation that has persisted over many years.

In relation to child poverty, rates at a CCG level (2013) range from 7.3% in Horsham and Mid Sussex to 22.7% of children in Hastings and Rother, but again there are neighbourhoods where more than a third of children live in low income households.

The pace of change in older age will increase markedly over the next ten years

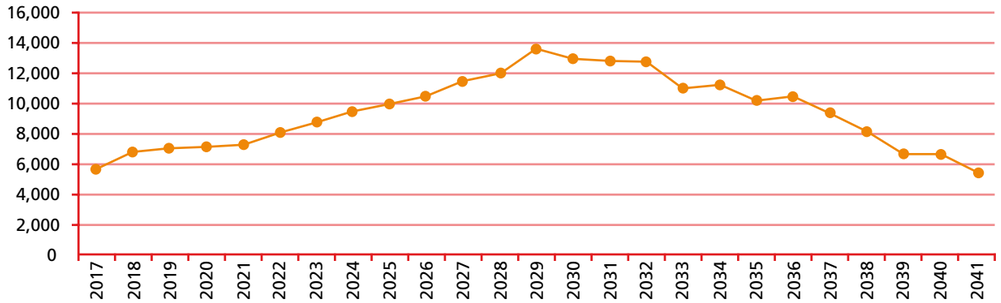
POPULATION – KEY FACTS

The population is increasing, with higher increases in the older age groups. It is also important to note that the pace of change in older age will increase markedly over the next ten years. In the first five years, the annual increase in the 65+ population is projected to be between 6,000 to 8,000(across the whole STP area) but this then starts to rise, and peaks at around 14,000 in the next 10 years.

YEAR-ON-YEAR CHANGE IN THE POPULATION AGED 65 OR OVER 2017 TO 2041 (COMBINED EIGHT CCGS AREAS)

Given the increase in the old age groups, there will be more people living with a long term health condition. Many people will have multiple long term conditions. There will be considerable challenges in sustaining services and maintaining quality.

Year-on-year change in the population aged 65 or over 2017 to 2041 (Combined eight CCGs areas)

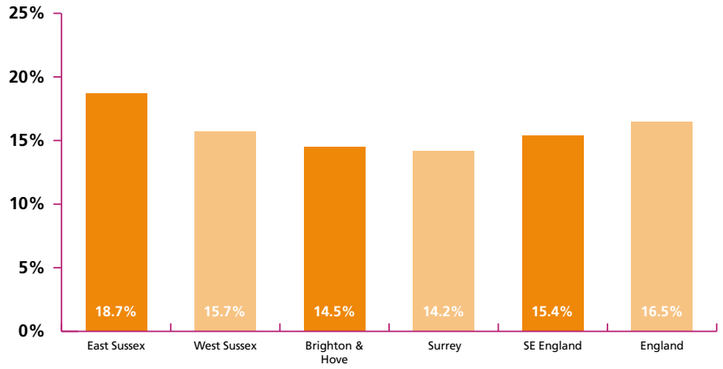


Source: ONS Population Projections (combined CCG areas)

LONG TERM CONDITIONS - DATA FROM QOF REGISTERS OF PATIENTS IDENTIFIED V MODELLED ESTIMATES OF PREVALENCE

Figures rounded to nearest 50. Register data relate to 2016/17	ASTHMA		ATRIAL FIBRILLATION		COPD		DEMENTIA		DIABETES		HYPERTENSION	
	QOF Register	Estimated undianosed	QOF Register	Estimated undianosed	QOF Register	Estimated undianosed	QOF Register	Est diagnosis rate (65+)	QOF Register	Estimated undianosed	QOF Register	Estimated undianosed
Brighton & Hove	16,750	No recent estimate	4,100	1,850	4,250	No recent estimate	1,700	64%	10,500	7,800	28,900	27,950
Coastal West Sussex	32,750		13,900	3,650	10,050		5,750	63.2%	30,250	9,250	83,400	54,550
Crawley	7,650		1,950	750	2,050		800	64.3%	7,100	1,150	16,250	11,750
East-bourne Hailsham & Seaford	12,900		6,350	700	4,400		2,500	67.3%	10,750	4,900	34,100	22,100
East Surrey	10,600		3,800	750	2,500		1,500	68.2%	7,800	3,300	22,250	17,050
Hastings and Rother	10,250		5,000	950	4,250		1,950	65.0%	10,150	5,450	30,700	17,650
High Weald Lewes Havens	10,150		4,300	950	2,900		1,700	66.0%	7,750	4,300	25,750	17,300
Horsham & Mid Sussex	14,750		5,050	1,650	3,250		2,200	67.9%	10,400	4,400	33,650	22,850

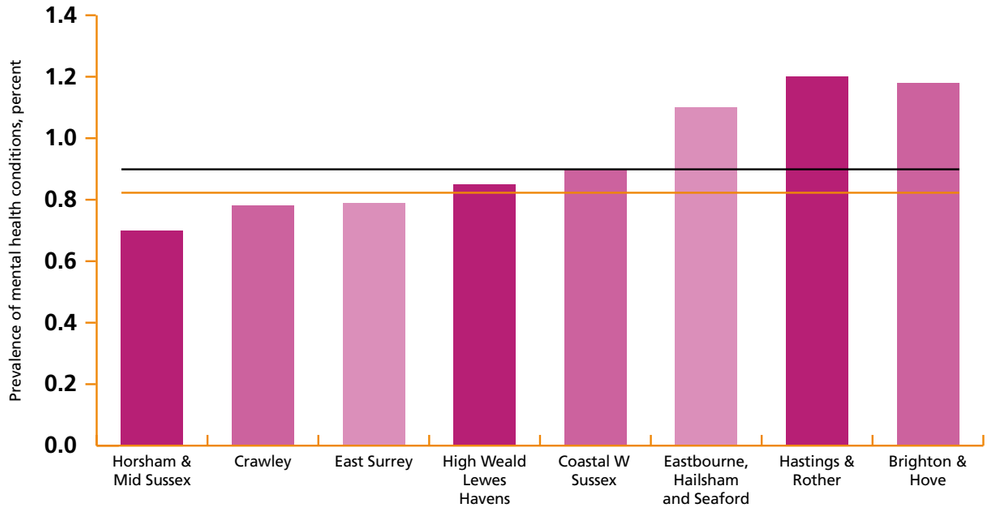
% Of Patients Reporting a Long Term Musculoskeletal Problem (2017 LA Level)



MENTAL HEALTH ESTIMATION OF COMMON MH MENTAL HEALTH PROBLEMS

MENTAL HEALTH	
Estimation of Common Mental Health Problems	**MH**
2014/15	**% of 16-74 years**
High Weald Lewes Havens	12.0%
Eastbourne, Hailsham & Sfd	12.4%
Crawley	12.7%
Horsham & Mid Sussex	12.8%
Coastal West Sussex	12.9%
East Surrey	13.3%
Hastings & Rother	13.8%
Brighton & Hove	17.3%

SERIOUS MENTAL ILLNESS



START WELL

Smoking at the time of delivery
In 2017/18, 1,600 women were known to be smokers at the time of delivery (9.1% of those with recorded status). The percentage in Hastings and Rother was over 15%.

Breastfeeding initiation is high
Over 82% of mothers breastfed their babies in the first 48hrs after delivery in 2016/17. The rate was highest in Brighton & Hove (88.2%), lowest in Hastings and Rother (73.3%)

Readiness for School
In 2017, the percentage of children achieving a good level of development in Brighton & Hove (69.7%) and West Sussex (70.6%) lags behind East Sussex and Surrey, and is lower than England.

Social mobility rated very good in ...Tendridge (Surrey)
But rated very poor in Arun, Crawley and Hastings

Obesity
7.8 % fo reception pupils and 15% of year 6 pupils were measured as obese in the STP area (2014/15 to 2016/17). Higher percentages of excess and obese children in more deprived areas.

7 hours + of sedentary behaviour
In the 2014/15 "What about Youth" Survey over 60% of 15 years olds surveyed in the STP area reported a mean daily sedentary time (in the last week) over 7 hours per day

Smoking at age 15 years
The percentage of 15 year olds who said they were "current smokers" was high in Brighton & Hove (14.9%), East Sussex (12.8%) and West Sussex (10.6%). Nationally the rate was 8.2%.

Hospital admissions for self-harm (10-24 years)
In STP areas compared with England, Brighton & Hove, Hastings and Rother and Coastal West Sussex have particularly high rates of admission.

LIVE WELL

Low Unemployment
STP area has, overall, a low unemployment rate, but some areas higher such as Hastings

But low wages in some areas
Notably full-time wages (2017) are low in Adur, Hastings and Eastbourne.

Housing Pressures
Over 40,000 households on council waiting lists, 450-500 households a quarter accepted as homeless and in priority need.

Over 250,000 smokers on GP registers
Considerable differences across the patch and between socio-economic groups. High rates in Brighton and Hove and Hastings .

Falling short of the "5-a-day"
Across the STP area, adults consume only 2.5 to 3 portions of fruit & vegetables a day, and estimates of overweight or obese adults at local authority level range from 48% to 64%.

250,000+ adults estimated to be "binge" drinkers
In 2016/17 there were over 1,600 alcohol-specific hospital admissions

Over 155,000 adults with depression on GP registers
This represents over 10% of patients. Again there is variation – with 13% of patients in Eastbourne, Hailsham and Seaford identified with depression.

Physical activity rates vary
Measured at local authority level, the % of adults undertaking the recommended physical activity level vary from 78% in Brighton & Hove to 62.2% in Crawley.

Rates of physical inactivity vary
In Eastbourne 27% of adults are estimated to undertake less than 30 minutes of physical activity per week.

AGE WELL

Over 110,000 older people live alone in the overall STP area
Of the older people living on their own the vast majority are women (over 70%). Over 83% of older people are owner occupiers

70,000 households estimated to be in fuel poverty
Not restricted to older people, but health effects can be greater on the very young and very old.

Admissions after a fall are high
In old age groups a fall can trigger a move into residential care. For people aged 80+ Brighton & Hove, Surrey and West Sussex rates of emergency admissions are far higher than the England rate

Over 183,000 Carers
….in the STP area, including over 37,000 people who area caring for 50 hours a week or more, including 15,000 carers aged 65 or overs.

18,000+ on Dementia Registers
But we know that many people with dementia are not diagnosed.

Social isolation and loneliness
Frequently reported by older people and has an impact on mental and physical wellbeing. Over 60% of carers known to social care say they do not have as much social contact as they would like.

Deaths at home Overall a higher percentage (50.7% in 2016) of people in the STP die in their usual residence (including care homes), compared with England, but this is far lower in Crawley (37.2%)

Variation in Disability Free Life Expectancy (DFLE)
Hastings and Rother has the lowest DFLE for both men and women (62.5 years and 64.1 years respectively) and Horsham and Mid Sussex the highest (69.1 years for men and 69.4 years for women)

CASE STUDY - WELLBEING PRESCRIPTION SERVICE – EAST SURREY

The Wellbeing Prescription service allows GPs and other health and social care workers to refer people to local Wellbeing Advisors. The Wellbeing Advisors are trained to identify the clients' needs, provide them with advice and signpost them to relevant local services and activities. The service is delivered in partnership by Tandridge District Council, Reigate & Banstead Borough Council and East Surrey GP practices and is commissioned working closely with NHS East Surrey Clinical Commissioning Group and Surrey County Council through the Better Care Fund.

Quarter 1 18/19 monitoring report shows that 77% of people who have used the Wellbeing Prescription service made a positive change to their lifestyle and 75% have visited their GP less often since using the service. The Wellbeing Advisors can help people with issues such as weight management, getting more active, smoking cessation, social isolation and support with mental and emotional wellbeing. In addition there is Wellbeing Prescription Plus service, which is provided in the homes of patients with multiple, complex needs, as part of an integrated care approach.

CASE STUDY - WEST SUSSEX - SUGAR REDUCTION PROGRAMME

The West Sussex Sugar Reduction Programme was launched in January 2015 (N.B. primary school meals sugar reduction began at the end of 2014). Whilst the overall programme has been successful, sugar reduction in primary school meals has achieved particularly significant results, winning a Public Health England (PHE) award in September 2016 in recognition of this. To date, the following achievements have been made:

- Primary school meals now have over 2 kilos less sugar, per child, per average school year.
- Daily sugar consumption reduced from 18.5g to 6.6g per child
- The total amount of sugar reduced equals 5 double decker London buses per school year!
- That's a 65% sugar reduction in just 3 years!
- 30,000 children per day are benefiting

CASE STUDY - EAST SUSSEX - EMBEDDING PREVENTION ACROSS THE SYSTEM

The Personal and Community Resilience Programme in East Sussex brings together partners across the statutory (CCGs, local authorities, Healthcare Trusts, Police, Fire and Rescue Service, Department for Work and Pensions) and voluntary and community sectors to take action to grow strong communities which improve health; and to co-ordinate activity to embed prevention across the system. The programme includes transformation programmes in key 'settings' (the places where people spend their lives) such as schools, nurseries, and healthcare settings including GPs, pharmacies, hospitals and community health care services, to support them to play a greater role in improving health. As part of this:

- 3,169 frontline staff have been trained to 'Make Every Contact Count'
- 96% of all primary and secondary schools have developed and are delivering whole school health improvement plans
- 81% of all nurseries (private and local authority) have audited and are improving their healthy eating and physical activity offer
- 89% of General Practices are undertaking new health improvement programmes in their practices
- 96% of pharmacies registered as Healthy Living Pharmacies (HLP) Level 1, and 30 targeted pharmacies are being developed as HLP Level2
- 88,579 people received their NHS Health Check (over the past 5 years)
- A whole systems approach to Social Value is being developed across the county, linked to local priorities and growing strong communities

The programme includes transformation programmes in key 'settings' such as schools, nurseries, and healthcare settings including GPs, pharmacies, hospitals and community health care services

This programme is aiming to reduce the harm caused by substance misuse and unsafe, early sexual behaviour in young people

CASE STUDY – BRIGHTON AND HOVE ADOLESCENT HEALTH OFFER

This programme is aiming to reduce the harm caused by substance misuse and unsafe, early sexual behaviour in young people. The offer is a single, integrated service including:

- Music workshops and mentoring programme for young people use cannabis but do not see it as a problem
- DASH (Drug, Alcohol and Sexual Health) Prevention team which provides a package of resilience building interventions
- Specialist Substance Misuse Treatment Service
- School based health drop-ins staffed by school nurses and youth workers and text messaging support via CHATHEALTH
- PSHE (Personal, Social, Health and Economic) direct support to schools to improve the universal curriculum
- Communication plan, including social media campaign which is aimed at equipping parents to have direct conversations with young people to explain the harms caused by using drugs / drink / tobacco.

Our evidence: Our public and our patients

We always value the views of patients and carers and we have quoted a few examples of patient experience throughout. Some show excellent care and some highlight areas for improvement. For example:

GOOD EXPERIENCES

"Every staff member I have encountered has been brilliant, respectful and knowledgeable."

"When my husband had a TIA, I could not fault the care of ambulance crew, A&E at hospital, emergency floor"

EXAMPLE

A homeless woman with mental health issues including suicidal thoughts, supported by an outreach team to apply for funding, diary reminders for appointments. The support has dramatically reduced her illicit substance use and she feels more in control.

EXPERIENCES THAT COULD BE BETTER

"Not enough people know about the wide range of services pharmacies can offer."

EXAMPLE
87 year old discharged post-surgery and told to expect a visit from social care that day. No one came. Only allowed one visit to change her dressing. (ESBT)

EXAMPLE
The importance of continuity of relationships (for young people) with professionals came out in her frustration with the variability and short term nature of those encounters. (Coastal Cares)

IDEAS FOR IMPROVING CARE

"I would like advocates, community navigators and health coaches to have a greater role in supporting people to understand their health conditions and medicine"

"People need to be more aware of healthy lifestyles and to take more responsibility for own health. So more education."

EXAMPLE
The daughter of a 95 year old woman with dementia raised concerns over her mother's care in a care home. Even though they were funding the care, support to raise concerns would have been welcomed.

Whenever we get into a discussion with patients and the general public there are a number of recurring themes which regularly surface, they are:

- Good access to primary care,
- Keeping care local,
- Care that is well coordinated,
- Having the right information to support self-care and as much focus on wellbeing as on health,
- In addition, local people recommended expansion of the range of local services in local communities so these would be more integrated and accessible both for patients and also for family and carers.

All across the STP, commissioners have been engaging the public to gain their views on current services and/or proposed changes. In the Alliance, CCGs have been conducting a series of discussions called the 'Big Health and Care Conversation' and more of these events are planned.

Once we have agreement on the content and strategic direction of the Population Health Check we will engage more widely with our staff, wider partners, Health Overview and Scrutiny Committees etc. and mobilise our communications and engagement resources to widen debate and gain ownership of the plan.

OUR EVIDENCE: WHAT DO PATIENTS EXPERIENCE?
We need to move from how things are now, a fragmented and reactive system, to a future system designed around the individual.

How it looks now:

- A fragmented system with multiple providers, characterised by a lack of coordination,
- A service which is reactive not proactive,
- Pathways of care that are unnecessarily complex.

We need to move from how things are now, a fragmented and reactive system, to a future system designed around the individual.

We need to work with our local communities to help people help themselves. This is what most people tell us they want.

OUR EVIDENCE: WHAT SHOULD OUR PUBLIC AND PATIENTS EXPECT (PRINCIPLES OF CARE)?

We understand the importance of a person centred asset based approach to empowering people to develop the knowledge skills and confidence to self-manage.

The focus needs to be on our population rather than organisational silos, with prevention and self-management at its core. This is enabled through strength based social care, shared decision making, making every contact count, collaborative care and support planning and health coaching.

People have the right to a high-quality health and care service when they really need it.

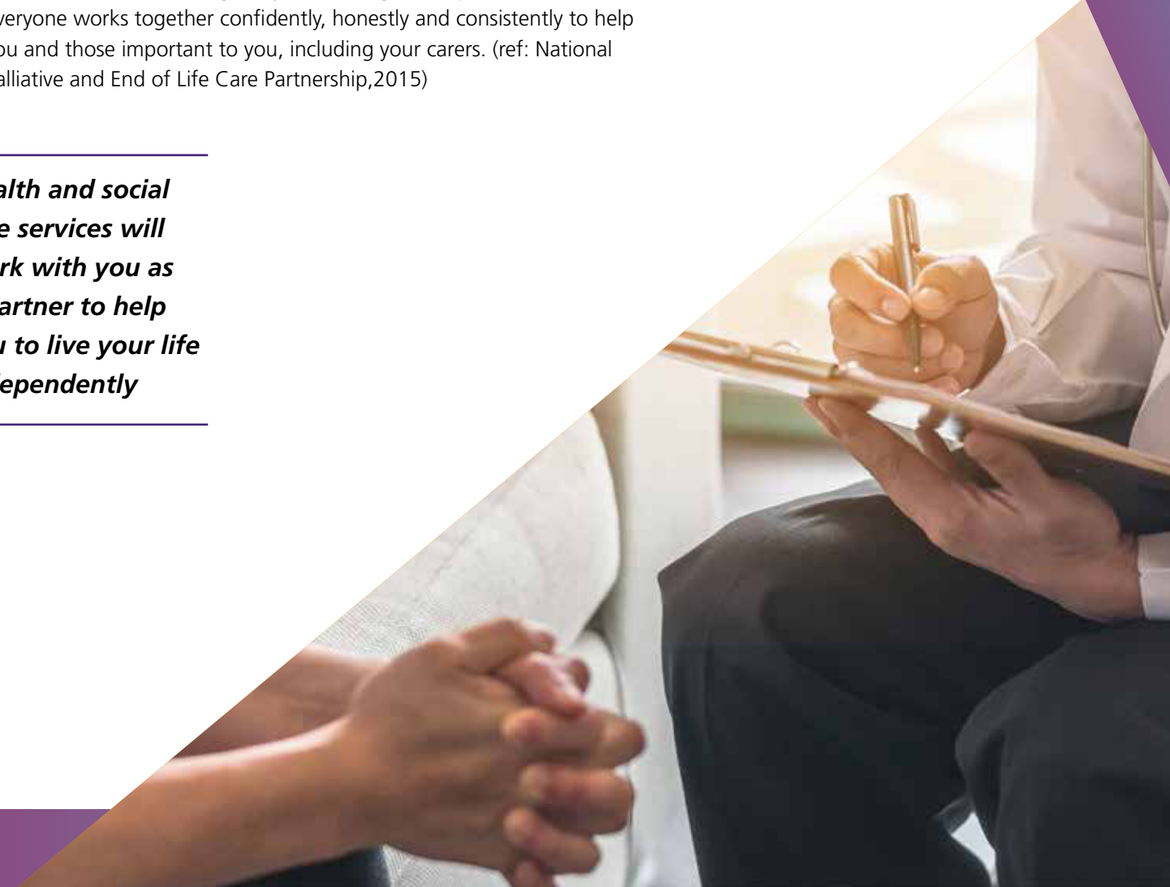
With rights, however, come responsibilities. We need to work with our local communities to help people help themselves. This is what most people tell us they want. We need to work with people to redesign the system. To do this, we will adopt the following principles of care:

- Make Prevention Everybody's business,
- Maximise Independent Living and Self-Care,
- Target proactive care of people at highest risk of hospitalisation and needing higher intensity care,
- Reduce the time people stay in hospital for and discharge them safely,
- Make patient journeys more joined up, without waste, repetition or duplication,
- Make Sussex and East Surrey STP a great place to work in all our local organisations,
- Prioritise investment areas which bring maximum benefit for patients.

OUR EVIDENCE: WHAT WILL THIS MEAN FOR US ALL?

- You will be empowered and supported to develop the knowledge, skills and confidence to self-manage and stay well.
- We will create environments which make it easier to be healthy. You are also more likely to be offered a personal care or health budget.
- If you become unwell with a long-term condition, you will work collaboratively with your health and care professionals to develop a care and support plan describing what's important to you.
- There is likely to be a key worker or co-ordinated assigned to you.
- You will have a care record which you will be able to see and add to.
- If you need hospital care, there may be changes to how and where this is offered, with hospitals working as partners to provide more specialised services and with more technology-enabled care.
- If you are frail and elderly and you need to go into hospital, you are more likely to receive support to go straight home to recuperate, rather than having to go somewhere else first.
- Health and social care services will work with you as a partner to help you to live your life independently
- You can make the last stage of your life as good as possible because everyone works together confidently, honestly and consistently to help you and those important to you, including your carers. (ref: National Palliative and End of Life Care Partnership,2015)

Health and social care services will work with you as a partner to help you to live your life independently



Whilst some people receive excellent care, others experience fragmented and poorly co-ordinated care.

Our evidence: Our services

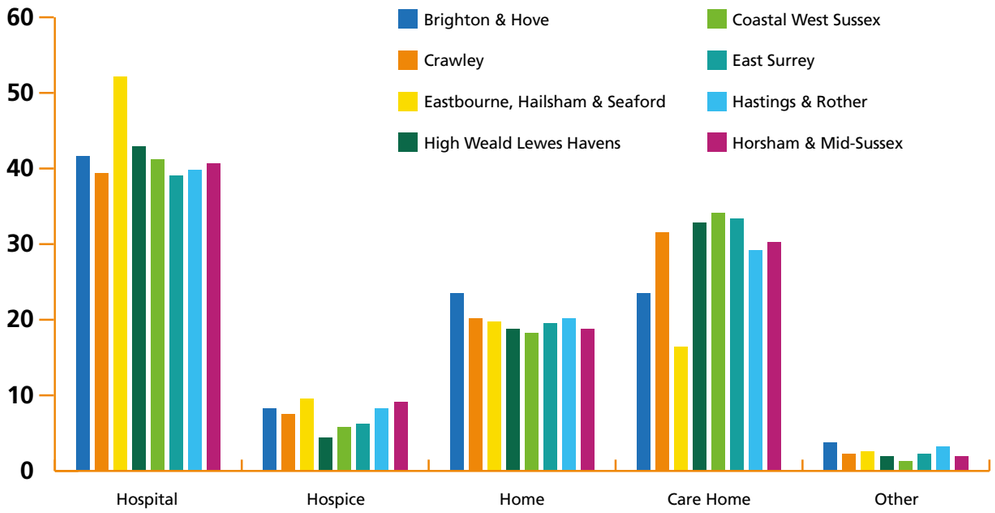
DYING

- We want more patients to die in their usual place of residence. Across the STP we have a high number of care homes and we should capitalise on this and support more residents to die in these supported and homely environments.
- In the Sussex and East Surrey STP, there were 19,585 deaths in 2015. The percentage of all deaths with dementia as an underlying or contributory cause of death were higher in 50% of the CCGs.
- The percentage of all deaths that are aged 85 years and older were higher than the national average for all CCGs.
- We are poor at identifying people who are at the end of their life.
- There is fragmentation of services and lack of shared records.
- Whilst some people receive excellent care, others experience fragmented and poorly co-ordinated care.

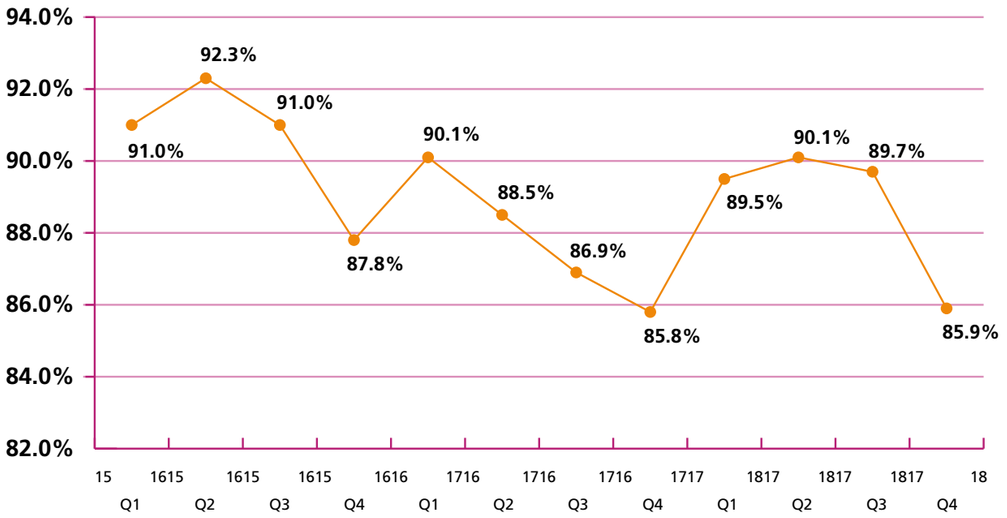
"Due to the complexity of four parties being involved in our mother's care ([hospice], [care home], District nurses and the GP) there were times when communication and responsibility were disconnected"
St Catherine's hospice

"I can't think of anything you can improve on, I am 91 years old and my wife passed away in March of this year at the age of 95. She had Parkinson's and dementia, she wanted to die at home so I looked after her at home for 3 years or more and the help and care I got from the NHS was so good I can't say a bad word about it."
Coastal Care-Primary and Urgent care survey)

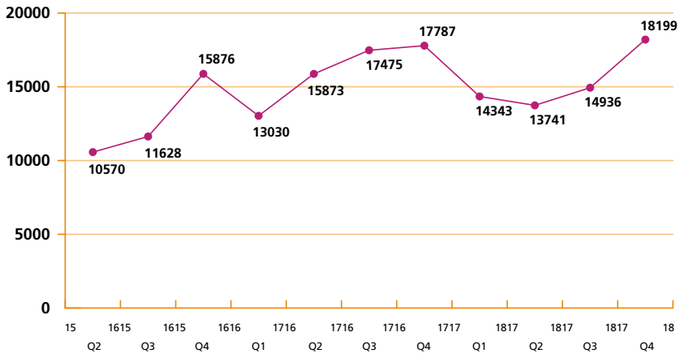
Percentage of death in different locations by CCG



A&E 4HR WAITING TIME PERFORMANCE STP WIDE



A&E BREACHES STP WIDE



Whilst individual Trusts occasionally meet the 95% 4 hour A&E waiting time standard, as a whole, the Sussex and East Surrey STP has not met the standard since it was formed in late 2015.

4/4 acute providers have breached the four hour waiting time target at Q3 16/17. In 2016/17, 2 of the acute trusts were more than 5% below the expected 95% of patients to be seen within 4 hours – for Type 1 A&E attendances. The other 2 trusts were above 90% but below 95% for 3 of the 4 quarters. The NHS Planning Guidance (2018/19) expects 95% to be achieved by month 12.

There are significant hand over delays at our hospitals. Between 24-12-2017 and 02-01-2018 SECAmb lost in excess of 3,200 operational ambulance hours to turnaround delays greater than 30 minutes. This was a 13% increase over the same period last year. This is equivalent to losing 13 ambulances on duty every day of this 10 day period.

Coastal West Sussex and East Sussex areas showing levels of hospitalisation almost four times as high as in other areas of the STP.

ACCESS

ADMISSIONS

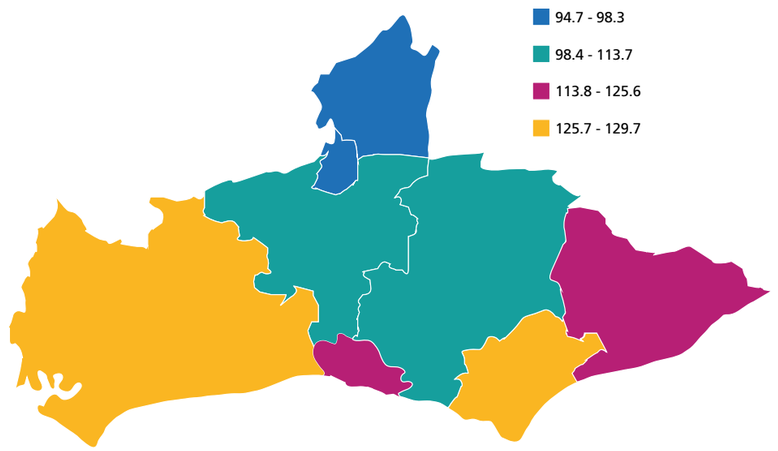
There is very large variation in patterns of hospital use for conditions that would not usually require hospitalisation, with Coastal West Sussex and East Sussex areas showing levels of hospitalisation almost four times as high as in other areas of the STP.

The reasons for this are multi-fold and span patient behaviours but also the availability, accessibility and responsiveness of non-hospital based services.

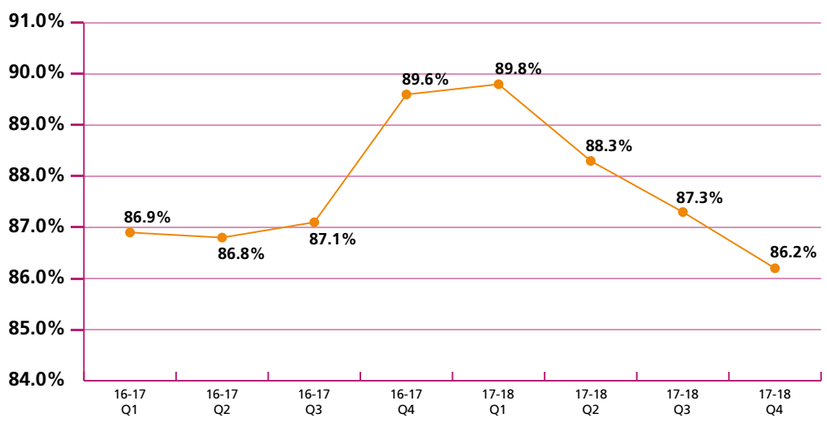
Although there is no right or wrong formula of what services should be provided in a non-acute setting, it is generally viewed that an over-reliance on acute based care is comparatively more expensive due to the prevailing payment system (Payment by Results).

There is variation across the trusts in delivering on Referral to Treatment Times (RTT).

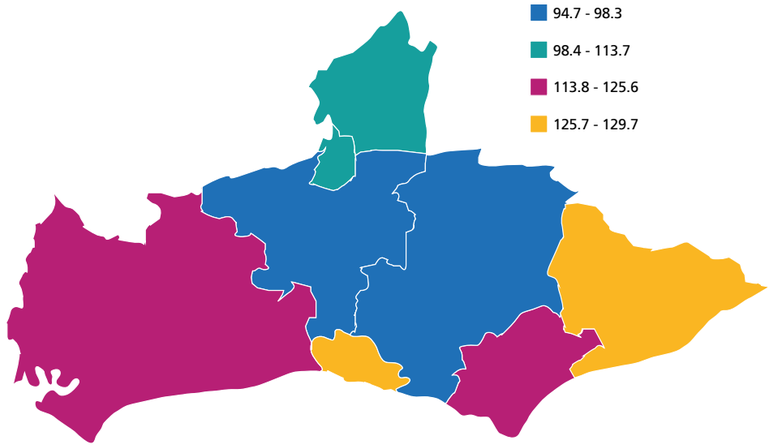
3.3.3.1 Admissions
CCG Outcomes Indicator Set- domain 3 >> 3.1 Emergency admissions for acute conditions that should not usually require hospital admission (2016-2017 (Jul-Jun)) >> East Surrey and Sussex



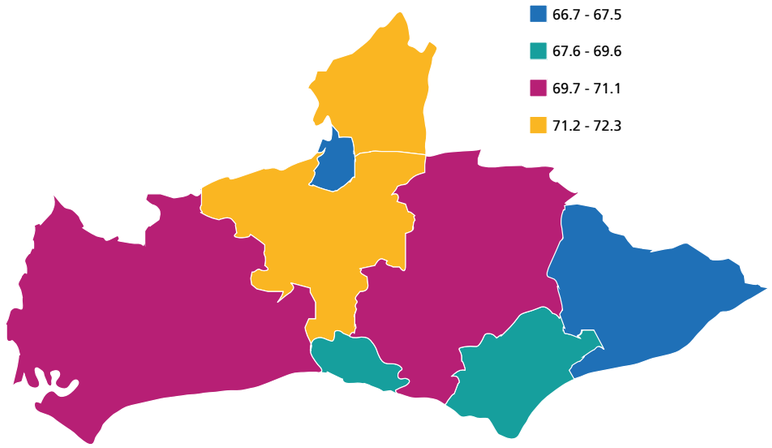
RTT performance STP wide



CANCER MORTALITY
CCG Outcomes Indicator Set- domain 1 >> 1.9 Under 75 mortality rates from cancer (2015) >> East Surrey and Sussex



CANCER SURVIVAL
CCG Outcomes Indicator Set- domain 1 >> 1.10 One-year survival from all cancers (Diagnosed 2014) >> East Surrey and Sussex



"I was recently diagnosed with breast cancer following my first over 50 screening. I have had the surgery and I have just started chemotherapy. I just wanted to let you know how amazing the staff at BSUH have been; The radiographers and nurses in the breast care unit, pre assessment clinic, theatre and Ansty ward at PRH and imaging."

- There is significant variation in mortality rates from cancer, with patients in coastal areas, in particular Brighton and East Sussex being in some instances 20% more likely to die from cancer than patients in Horsham/Mid Sussex.
- In our STP, cancer incidence is high, with low diagnosis at stage 1 and 2. Take up of cervical and breast screening is low.
- We lack of access to modern, high quality and local radiotherapy services.
- There is inadequate introduction and adoption of timed pathways in Lung, Prostate and Colorectal cancer.
- There is variation across the trusts in delivering on cancer waits.
- Diagnostic capacity and workforce shortages continue to be an issue.

(Ref: STP dashboard 2018)

	LATEST PERIOD	LATEST VALUE	RANK WITHIN SOUTH	SPINE CHART ● = selected STP ▬ = middle 50% of South STPs X = England average | = STP median
				WORST … BEST
Cancer incidence (total tumours)^	2014	11403	13/13	
Cancer incidence (rate)	2014	611.8	9/13	
Breast cancer screening coverage	2015/15	72.4%	12/13	
Cervical cancer screening coverage	2015/16	73.7%	9/13	
Bowel cancer screening coverage	2015/16	60.3%	8/13	
Diagnosis at stage 1 or 2	2015	50.6%	12/13	

UNWARRANTED VARIATION

We know there are areas of healthcare, which demonstrates variation in practice and quality across our STP.

Key areas of variation in our STP are:

- Cardio Vascular Disease (including Stroke care, Atrial Fibrillation, stable angina and diabetes)
- Trauma and Injuries (Falls and Fragility Fractures)
- MSK

"After my stroke, I felt isolated and lost confidence"

"Mum wasn't admitted to the ward for 9 hours"

"The aftercare failed to meet any expectations"

UNWARRANTED VARIATION: CARDIOVASCULAR STROKE

In stroke care there is:

- Inadequate achievement of NICE (National Institute for Health and Care Excellence) Guidelines standards for non-elective stroke care and the South East Clinical Network Stroke standards.
- There continues to be variation across the STP in stroke services, especially in relation to access to allied access to six-month reviews.

PATIENT CENTRED - APRIL TO JULY 2017 — SOUTH ENGLAND - SOUTH EAST SCN

Routinely Admitting Teams	Trust	Brighton and Sussex University Hospitals NHS Trust	East Sussex Healthcare NHS Trust	Maidstone and Tunbridge Wells NHS Trust	Maidstone and Tunbridge Wells NHS Trust	Medway NHS Foundation Trust	Surrey and Sussex Healthcare NHS Trust	Western Sussex Hospitals NHS Trust	Western Sussex Hospital NHS Trust
	Team Name	Royal Sussex County Hospital	Eastbourne District General Hospital	Maidstone District General Hospital	Tunbridge Wells Hospital	Medway Maritime Hospital	East Surrey Hospital	St Richards Hospital	Worthing Hospital
Number of patients	Admit	200	149	110	140	89	191	164	189
	Disch	167	175	101	142	84	198	156	186
Patient Centred Data	D1 Scan	A	A	A	A↑	C↓	A	B↓	A
	D2 SU	B	B	C	D↑	E	D	C	C↓
	D3 Throm	B	C↓	C	D↓↓	D	B↑↑	B	B
	D4 SpecAsst	A	B↓	B↑	C	D	B↑	C	A↑
	D5 OT	B	C	A	B↓	E	B↓	C	A
	D6 PT	B↑	C	A	A	D	C↓	C	B
	D7 SALT	C↑	E	A	B↑	C	C↓	B	C↑
	D8 MDT	D	D	B	C	D	B↑	C	B↑
	D9 Std Disch	A	A	C	D	A↑	B	B	A
	D10 Disch Proc	B	B↑	B	B	B↓	D	C↑	D↓
	PC KI Level	B	C↓	A↑	C	D	B↑	C	B
Six Month Assessment	Number Applicable	126	109	73	84	85	124	112	106
	% Applicable	98%	100%	100%	100%	98%	99%	99%	100%
	Number assessed	8	14	0	0	3	3	0	0
	% Assessed	6%	13%	0%	0%	4%	2%	0%	0%

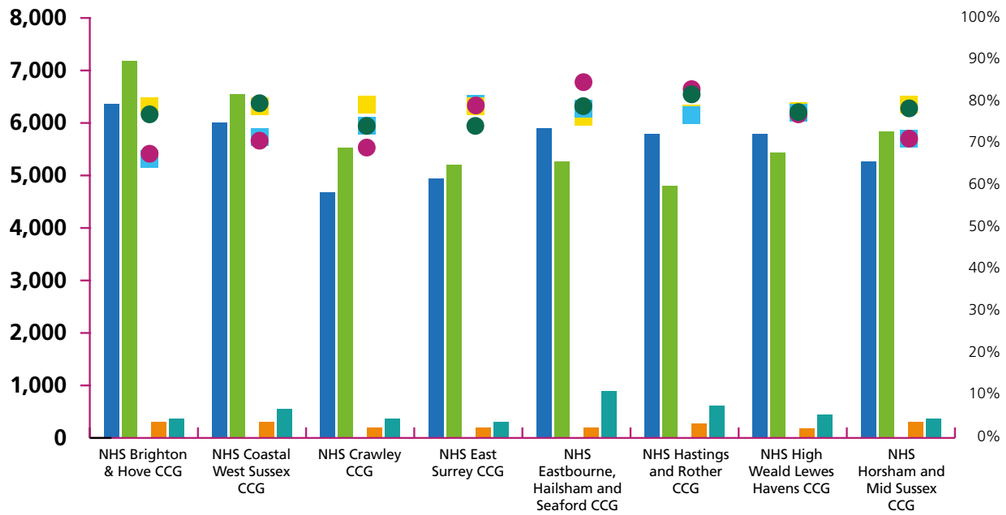
PATIENT CENTRED - APRIL TO JULY 2017 — SOUTH ENGLAND - SOUTH EAST SCN

Routinely Admitting Teams	Trust	Brighton and Sussex University Hospitals NHS Trust	East Sussex Healthcare NHS Trust	Maidstone and Tunbridge Wells NHS Trust	Maidstone and Tunbridge Wells NHS Trust	Surrey and Sussex Healthcare NHS Trust	Western Sussex Hospitals NHS Trust	Western Sussex Hospital NHS Trust
	Team Name	Royal Sussex County Hospital	Eastbourne District General Hospital	Maidstone District General Hospital	Tunbridge Wells Hospital	East Surrey Hospital	St Richards Hospital	Worthing Hospital
Number of patients	Admit	210	146	122	148	193	148	164
	Disch	180	188	111	132	177	145	159
Patient Centred Data	D6 PT	A↑	B↑	A	A	B↑	C	B
	D7 SALT	B↑	E	A	B	C	C↓	C
	D8 MDT	B↑↑	D	B	B↑	B	C	B
	D9 Std Disch	B↓	A	D↓	D	A↑	A↑	A
	D10 Disch Proc	B	C↓	B	C↓	D	D↓	C↑
	PC KI Level	A↑	B↑	B↓	C	B	C	A↑
Six Month Assessment	Number Applicable	104	126	75	88	158	114	124
	% Applicable	98%	100%	100%	100%	98%	100%	100%
	Number assessed	2	13	0	0	0	0	0
	% Assessed	2%	10%	0%	0%	0%	0%	0%

UNWARRANTED VARIATION: CARDIOVASCULAR: STROKE PREVENTION AND ATRIAL FIBRILLATION (AF)

For every 25 high risk patients treated for AF, one serious/debilitating stroke is avoided. The chart below shows that, compared with our demographic peers, we often have a gap between our expected prevalence versus our actual prevalence. Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG are identifying more cases than their comparative peers. Where we are finding patients and putting them on blood thinners, our spend on non elective stroke is lower than our demographic peers because we are preventing strokes. Within three years we could stop 660 Strokes if we treated all patients with AF with anti coagulation. This equates to £11.2 million.

- Stroke- Non-elective spend on discharges - Best 5
- Stroke- Non-elective spend on discharges - CCG
- Direct current cardioversion (Majority PBC=10C) - Total spend on discharge - Best 5
- Direct current cardioversion (Majority PBC=10C) - Total spend on discharges - CCG
- AF & CHADS2 score >1: % currently treated with anti-coagulation therapy - Best 5
- AF & CHADS2 score >1: % currently treated with anti-coagulation therapy - CCG
- AF observed prevalence compared to expected prevalence - Best 5
- AF observed prevalence compared to expected prevalence - CCG



	NHS Brighton & Hove CCG	NHS Coastal West Sussex CCG	NHS Crawley CCG	NHS East Surrey CCG	NHS Eastbourne, Hailsham and Seaford CCG	NHS Hastings and Rother CCG	NHS High Weald Lewes Havens CCG	NHS Horsham and Mid Sussex CCG
EST. AF PREVALENCE	1.97%	3.44%	2.04%	2.51%	3.58%	3.52%	3.11%	2.81%
EST. BEST 5 PREVALENCE	2.06%	3.07%	2.24%	2.42%	3.15%	3.21%	2.97%	2.53%

The NHS reports that people who have diabetes are 15 times more likely to undergo amputations than other people without the condition.

UNWARRANTED VARIATION: CARDIOVASCULAR DISEASE: DIABETES

In diabetes care there is wide variation in:

- The number of major and minor amputations and length of stay.

- The average number of major amputations in England is 8.1 per 10,000 (standardised rate). Across our STP the rate ranges from 5.8 High Weald Lewes Havens CCG to 10.2 Eastbourne, Hailsham and Seaford CCG. The average number of minor amputations in England is 20.7 per 10,000 (standardised rate). Across our STP the rate ranges from 17.7 (Crawley CCG) to 28.9 Eastbourne, Hailsham and Seaford CCG.

- Our current diabetic foot amputation rate will continue to rise. Currently 52% of our diabetic foot ulcers are rated as severe and at least 56% were unhealed at 12 weeks, with 83% of patients waiting more than two days for referral and triage and 38% waiting at least 14 days (NICE recommendation for referral and triage within two days).

- There is still a gap in the actual to expected prevalence rate of diabetes. There is variation across our STP in terms of Primary Care achievement of quality targets such as blood sugar management, blood pressure, cholesterol and the other 8 Care processes.

KEY FACT

The NHS reports that people who have diabetes are 15 times more likely to undergo amputations than other people without the condition. Diabetes is one of the leading causes of amputation of the lower limbs throughout the world. Charity Diabetes UK notes that problems of the foot are the most frequent reasons for hospitalisation amongst patients who have diabetes.

"In the first 5 weeks of attending (the National Diabetes Prevention Programme tailored education) I had lost almost a stone in weight and my cholesterol is falling"

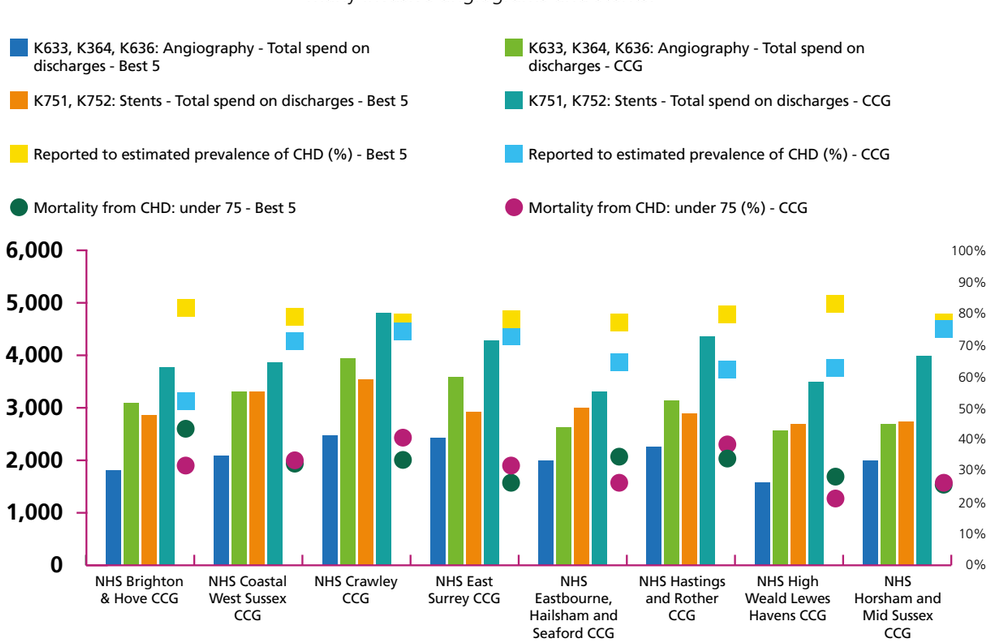
CCG	Major amputations per 1,000 diabetic patients April 2011 - March 2014	Major amputations per 1,000 diabetic patients April 2012-2015	Major amputations per 1,000 diabetic patients 2013-14 2015-16
England	0.8	0.8	0.81
East Surrey CCG	1.0 (19)	0.8 (17)	0.9 (19)
Horsham & Mid Sussex CCG	0.6 (15)	0.8 (21)	0.82 (21)
Crawley CCG	0.5 (9)	0.9 (17)	0.93 (16)
Coastal West Sussex CCG	0.9 (71)	1.0 (79)	0.54 (80)
Brighton & Hove CCG	1.0 (32)	0.9 (29)	0.8 (27)
High Weald, Lewes & Havens CCG	0.6 (12)	0.6 (14)	0.58 (16)
Hastings & Rother CCG	1.0 (27)	0.9 (27)	0.81 (29)
Eastbourne, Hailsham & Seaford CCG	1.7 (47)	1.1 (33)	1.02 (36)
South East Coast Total	**578**	**581**	**0.82 (613)**

CCG	Minor amputations, annual rate per 1,000 adults with diabetes	Minor amputations, annual rate per 1,000 adults with diabetes 2012-2015	Minor amputations, annual rate per 1,000 adults with diabetes 2013-2016
England	1.7	1.8	2.1
East Surrey CCG	2.6 (51)	2.3 (48)	2.42 (57)
Horsham & Mid Sussex CCG	1.5 (39)	2.0 (57)	2.23 (67)
Crawley CCG	1.4 (25)	1.4 (26)	1.77 (30)
Coastal West Sussex CCG	1.9 (143)	2.1 (163)	1.84 (184)
Brighton & Hove CCG	2.1 (66)	1.8 (58)	2.07 (71)
High Weald, Lewes & Havens CCG	2.3 (49)	1.8 (39)	2.15 (59)
Hastings & Rother CCG	2.4 (68)	2.4 (69)	2.05 (74)
Eastbourne, Hailsham & Seaford CCG	2.7 (76)	2.9 (84)	2.89 (98)
South East Coast Total	**2.02 (1334) (SEC average)**	**2.07 (1274)**	**2.33 (1739)**

We have a higher spend on angiography and stents than our demographic peers but not always resulting in better outcomes

UNWARRANTED VARIATION: CARDIOVASCULAR DISEASE: OVER-TREATING PATIENTS WITH STABLE ANGINA

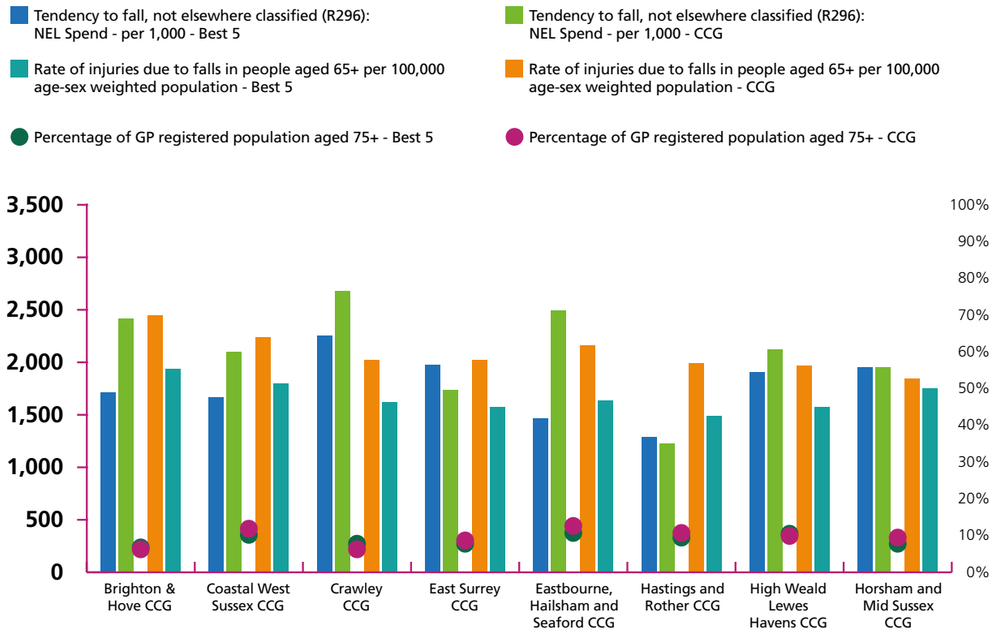
The NICE pathway states that patients with stable angina should have a computerised temography angiogram first which is non-invasive and cheaper than an invasive angiogram. Only about 20% of patients who have had a CT angiogram would need to go on to have an invasive angiogram. 80% should be given medication to manage their angina. If the medication does not help the pain, a shared decision-making conversation should take place which makes it clear that if the patient has a stent inserted, it will not prolong their life, with the exception of a small defined cohort of our population, but it will help with chest pain. The chart below shows that compared with our demographic peers, we have a lower reported prevalence of CHD than our estimated numbers. Also we have a higher spend on angiography and stents than our demographic peers but not always resulting in better outcomes. There is variation in the implementation of these NICE guidelines across our STP, resulting in too many invasive angiograms and stents.



	NHS Brighton & Hove CCG	NHS Coastal West Sussex CCG	NHS Crawley CCG	NHS East Surrey CCG	NHS Eastbourne, Hailsham and Seaford CCG	NHS Hastings and Rother CCG	NHS High Weald Lewes Havens CCG	NHS Horsham and Mid Sussex CCG
CCG CHD PREVALENCE	2.19%	4.11%	2.77%	2.77%	4.12%	4.20%	3.11%	2.96%
BEST 5 PREVALENCE	2.86%	3.71%	2.71%	2.69%	3.89%	3.85%	3.33%	2.70%

UNWARRANTED VARIATION: TRAUMA AND INJURIES (FALLS AND FRAGILITY FRACTURES)

The chart below shows that there is wide variation in the number and treatment of falls compared with our demographic peers: One in three over-65s and half of those over 80 will suffer a fall each year. The Department of Health and Social Care has stated that a falls prevention strategy could reduce the number of falls by 15-30%. Admissions relating to fractures where a fall has occurred, notably hip fractures and those people over 65 without significant injury and are not always getting a multifactorial falls assessment and exercises, which we know reduce subsequent falls by 24%. We do not always have effective case-finding and appropriate drug treatment for osteoporosis, particularly after the first fracture has occurred. We know if this treatment is taken then there is a reduction in the risk of the next fracture by 50%.

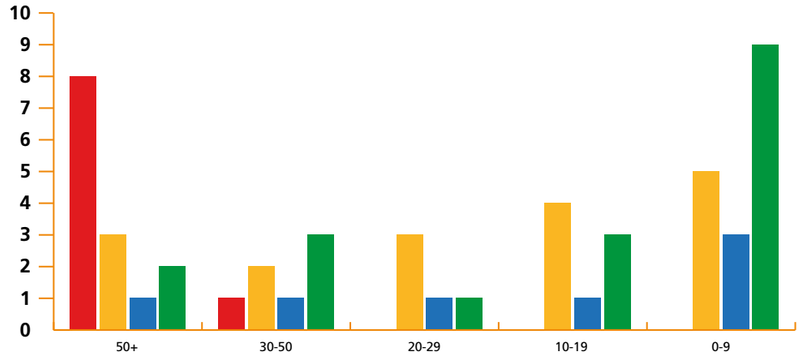


UNWARRANTED VARIATION: MSK

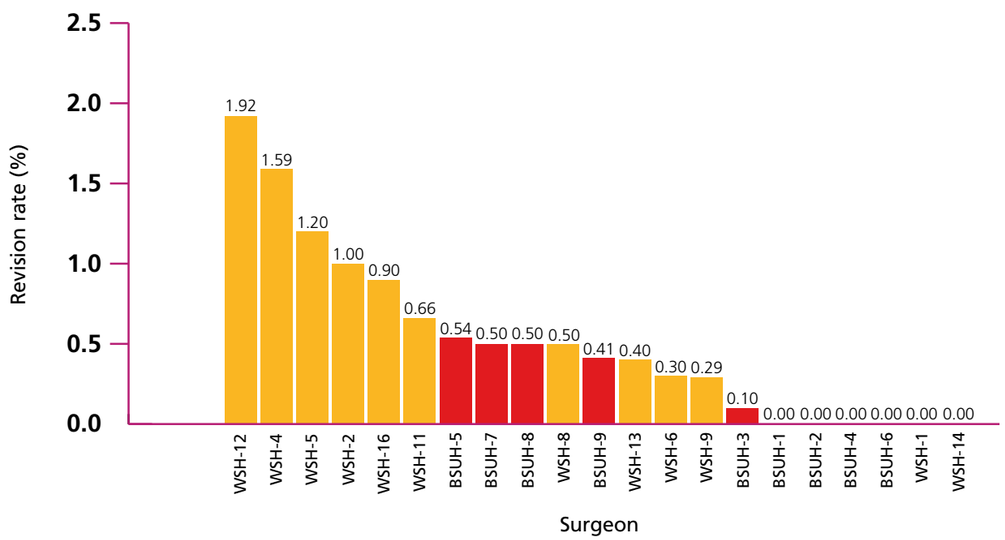
For example, In musculoskeletal surgery there is wide variation in:

- The volume of Total Hip Replacement surgery per surgeon. 34% of surgeons do less then 10 procedures a year, 54% do less than 20 procedures a year and only 30% perform greater or equal to 50
- The number of revisions within a year post joint replacement per surgeon
- The rate of infection post joint replacement per hospital

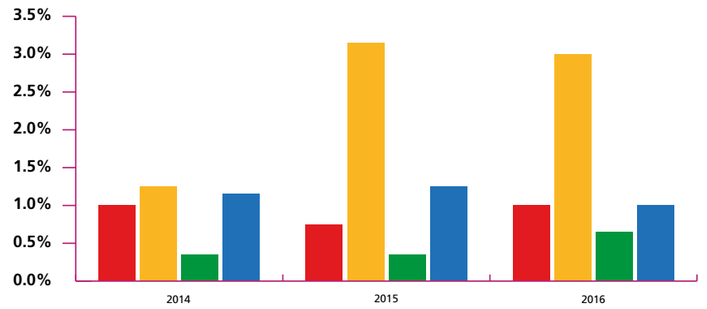
Number of Total Hip Replacement per surgeon



Total Knee Replacement 1 year revision rates

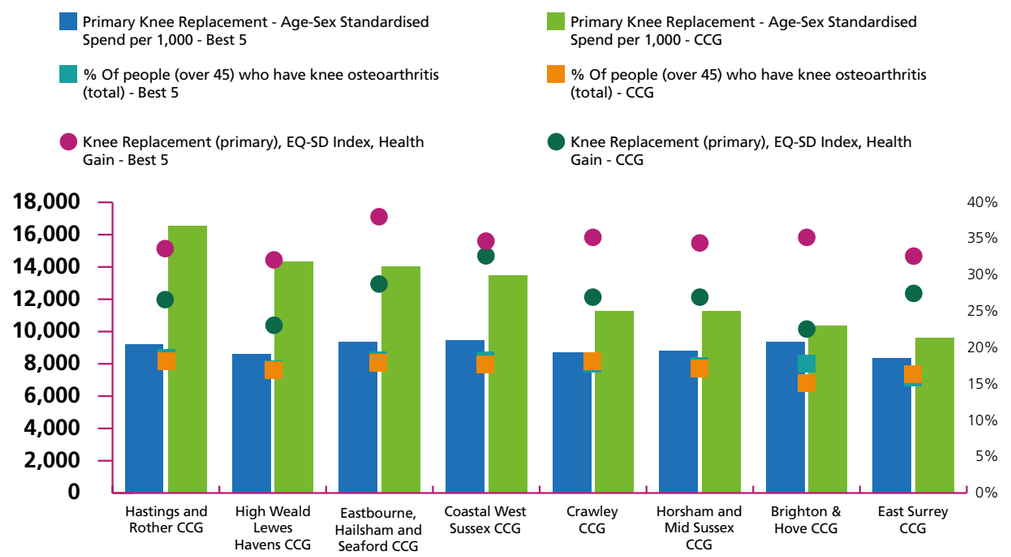


Surgical site infection rates per Trust for Total Hip Replacement



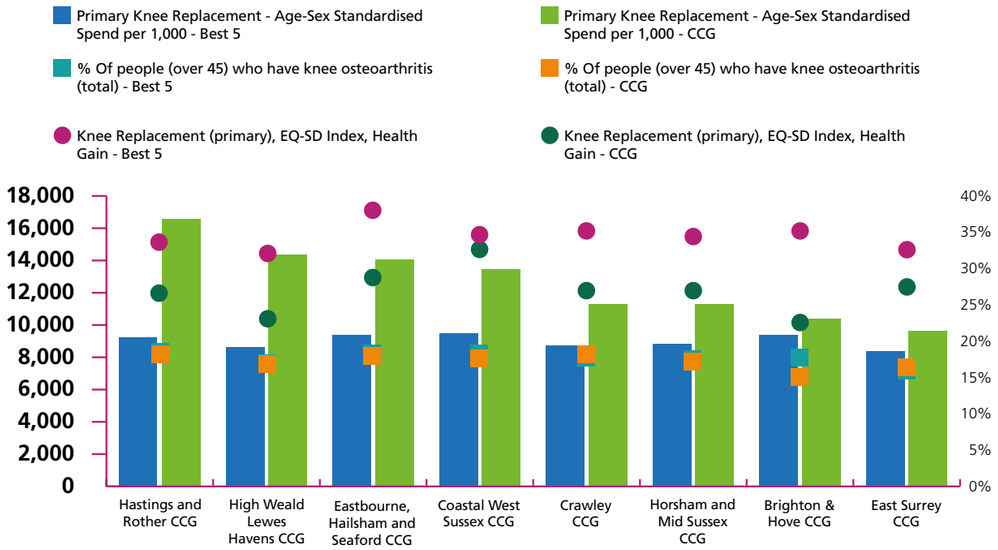
UNWARRANTED VARIATION: MSK - TOTAL KNEE REPLACEMENT

The chart below shows that we are doing more procedures, spending more on elective care and delivering poorer outcomes than our demographic peers. The % of patients 60 and over having same side knee replacement within one year of arthroscopy is declining but is still six times higher than the national average. Nice Guidance recommends conservative management (exercise/weight management/patient education) before consideration for surgery as these approaches can reduce pain, improve function and avoid the need for a Joint replacement as osteoarthritis is not always a progressive condition. Good quality Shared decision making is important to give patients the information they need to make a decision that's right for them.



UNWARRANTED VARIATION: MSK - TOTAL HIP REPLACEMENT

The chart below shows we are spending more than our demographic peers with health gain worse (apart from Eastbourne, Hailsham and Seaford CCG) and prevalence is identical.



AMBULATORY CARE SENSITIVE CONDITIONS

Attendances at our A&E Departments continue to rise with a 4% increase reported over the first 3 quarters of 17-18 compared to 16-17.

Over a quarter of all attendances at A&E could have been treated at another suitable location (e.g. primary care provision) however patient behaviours and the availability of alternative pathways continue to drive this increase in activity.

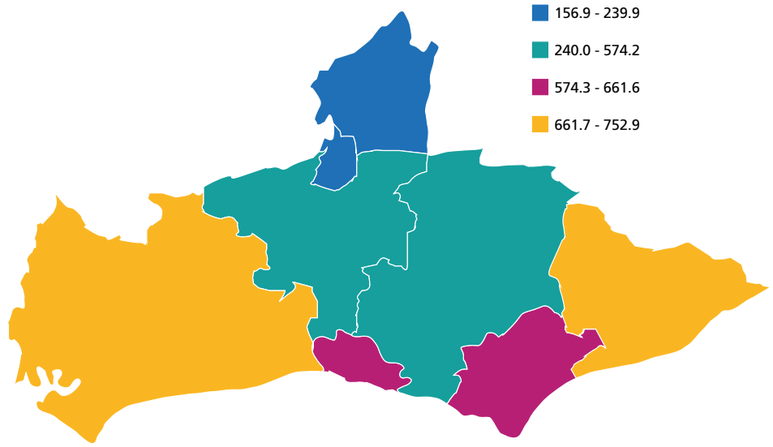
There are several points of contact for access to services, fragmented pathways and gaps in service availability (geographic and time of day), particularly around admissions avoidance and to support hospital discharges. This results in multiple handoffs and confusion over the correct pathways, building in inefficiencies in how services are being delivered, increasing conveyance and admissions and the length of stay in hospitals.

"I would like Community Navigation to be extended in the city. I would like patients to be able to self-refer and to have navigators in communities, like a "go to" person.

"Some people only know to go to A&E for urgent care – there is a lack of awareness about other places people can go. "

"More needs to be done to promote the alternative to A&E and opening times."

Ambulatory care sensitive conditions
CCG Outcomes Indicator Set- domain 2 >> 2.6 Unplanned hospitalisation for chronic ambulatory care sensitive conditions (2016-2017 (Jul-Jun)) >> East Surrey and Sussex



DELAYED TRANSFER OF CARE (DTOCS)

There are many patients in hospital beds who should be cared for at home.

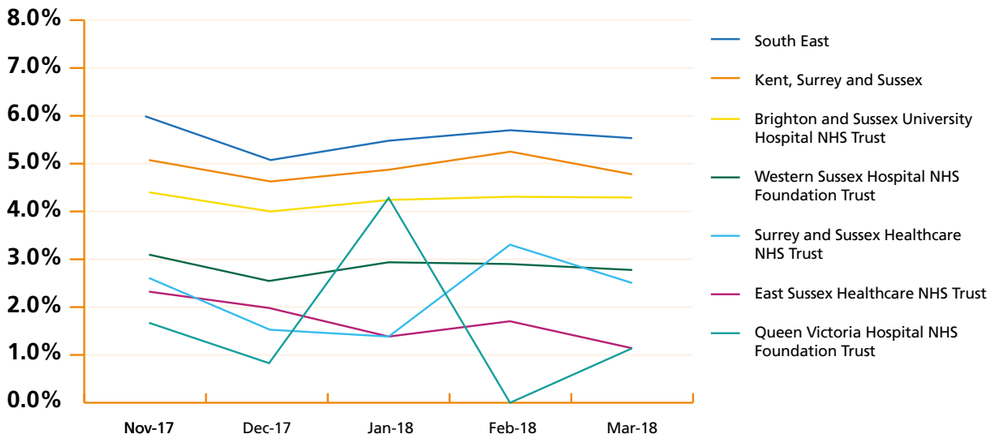
An increasing rate of incomplete to complete pathways has caused a worsening performance against the Referral to Treatment 18 week incomplete standard. At quarter 2 of 2017/18, 5 out of the 6 providers breached the standard. In 2016/17 bed occupancy was at 92.7% (ranked as 35/44 across the STPS) and the percentage of beds attributable to Delayed Transfers of Care (DTOC) was 8.9% (ranked as 37/44 across the STPs). 1 = best, 44 = worst.

A disproportionate number of those fit to leave their current setting of care have dementia, with over a quarter of patients with dementia or a cognitive impairment fit to leave waiting for over 50 days to leave their settings of care.

KEY FACT

47% of carers in the "Counting the Cost" survey reported that being in hospital had a significant detrimental effect on the general physical health of the person with dementia and 54% reported a negative effect on the symptoms of dementia such as becoming more confused and less independent (Alzheimer's Society 2009)

South East DTOC % (Bed day delays per occupied bed)
Sussex & East Surrey



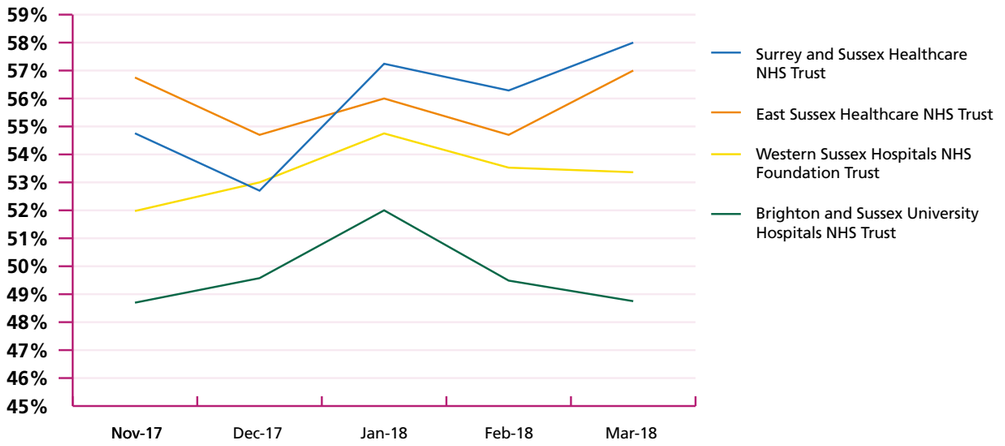
FLOW

A bed audit carried out across the STP identified 22% of patients across Sussex and East Surrey that are "fit to leave" their current setting of care.

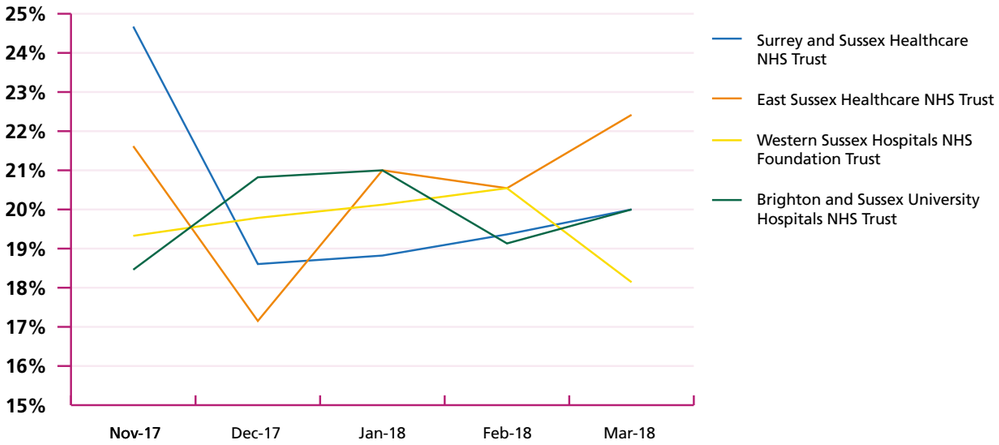
A total of 49% of patients who were classified as fit to leave their current setting of care have remained in hospital for over a week. There were 97% of acute patients fit to leave who were admitted as non-elective patients. A total of 75% of acute patients and 92% of community patients fit to leave their current setting of care are over the age of 70. A majority of delays are attributed to patients awaiting social care, although patient and family choice is a major cause for delay in the community setting. (CF April 2017).

49% of patients who were classified as fit to leave their current setting of care have remained in hospital for over a week.

Beds Occupied by Stranded Patients (7+ days)
Sussex and East Surrey



Beds Occupied by Extended lenght of stay Patients (21+)
Sussex and East Surrey



BED DAY UTILISATION

Across the STP, bed occupancy per provider ranged from 62% (at the specialist provider) to 96% at Quarter 2 2017/18.

Compared with our peers, there is statistically significant variation in the number of bed days across all common conditions. There are currently 3,519 acute inpatient beds across the STP.

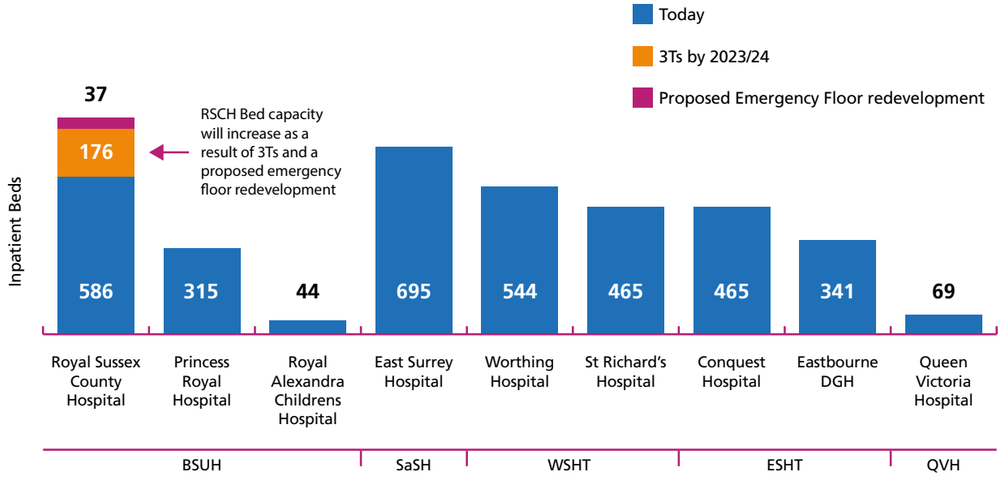
- Average length of stay (AloS) increased between 2010/11 – 2016/17.
- Over the last three years, the general and acute bed base has remained relatively constant but bed occupancy has increased over time.
- Bed capacity is expected to increase by 176 beds by 2023/24 at BSUH as a result of the 3Ts rebuild.
- Elective referral rates are increasing across the system and longer lengths of stays are driving a significant elective backlog at all Trusts.
- Demand must be managed to align acute capacity and demand and to prevent shortfalls in available beds to meet the needs of the population.

Demand must be managed to align acute capacity and demand and to prevent shortfalls in available beds to meet the needs of the population.

Reduction in beds:
The Royal Sussex County Hospital site in Brighton is delivering a 10-year strategy to improve their estate, which will impact on their ability to deliver care in a timely way. A strategic/system-wide solution is needed to support those pathways affected as all Trusts will be affected.

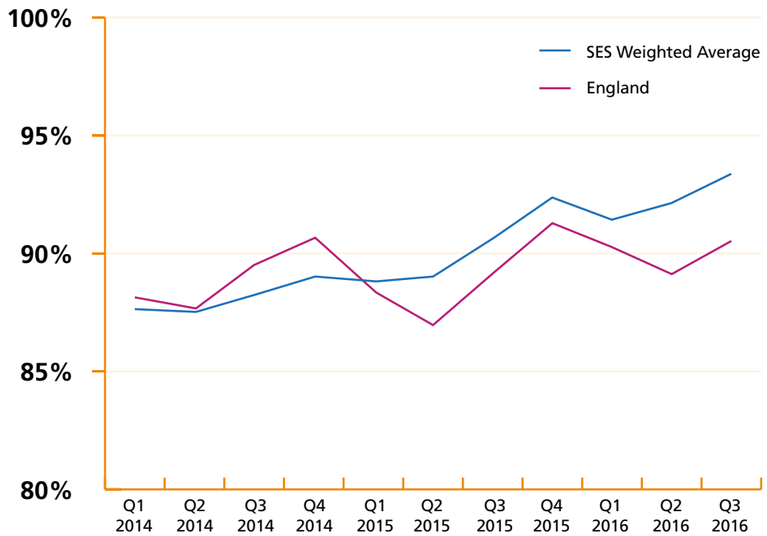
BED DAY UTILISATION

There are currently 3,519 acute inpatient beds across the STP. Bed occupancy across all sites is forecast to increase in 2016/17.

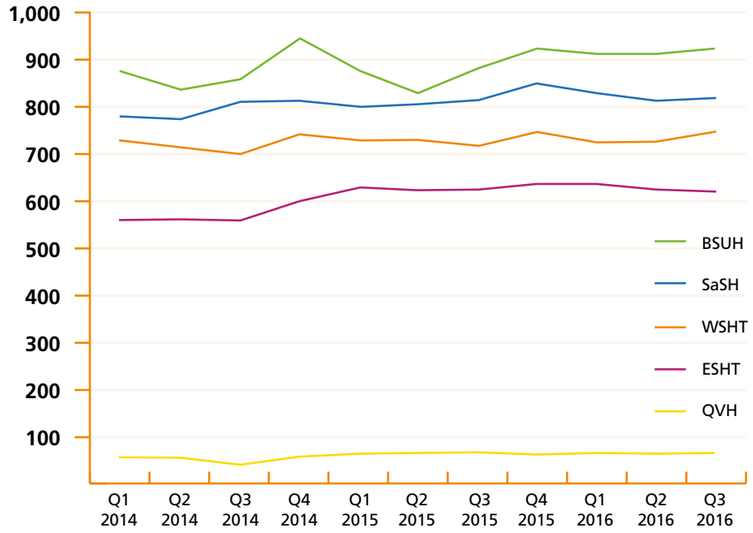


BED OCCUPANCY									
15/16	93%	72%	85%	94%	89%	85%	88%	101%	62%
16/17	96%	74%	88%	96%	91%	87%	90%	103%	64%
	Royal Sussex County Hospital	Princess Royal Hospital	Royal Alexandra Childrens Hospital	East Surrey Hospital	Worthing Hospital	St Richard's Hospital	Conquest Hospital	Eastbourne DGH	Queen Victoria Hospital

Average occupancy by quarter
Q1 2014 - Q3 2016



Total general and acute bed base
Q1 2014 - Q3 2016



CARE QULITY COMMISSION (CQC) RATINGS

Brighton and Sussex University Hospitals NHS Trust (BSUH): The Trust was last inspected in April 2016 and updated in August 2016. CQC found them to be inadequate in the areas of safety, responsiveness and leadership. The culture of the Trust was viewed as exceptionally challenging. Since the inspection, Western Sussex Hospitals NHS Foundation Trust has taken over the management of the BSUH and improvements have been seen in a number of areas.

East Sussex Healthcare NHS Trust: In June 2018, the CQC noted the Trust has made a marked improvement in the quality of its care, and concludes that the Trust no longer needs to be in special measures for quality. In the areas inspected by the CQC, everything was rated as 'good' or 'outstanding', apart from the Emergency Department at Eastbourne, which was rated as 'requires improvement', but 'good' for well led and caring.

Everything was rated as 'good' or 'outstanding', apart from the Emergency Department at Eastbourne, which was rated as 'requires improvement', but 'good' for well led and caring.

SECAmb: Following CQC inspection in 2017 the Trust was rated as Inadequate. This resulted in the Trust remaining in Special Measures and the development of a recovery plan that addresses CQC findings together with work across different areas of the Trust. This includes an overarching Culture and Organisational Development and an extensive programme of work dealing with workforce, recruitment, training and retention. CQC is conducting an inspection of the Trust in July (Core Services and Emergency Operations Centre) and August (Well Led) this year. The results of the inspection will be published in the Autumn. The work across the Trust is also being informed by a jointly commissioned Demand and Capacity review to identify resource requirements to fully meet Ambulance Response Programme standards.

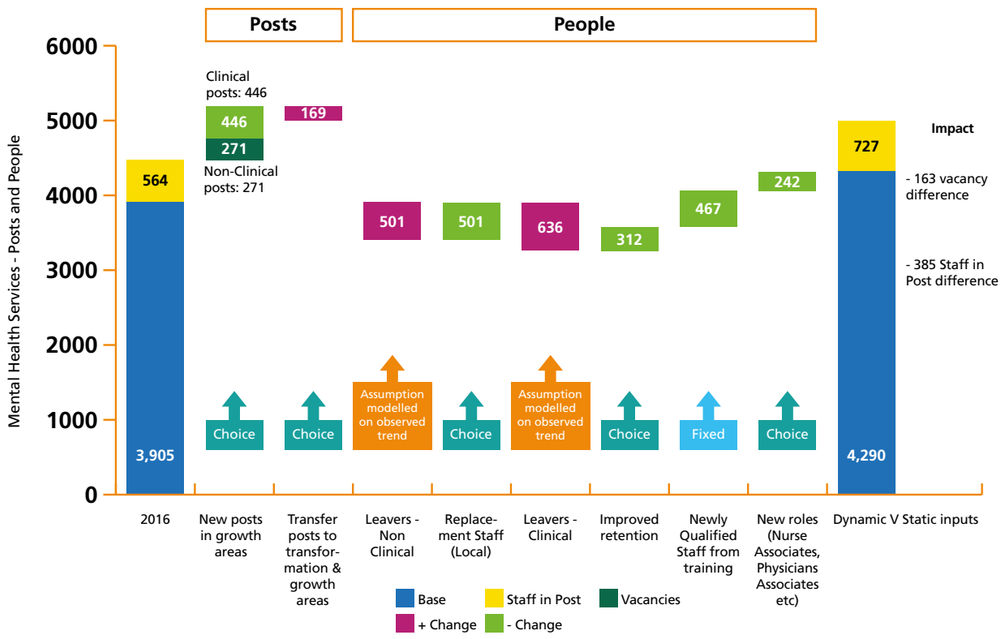
TRUST	CQC RATING
BSUH	Good
ESHT	Requires improvement
WSHT	Outstanding
SASH	Outstanding
QVH	Good
SPFT	Good
SCFT	Good
FCH	Outstanding
SB	Good
SECAMB	Inadequate
IC24	Good

MENTAL HEALTH SERVICES

The health and life outcomes for people experiencing mental health issues in our STP will continue to fall short of those of the general population unless we act to deliver the opportunities aligned with the five year forward view for mental health. To meet the government target of 21,000 new mental health posts by 2021, the STP projected response is set out below

The Sussex and East Surrey STP has an agreed Mental Health Strategy following a detailed Case for Change which identified that:

- Sussex and East Surrey STP need to ensure that 25% of people living with common mental health problems are seen by a local Improved Access to Psychological Therapies service every year.
- Capacity needs to be built in primary care, closer to home and thereby reduce presentations and referrals to physical and mental health secondary care.
- The prevalence of Severe Mental Illness is 5% higher than nationally, affecting 25,000 individuals.



- For dementia, prevalence is 25% higher than nationally, will increase further as the population ages, while the proportion of those with a diagnosis is 5% lower.
- A quarter of those patients with dementia who are fit to leave acute care wait over 50 days for discharge.
- Three quarters of first episodes of mental ill health occur in young people before the age of 25.

KEY FACT
Life expectancy for those with severe mental illness is twenty years' worse than the general population

"My partners mental health and mine wasn't a priority after my stillborn, they took slightly better care but no mention of mental care at any appointments"

GP SERVICES

The National Picture

Workload: Actual GP appointment numbers are not routinely collected by NHS England but the information we have would suggest significant rises, for instance 15.4% between 2010/11 and 2014/15. The Kings Fund (2016) estimated that there had been a 15 per cent overall increase in contacts, 13 per cent increase in face-to-face contacts and a 63 per cent increase in telephone contacts.

Workforce numbers: Nearly a quarter (23%) of the GP workforce is over 55. Less than a quarter (22%) of GP trainees plan to practise full-time one year after qualifying, according to a recent study by the King's Fund, falling to 5% who expect to be working full time after 10 years. 'The intensity of the working day' was cited as the most common reason.

Morale: A 2017 survey conducted by Exeter University in the South West indicated that over half of the GP workforce reported low or very low morale, and 40% of all GPs intended to retire within five years.

Practice Closures: Increasing numbers of practices are either closing their lists to new patients (a medium term approach) or capping their list (a shorter term approach), in order to maintain the quality of the service to existing patients within the resources they have.

Estates Issues: A 2018 BMA Survey revealed that four out of 10 GPs feel their premises are not adequate for patient care, describing how they are struggling to provide essential services in buildings that are cramped and

Less than a quarter (22%) of GP trainees plan to practise full-time one year after qualifying

Pressure through retirement of partners and salaried GPs has been a contributing factor to 16 practices closing and 10 mergers since 2013

outdated. It also reported that six out of 10 GPs in England are forced to share consulting rooms or 'hot-desk' around their surgeries.

STP examples

- Increasing elderly: The West Sussex Joint Services Needs Assessment (JSNA) estimates that the local population aged 70+ will grow at the fastest rate of any demographic; and that by 2039 more than 30% of the CCG resident population will be aged 65 or over. They also project that this means that the number of adults in this age group admitted to hospital with falls will nearly double over the same period. There are already some small areas of West Sussex where more than 50% of the resident population are aged 65 or above. Between 2018 and 2030 the JSNA predicts that the number of cases of dementia will rise by 45%.

- Workforce: According to NHS England figures, in 2015 there were 960 full time equivalent (FTE) GPs across East Surrey and Sussex. In order to deliver the growth required to deliver our proportion of the 5,000 extra GPs promised in the GP Forward View we would need to boost that to 1106 FTE GPs (so an increase of 146) . However the GP FTE across the patch as of Sept 2017 number 936 – a fall of 24 FTE, or 170 short of the target 1106. Figures for nurses seem to be broadly stable, GP Nurses FTE as of Sept 2015 numbering 502, and as of June 2018, 522. Large percentage of both practice nurses and GPs in our area that are over 55 and coming up to retirement. It is anticipated that there will be a loss of a third of GPs over next 10 years as they reach 55+. The retirement risk in ESBT is 46% of practice nurses in Hastings and Rother and 31% in Eastbourne, Hailsham and Seaford age 55+ with GPs 55+ at 24% in Hastings and Rother and 17% in Eastbourne, Hailsham and Seaford. Currently 210 GPs (18.5% of the workforce) are over 55 years.

- The STP has 203 practices. There are 12 single-handed GP practices and 189 partnerships, with the smallest registered list of 1,379 and the largest being 25,054. Pressure through retirement of partners and salaried GPs has been a contributing factor to 16 practices closing and 10 mergers since 2013. The GP workforce across the STP is in decline, of between 3% in the Coastal West Sussex area to 15% in Hastings and Rother CCG. In Brighton, nine surgeries (out of an initial total of 44) have closed in the last four years, displacing more than 33,000 patients, and putting extra pressure on already-struggling practices nearby. Brighton has been described in the press as possibly 'the hardest hit town in the whole of the UK?' In Hastings and St Leonards, at one point in the last 12 months 10 out of 14 practices had either closed or capped their patient lists, putting enormous pressure on the remaining practices. In Arun in Coastal West Sussex, three out of six practices have had to cap their lists due to the closure of a practice of 8,000 patients. The retirement of partners and salaried GPs has been a contribution factor to 16 practice closures and 10 mergers.

- Utilising the GP international recruitment scheme has not delivered the volume of new GPs anticipated. A target of 25 was set for 2018 but only five have been recruited.

OUR SERVICES – KEY FACTS

- Our pathways are often fragmented and there are frequent breakdowns in handoffs between agencies.

- There are delays in people accessing services and therefore may be missing out on timely treatment.

- There is a lack of timely access to effective primary and community services driven by insufficient capacity in primary care and community services.

- Discharge arrangements from acute care is variable, which means patients spend longer than necessary in hospital.

- We are often not meeting our constitutional standards for A&E, Referral – to-Treatment.

- There are gaps in reaching minimum standards of care in such areas as stroke, diabetes and cancer.

- General practice is facing significant issues in workforce with a backdrop of increasing demand

MAIN CHALLENGES:

- Addressing the significant un-warranted variation in MSK, Cardiovascular and falls/ fragility fractures.

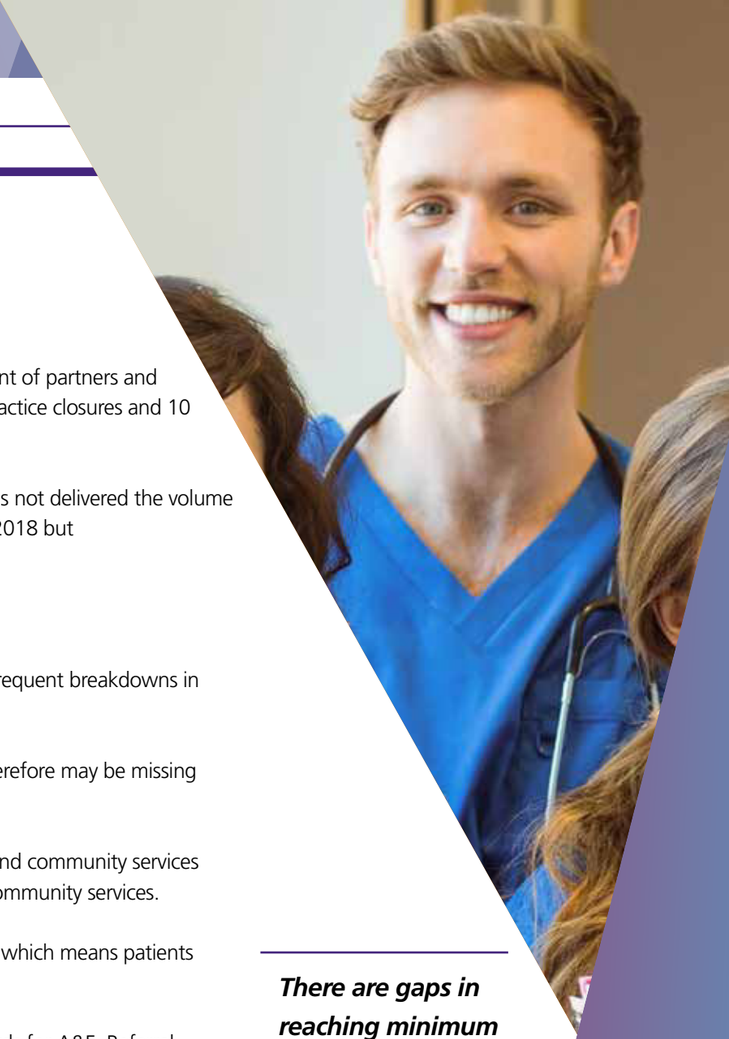
- Making a step change in managing flow, stranded and super stranded patients.

- Improving shared decision making.

THE CONSEQUENCE WE OBSERVE:

- Frequent, unnecessary admissions to hospital when patients could be cared for in a different setting.

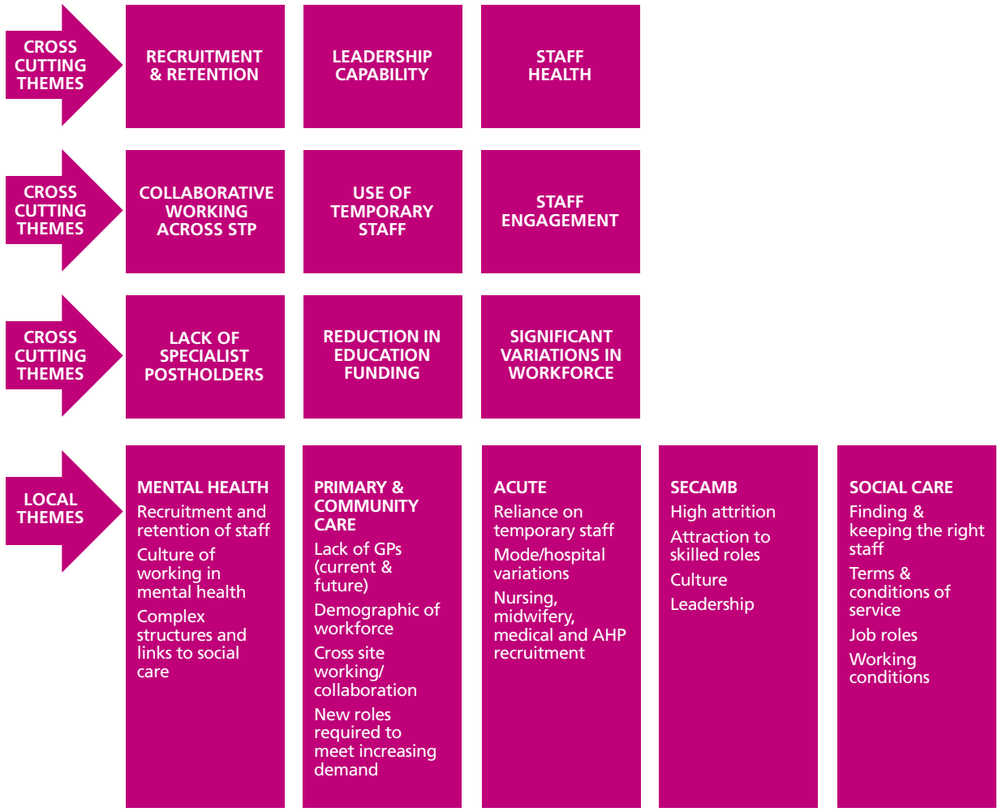
- Challenge in meeting and maintaining A&E and elective care targets.



There are gaps in reaching minimum standards of care in such areas as stroke, diabetes and cancer.

Our evidence: Our staff

OUR PEOPLE - OUR CHALLENGES



KEY FACTS

- There are 10,926 headcount staff and 9,375.90 FTE Registered Nursing, Midwifery and Health Visiting Staff across Sussex and East Surrey STP.
- The average retirement age is 59, with 15.38% of staff aged 55 years and over. The staff groups with over 20% of staff aged 55 and over that may be approaching retirement ranges from Registered School Nurses at 31% to Community Services (excl. Health Visitors and District Nurses) at 20.68%.
- The Turnover Rate for all Registered Nursing, Midwifery and Health Visiting Staff ranges from 12.84% in Maternity Services (excl. Registered Midwives) to 20.29% in district nursing.

- In social care there is a significant annual turnover of 26% for registered nurses, which rises to 32% turnover amongst support workers providing direct care in East Sussex.
- Skills for care estimates that in Brighton & Hove, 8.6% of roles in adult social care were vacant, this equates to around 700 vacancies at any one time. This vacancy rate was similar to the region average, at 6.8% and similar to England at 6.6%.
- Difficulty recruiting and retaining substantive mental health nurses and psychiatrists, has led to a sustained and increasing agency spend (in Sussex agency spend in mental health services was £2.6m in 2012/13 rising to £9.8m in 2015/16).
- In June 2017, the SES STP had a shortfall of GPs (FTE) of 193.
- The average level of sickness absence across acute trusts for 2014-15 was just over 4%. Just a 1% improvement in sickness absence equates to £280m in staff costs – without accounting for lower dependence on agency staff and reduced cancellations.
- Spend on temporary staffing continues to increase.

Difficulty recruiting and retaining substantive mental health nurses and psychiatrists, has led to a sustained and increasing agency spend

KEY ISSUES:

- We have significant issues relating to workforce and need to ensure we have the right people in the right place at the right time to deliver care.
- Given our demography, we need to rely as much on technology-enabled care as on state funded clinical and domiciliary workforce. There just won't be as many employees available in future as would be needed to provide current services to a larger population with more retired people and not many more working-age citizens.
- We have an inadequate number of mental health posts to meet the needs of our population.
- We need to increase the workforce within Primary Care to support changes to the way we deliver care across the system.

THE CONSEQUENCES WE OBSERVE:

- There is a real risk that we are failing to attract and retain the best talent.
- There is a significant risk to the resilience of services and the sustainability of a workforce.

Significant elements of the estate are either functionally unsuitable or compromised in the current configuration

Our evidence: Our infastructure

ESTATES

There is a diverse legacy of primary, community and acute provider estate across the STP.

Historically there have been many years of under-investment in estate, which has resulted in non-compliance, high backlog maintenance and inefficient estate with high running costs.

Significant elements of the estate are either functionally unsuitable or compromised in the current configuration.

There is multiple ownership of the estate, which ranges from NHS acute and community provider organisations, GP partners, NHS Property Services, third party commercial landlords, public/private partnerships to local authority partners.

There is a lack of formal lease/licence agreements in place resulting in ambiguity over estates running costs, occupation and utilisation information.

Estates running costs are higher than the national "Carter" benchmark indicators. Key high cost acute sites include the Royal Sussex County Hospital, St Richards Hospital, Worthing Hospital, East Surrey Hospital and Eastbourne District General Hospital. There is also a substantial backlog maintenance requirement across the acute and community estate, with high and significant risk elements exceeding £81million (excluding primary care and NHS Property Services community estate).

OUR EVIDENCE

DIGITALISATION

Individual Digital Maturity of secondary care providers is broadly in line with national average with evidence of improvement over the past year. However the maturity levels between providers vary significantly.

There is significant variation in technology usage across the STP with limited consolidation of suppliers except for PACS (Picture and Communication System) for Radiology, which represents a significant opportunity.

There is a lack of effective information sharing which presents a significant barrier to implementing new models of care.

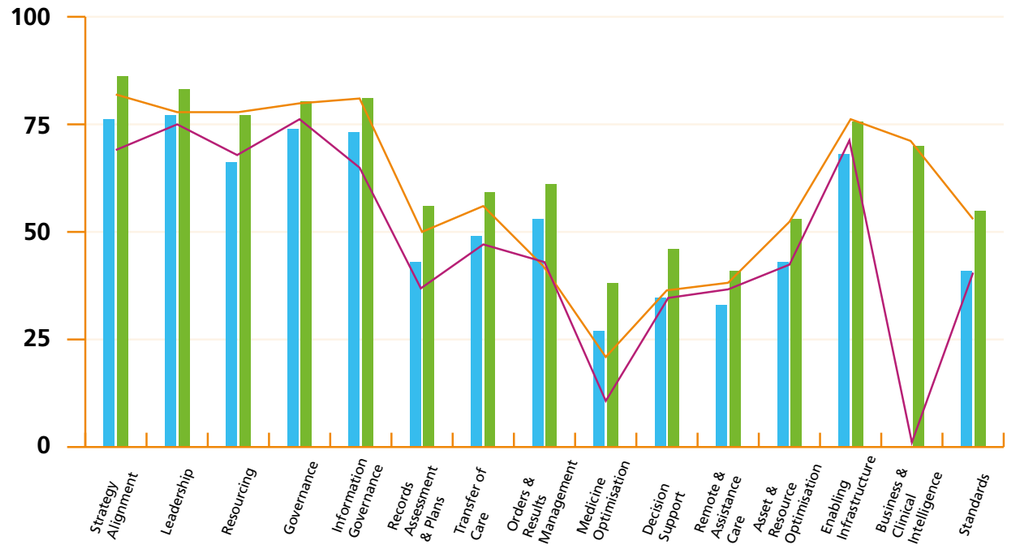
Population Health Management and Risk Stratification are fragmented and vary in use and sophistication.

The information governance community is capable and enthusiastic, but capacity is variable and is a limited resource overall.

Clinicians and professionals lack clarity and confidence to support information sharing.

Digital Maturity - Secondary Care

Sussex and East Surrey 2016
Sussex and East Surrey 2017



FINANCE

Current situation: The STP covers a wide geographical area and many organisations, with a notable amount of variation in financial performance. In 2017/18, seven out of nine Trusts ended the year in surplus. The two trusts in deficit - East Sussex Healthcare NHS Trust and Brighton and Sussex University Hospitals NHS Trust - are in Financial Special Measures. Of eight CCGs in the footprint, one ended the year in surplus. Overall the combined net deficit (surpluses and deficits added together) for CCGs and trusts was £228.2m. It should also be noted that this figure includes significant amounts of one-off funding, including Sustainability and Transformation Funding, which was released at the end of the year.

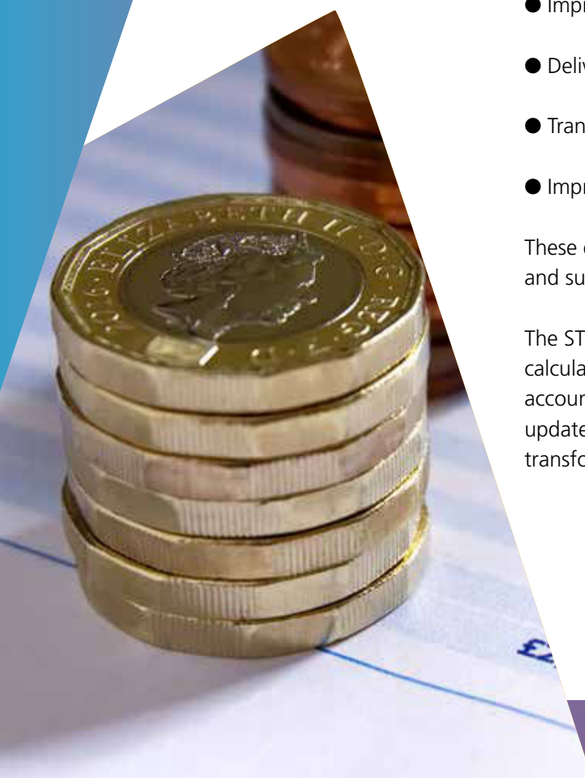
2018/19 planning: Control totals (the required surplus/deficit set by regulators) for 2018/19 add up to a total net deficit of £185.8m for CCGs and Trusts, including one-off sustainability funding for providers. An additional £111.6m of commissioner sustainability funding is available to those CCGs that meet their deficit control totals.

Strategic Financial Framework: The STP has a Strategic Financial Framework that sets out the approach to system-wide financial sustainability over a 5-year time horizon. It is comprised of four elements:

- Improving productivity and efficiency
- Delivering the right care to improve value
- Transforming and investing for change
- Improving system contracting/admin

These elements are progressed through 11 STP programme priority areas and supported by four enabling work streams.

The STP five-year financial model brings these aspects together and calculates their combined medium to long-term financial impact, taking account of risk, to allow financial sustainability to be assessed. This is updated iteratively to reflect the progress and evolution of ongoing transformation work, and to allow reassessment of its financial impact.



OUR INFRASTRUCTURE – KEY FACTS

There is a multiplicity of IT system many of which do not communicate to each other.

- We have Information Governance issues.
- There is a significant mismatch between revenue and expenditure.
- We have higher use of acute services that are proportionally more expensive.
- Our community and primary care assets are not optimised or necessarily fit for purpose.

Main challenges:

- The provision of a balanced estate portfolio that is fit for purpose in a constrained capital environment and meets the needs of the population.
- Achieving a sizable reduction in the current deficit position of the STP.
- Rising to the Digital requirements as a priority.

The consequence we observe:

- Duplication in processes.
- Inability to maximise use of technology for patient benefits.

Our community and primary care assets are not optimised or necessarily fit for purpose.

Our priorities

The evidence presented in the Population Health Check naturally leads to the following priorities.

- Addressing capacity and demand
- Tackling unwarranted clinical variation
- Focussing on workforce
- Moving to a people centred value based system
- Reducing the financial deficit

We need to deliver value across our STP i.e. the best outcomes for the individual and for our population within the available resources. This includes doing less of things that add little or no value to patients. This includes reducing the over – medicalisation of care.

This requires:

1. The development and implementation of a clear workforce and capacity strategy, which will address the short-term and long term (future-proofing) crisis in relation to the number of staff and skills.

2. Improving shared decision making i.e. more active involvement with well-informed patients and developing and using standardised outcome measures that are more relevant to patients (such as the impact on their functional status and wellbeing).

3. Leading the reframing our cultural norms, so that making the right choice in relation to lifestyle changes, is the easy choice. This includes putting initiatives, such as "Making Every Contact Count" and healthy eating, into relevant contracts to deliver the highest standards of work-based health.

4. Recognising unwarranted clinical variation and addressing it. We can achieve this through the combination of Right Care, Clinically Effective Commissioning and Getting it Right First Time (GIRFT) all of which describe key clinical areas where Quality Improvement is required.

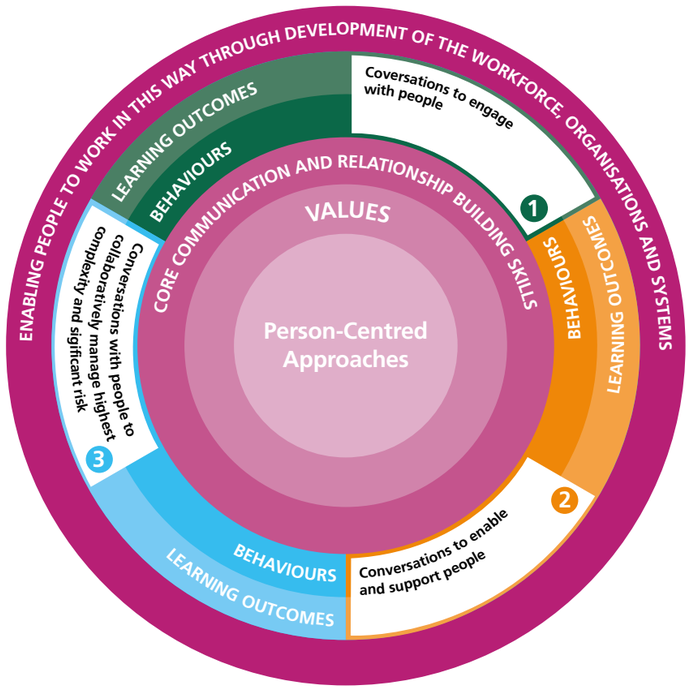
- Reduced productivity.
- We cannot afford to continue to pay for services at the current rate.

5. Reducing A&E attendances through ensuring the resources are available to support patients nearer home, including addressing fragmented pathways, gaps in service availability, communication across services, mental health support and digital shortfalls which block shared access to information. Make navigating the system easy for the public and encourage the development of advance and anticipatory care plans which are accessible to all who need to see them.

Next steps

We need to develop a clinical strategy which delivers "best value" and patient centred care.

PERSON CENTRED APPROACHES FRAMEWORK (SKILLS FOR HEALTH/SKILLS FOR CARE/HEALTH EDUCATION ENGLAND)



WE NEED TO DEVELOP A CLINICAL STRATEGY WHICH IS FUTURE PROOFED

On a local level Sussex and East Surrey is facing significant challenges in providing sustainable care for its population. These challenges include financial pressures as well as workforce recruitment and retention shortfalls. Much of this Population Health Check describes variation in consumption of healthcare, through variation in referral from primary care, through to differences locally to peers in secondary care intervention, length of stay and bed occupancy (note the Carnell Farrar data and information provided by Rightcare), and the consequent opportunity this affords the STP. This provides both the immediate case for change and the initial targets.

Eric Topol is conducting his review with Health Education England for the Secretary of State on how technology will impact care and the training of carers. This review builds on Facing the Facts, Shaping the future (Health Education England, December 2017) and starts with acknowledging that the pace of development of genomics, digitisation and data analytics, machine learning and AI, biotech, nanotech and robotics is game changing.

An empowered and more digitally aware and competent population will demand at the least that the medical information known about them is recorded in a way that promotes their care. We already see both the success and acceptability of care records that can be read by paramedics, primary care and the emergency department. Advanced care decisions that are not paper based and don't need to be sought and transferred with the patient from the nursing home out of hours with a high chance of loss is acceptable to the public and to staff. In fact it is probably already more acceptable than the unreliable paper based norm. We already see the common theme of complaint of people being asked repeatedly, by a succession of carers for the same information. This is probably a basic and the advantage in reducing conveyance, reducing harm and reducing length of stay has been demonstrated.

Beyond this people will increasingly expect a better offering, more tailored to them as an individual, responsive when they need it not batched for provider convenience. Again, within this STP, there are models of care that are not face to face and are IT-enabled. These have reduced out-patient attendance, crowding in waiting rooms, and cost (e.g. Digital virtual clinics for people living with inflammatory bowel disease and Virtual Fracture Clinics in BSUH). Importantly they have left patients feeling better supported and better able to manage their long term conditions and stay motivated in their recovery. They provide a digital relationship and connection to clinicians and healthcare professionals more suited to the always on expectations of our digital selves.

The importance of the digital agenda has been underlined by the Prime minister in her Macclesfield speech. The Office for Life sciences (OLS) has issued a variety of challenges and at the present time there are open calls for a second wave of digital and Internet of Things (IOT) test beds, industrial strategy challenge funding, ageing grand challenges, an active

An empowered and more digitally aware and competent population will demand at the least that the medical information known about them is recorded in a way that promotes their care.

Brighton ranked particularly strongly in its innovation for data, virtual reality, health and artificial intelligence despite being relatively smaller than its competitors

call for new Collaborations of Leadership in Applied Health Research and Care (this time badged as Applied Research Collaborations). All of these calls have tens of millions of pounds available to demonstrate new ways of working, drawing on modern and forward-facing technology, that deliver improved outcomes with a different kind of workforce. All require scalability and all require a legacy to be left locally.

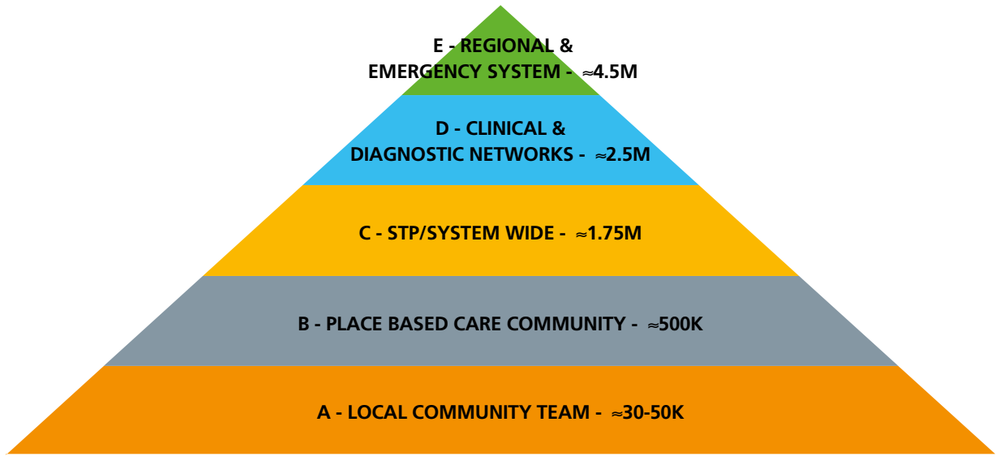
Our STP contains a medical school, two universities, thoughtful and effective collaborations between health and social care, between academia and industry and care. It has an abundance of small and medium enterprises with Brighton & Hove ranked fourth in a new index highlighting the size and success of digital industries around the country and their potential for growth. Brighton ranked particularly strongly in its innovation for data, virtual reality, health and artificial intelligence despite being relatively smaller than its competitors. It has a strong record of research and of education. It is bracketed by two STPs with similarly strong records of new models of care (Kent vanguard, Surrey wave one Internet of Things test bed). Its hospitals already connect digitally around imaging and diagnostics.

We also should not miss the link that investment in the local economy improves job prospects, affluence and helps mitigate the impact that poverty has on the health and wellbeing of our local population. There are strong digital and IT economic sectors already in our local economies with around 25% of Brighton & Hove's economy is in the Creative Digital and IT sector which has seen 40% growth over the past 5 years, with strong academic relationships through the Digital Catapult and one of the first 5G testbeds in the country.

In our quest to drive out waste and address historic financial over spend, which is urgent, we will take the opportunity to work on models of care that put our people at the heart of new pathways. We must not lose sight of this.

WE NEED TO DEVELOP A CLINICAL STRATEGY WHICH IS CLEAR ON THE OPTIMAL POPULATION SIZE TO LEAD DELIVERY

Some of the changes needed will be led and delivered locally, supported by the STP as the direction of travel. A few will be led by the STP organisations together, providing that adds value and does not duplicate local work.



BUSINESS LANDSCAPE

National Engagement	Emergency System	Partner Support	Regional & Emergency System (E)
Surrey & Sussex Cancer Alliance	Regional Diagnostics Alliance	Population Health Intelligence	Clinical & Diagnostic Networks (D)
Operational Delivery Networks	Population Health Management	Integrated Care/ wider system pathways	STP/Urgent Care System (C)
Expert Opinion & Diagnostics	Capacity Planning & Coordination	Integrated Urgent & Emergency Care	Place Based Care Community (B)
Prevention & Self Management	Patient Identification & Care Planning	MDTs	Local Community Team (A)

LOCAL COMMUNITY TEAM 30-50K

Prevention & Self Management	Patient identification & care planning	Multi-disciplinary Teams
● Falls prevention ● Social prescribing ● Health coaching ● Building knowledge & changing behaviours ● Support for people to manage their long term condition	● Identifying frail & vunerable patients ● Developing and implementing care plans	● Care coordination ● Reablement ● Bringing integrated Health and Social Care into the home

PLACE BASED CARE COMMUNITY ≈500K

Expert Opinion & Diagnostics	Capacity Planning & Coordination	Integrated Urgent & Emergency Care
● Timely diagnostics ● Access to expert opinion ● Timely assessment	● Demand & Capacity Planning ● Transitions of care & patient flow ● Mental health liaison ● Social care coordination ● Community & capacity development	● A&E coordination ● See and Treat ● Rapid response ● Single Point of Access ● Telecare/health

STP/WIDER SYSTEM ≈1.7M

Operational Delivery Networks and clinical networks	Population Health Management	Integrated Care/wider system pathways
● Trauma ● Maternity ● Vascular ● Burns ● Clinical networks: specialist cardiology, cardiac surgery, renal dialysis, and paediatric surgery	● Population health planning ● research and Evaluation ● Provider and collaboration	● 111 Service ● UEC ● Mental Health ● Capacity (3Ts) ● Clinical variation ● Maternity

CLINICAL & DIAGNOSTIC NETWORKS ≈12.5

Clinical & Diagnostic Networks	Population Health analytics
● Surrey & Sussex Cancer Alliance ● Radiology Network ● Pathology ● South East Clinical Networks	● Sussex & Surrey Integrated Dataset ● Research and Evaluation

REGIONAL & ≈1.7M

National Engagement	Emergency System	Partner Support
● NHS England ● NHS Improvement ● NHS Digital ● Specialist Commissioning	● 999 & Ambulance Service ● care Plan Sharing service	● HEE KSS ● KSS AHSN ● NIHR Clinical Research Network KSS ● South East Coast Clinical Senate

NEXT STEPS

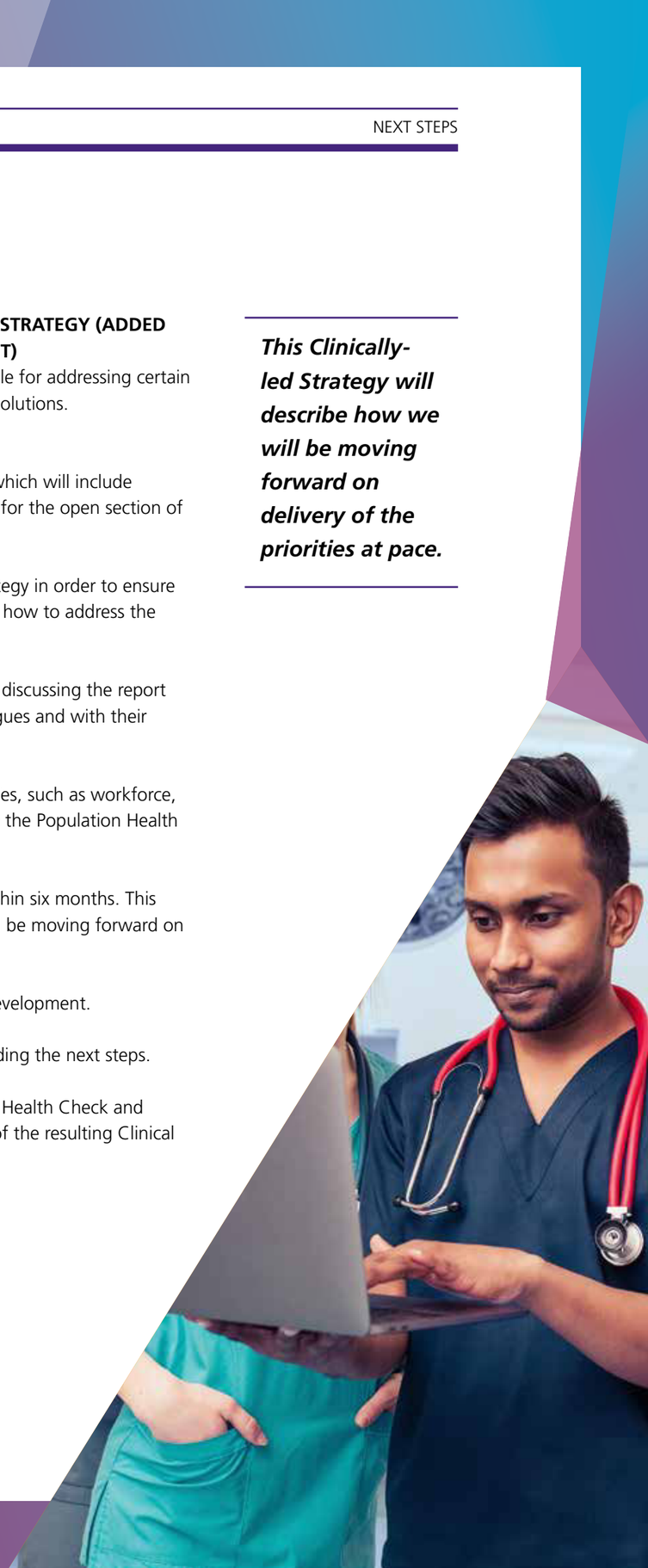
THE PROCESS OF DEVELOPING THE CLINICAL STRATEGY (ADDED POST SIGN OFF. STP EXEC GROUP AGREEMENT)

The Population Health Check provides the rationale for addressing certain themes as priorities; it does not attempt to offer solutions.

In order to achieve that, we will now:

- Develop a public-facing version of the report, which will include graphics and a visual explanation of the report for the open section of Boards and Governing Bodies.
- Draft an engagement and communication strategy in order to ensure we are engaging at the earliest opportunity on how to address the themes identified.
- Our Medical Directors and Chief Nurses will be discussing the report more widely internally with their clinical colleagues and with their Executive leads.
- We will be ensuring that co-dependent strategies, such as workforce, digital technology, estates etc. are aligned with the Population Health Check and the developing Clinical Strategy.
- Develop a plan to deliver a Clinical Strategy within six months. This Clinically-led Strategy will describe how we will be moving forward on delivery of the priorities at pace.
- Have had an opportunity to contribute to its development.
- Agree with the Population Health Check, including the next steps.
- Are committed to championing the Population Health Check and contributing to the development and delivery of the resulting Clinical Strategy.

This Clinically-led Strategy will describe how we will be moving forward on delivery of the priorities at pace.



Agreement from the Core members of the STP Clinical and Professional Cabinet

We would like to formally confirm our support for this Population Health Check. We confirm that we:

- Have had an opportunity to contribute to its' development
- Agree with the Population Health Check, including the next steps
- Are committed to championing the Population Health Check and contributing to the development and delivery of the resulting Clinical Strategy

Name	Title	Organisation	Date agreed
Minesh Patel	Clinical Chair (Co-chairperson)	NHS Horsham and Mid Sussex CCG	25/09/2018
Peter Larsen-Disney	Clinical Director of 3Ts (Co-chairperson)	Brighton and Sussex University Hospital NHS FT	20/08/2018
Rob Haigh	Medical Director	Brighton and Sussex University Hospitals NHS Trust	14/09/2018
George Findlay	Chief Medical Officer/ Deputy CEO	Brighton and Sussex University NHS Trust and Western Sussex Hospitals NHS FT	02/10/2018
David Supple	Clinical Chair	NHS Brighton and Hove CCG	05/09/2018
Gill Galliano	Acting Lay Chair	NHS Coastal West Sussex CCG	02/10/2018
Laura Hill	Clinical Chair	NHS Crawley CCG	05/09/2018
Elango Vijaykumar	Clinical Chair	NHS East Surrey CCG	25/09/2018
Martin Writer	Clinical Chair	NHS Eastbourne, Hailsham and Seaford CCG	02/10/2018
David Warden	Clinical Chair	NHS Hastings and Rother CCG	13/09/2018
Elizabeth Gill	Clinical Chair	NHS High Weald Lewes Havens CCG	25/09/2018

David Walker	Medical Director	East Sussex Healthcare NHS Trust	22/08/2018
Ed Pickles	Medical Director	Queen Victoria Hospital NHS FT	17/09/2018
Karen Eastman	Clinical Lead for Unwarranted Clinical Variation	SES STP	12/09/2018
Fionna Moore	Medical Director	South East Coast Ambulance Services NHS FT	29/08/2018
Des Holden	Medical Director	Surrey and Sussex Healthcare NHS Trust	02/10/2018
Richard Quirk	Medical Director	Sussex Community NHS FT	13/09/2018
Rick Fraser	Consultant Psychiatrist and Chief Medical Officer	Sussex Partnership NHS FT	30/08/2018
Justin Wilson	Chief Medical Officer	Surrey and Borders Partnership NHS Trust	09/10/2018
Sue Marshall	Executive Chief Nurse	Sussex Community NHS FT	13/09/2018
Jonathon Warren	Chief Nurse	Surrey and Borders Partnership Trust	22/08/2018
Liz Mouland	Chief Nurse and Director of Clinical Standards	First Community Health and Care	21/08/2018
Patricia Brayden	Medical Director	St Catherine's Hospice, Crawley	31/08/2018
Andrew Catto	Medical Director	IC24	31/08/2018
Alison Taylor	Deputy Medical Director	NHSE	29/08/2018
Allison Cannon	Chief Nurse	STP Commissioners	28/08/2018
Karen Devanny	Chief Nurse and Director of Quality	CSESCA	12/09/2018
Guy Boersma	Managing Director	KSS AHSN	17/09/2018
Michael Bosch	RCGP STP Ambassador and Alliance for Better Care GP Federation	Alliance for Better Care GP Federation	20/08/2018
Anna Raleigh	Director of Public Health	WS CC-Evidence: Our Population and Demographics	18/09/2018
Richard Brown	Medical Director	S&SLMCs	20/09/2018

Agreement from the Core members of the STP Clinical and Professional Cabinet

We would like to formally confirm our support for this Population Health Check. We confirm that we:

- Have had an opportunity to contribute to its development
- Agree with the Population Health Check, including the next steps

Name	Title	Organisation	Date agreed
Lawrence Goldberg	Chair	South East Clinical Senate	20/08/2018

Contribution list

List of colleagues who have received and have been given the opportunity to contribute to the Population Health Check so far

Bob Alexander	STP Executive Chair	SES STP
Bruce Allan	GP	Worthing Medical Group
Sam Allan	Chief Executive	SPFT
Helen Atkinson	Executive Director of Public Health and Head of Adult services	Surrey County Council
Michael Bailey	STP workforce Project lead	SES STP
Gaynor Baker	STP Estates Lead	SES STP
Paul Bennett	Delivery and Improvement Director	NHSI (SE)
Sarah Billiard	Chief Executive	First Community Health and Care
Michael Bosch	RCGP STP Ambassador and Alliance for Better Care GP Federation	Alliance for Better Care GP Federation
Guy Boersma	Managing Director	KSS AHSN
Patricia Brayden	Medical Director	St Catherine's Hospice, Crawley
Karen Breen	TP Programme Director	SES STP
Richard Brown	Medical Director	Surrey and Sussex LMC
Jessica Britten	Chief Operating Officer	ESBT
Adrian Bull	Chief Executive	ESHT
Allison Cannon	Chief Nurse	STP Commissioners
Andrew Catto	Medical Director	IC24
Jacqueline Clay	Principal Manager	West Sussex Public Health and Social Research Unit
Karen Devanny	Chief Nurse and Director of Quality	CSESCA
Sarah Doffman	Chief of Medicine	Brighton and Sussex University Hospital NHS FT
Adam Doyle	Accountable Officer	CSESA and CWS CCG
Karen Eastman	Lead for Unwarranted Clinical Variation	SES STP

Fiona Edwards	Chief Executive	Surrey and Borders NHS Trust
Amanda Fadero	Director	Coastal Care
George Findlay	Chief Medical Officer/ Deputy CEO	Brighton and Sussex University Hospitals NHS Trust Western Sussex Hospitals NHS FT
Pennie Ford	Director of Assurance and Delivery	NHSE (SE)
Rick Fraser	Consultant Psychiatrist and Chief Medical Officer	Sussex Partnership NHS FT
Darrell Gale	Director of Public Health	East Sussex County Council
Elizabeth Gill	Clinical Chair	NHS High Weald Lewes Havens CCG
Rachel Gill	Consultant in Public Health	Surrey County Council
Lawrence Goldberg	Chair	South East Clinical Senate
Marianne Griffiths	Chief Executive	WSHT and BSUH
Tom Gurney	Communications Lead	SES STP
Rob Haigh	Medical Director	Brighton and Sussex University Hospitals NHS Trust
Des Holden	Medical Director	Surrey and Sussex Healthcare NHS Trust
Laura Hill	Clinical Chair	NHS Crawley CCG
Jackie Huddleston	NHS England – South East (Kent, Surrey, Sussex)	NHS England – South East (Kent, Surrey, Sussex)
Caroline Huff	Clinical Programme Director	SES STP
Steve Jenkin	Chief Executive	QVH
Maggie Keating	STP UECN Senior Programme Manager	SES STP
Peter Kottlar	Chief Operating Officer	East Surrey CCG (CSESA)
Peter Larsen-Disney	Clinical Director of BSUH 3Ts and Co-chairperson of the SES STP Clinical and Professional Cabinet	Brighton and Sussex University Hospital NHS FT
David Lipscomb	Chair Diabetes Oversight Group Sussex and Surrey STP	SCFT
Hugo Luck	Associate Director of Operations	HWLH CCG and CSESA (S)
Nick Lake	Deputy Medical Director	SPFT
Vaughan Lewis	Medical Director Specialised Commissioning NHS South	NHSE
Susan Marshall	Chief Nurse	Sussex Community NHS FT
Siobhan Melia	Chief Executive	SCFT
Alistair Hill	Director of Public Health	BH City Council
Fionna Moore	Medical director South East Coast Ambulance Services	NHS FT

Ralph McCormack	Programme Director – Commissioning Programmes	STP
Liz Mouland	Chief Nurse and Director of Clinical Standards	First Community Health and Care
Minesh Patel	CCG Clinical Chair and Co-chairperson of the SES STP Clinical and Professional Cabinet	NHS Horsham and Mid Sussex CCG
Maggie Patching	Workforce Transformation Lead	HEKSS
Amanda Philpott	Accountable Officer	HR CCG and EHS CCG
Ed Pickles	Medical Director	Queen Victoria Hospital NHS FT
Mark Preston	Director of Organisational Development & People	SASH
Richard Quirk	Medical Director	Sussex Community NHS FT
Anna Raleigh	Director of Public Health and co-ordinating lead for SES STP DsPH input	West Sussex CC
Rosalind Ranson	Primary Care Lead	IC24
Nicola Rosenberg	Public Health Consultant	BH CC
Paul Simpson	Chair	SES STP Finance Group
Ashley Scarff	Director of Commissioning & Deputy Chief Officer	HWLH CCG
Sam Stanbridge	Director of Commissioning	East Surrey CCG (CSESA)
Su Stone Clinical chair	NHS Coastal West Sussex	CCG
David Supple	Clinical Chair	NHS Brighton and Hove CCG
Alison Taylor	Deputy Medical Director	NHSE
Tim Taylor	Medical Director	Western Sussex Hospitals NHS FT
Sarah Valentine	Strategic Director of Contracting & Performance	Sussex & East Surrey CCGs
David Walker	Medical Director	East Sussex Healthcare NHS Trust
David Warden	Clinical Chair	NHS Hastings and Rother CCG
Jonathan Warren	Chief Nurse	Surrey and Borders Partnership Trust
Mark Watson	Digital Programme Manager	SES STP
Justin Wilson	Chief Medical Director	Surrey and Borders Partnership NHS FT
Michael Wilson	Chief Executive	SASH
Martin Writer	Clinical Chair	NHS Eastbourne, Hailsham and Seaford CCG
Elango Vijaykuma	Clinical Chair	NHS East Surrey CCG

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Sussex & East Surrey
Sustainability & Transformation Partnership

Produced by Creative@sussexpartnership.nhs.uk
Published February 2019
All information correct at time of printing

South East Coast Ambulance Service
NHS Foundation Trust

Integrated Performance Report

Performance Data for our 999 and 111 Services

Aspiring to be
Better Today and
Even Better Tomorrow
For our people and our patients

Board Meeting

January 2019

Taking Pride | Striving for Continuous Improvement | Acting With Integrity | Demonstrating Compassion and Respect | Assuming Responsibility

Contents Summary

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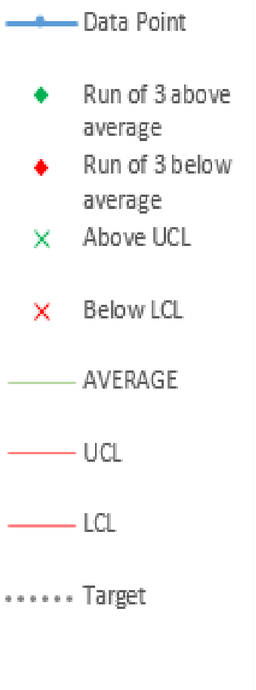
SECAmb CQC Rating and Oversight Framework

Use of Resources Metric (Financial Risk Rating)	3
Segmentation	Segment 4 (Special Measures)
IG Toolkit Assessment	Level 2 - Satisfactory
REAP Level	3

Chart Key



This represents the value being measured on the chart
These points will show on a chart when the value is above or below the average for 3 consecutive points. This is seen as statistically significant and an area that should be reviewed.

When a value point falls above or below the control limits, it is seen as a point of statistical significance and should be investigated for a root cause.

This line represents the average of all values within the chart.

These lines are set two standard deviations above and below the average.

The target is either and Internal or National target to be met, with the values ideally falling above or below this point.

SECAmb Executive Summary

This report sets out data and supporting narrative to provide the Trust Board with assurance that the Executive Directors review historic information and data reflecting performance and service delivery across a number of domains. This is then interpreted and within the body of this report individual Directorates highlight the management response to data where this is applicable. In this way the Board is asked to note the Trust's oversight of performance and management data together with how this data supports decision making and action within the Trust.

The performance data shared in this report from Operations 999 is as at 7/1/19

The format and content of this report is continually reviewed to provide greater utility to the Trust Board and clearly communicate the status and actions undertaken by the Trust over time. During February and March 2019 this report and our quality reporting will be reviewed in order to further develop and refine our reporting going forward into 2019/20.

SECAmb Our Enablers

Enabling strategies continue to be reported within the supporting Trust Delivery Plan and narrative.

SECAmb Financial Performance

The Trust achieved its planned surplus of £0.1m for the month of November. The cumulative deficit of £3.1m is marginally better than plan, maintaining operational performance.

The Trust is forecasting delivery of its core control total for the year of £0.8m deficit.

The Trust achieved cost improvements of £1.0m in the month, which was slightly ahead of plan. The target for the full year is £11.4m.

The Trust's Use of Resources Risk Rating (UoRR) at this point in the year is 3, in line with plan.

Risks to this plan include recruitment to provide the resources to meet the Demand and Capacity review, delivery of performance targets, any financial impact of unfunded cost pressures and the delivery of CIP targets.

Engagement with the Trust's stakeholders is ongoing in order to mitigate as many of these as possible.

Further details of financial performance are included in this report. A more detailed reporting pack is provided to directors, senior managers and regulators and this is closely monitored through the Finance & Investment Committee, a subcommittee of the Board.

CQC Findings ('Must or Should Do's')

Safe

- The Trust must take action to ensure they keep a complete and accurate recording of all 999 calls.
- The Trust must protect patients from the risks associated with the unsafe use and management of medicines in line with best practice and relevant medicines licences. This should include the appropriate administration, supply, security and storage of all medicines, appropriate use of patient group directions and the management of medical gas cylinders.
- The Trust must take action to ensure there are a sufficient number of clinicians in each EOC at all times in line with evidence-based guidelines.
- The Trust must take action to ensure all staff understand their responsibilities to report incidents.
- The Trust must ensure improvements are made on reporting of low harm and near miss incidents.
- The Trust must investigate incidents in a timely way and share learning with all relevant staff.
- The Trust must ensure all staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns receive an appropriate level of safeguarding training.
- The Trust must ensure patient records are completed, accurate and fit for purpose, kept confidential and stored securely.
- The Trust must ensure the CAD system is effectively maintained.
- The Trust must ensure the risk of infection prevention and control are adequately managed. This includes ensuring consistent standards of cleanliness in ambulance stations, vehicles and hand hygiene practices, and uniform procedure followed.
- The Trust must ensure all medical equipment is adequately serviced and maintained.
- The Trust should take action to audit 999 calls at a frequency that meets evidence based guidelines.
- The Trust should review all out of date policies.
- The Trust should ensure all first aid bags have a consistent contents list and they are stored securely within the bags.
- The Trust should ensure all ambulance stations and vehicles are kept secured.
- The Trust should ensure all vehicle crews have sufficient time to undertake daily vehicle checks within their allocated shifts.

Caring

- The Trust should ensure that patients are always involved in their care and treatment.
- The Trust should ensure that patients are always treated with dignity and respect.

Effective

- The Trust must take action to meet national performance targets.
- The Trust must improve outcomes for patients who receive care and treatment.
- The Trust must continue to ensure there are adequate resources available to undertake regular audits and robust monitoring of the services provided.
- The Trust should ensure there are systems and resources available to monitor and assess the competency of staff

Responsive

- The Trust must ensure the systems and processes in place to manage, investigate and respond to complaints, and learn from complaints are robust.
- The Trust should ensure 100% of frequent callers have an Intelligence Based Information System (IBIS) or other personalised record to allow staff taking calls to meet their individual needs.
- The Trust should take action to ensure all patients with an IBIS record are immediately flagged to staff taking calls 24 hours a day, seven days a week.
- The Trust should consider reviewing the arrangements for escalation under the demand management plan (DMP) so that patients across The Trust receive equal access to services at times of DMP.
- The Trust should continue to address the handover delays at acute hospitals.
- The Trust should ensure individual needs of patients and service users are met. This includes bariatric and service translation provisions for those who need access.

Well Led

- The Trust must take action to ensure all staff receive an annual appraisal in a timely way so that they can be supported with training, professional development and supervision.
- The Trust must ensure that governance systems are effective and fit for purpose. This includes systems to assess, monitor and improve the quality and safety of services.
- The Trust should consider improving communications about any changes are effective and timely, including the methods used.
- The Trust should engage staff in the organisation's strategy, vision and core values. This includes increasing the visibility and day to day involvement of The Trust executive team and board, and the senior management level across all departments.
- The Trust should continue to sustain the action plan from the findings of staff surveys, including addressing the perceived culture of bullying and harassment.

Our Patients

SECAmb Clinical Safety Scorecard

Cardiac Return of Spontaneous Circulation (ROSC) - Utstein (a set of guidelines for uniform reporting of cardiac arrest)

	May-18	Jun-18	Jul-18	12 Months
Actual %	50.0%	69.7%	46.7%	
Previous Year %	56.8%	44.8%	37.9%	
National Average %	55.9%	56.6%	55.9%	

Cardiac ROSC - ALL

	May-18	Jun-18	Jul-18	12 Months
Actual %	25.1%	36.6%	28.8%	
Previous Year %	22.8%	28.1%	24.4%	
National Average %	31.6%	31.8%	31.9%	

Cardiac Survival - Utstein

	May-18	Jun-18	Jul-18	12 Months
Actual %	20.7%	33.3%	28.6%	
Previous Year %	30.3%	17.9%	17.2%	
National Average %	29.4%	30.9%	33.9%	

Cardiac Survival - All

	May-18	Jun-18	Jul-18	12 Months
Actual %	4.5%	10.2%	8.4%	
Previous Year %	6.3%	5.9%	3.6%	
National Average %	10.0%	11.3%	11.8%	

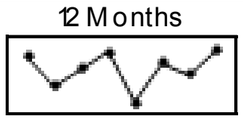
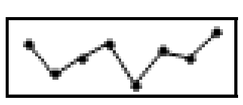
Acute ST-Elevation Myocardial Infarction (STEMI) Care Bundle Outcome

	May-18	Jun-18	Jul-18	12 Months
Actual %	69.6%	75.0%	69.4%	
Previous Year %	57.5%	70.5%	62.9%	
National Average %	79.5%	79.5%	81.2%	

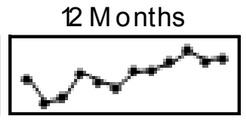
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography

	May-18	Jun-18	Jul-18	12 Months
Mean (hh:mm)	02:11	02:19	02:14	
National Average	02:09	02:11	02:07	
90th Centile (hh:mm)	03:06	03:15	03:09	
National Average	02:56	03:05	02:51	

Stroke - call to hospital arrival

	May-18	Jun-18	Jul-18	12 Months
Mean (hh:mm)	01:12	01:10	01:14	
National Average	01:18	01:13	01:15	
Median (hh:mm)	01:03	01:01	01:04	
National Average	01:05	01:05	01:06	
90th Centile (hh:mm)	01:47	01:45	01:52	
National Average	01:47	01:49	01:52	

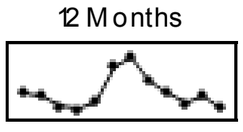
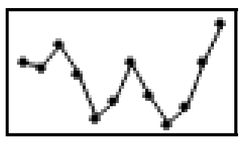
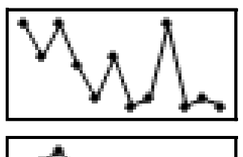
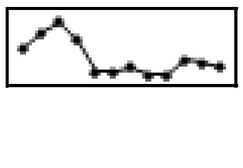
Stroke - assessed F2F diagnostic bundle

	May-18	Jun-18	Jul-18	12 Months
Actual %	98.7%	97.5%	97.8%	
Previous Year %	92.3%	94.4%	95.2%	
National Average %	98.3%	98.3%		

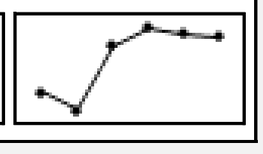
Post ROSC Care Bundle

	May-18	Jun-18	Jul-18	12 Months
Actual %	77.6%	75.2%	93.3%	
National Average %			57.3%	

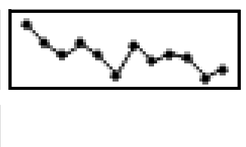
Medicines Governance

	Sep-18	Oct-18	Nov-18	12 Months
Total Number of Medicines Incidents	80	93	74	
Single Witness Sig/Inapt Barcode Use CDs Omnicell	9	17	24	
Single Witness Sig/Inapt Barcode Use CDs Non-Omnicell	0	1	0	
Total Number of CD Breakages	17	16	15	
PGD Mandatory Training	44	20	17	
Key Skills Medicine Governance	166	180	82	

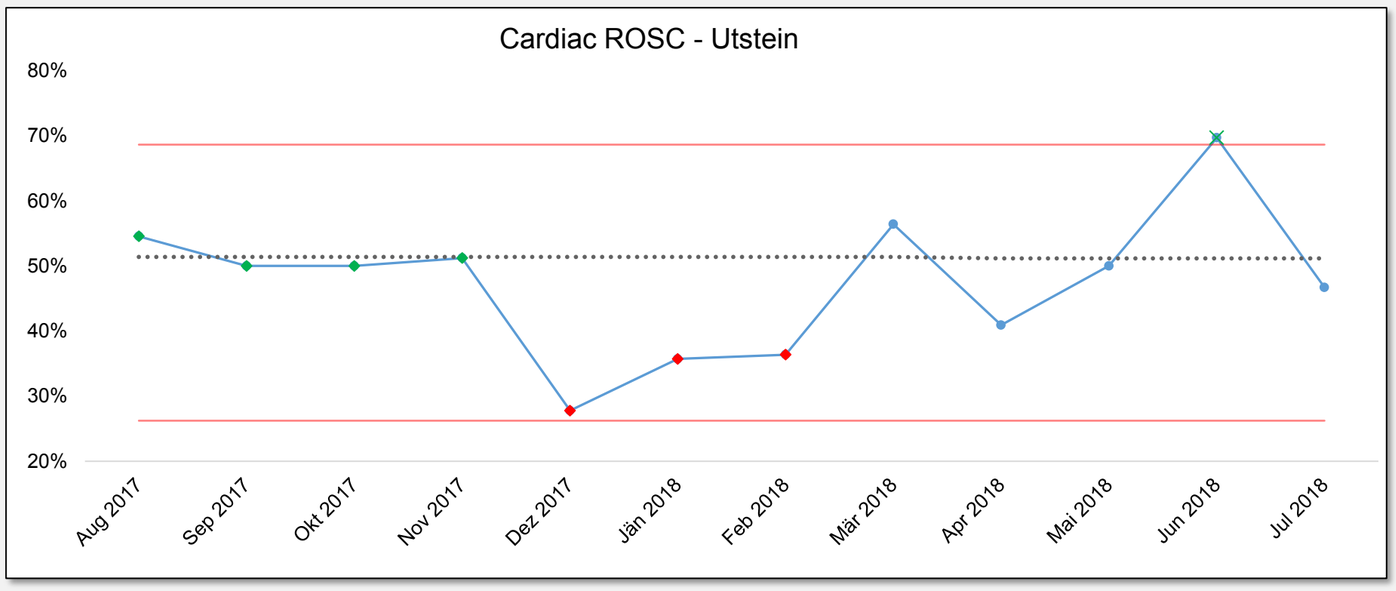
Sepsis Care Bundle Compliance

	May-18	Jun-18	Jul-18	12 Months
Actual %	84.7%	83.0%	82.2%	

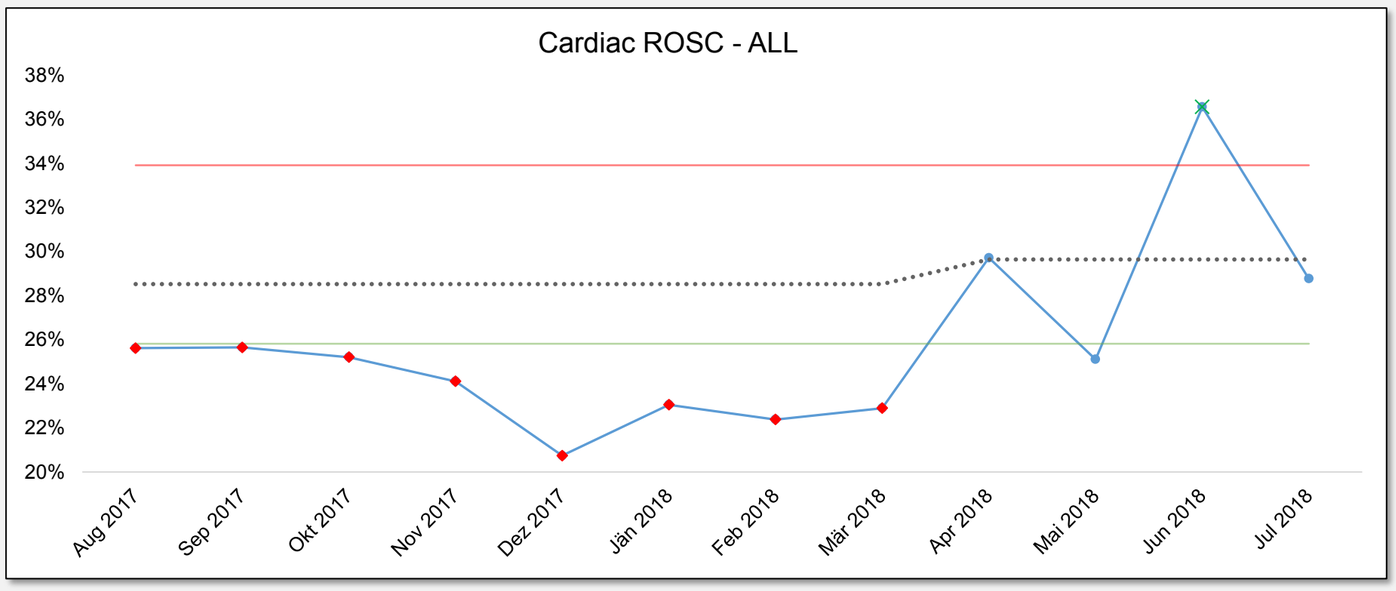
Medicines Management

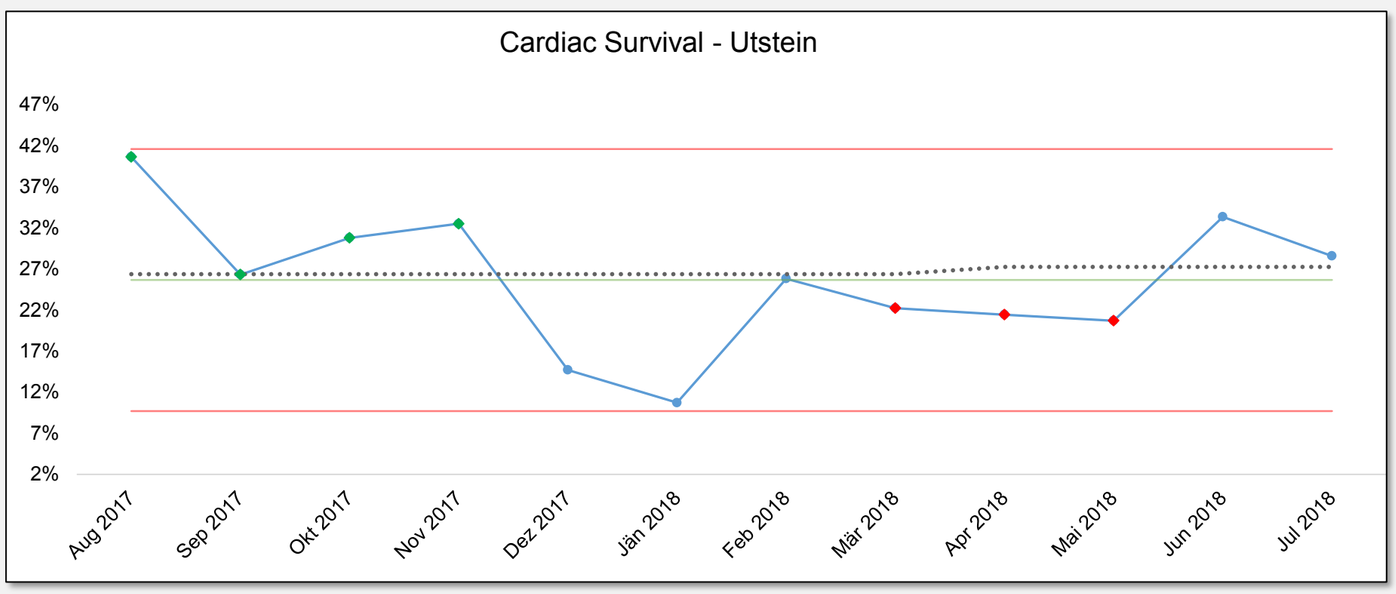
	Sep-18	Oct-18	Nov-18	12 Months
Number of Audits	187	169	178	
Percentage of Audits	99.0%	99.4%	99.0%	

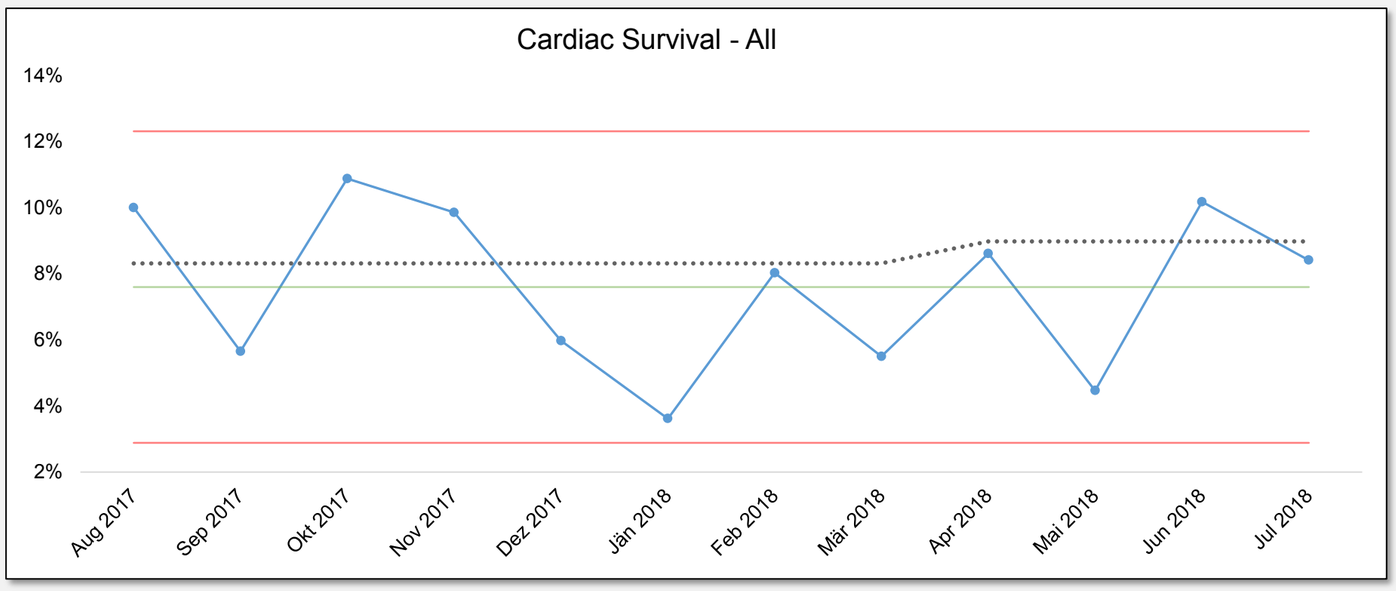
SECAmb Clinical Safety Charts

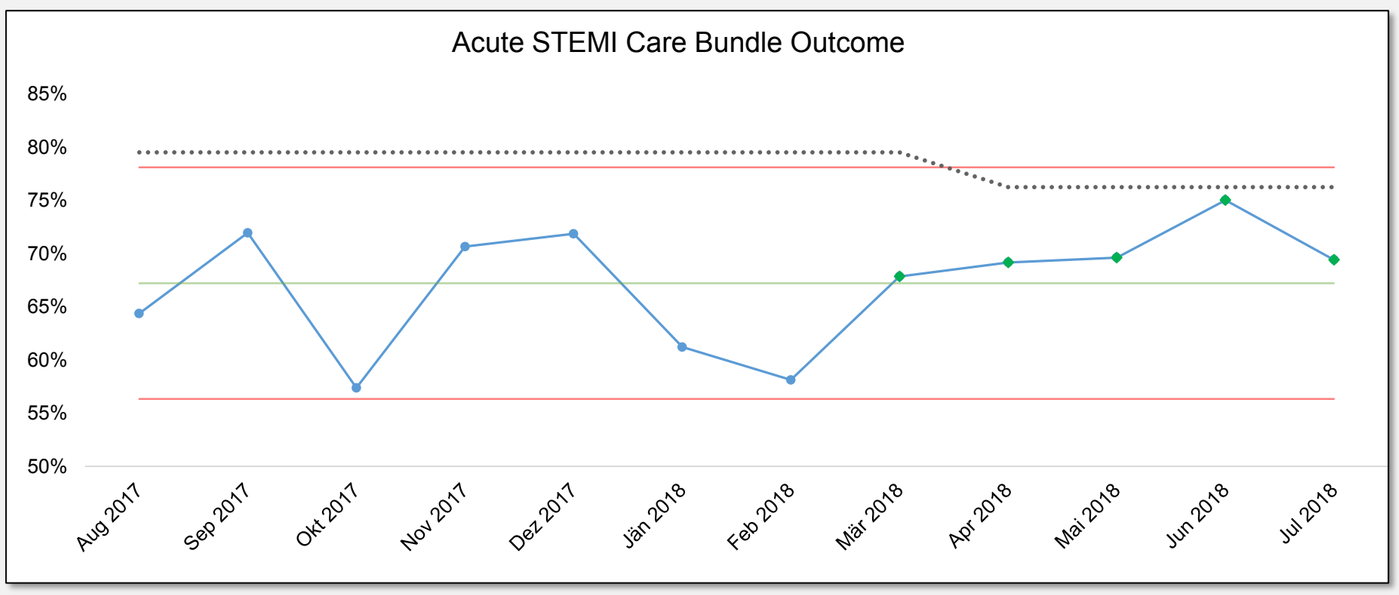


This data continues to show normal patterns of variation. Upcoming programmes of work to improve outcomes from cardiac arrest include; the introduction of the GoodSam App, a full day of resuscitation training in Key Skills 19/20, the relaunch of the cardiac arrest downloads programme, a new resuscitation procedure and the STAD programme that will improve our response time to all incidents.



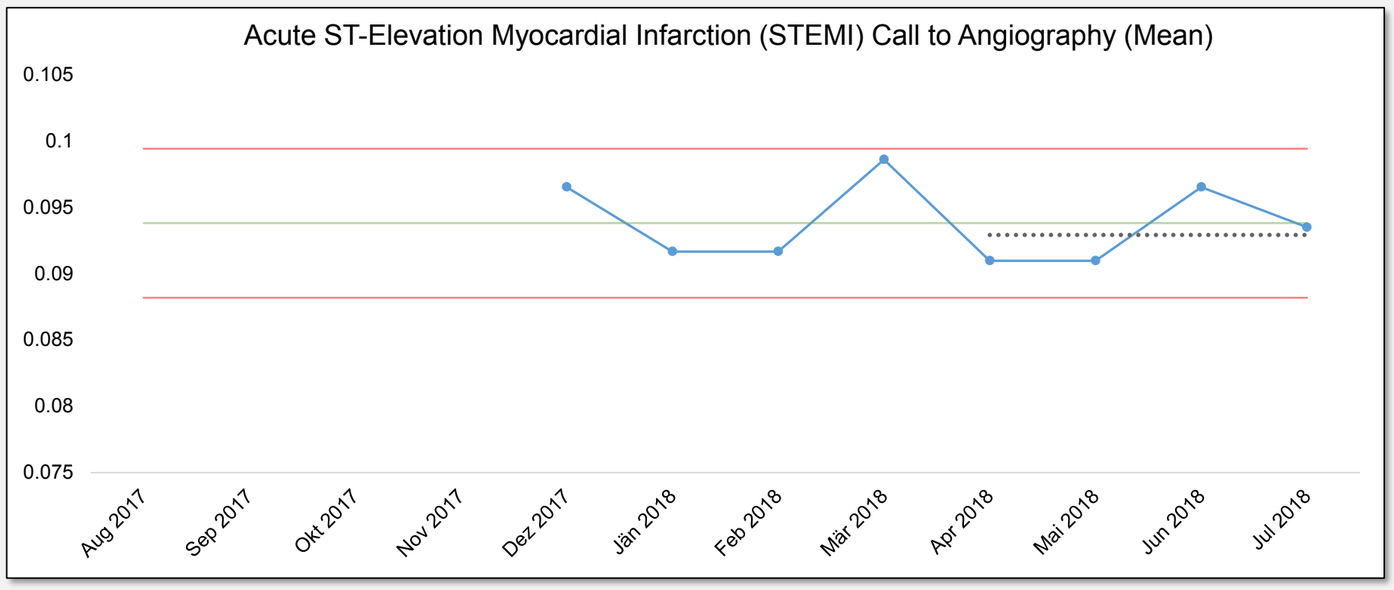




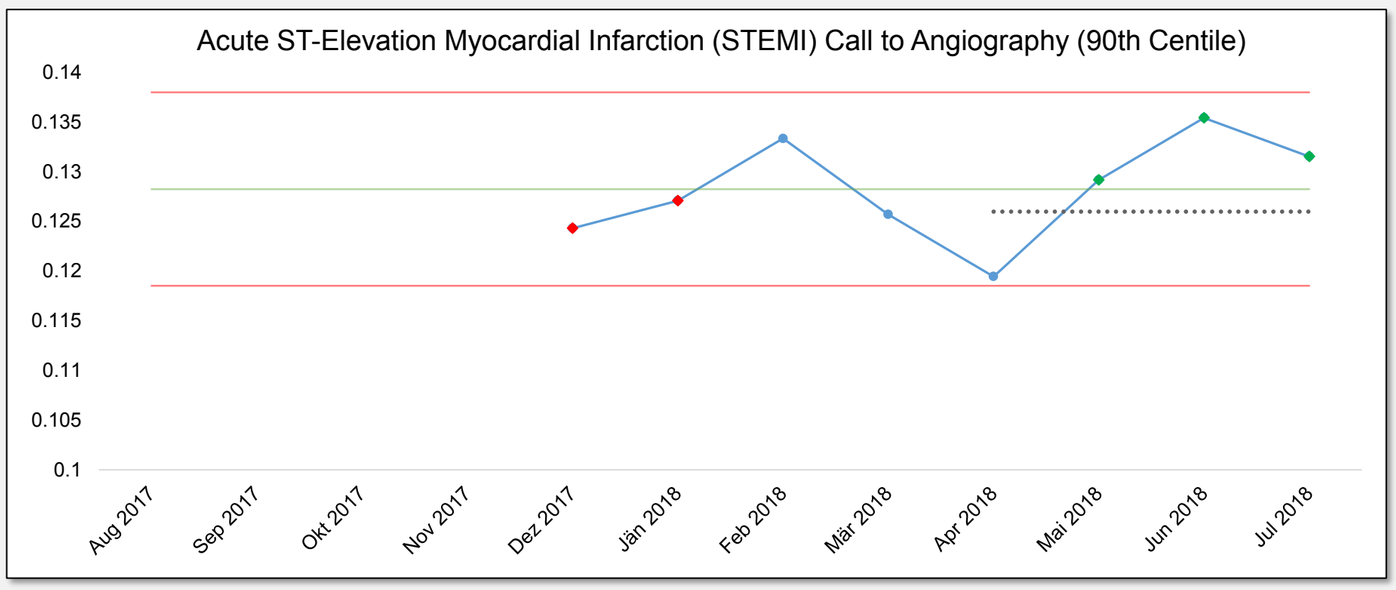


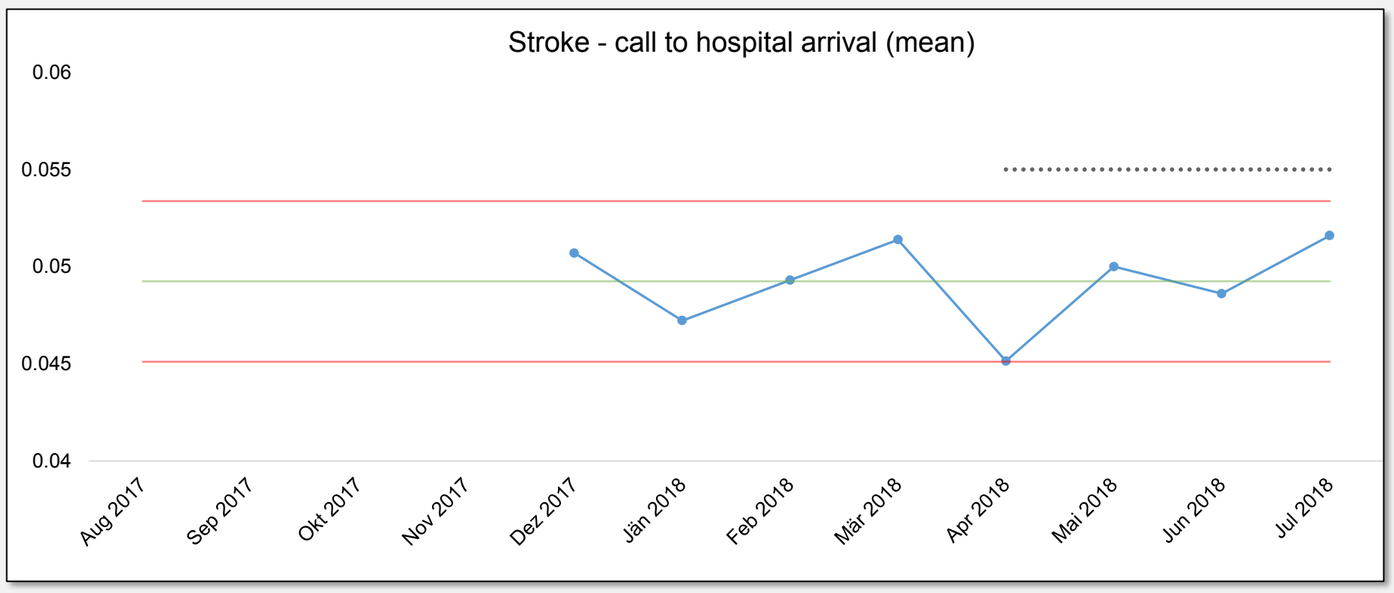
The acute STEMI care bundle shows sustained improvement. Plans to improve this further include a refresher training in the Key Skills programme, the procurement of an electronic Clinical Audit system that will give individual clinicians and their managers access to performance data and changes to our paper and electronic patient records to discourage documentation omissions.

SECAmb Clinical Safety Charts

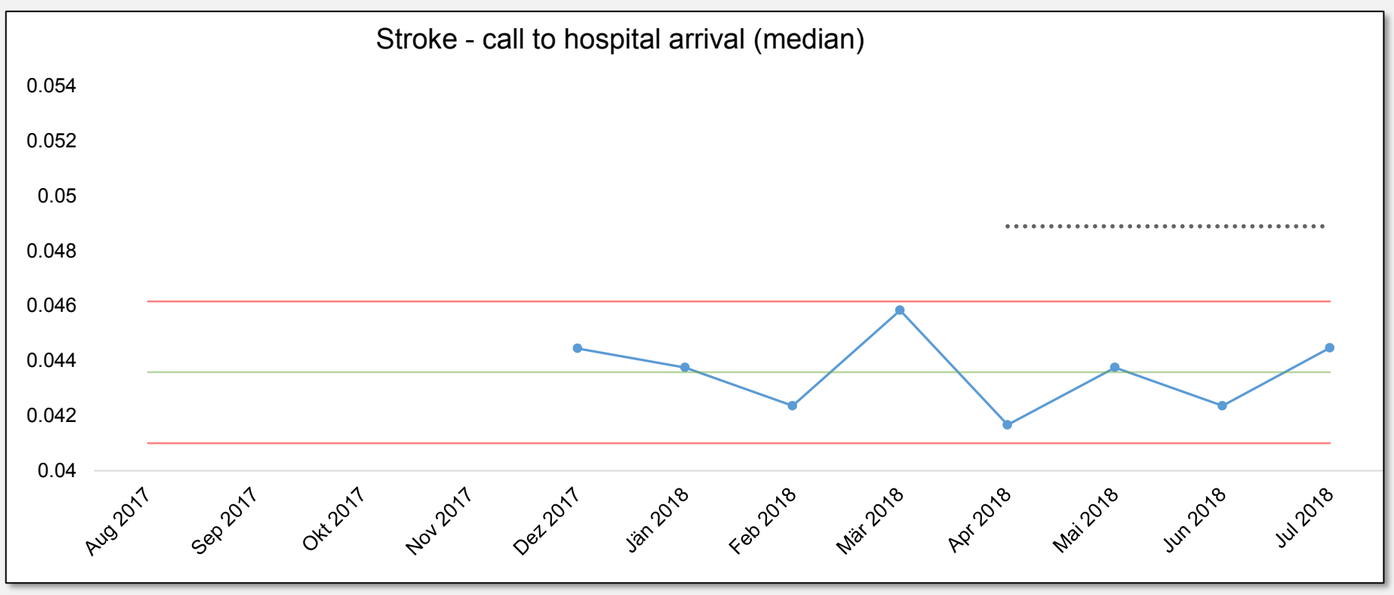


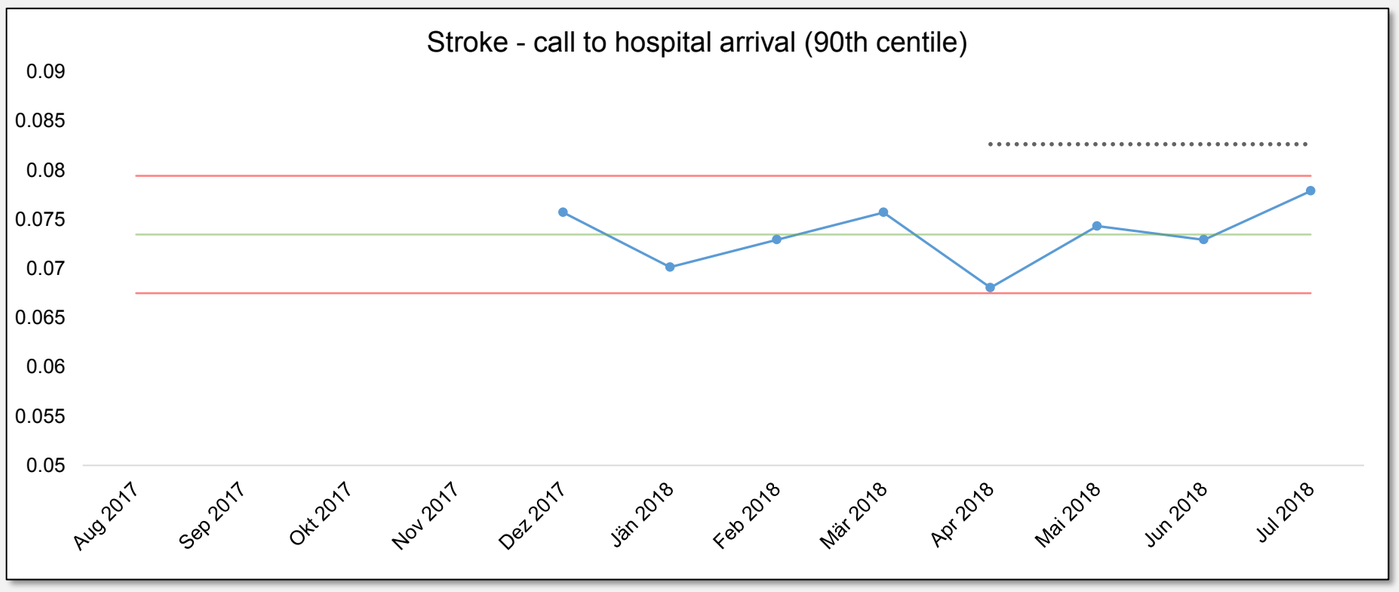
Our call to angiography timeliness measures continue to show normal patterns of variation. We continue to perform in line with the national average. The Trust plans to improve performance against this measure by increasing our focus on reducing on scene times. A focus on the 10:10:10 approach will be make in Key Skills 19/20. This approach gives clinicians 10 minutes to assess the patient and decide the management plan. 10 minutes to remove the patient to the vehicle and 10 minutes to depart from scene.



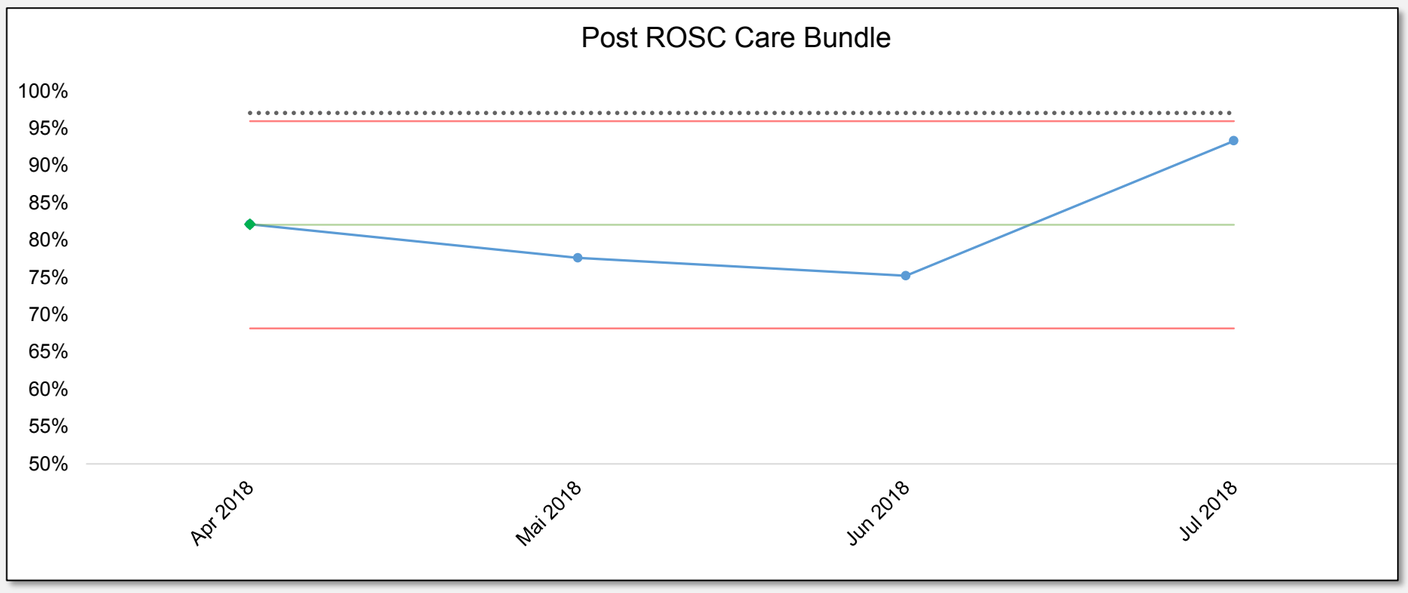


Our stroke timeliness data continues to show normal patterns of variation. Our average call to hospital time is still more timely than the national average. A focus on the 10:10:10 approach will be taken in Key Skills 19/20.

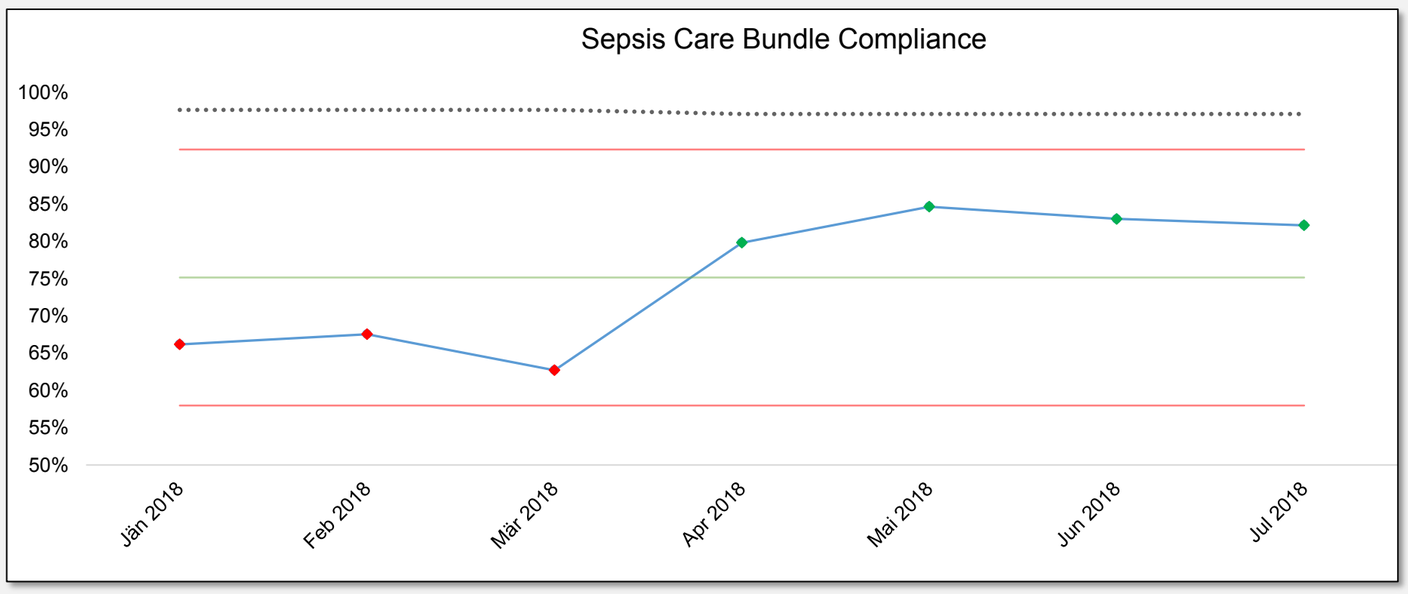




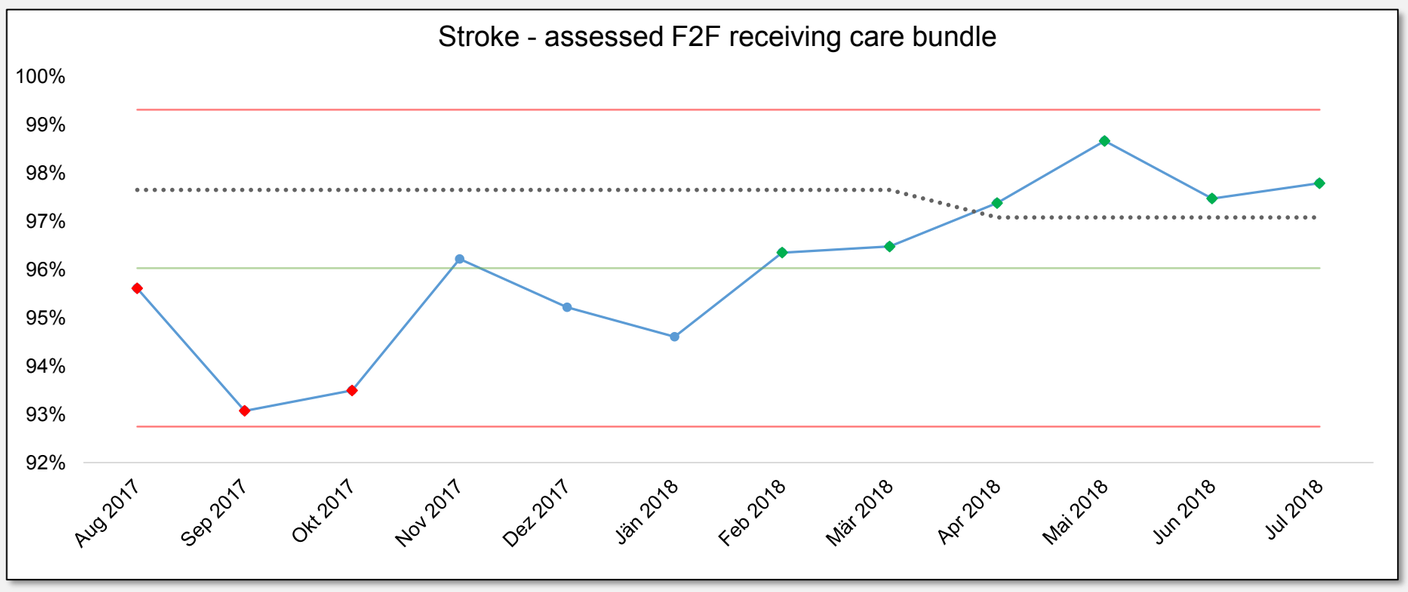
SECAmb Clinical Safety Charts



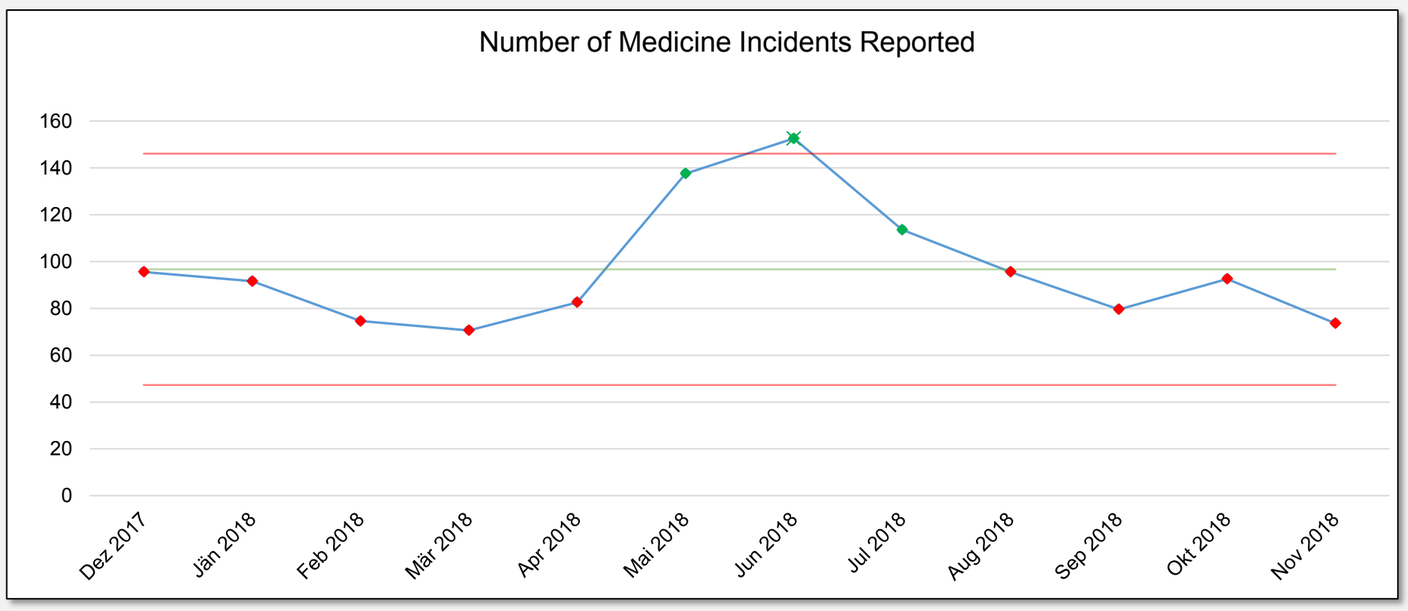
The post-ROSC care bundle continues to show normal patterns of variation. The Trust continues to be one of the highest performing Trusts nationally against this measure.



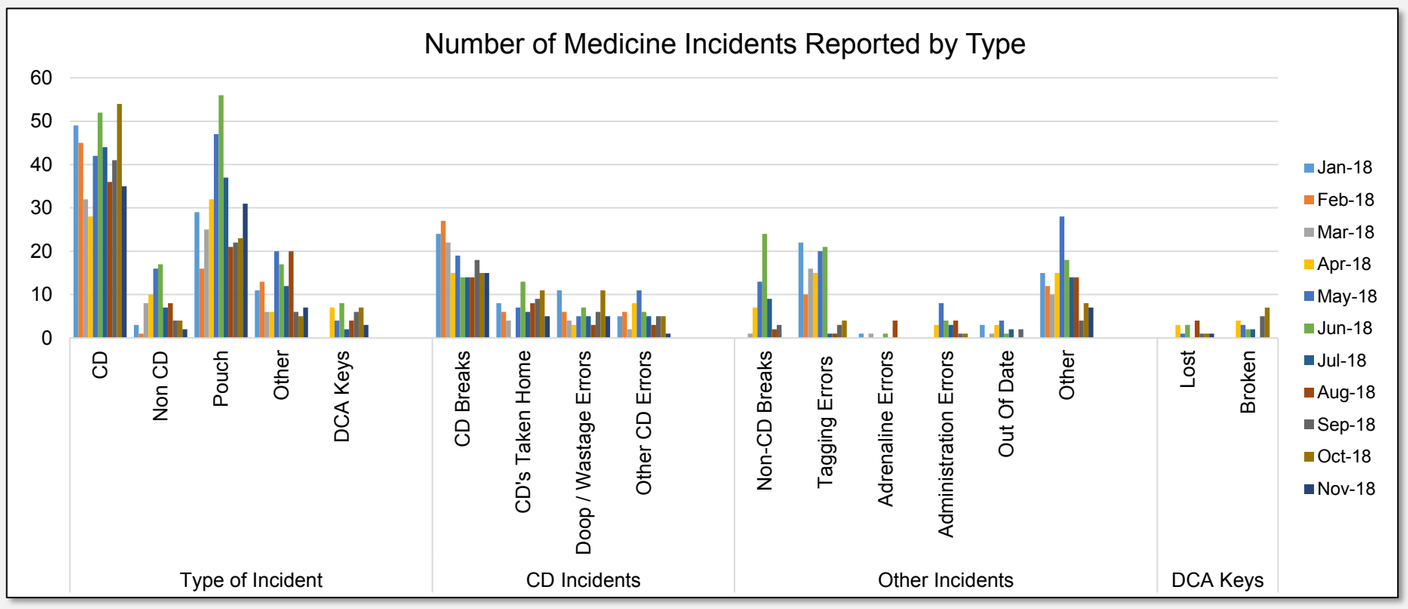
The sepsis care bundle continues to show normal patterns of variation. The Trust continues to be one of the highest performing Trusts nationally against this measure. Performance against this measure would be improved with consistent documentation of pre-alert calls. An improvement is expected following forthcoming changes to our vehicle's mobile data terminals which will soon prompt crews to select whether a pre-alert call was provided, every time they clear from hospital.



The Stroke Diagnostic Bundle shows sustained improvement and continued performance above the national average. Plans to improve this further include a refresher training in the Key Skills programme, the procurement of an electronic Clinical Audit system that will give individual clinicians and their managers access to performance data and changes to our paper and electronic patient records to discourage documentation omissions.

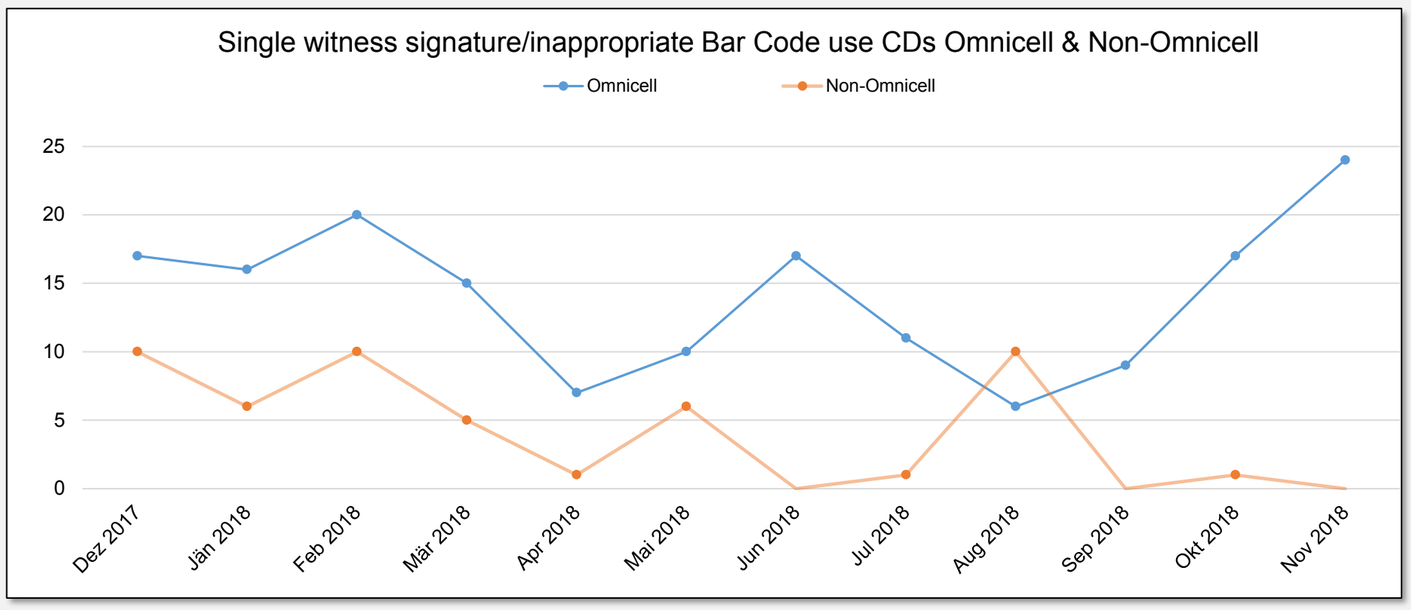


79 medicines incidents recorded in November 2018. This is a reduction on previous months. Staff are encouraged to report medicines incidents. There are still incidents occurring where staff take Controlled Drugs home at the end of their shifts. Eight incidents were reported in November 2018 around this activity. A process is in place to ensure the drugs are returned without delay, and medicines team are monitoring trends in this area. There was 15 CD breakages recorded for the month of November.
31 of the incidents reported were in relation to medicines pouches and incorrect tagging, missing medicines or incomplete pouch paperwork. This is currently under reported by staff. There was 2 incidents reported in November where medicines were not available for our patients due to incorrect tagging of pouches.

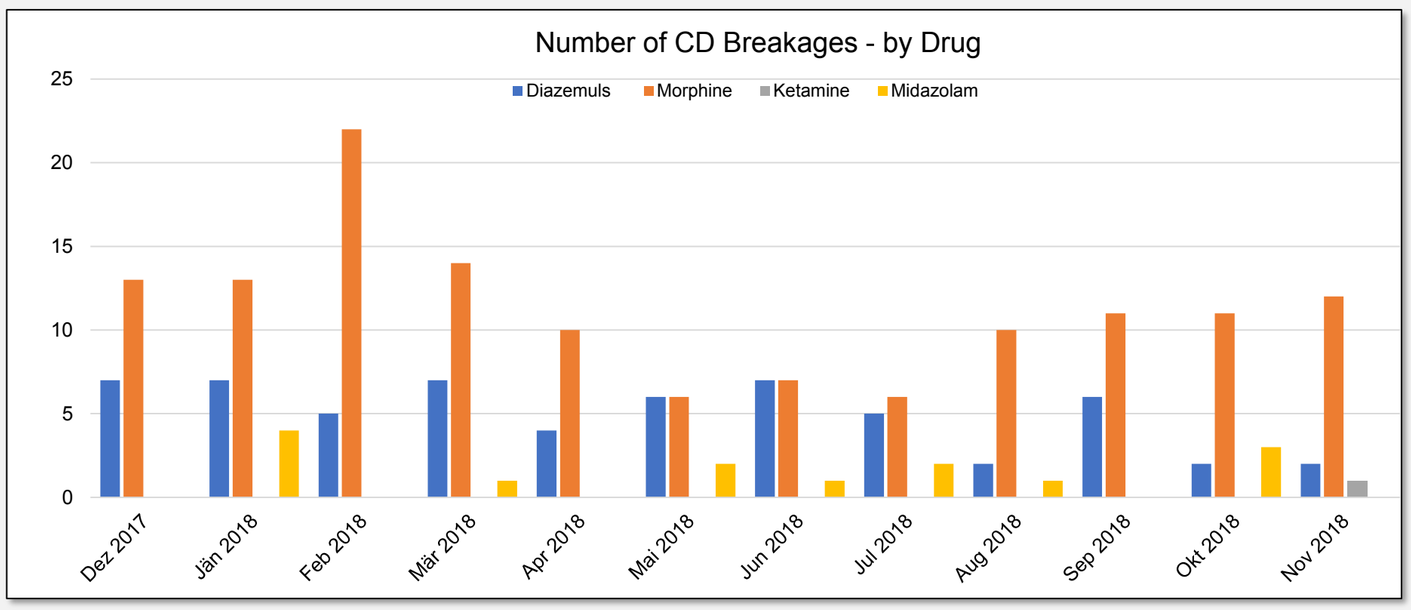


This relates to graph above.
SOP compliance around CDs continues to be reported well. Tagging errors, breakages and incomplete paperwork with medicines pouches continue to be reported by operational staff, however it is under reported. More work is required around encouraging staff to report more and learning from incidents with feedback to staff.

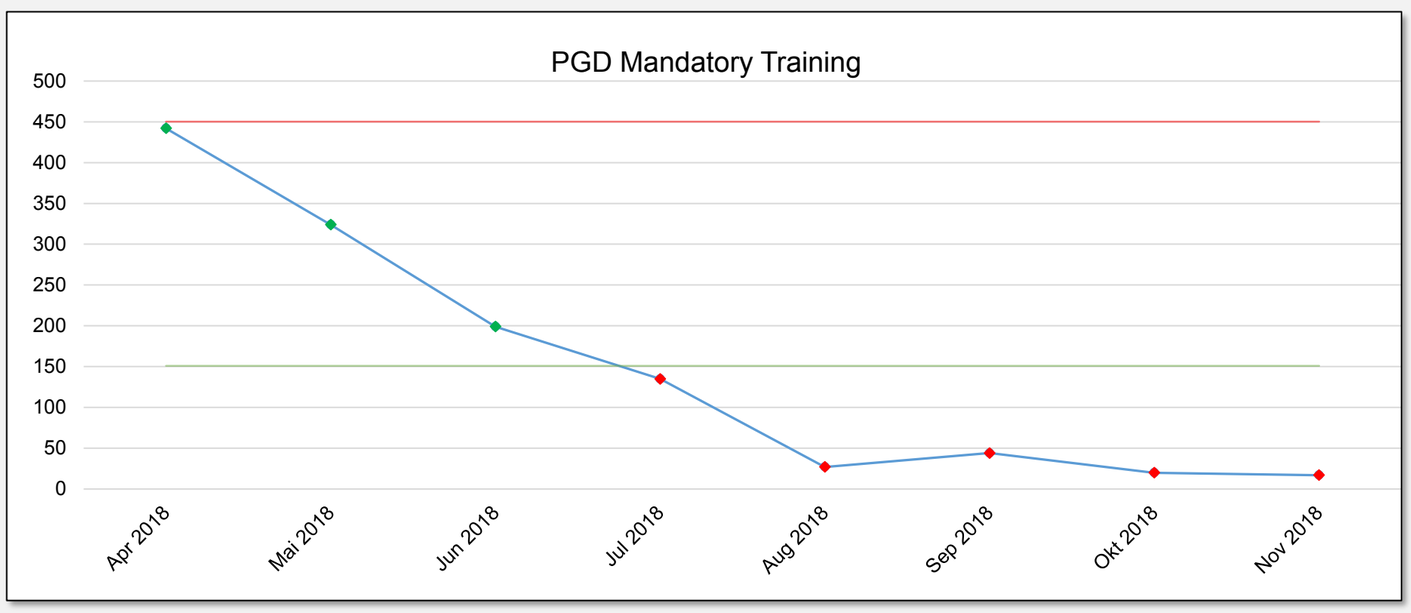
SECAmb Clinical Safety Charts



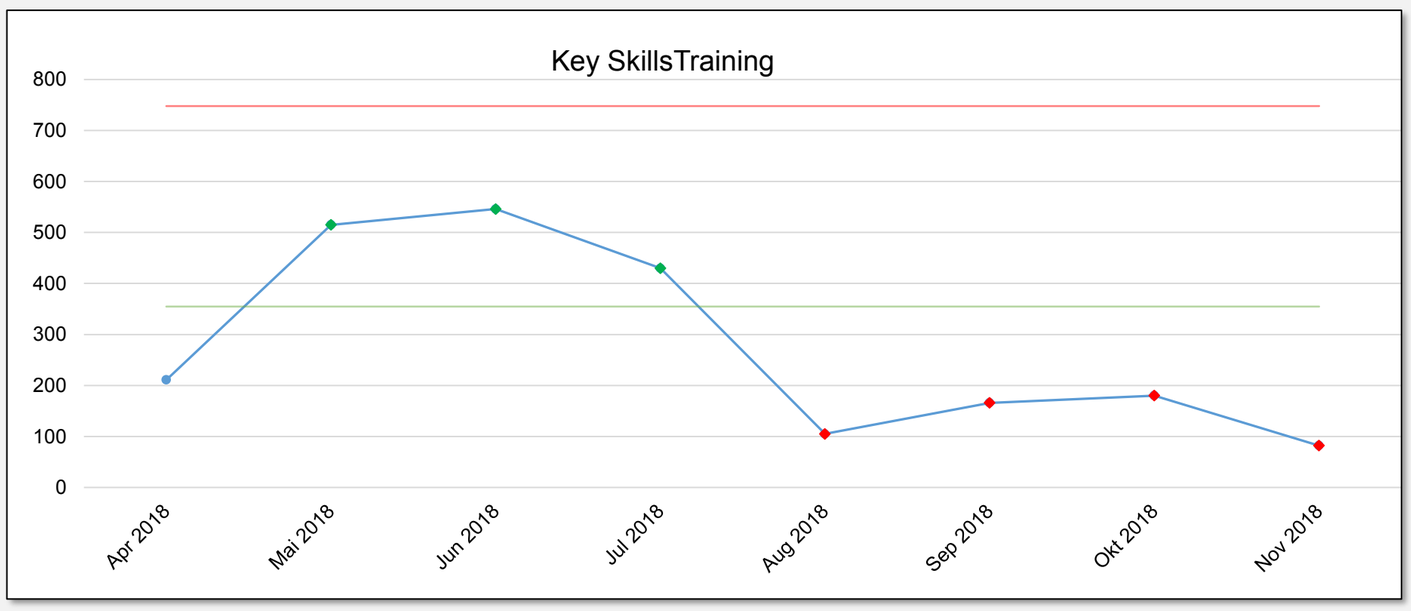
Weekly reports from the medicines governance team are sent to the OTLs on Omnicell sites to confirm the single signature is authorised. Medicines Governance Team rely on the OTLs reporting on this CD activity for non-Omnicell sites. OTLs are encouraged to complete a DIF1 for all unauthorised single CD signatures. The Trust is seeing improvement in the use of single signatures as operational sites look to reduce this activity



As a Trust we have seen significant improvement in CD breakages. All CD breaks are reported via DIF1 and CD registers updated. Midazolam and ketamine are only available to CCPs whereas morphine and diazemuls are used by all Paramedics. November 2018 saw 15 CD breakages. Breakages occurred in the following areas. 8 broken during issue/return, 4 dropped accidently and 3 shattered whilst opening



Total headcount PGD Mandatory Training completed to date (1208)
85.13%



Total headcount Key Skills Training completed to date (2235)
70.71%

Analysis of Cardiac Arrest Data – July 2018

Total number of cardiac arrests identified = 560

Number of resuscitation attempts = 219
excluding DNACPR 81, DOA 251, No Resus by SECAmb 5,
Post arrest 1, ADRT 3

Utstein definition
Bystander witnessed
Presenting rhythm VF
Cardiac in origin

Non ROSC Definition
Patients transported to hospital
in cardiac arrest with resuscitation
still in progress

Cardiac Arrests (Utstein incidents) = 3(rdiac Arrests (All incidents) = 219 (10(

(Utstein)
= 14 (46.7%) + 1 non ROSC

ROSC sustained to hospital (All) = 63
(28.8%) + 8 non ROSC

Outcomes for ROSC at hospital and non ROSC at hospital patients		
Utstein	Details	Overall
8	Patient survived to discharge	18
5	Patient died in hospital	48
0	Patient still in hospital*	0
2	Outcome unknown (Patient identifiable data incomplete)	5

Survival to discharge is calculated as a percentage of the Overall or Utstein figures
minus any incident missing patient outcomes (as detailed * above)

Survival to Discharge (Utstein) = 8 (28.6%)

Survival to Discharge (All) = 18 (8.4%)

Additional Information – Resuscitation Attempts

Cardiac Rhythm	Overall Totals	ROSC at Hospital	Non ROSC at Hospital
Asystole	113 (52%)	19	5
PEA	48 (22%)	11	1
VF	50 (23%)	28	1
Non-shockable	0 (0%)	0	0
Not recorded	8 (3%)	5	1

CPR Bystander – 131

EMS Witnessed arrest – 27

Cardiac Arrest downloads received for July 18	0
Cardiac Arrest download reports sent to crews	0

Analysis of Cardiac Arrest Data by area - July 2018

Number of resuscitation attempts = 219

Cardiac Arrests (Utstein) East = 20 (9%)	Cardiac Arrests (All) East = 123 (56%)
Cardiac Arrests (Utstein) West = 10 (5%)	Cardiac Arrests (All) West = 96 (44%)
ROSC sustained to hospital (Utstein) East = 9 (45%) + 0 non ROSC	ROSC sustained to hospital (All) East = 35 (28%) + 4 non ROSC
ROSC sustained to hospital (Utstein) West = 5 (50%) + 1 non ROSC	ROSC sustained to hospital (All) West = 27 (28%) + 4 non ROSC

Outcomes for ROSC at hospital and non ROSC at hospital patients

Area	Utstein	Details	Overall
East	6	Patient survived to discharge	13
West	2		5
East	2	Patient died in hospital	23
West	3		25
East	0	Patient still in hospital*	0
West	0		0
East	1	Outcome unknown* (Patient identifiable data incomplete)	3
West	1	Outcome unknown* (Patient identifiable data incomplete)	2

Survival to discharge is calculated as a percentage of the Overall and Utstein figures minus any missing patient outcomes as detailed * above

Survival to Discharge (Utstein) East = 6 (32%)	Survival to Discharge (All) East = 13 (11%)
Survival to Discharge (Utstein) West = 2 (22%)	Survival to Discharge (All) West = 5 (5%)

Mental Health Care (November 2018 data)

Rag Ratings:

Within	Cat 2 (18 mins)	= GREEN
Outside	Cat 2 (18 mins, up to 40 mins)	= AMBER
Outside	Cat 2 (18 mins, beyond 40 mins)	= RED
Within	90th Percentile (40 mins)	= GREEN
Outside	90th Percentile (40 mins, up to 1 hour)	= AMBER
Outside	90th Percentile (40 mins, beyond 1 hour)	= RED

Overall RAG Rating = 

The mental health indicator has been rated **GREEN** as the mean response measures are **on balance** within Cat 2 standard.
Cat 2 = 00:18:50
90th Centile= 00:39:31

Mental Health Response Times (Section 136 MHA)

During November 2018 there were 120 Section 136 related calls to the service. 110 (91.6%) of these calls received a response (compared to 86.3% in October) resulting in a conveyance to a place of safety by an ambulance of 104 calls (86.6%) (compared to 82.5% in October) on these occasions.

The overall performance mean shows a response time across the service as 00:18:55 for November (October 00:18:50). Against the 90th centile measure, the response was 00:38:27 (October was 00:39:31).

There were 3 transports of under 18's in November (7 during October).

There were 10 occasions when SECAmb did not provide a response. This is down from 18 in October. This report RAG rates against **both** mean ARP standards within Cat 2; these being 18 minutes and the 90th percentile within 40 minutes. The report also details conveyances measured under Cat 3, Cat 4, C60 HCP, C120 HCP and C240 HCP (these are likely to be secondary conveyances and are not RAG rated) and these are as follows:

Cat 3:	Total calls 3	Total responses 3	Total transports 2

Performance Mean 00.00:24.41 90th centile 00:36.12

Cat 4:	Total calls 0	Total responses 0	Total transports 0
C60 HCP:	Total calls 6	Total responses 2	Total transports 1

Performance Mean 00:31:29 90th centile 00:42:43

C120 HCP:	Total calls 0	Total responses 0	Total transports 0
C240 HCP:	Total calls 0	Total responses 0	Total transports 0

(These responses are collectively reported by Operational Unit on the attached dashboard)

Quality and Patient Safety Report :

Unreconciled Clinical Records: Improvements made in the number of unreconciled incidents have been sustained, but has plateaued at circa 11% unreconciled each month. Procurement for an IT solution that will improve this figure has commenced.

Medicines compliance to safe and secure handling weekly audits by Operational Team Leaders (OTLs) for ranged between 79% and 100% on station sites for November 2018. The Trust average for compliance was 94.04%. Eleven stations achieved 100% each week for November. 5 sites missed a weekly report in November. The monthly audits have remained at 100% for those submitted by the OUMs. Compliance for the monthly checks was 93%.

Infection Prevention Control: Hand Hygiene (HH) compliance was above the compliance target this month at 94%, which is due to the new 3R's for hand hygiene procedure and staff understanding of it compared to the Five Moments for Hand Hygiene previously used. Clinically Ready was also above target again for the month at 97%. A total of 302 audits were carried during the month compared to 235 last month. Make Ready Centre (MRC) and Vehicle Preparation programme (VPP) Deep Clean rates were both fell below the 99% target for the month and VPP was only 88% with Surrey West only achieving 73% completion. Polegate MRC was very low at 53% due to staffing issues. Infection Prevention and Control (IPC) Level 2 training showing as below the monthly target of 91% this month and currently stands at 82%. Environmental Cleanliness audit completion was 80% for the month, so we still need to improve on the monthly completion rates. The IPC Lead will email all areas and ask that these audits are completed for November. Compliance was 77% against the 85% target. The IPC and Estates Team continue to hold a monthly meeting with the contractors to discuss any concerns raised locally in regard to cleaning standards.

Safeguarding referral rates continue to increase (currently a 8% increase compared to December 2017). Training on Level 2 child safeguarding for all operational staff is 79.19% and for Level 2 adult safeguarding (both e-learning) is 80.14% (increased from 58% in July).

Incidents: There have been 31 more incidents in this reporting period. The additional reporting being undertaken to track tail audit data in relation to not sending ambulance resources has generated a number of incidents which have increased reporting in the past month. Reporting is reaching levels similar to those reported under the winter pressures of 2017-2018. Incident reporting remains above the 20% increase in incidents that the Trust has set itself under the improvement plan. Backlogs associated with allocation to an investigator continue to increase with 177 now over due. The Datix department is working with the Quality Improvement Hub to reduce the number of overdue incidents in this area which has mainly been effected by the high number of tail audit incidents not being moved to being investigated. The deadline for completion of investigations is 20 working days. The figure has stabilised at around 216 in November 2018.

Serious Incidents (SIs) and Duty of Candour (DoC): 12 SIs were reported in November (2 in October). 52 SIs were open on STEIS at the end of November (56 in October). A decrease to 23 (from 27 in October) were overdue for first submission to the CCG. 13 incidents were submitted for review at the monthly closure panel, 6 incidents were closed overall in November.
The Trust achieved 100% compliance with DoC requirements for SI's. 100% compliance was also achieved for DoC made/attempted within deadline.

Patient Experience: The Trust received and opened 79 complaints in November, a substantial drop from the 94 received in October and against a monthly average for the year of 95 (01/12/17 to 30/11/18). There were 93 complaints closed, with 59% upheld in some way. The top three complaint subjects were staff behaviours where complaints increased to 38 from 21 in October; timeliness where there was also an increase from 18 to 21; however, patient care decreased from 35 to 29. Falls continues to be the top theme with 16 complaints reported, a slight decrease from October when 17 were reported. Complaints response timeliness performance since the end of January continues, with 97% responded to within the Trust's 25 working day timescale this month. November saw an increase in compliments received 159 against 133 in October, this is above the usual monthly trend of circa 130-140.

STEMI Care Bundle performance for July is at 69.4% (from 75%), which continues below the national YTD average of 76.4%. Stroke Diagnostic Bundle performance is now above the national average (97.1%) at 97.9%.

Clinical Audit: the 2018/19 Clinical Audit annual plan is on track and national requirements for the collection and submission of data are being met.

Our People

SECAmb Clinical Quality Scorecard

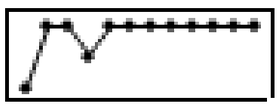
Number of Incidents Reported

	Sep-18	Oct-18	Nov-18	12 Months
Actual	837	716	762	
Previous Year	585	615	665	

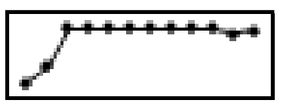
Number of Incidents Reported that were SI's

	Sep-18	Oct-18	Nov-18	12 Months
Actual	8	2	12	
Previous Year	11	6	4	

Duty of Candour Compliance (SIs)

	Sep-18	Oct-18	Nov-18	12 Months
Actual %	100%	100%	100%	
Target	100%	100%	100%	

Number of Complaints

	Sep-18	Oct-18	Nov-18	12 Months
Actual	74	96	79	
Previous Year	132	129	107	
Complaints Timeliness (All	98.8%	92.9%	97.0%	
Timeliness Target	95%	95%	95%	

Compliments

	Sep-18	Oct-18	Nov-18	12 Months
Actual	150	133	159	

Hand Hygiene

	Sep-18	Oct-18	Nov-18	12 Months
Actual %	89%	94%	97%	
Target	90%	90%	90%	

Safeguarding Training Completed (Adult) Level 2

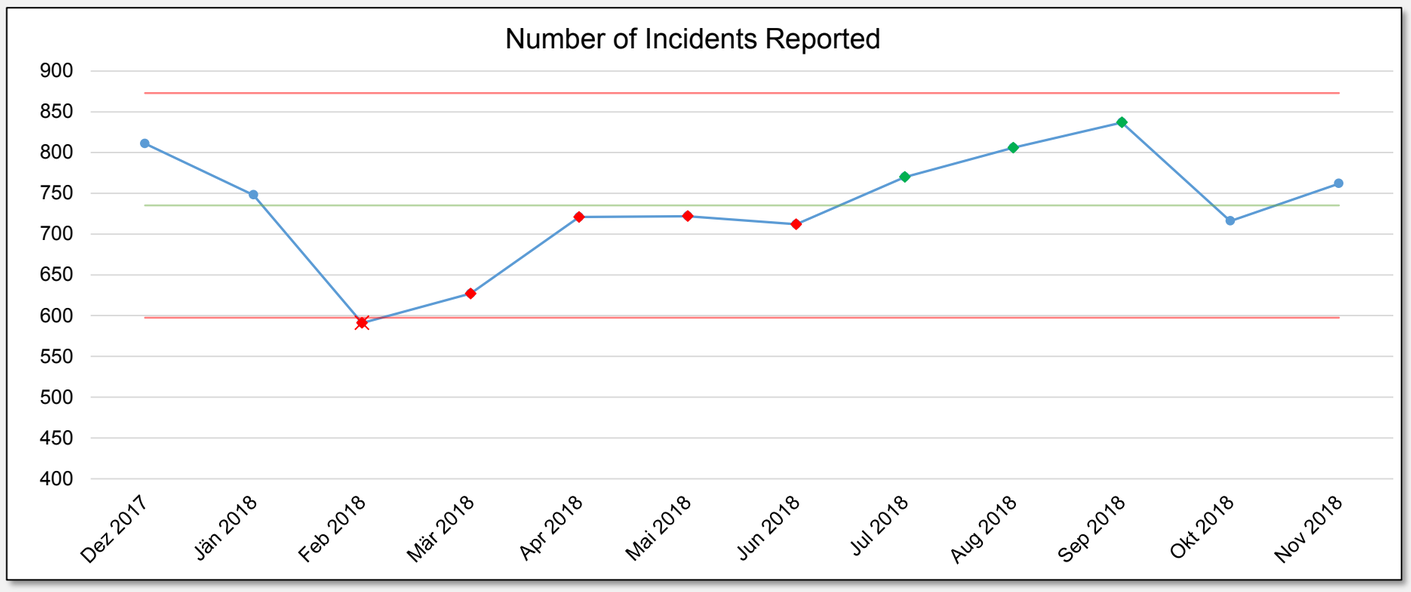
	Sep-18	Oct-18	Nov-18	12 Months
Actual %	77.07%	80.52%	80.14%	
Previous Year %	45.22%	50.82%	55.55%	
Target	85%	85%	85%	

*** Safeguarding training is completed each financial year, which explains the significant drop for April 2018**

Safeguarding Training Completed (Children) Level 2

	Sep-18	Oct-18	Nov-18	12 Months
Actual %	76.20%	79.30%	79.19%	
Previous Year %	46.62%	50.00%	54.70%	
Target	85%	85%	85%	

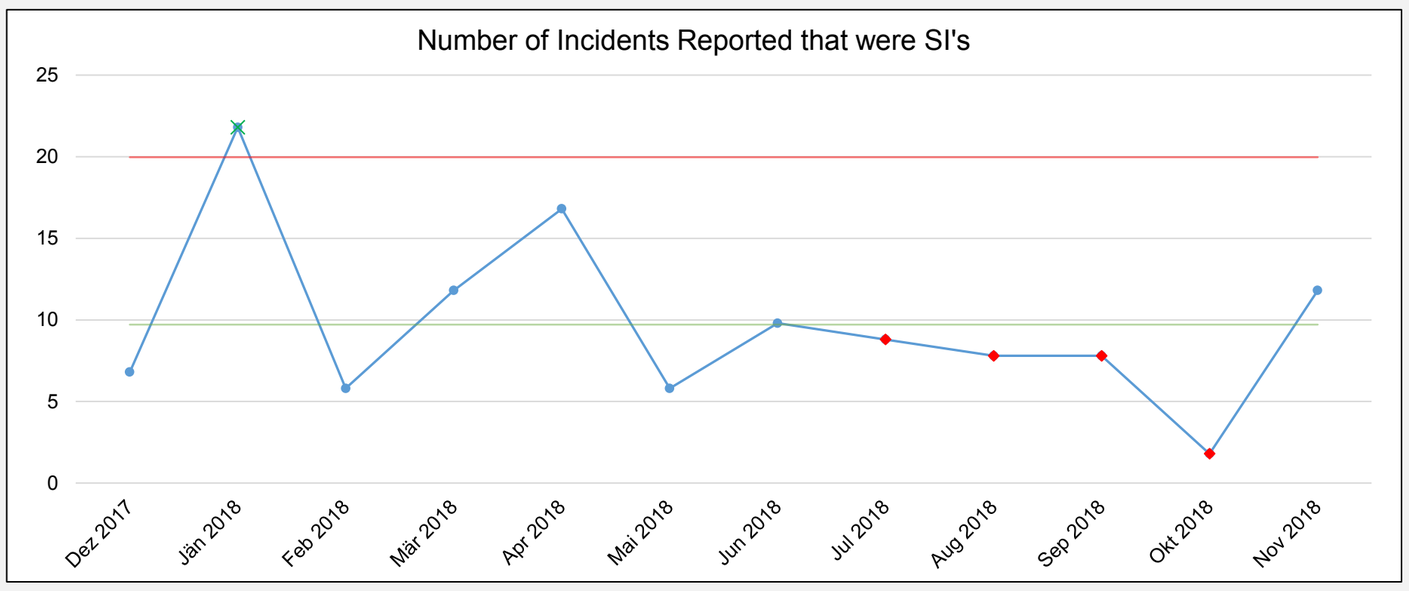
SECAmb Clinical Quality Charts



762 incidents were reported in November. 69 incidents were reported by EOC Clinical with the majority of these being around SMP no send audits. These are compiled for any audit that scores 10 or above.

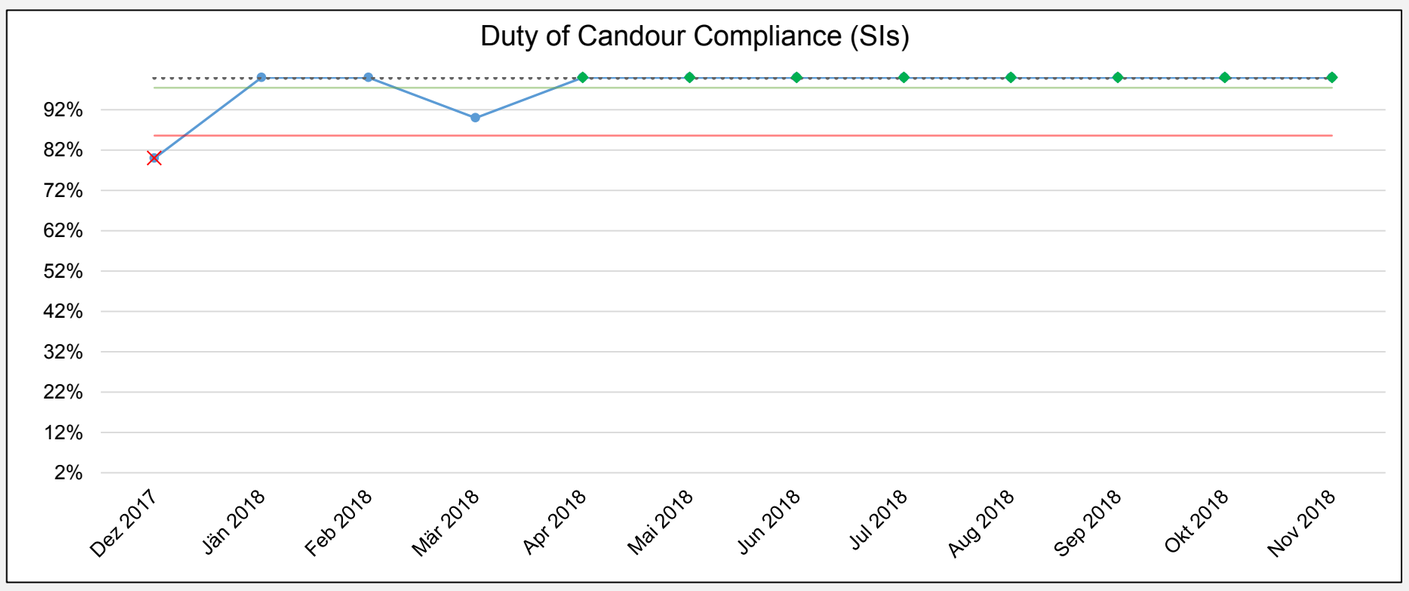
Other notable incidents are around meals breaks and delayed initial resources. In previous months, blue light audits have made up a good proportion of the reports. These were discontinued in November, due to ineffective reporting.

The organisation met the target of 96% of incidents being reported as no/low harm.



12 Serious Incident were reported in November.

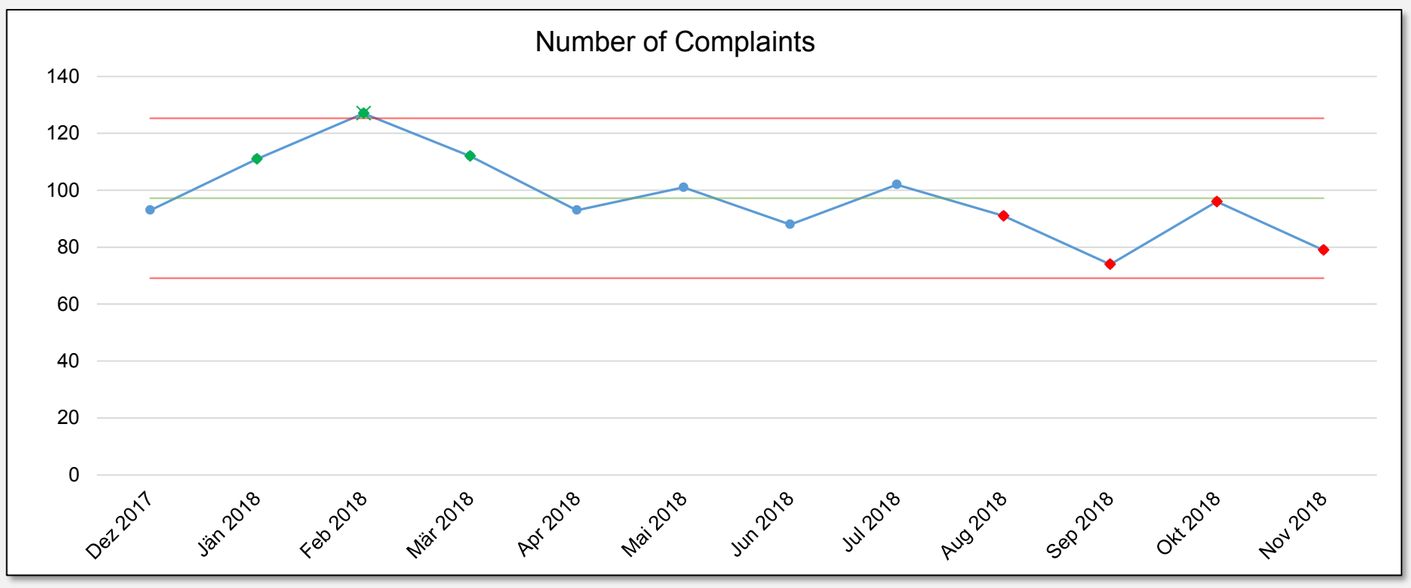
5 x Patient Care
3 x Timeliness / Delay
1 x Attendance Delay
1 x EOC Systems
1 x Incident affecting Trust
1 x Incident affecting Patient/Service User



Compliance with Duty of Candour (DoC) for SIs where DoC was required in November 2018 is: (due in the month)

SIs reported (where DoC due in November) - 5
Number where DoC required - 5
DoC made/attempted within deadline - 5 (100%).

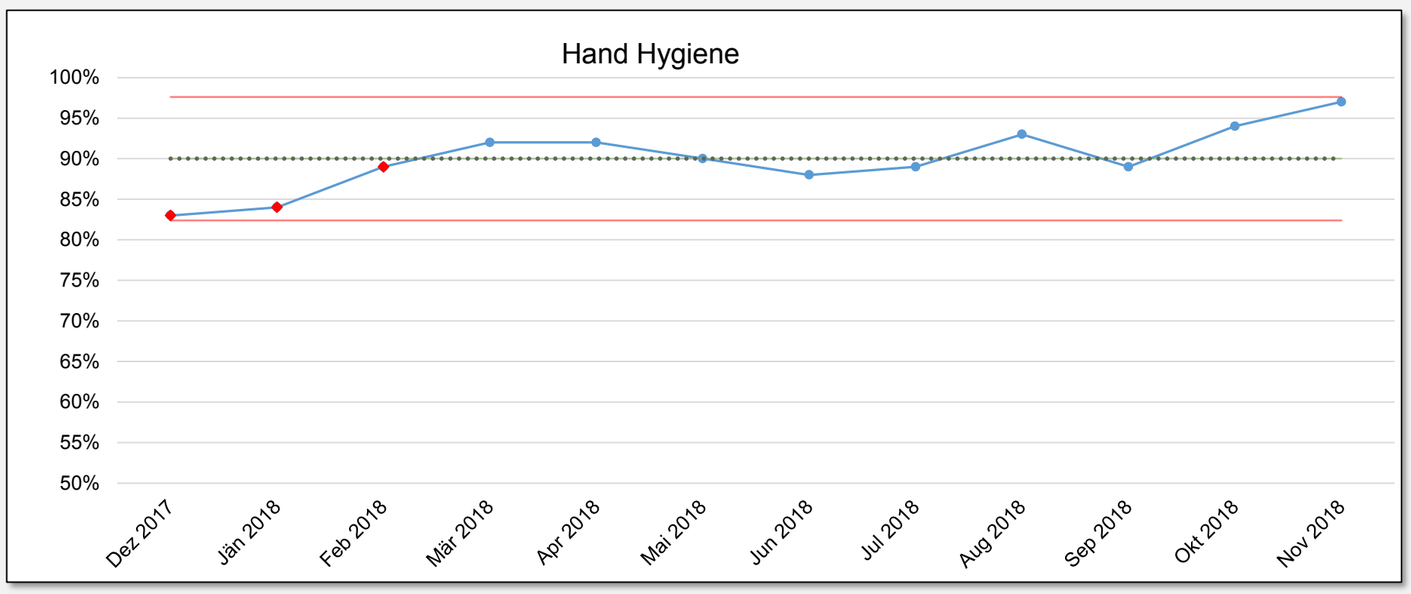
The organisation met the target of 100% of DoC being completed within the 10 working day time scale.



The Trust received and opened 79 complaints in November, a substantial drop from the 94 received in October and against a monthly average for the year of 95 (01/12/17 to 30/11/18).

There were 93 complaints closed, with 59% upheld in some way. The top three complaint subjects were staff behaviours where complaints increased to 38 from 21 in October; timeliness where there was also an increase from 18 to 21; however, patient care decreased to 35 from 29. Falls continues to be the top theme with 16 complaints reported, a slight decrease from October when 17 were reported.

Complaints response timeliness performance since the end of January continues, with 97% responded to within the Trust's 25 working day timescale this month.



November has seen a rise in the number of Hand Hygiene audits completed as well as our best compliance % for the year. The Infection Prevention Team are now able to schedule in more local visits to speak to frontline staff about all IP related issues.

SECAmb Duty of Candour and Moderate Harm

The verified data is not available for this report; it will be included in the next report.

SECAmb Health and Safety Reporting

The Health and Safety improvement plan is progressing well. Progress of the improvement plan is monitored every 2 weeks at our Quality Compliance Steering group. In addition to this a Task and Finish group meet every 2 weeks to review progress. The task and finish group consist of key internal stakeholders that contribute to the overall plan.

The Health & Safety team are preparing three new E-learning modules which will be available in April 2019.

Module 1 is a revised version of standard Health & Safety training for all employees.

Module 2 is a Risk Assessment training package which will further assist our Managers.

Module 3 is a specific training package for our fleet staff and is tailored around key hazards which are present in workshop environments.

The annual Health & Safety audit programme has been implemented. The Health & Safety team will undertake a minimum of 10 audits per month. The audit data will become an agenda item for discussion at our Central Health & Safety group meetings.

Violence and Aggression Incidents - See Figure 1 below
Violence and Aggression incidents reported in November were 54 this is an increase of 17 incidents from the previous month. November 2018 Violence and Aggression incidents are a similar amount when comparing to November 2017 V&A incidents.

Manual handling Incidents - See Figure 2 below
Manual handling incidents reported in November were 20 which is a decrease of 2 incidents from the previous month.

Health & Safety Incidents - See Figure 3 below
Health and Safety incidents reported in November were 32 which is a decrease of 7 incidents from the previous month.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) - See Figure 4 below
RIDDOR incidents reported in November were 10 with 5 incidents reported late to the Health & Safety Executive. The internal incident forms were completed late at local level which resulted in the late reports to the HSE. Further improvement work is required to educate our workforce in the requirements to comply with the RIDDOR regulations.

Figure 1

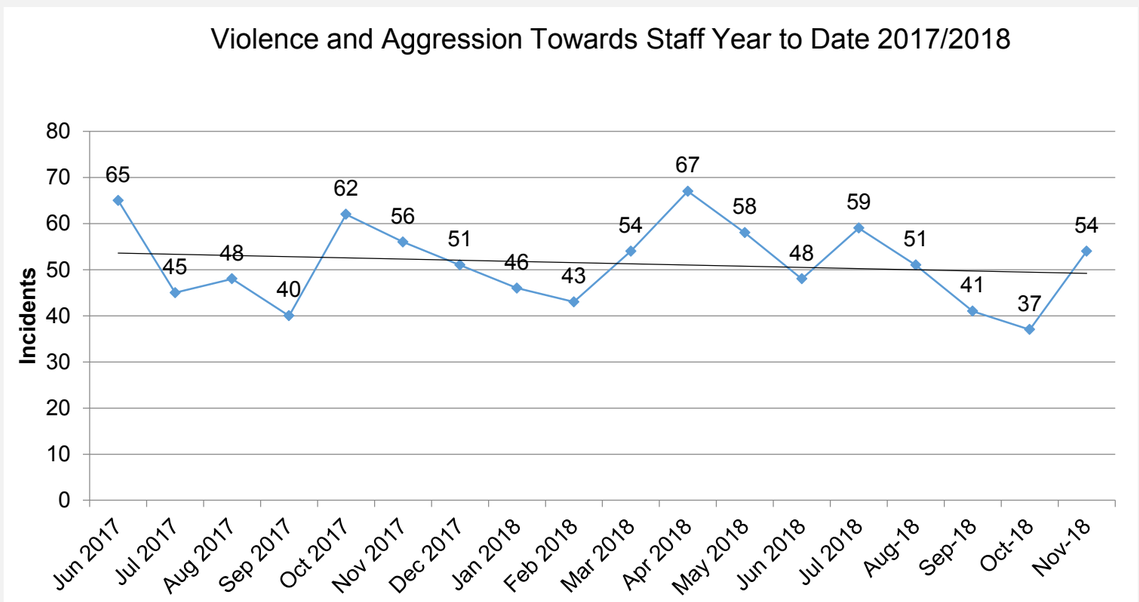


Figure 2

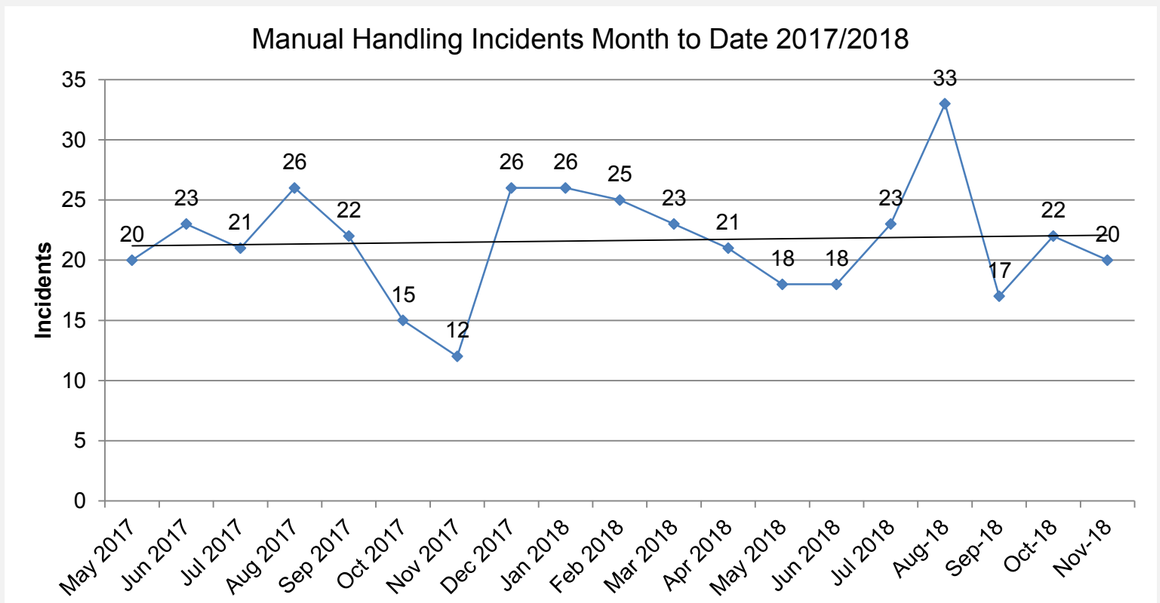


Figure 3

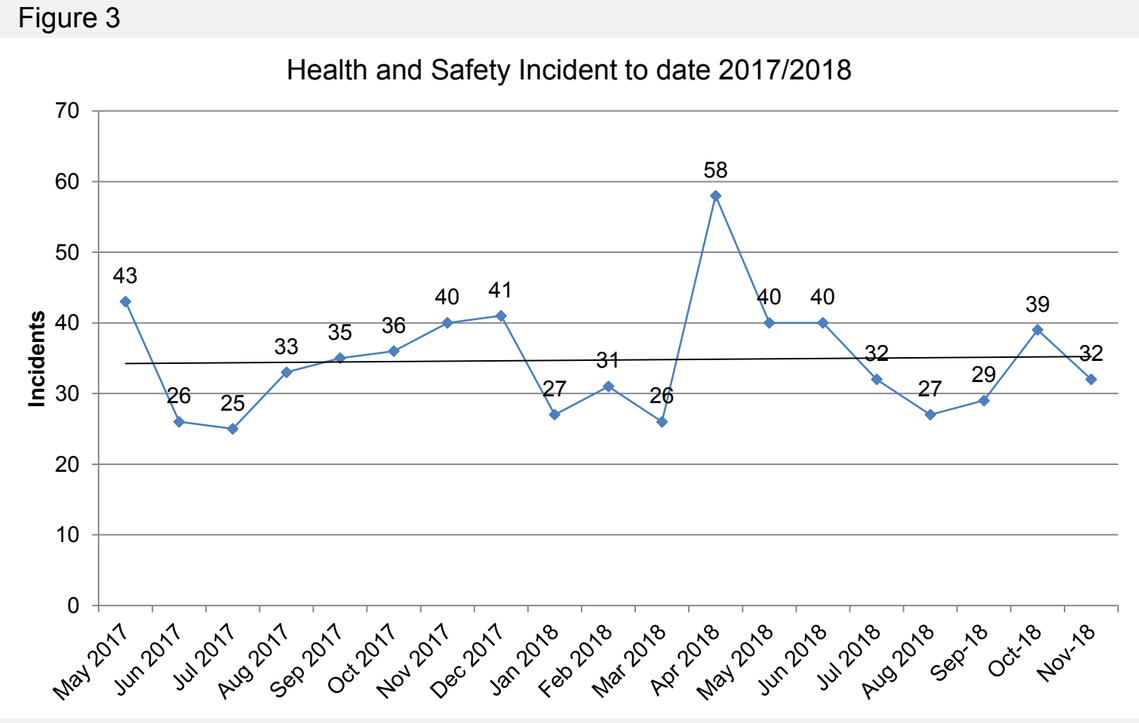
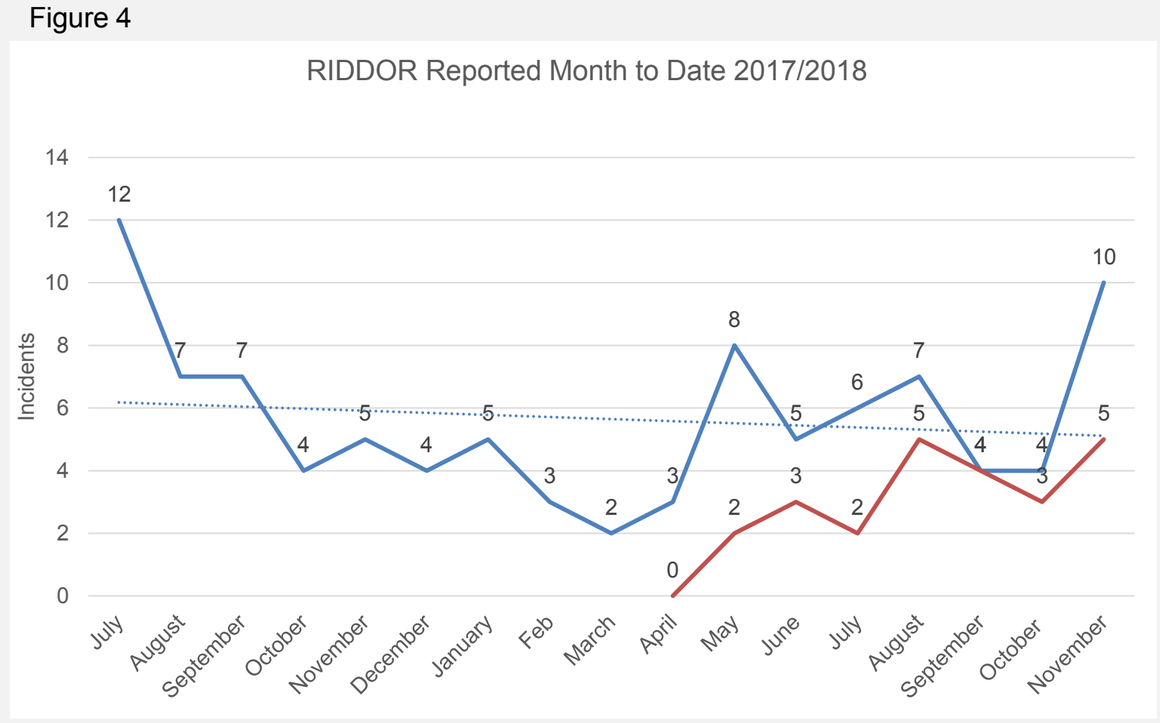


Figure 4



Our Enablers

SECAmb 999 Operations Response Time Performance Scorecard

Call Handling

	Sep-18	Oct-18	Nov-18	12 Months
5 Sec Performance (95% Target)	81.8%	85.5%	89.4%	
Mean Call Answer Time (secs)	15	12	8	
95th Centile Call Answer (Secs)	88	71	43	
National Mean Call Answer	8	7	6	
National 95th Centile Call Answer	45	42	36	

Category 1 Performance

	Sep-18	Oct-18	Nov-18	12 Months
Mean (00:07:00)	00:07:41	00:07:30	00:07:31	
90th Percentile (00:15:00)	00:14:13	00:13:56	00:13:59	
Mean Resources Arriving	1.71	1.71	1.73	
Count of Incidents	3385	3458	3536	
National Mean	00:07:20	00:07:13	00:07:11	

Category 1T Performance

	Sep-18	Oct-18	Nov-18	12 Months
Mean (00:19:00)	00:10:12	00:10:23	00:09:50	
90th Percentile (00:30:00)	00:18:54	00:19:40	00:18:35	
Mean Resources Arriving	1.77	1.74	1.73	
Count of Incidents	2101	2201	2183	
National Mean	00:11:31	00:11:15	00:11:11	

Category 2 Performance

	Sep-18	Oct-18	Nov-18	12 Months
Mean (00:18:00)	00:19:15	00:19:24	00:19:24	
90th Percentile (00:40:00)	00:36:01	00:36:36	00:36:44	
Mean Resources Arriving	1.12	1.12	1.11	
Count of Incidents	28425	29905	31036	
National Mean	00:21:41	00:21:17	00:21:56	

Category 3 Performance

	Sep-18	Oct-18	Nov-18	12 Months
Mean	01:25:30	01:21:35	01:23:05	
90th Percentile (02:00:00)	03:12:40	03:10:21	03:13:49	
Mean Resources Arriving	1.06	1.07	1.07	
Count of Incidents	19521	19964	20242	
National Mean	01:02:28	01:00:30	01:03:16	

Category 4 Performance

	Sep-18	Oct-18	Nov-18	12 Months
Mean	01:51:08	01:59:04	01:50:32	
90th Percentile (03:00:00)	04:06:21	04:38:29	04:12:29	
Mean Resources Arriving	1.05	1.05	1.01	
Count of Incidents	774	781	813	
National Mean	01:24:15	01:23:41	01:25:38	

Health Care Professional

	Sep-18	Oct-18	Nov-18	12 Months
HCP 60 Mean	01:31:07	01:46:00	01:37:18	
HCP 60 90th Percentile	03:01:22	04:02:54	03:43:06	
HCP 120 Mean	02:10:59	02:12:48	02:09:16	
HCP 120 90th Percentile	04:35:17	04:42:46	04:39:12	
HCP 240 Mean	03:19:34	02:46:04	03:10:25	
HCP 240 90th Percentile	07:03:18	06:00:05	06:14:14	

Call Cycle Time

	Sep-18	Oct-18	Nov-18	12 Months
Avg Allocation to Clear at Scene	01:15:22	01:14:59	01:15:54	
Avg Allocation to Clear at Hospital	01:46:07	01:46:10	01:46:56	
Handover Hrs Lost at Hospital (over 30mins)	4138	4413	4312	
Number of Handovers >60mins	361	430	427	

Incident Outcome AQI

	Sep-18	Oct-18	Nov-18	12 Months
Hear & Treat	5.7%	5.6%	5.4%	
See & Treat	33.5%	32.4%	32.8%	
See & Convey	60.8%	62.0%	61.6%	

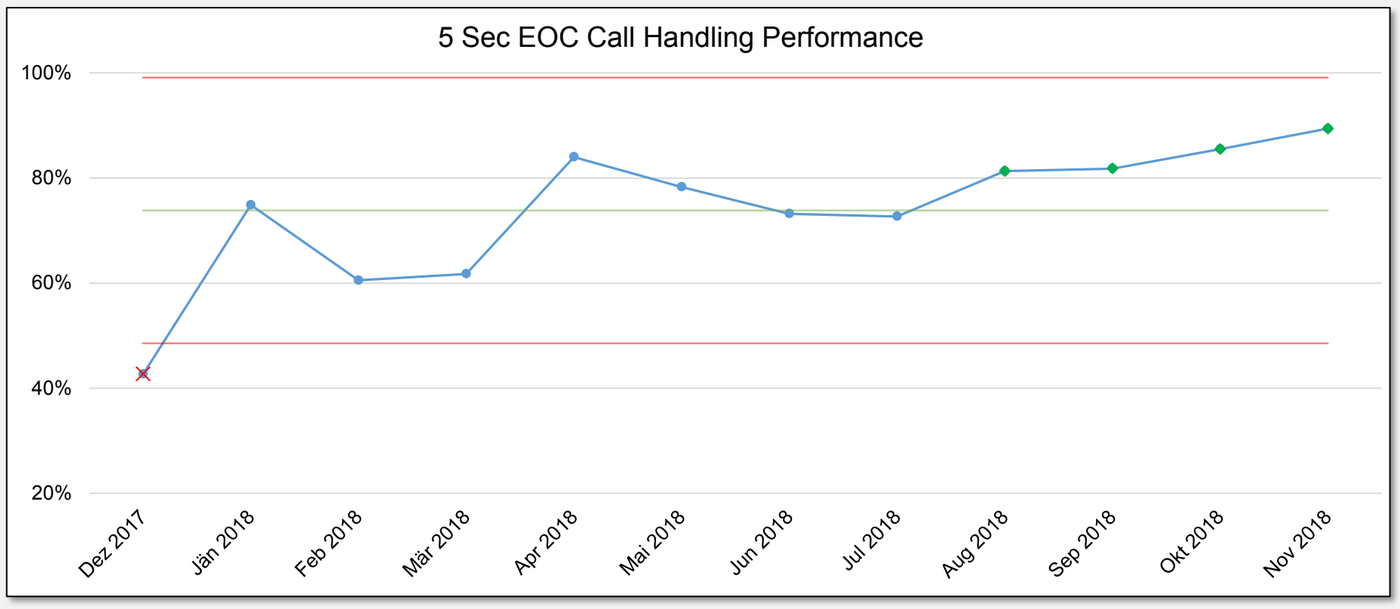
Community First Responders

	Sep-18	Oct-18	Nov-18	12 Months
Volume of Incidents Attended	1450	1385	1418	

Demand/Supply AQI

	Sep-18	Oct-18	Nov-18	12 Months
Calls Answered	63200	63761	63111	
Incidents	57222	59471	60863	
Transports	34788	36870	37595	

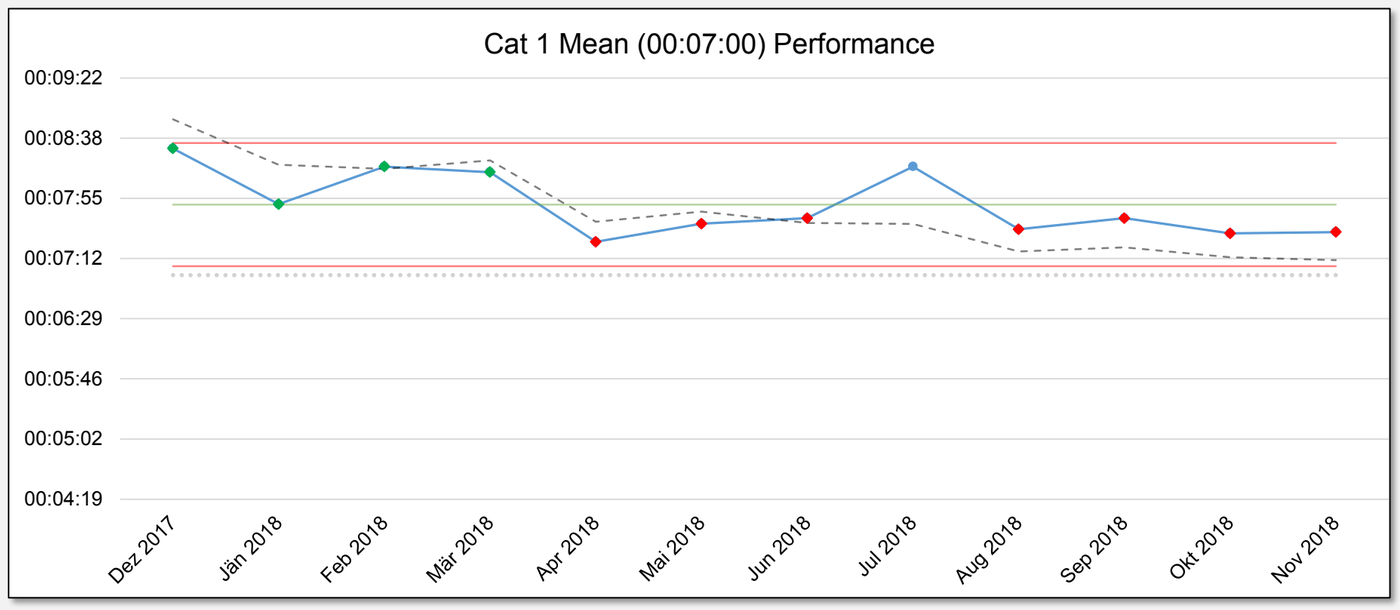
SECAmb 999 Operations Response Time Performance Charts



Call answering performance for November continues on a upward trajectory in performance with an average of 89% and the highest average since the introduction of ARP. This is the fourth consecutive month of improved performance.

The volume of duplicate calls regarding ETA of responses continues to make a significant contribution to increased call volumes. Abstraction rates continue to be scrutinised to deliver maximum unit hours, with the planned reduction in annual leave being commenced.

Call answer performance is covered in detail in the EOC action plan that is tracking the actions of the EOC task and finish group.

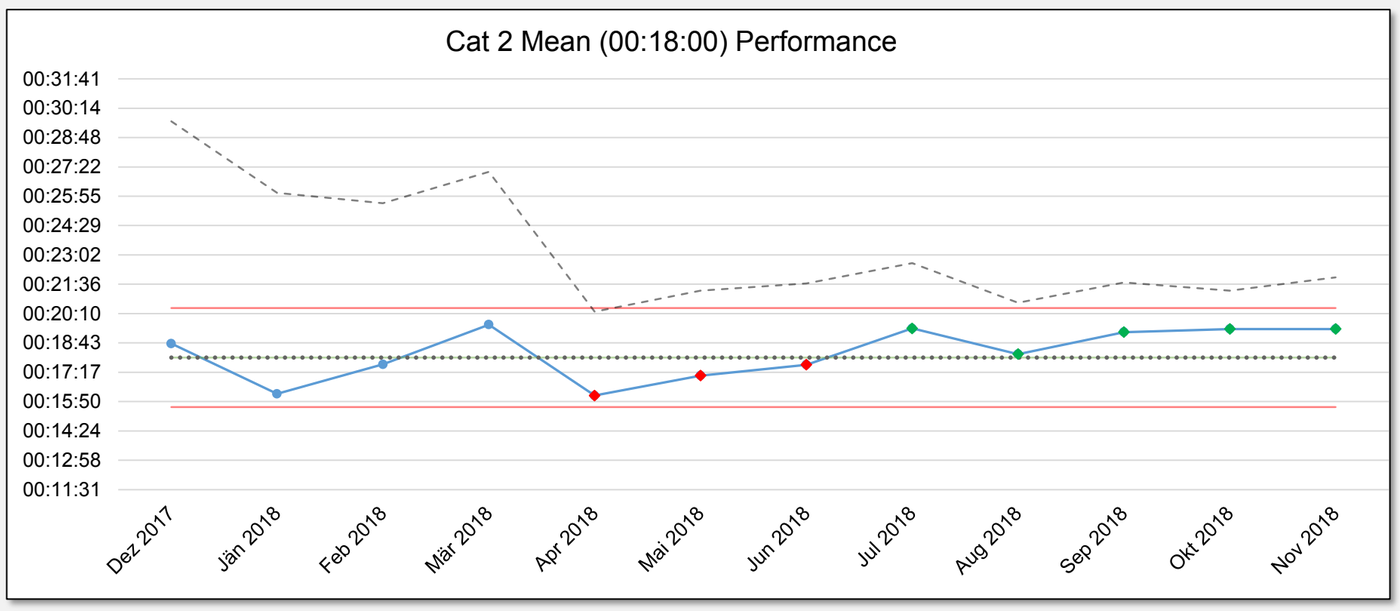


As shown in the graph the Cat 1 mean response performance remained static during October and November.

Whilst, the Trust are not yet delivering the Ambulance Response Programme (ARP) target of seven minutes, both our mean performance and 90th percentile performance are tracking consistently within the middle of the pack when measured against all other English ambulance services.

This consistency in delivery demonstrates the significant focus given to the high acuity patient groups.

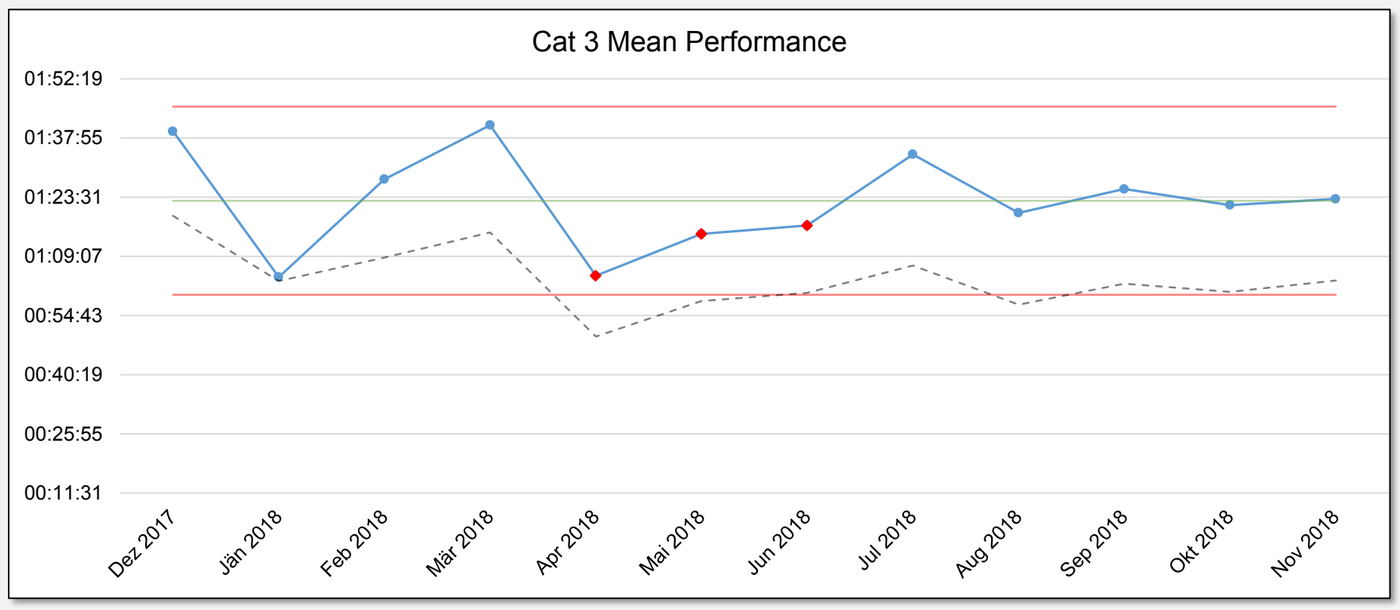
----- National Mean



November Cat 2 Mean Performance was 19.24, (the same as October) with a further increase of over 1400 incidents over the month. Performance remains significantly above mean National Performance by 2.32 minutes.

The improvement in performance can be in part attributed to the increase in the number of new front line staff joining the trust and a direct improvement in operational hours.

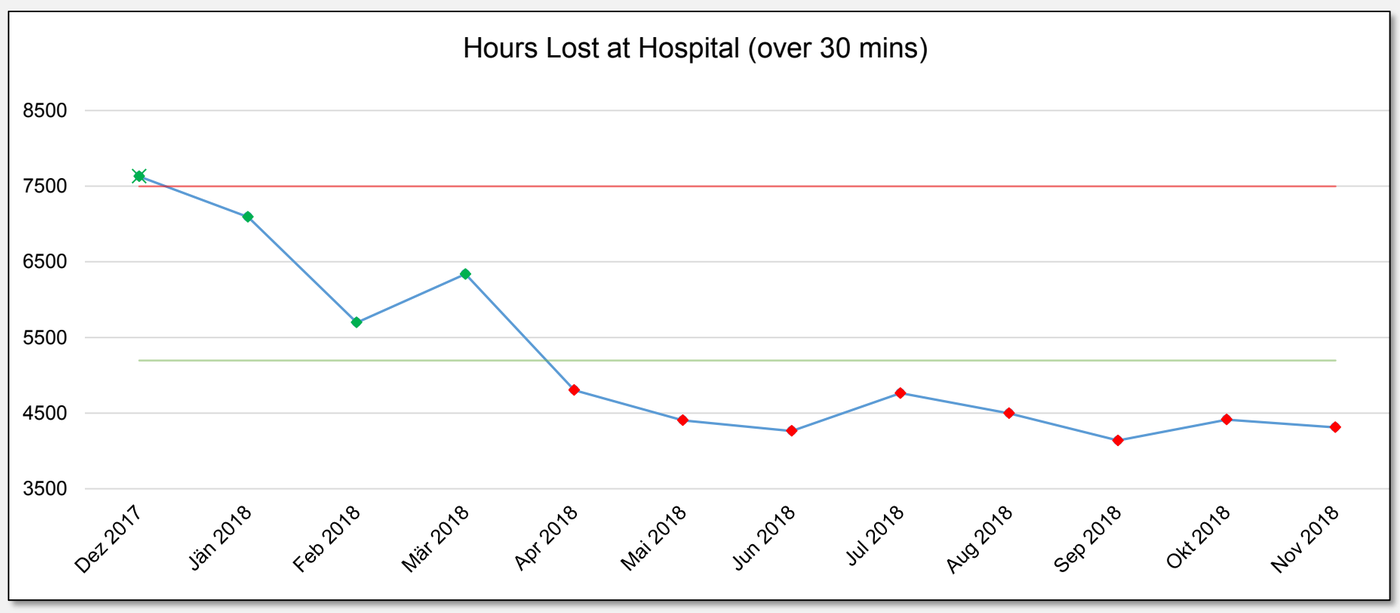
----- National Mean



Cat 3 mean has been included to provide the Board with oversight on the significant pressure against the performance requirements for this patient group.
Response to this Category of patients is below ARP target. The average performance remains approximately 20 minutes above the national average, which all ambulance trusts are challenged to achieving.

The 30 second-hand Non-Emergency Transport (NET) vehicles are currently being commissioned with the roll out starting in December 2018 with a planned roll out of 3 vehicles a week.

----- National Mean

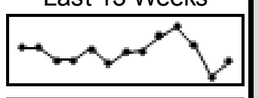
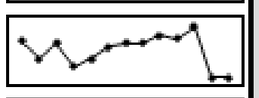


Hours lost to operational response capability through hospital delays in November are 4354 hours compared to October at 4434 . This is a decrease of 80 hours. Overall good progress has been made this month with 21% less hours lost in November 2018 compared with November 2017. There are however outliers where there are increases in hours lost in November compared to last year, they are: Darent Valley Hospital, Maidstone and Tunbridge Wells Hospitals and Royal Sussex County Hospital . Additional support is being provided at these sites. The two (East and West) operational groups have now been stood down over the winter period and the chairs will join the steering group. Local site based joint operational groups will however continue. The focus on the winter months will be to maintain improvements that have already been made, with an aim of achieving as many hospital handovers <15 minutes and crew to clear >15 minutes. In order to address the additional winter pressures, the individual hospital sites will also be focusing on having clear triggers and actions (both in internal, and system wide escalation plans) to prevent ambulance handover delays, and actions needed if ambulances start to queue.

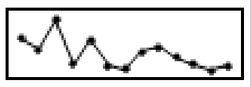
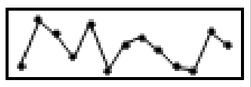
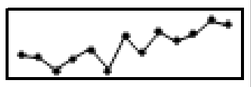
SECAmb unvalidated weekly Response Time Performance

SECAmb Weekly Operational Performance - 7th January 2019

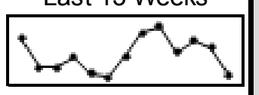
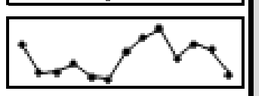
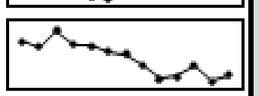
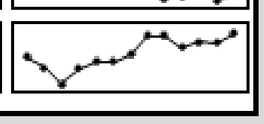
CAT 1

	17/12	24/12	31/12	Last 13 Weeks
Mean	00:07:43	00:06:50	00:07:15	
90th Centile	00:14:47	00:12:50	00:12:51	
RPI	1.73	1.80	1.78	
Count of Incidents	875	956	906	

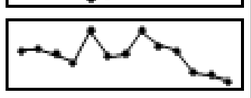
CAT 1T

	17/12	24/12	31/12	Last 13 Weeks
Mean	00:09:55	00:09:27	00:09:20	
90th Centile	00:18:46	00:18:17	00:18:38	
RPI	1.75	1.84	1.81	
Count of Incidents	552	580	570	

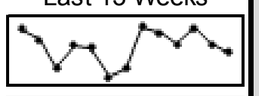
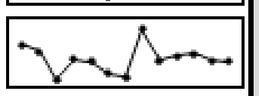
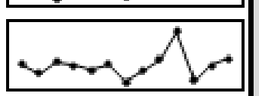
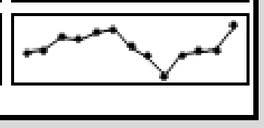
CAT 2

	17/12	24/12	31/12	Last 13 Weeks
Mean	00:20:37	00:20:08	00:18:13	
90th Centile	00:39:35	00:38:35	00:34:43	
RPI	1.11	1.10	1.10	
Count of Incidents	7610	7554	7859	

CAT 3

	17/12	24/12	31/12	Last 13 Weeks
Mean	01:46:04	01:38:12	01:20:41	
90th Centile	04:05:02	03:56:22	03:03:27	
RPI	1.07	1.06	1.06	
Count of Incidents	4350	4383	4833	

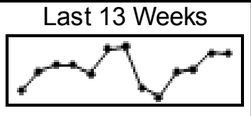
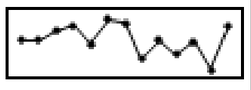
CAT 4

	17/12	24/12	31/12	Last 13 Weeks
Mean	02:17:21	02:01:59	01:53:47	
90th Centile	04:46:13	04:23:05	04:18:33	
RPI	1.03	1.06	1.07	
Count of Incidents	173	176	211	

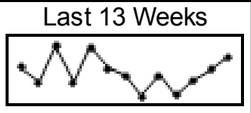
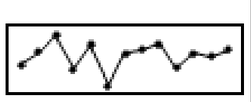
HCP 60

	17/12	24/12	31/12	Last 13 Weeks
Performance	26.3%	30.0%	40.0%	
Count of Incidents	19	20	15	

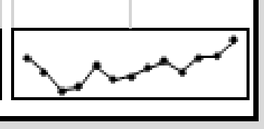
HCP 120

	17/12	24/12	31/12	Last 13 Weeks
Performance	56.8%	62.8%	62.5%	
Count of Incidents	333	288	360	

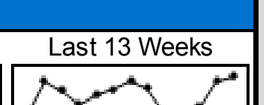
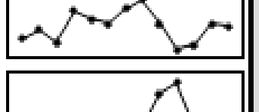
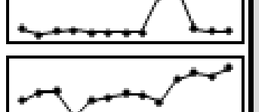
HCP 240

	17/12	24/12	31/12	Last 13 Weeks
Performance	64.5%	68.3%	73.4%	
Count of Incidents	62	60	64	

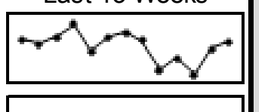
Call Cycle Time

	17/12	24/12	31/12	Last 13 Weeks
Clear at Scene (hh:mm)	01:14	01:12	01:13	
Clear at Hospital (hh:mm)	01:48	01:46	01:47	
Hours Lost at Hospital	1165	1185	1344	

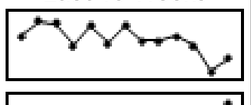
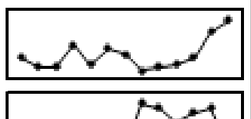
Call Handling

	17/12	24/12	31/12	Last 13 Weeks
Pickup 5 Second Performance	82.7%	93.6%	95.9%	
Average Call Pickup Time (Seconds)	10	5	3	
Call Pickup Time 95th Percentile (Seconds)	73	19	3	
Call Pickup Time 99th Percentile (Seconds)	128	95	72	
Average Call Length (seconds)	366	374	373	
Abandon Rate	0.80%	0.60%	0.60%	
Staff Hours Provided Against 4865 Hours	108.09%	106.25%	110.07%	

Community First Responders

	17/12	24/12	31/12	Last 13 Weeks
Volume of Incidents Attended	209	294	316	
Hours Provided				

Incident Outcome

	17/12	24/12	31/12	Last 13 Weeks
See and Convey	61.3%	60.3%	60.8%	
See and Treat	33.0%	33.8%	34.2%	
Hear and Treat	5.7%	5.8%	5.0%	

Demand/Supply

	17/12	24/12	31/12	Last 13 Weeks
Call Volume	15969	14664	14974	
Incidents	13531	13555	14385	
Transports	8787	8690	9205	
Staff Hours Provided Against 63000 Hours	105.08%	102.05%	111.46%	

Our Partners

SECAmb 111 Operations Performance Scorecard

Calls Offered

	Sep-18	Oct-18	Nov-18	12 Months
Actual	84650	87344	90785	
Previous Year	80053	84639	82468	

Calls answered in 60 Seconds

	Sep-18	Oct-18	Nov-18	12 Months
Actual %	70.9%	72.5%	73.5%	
Previous Year %	80.2%	75.3%	72.9%	
Target %	95%	95%	95%	

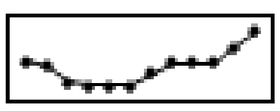
Calls abandoned - (Offered) after 30secs

	Sep-18	Oct-18	Nov-18	12 Months
Actual %	6.0%	5.4%	5.1%	
Previous Year %	2.0%	2.8%	3.6%	
Target %	2%	2%	2%	

Combined Clinical KPI

	Sep-18	Oct-18	Nov-18	12 Months
Actual %	63.8%	69.3%	73.1%	
Previous Year %	69.5%	78.2%	75.3%	
Target %	90%	90%	90%	

999 Referrals

	Sep-18	Oct-18	Nov-18	12 Months
999 Referrals % (Answered Calls)	11.3%	11.7%	12.6%	
999 Referrals (Actual)	8825	9457	10645	
National	11.5%	12.0%	12.6%	

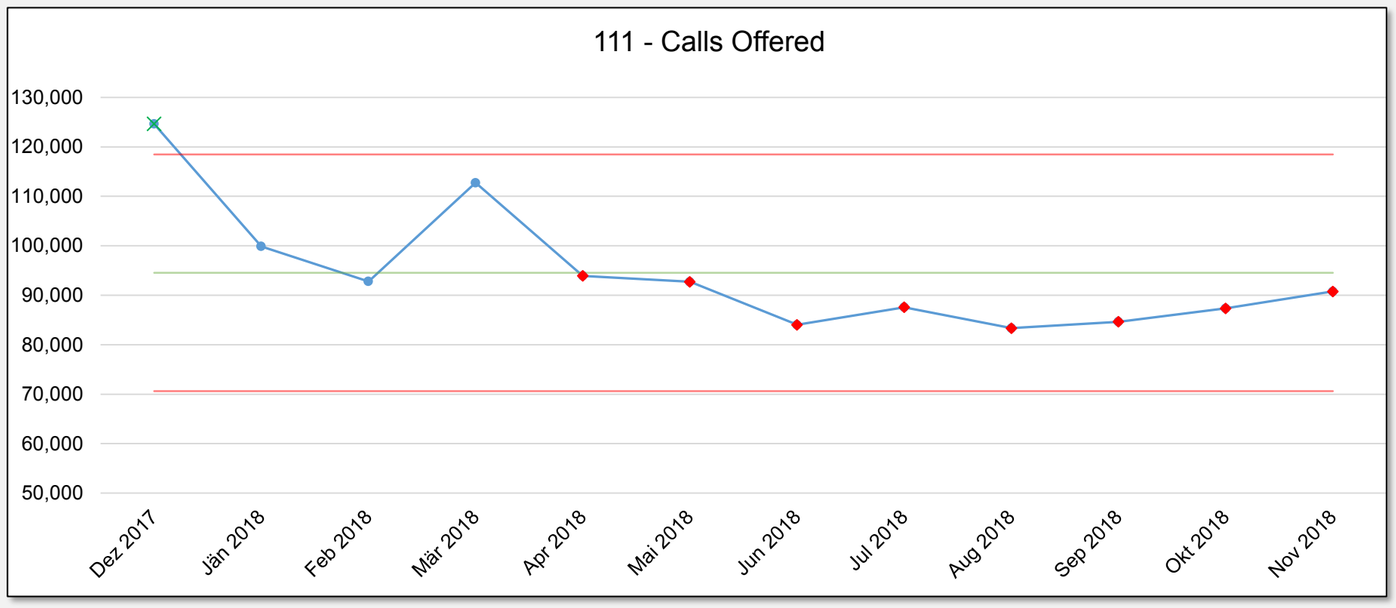
A&E Dispositions

	Sep-18	Oct-18	Nov-18	12 Months
A&E Dispositions % (Answered Calls)	7.9%	8.2%	8.3%	
A&E Dispositions (Actual)	6154	6666	7003	
National	8.3%	8.1%	8.3%	

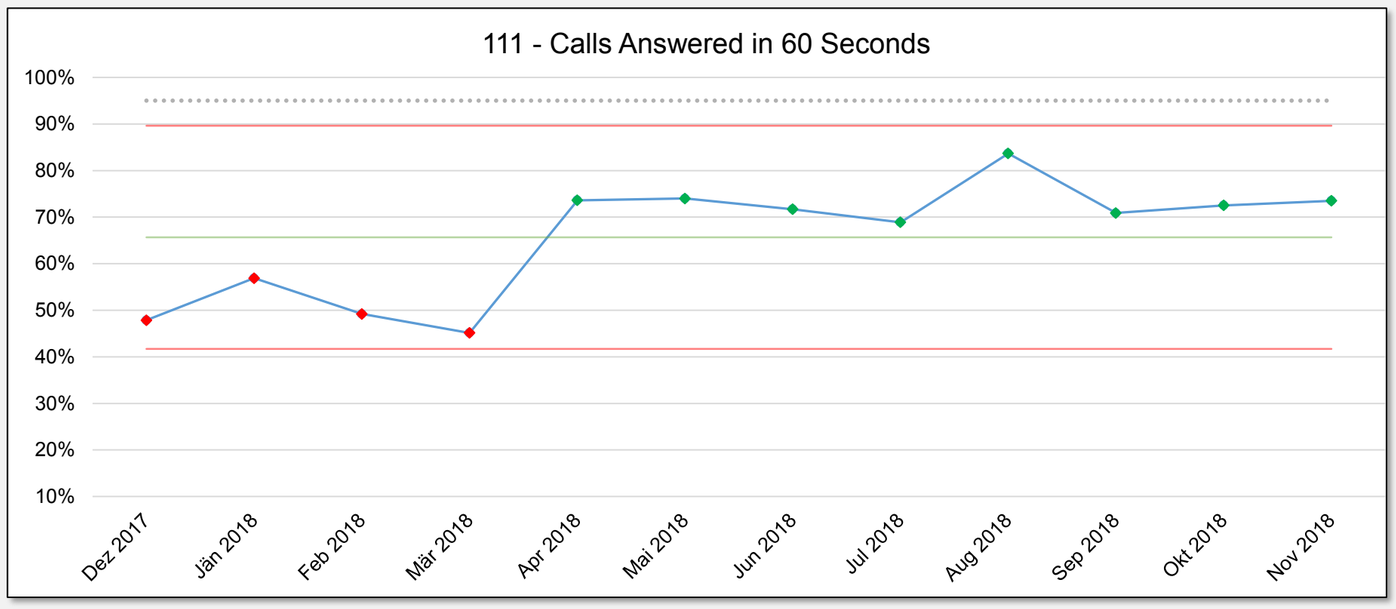
Home Management

	Sep-18	Oct-18	Nov-18	12 Months
Actual %	5.7%	6.2%	7.5%	

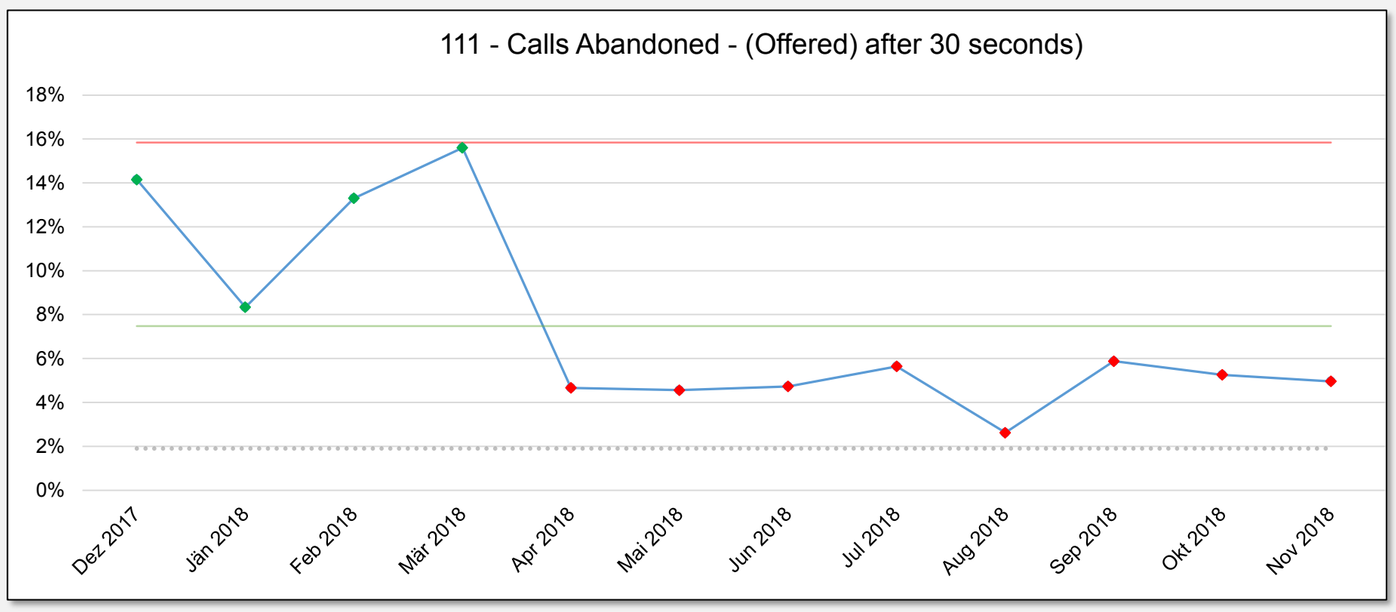
SECAmb 111 Operations Performance Charts

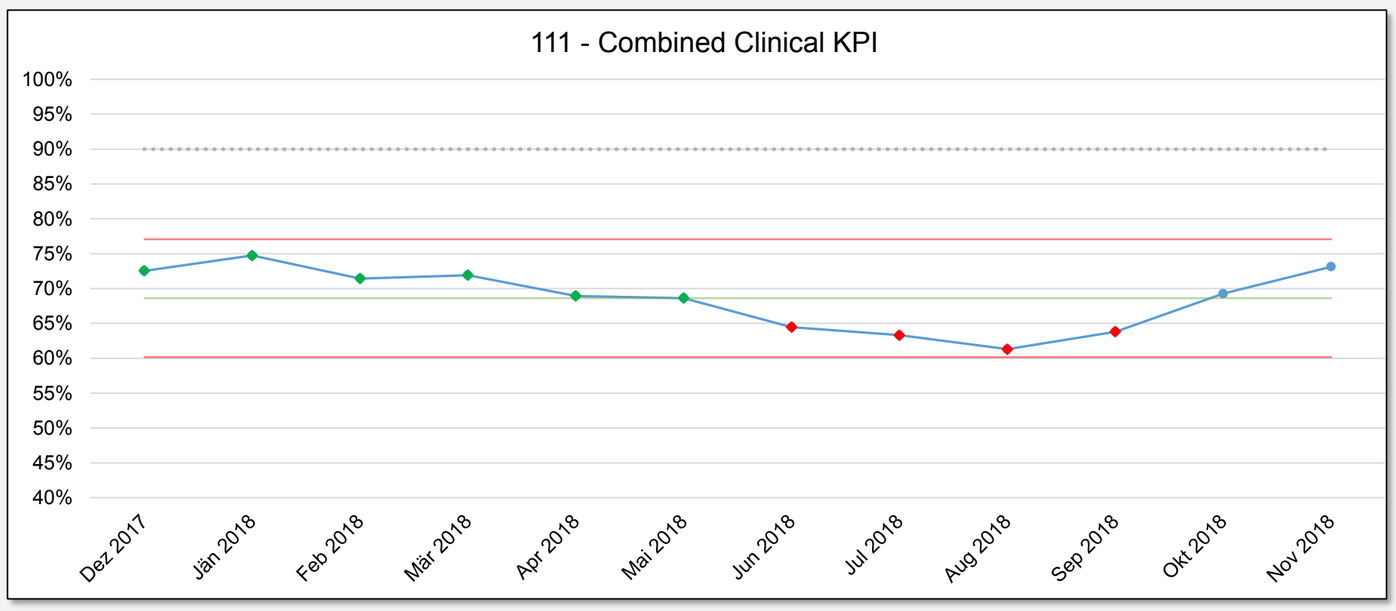


The Calls Offered volume of 90785 represented a 10% increase against the same month last year.

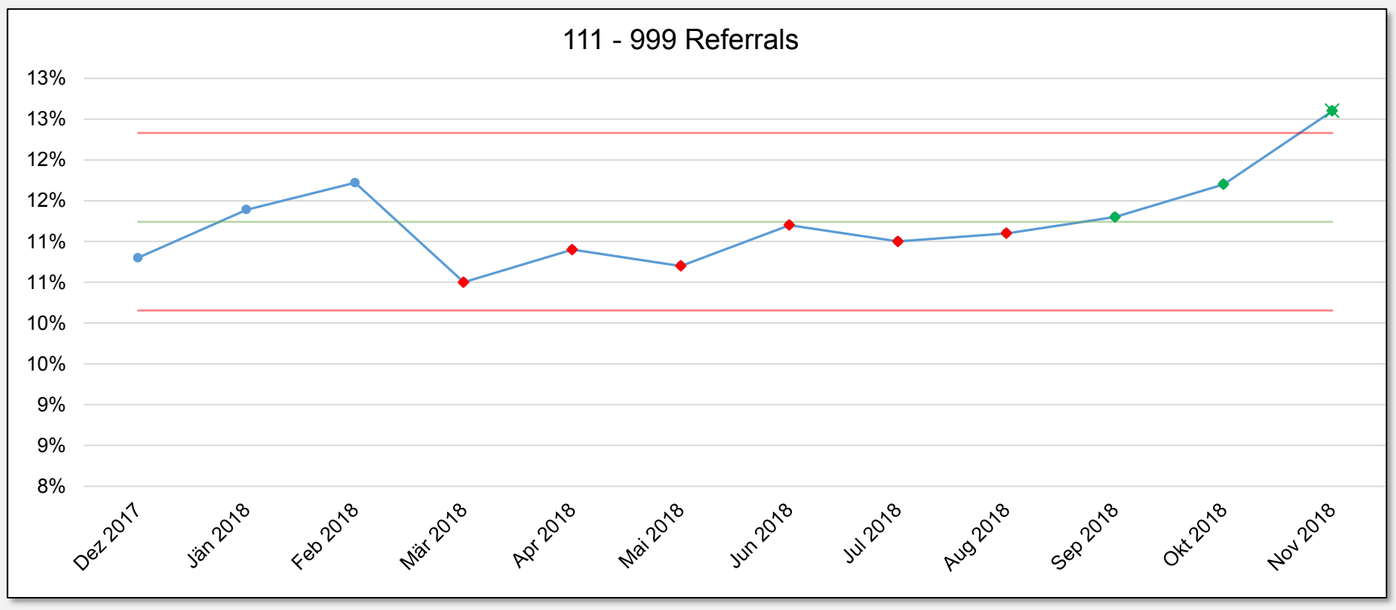


Despite this increase in activity, our Service Level fell only slightly to 73.5%. The Call Abandonment rate was stable at 5.1%, as was the Average Speed to Answer (72 seconds).





The service's best performance coincided with days when SECAmb did not declare SMP Level 3 or 4.

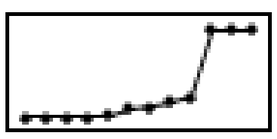


Our Clinical performance climbed to over 73%, considerably above the national benchmark for November.

Our People

SECAmb Workforce Scorecard

Workforce Capacity

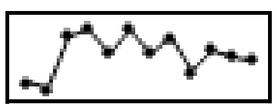
	Sep-18	Oct-18	Nov-18	12 Months
Number of Staff WTE (Excl bank & agency)	3215.4	3300.9	3387.4	
Number of Staff Headcount (Excl bank and agency)	3477	3575	3665	
Finance Establishment (WTE)	3837.50	3837.50	3837.50	
Vacancy Rate	16.21%	13.70%	11.73%	
Vacancy Rate Previous Year	13.90%	13.51%	13.09%	
Adjusted Vacancy Rate + Pipeline recruitment %	9.12%	6.50%	7.30%	

Workforce Compliance

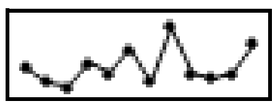
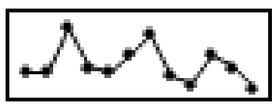
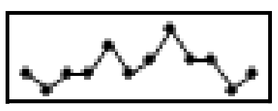
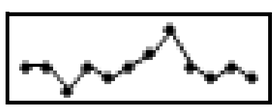
	Sep-18	Oct-18	Nov-18	12 Months
Objectives & Career Conversations %	48.09%	48.44%	50.47%	
Target (Objectives & Career Conversations)	80%	80%	80%	
Statutory & Mandatory Training Compliance %	75.50%	79.10%	79.08%	
Target (Stat & Mand Training)	95%	95%	95%	
Previous Year (Stat & Mand Training) %	65.46%	76.06%	71.06%	

* Objectives & Career Conversations and Statutory & Mandatory training has been measured by financial year. The completion rate is reset to zero on 01/04/2018

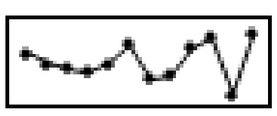
Workforce Costs

	Sep-18	Oct-18	Nov-18	12 Months
Annual Rolling Turnover Rate %	14.88%	14.62%	14.57%	
Previous Year %	17.77%	18.17%	18.05%	
Annual Rolling Sickness Absence	5.10%	5.08%	5.04%	
Target (Annual Rolling Sickness)	5%	5%	5%	

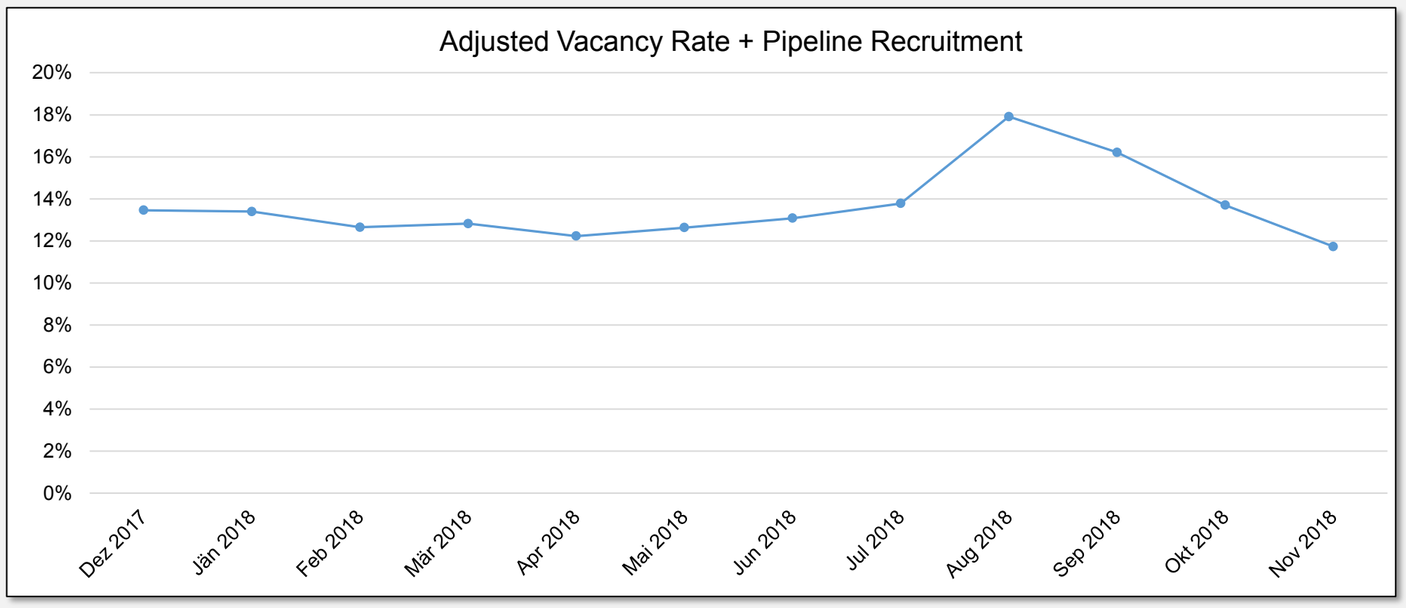
Employee Relations Cases

	Sep-18	Oct-18	Nov-18	12 Months
Disciplinary Cases	4	10	4	
Individual Grievances	6	1	4	
Collective Grievances	0	1	2	
Bullying & Harassment	2	1	0	
Bullying & Harassment Prev Yr	1	2	2	
Whistleblowing	0	0	0	
Whistleblowing Previous Year	0	0	0	

Physical Assaults (Number of victims)

	Sep-18	Oct-18	Nov-18	12 Months
Actual	9	25	30	
Previous Year	8	17	20	
Sanctions	1	1	18	

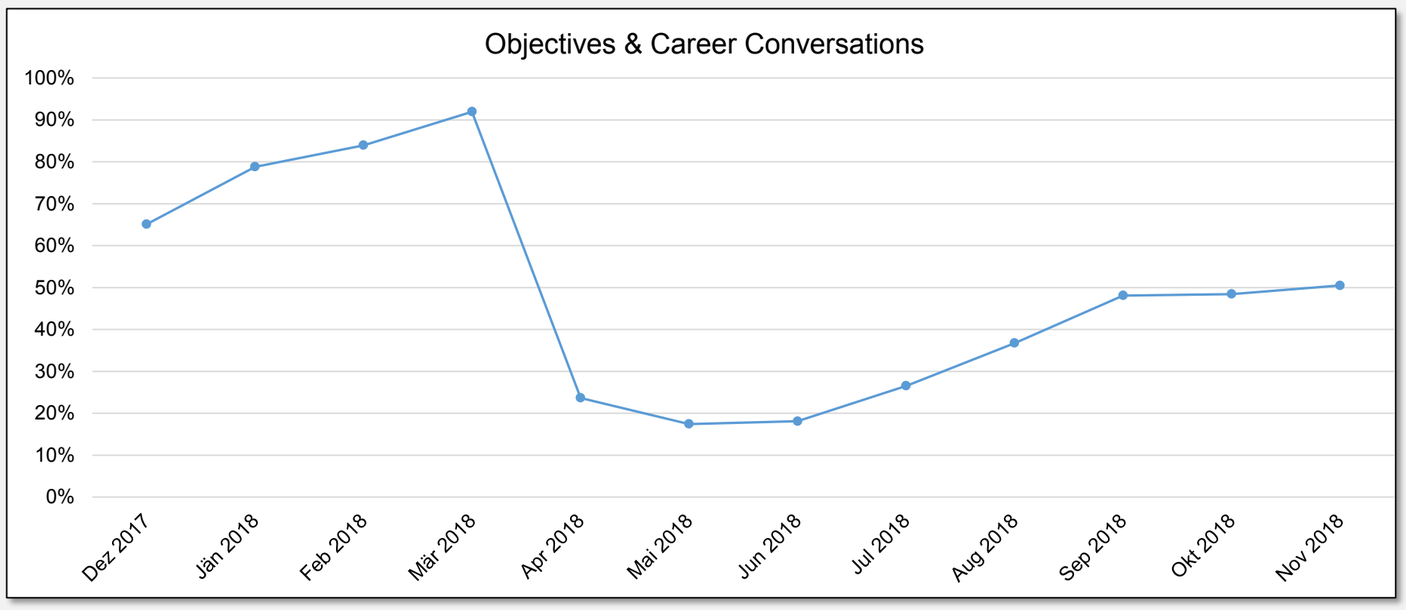
SECAmb Workforce Charts



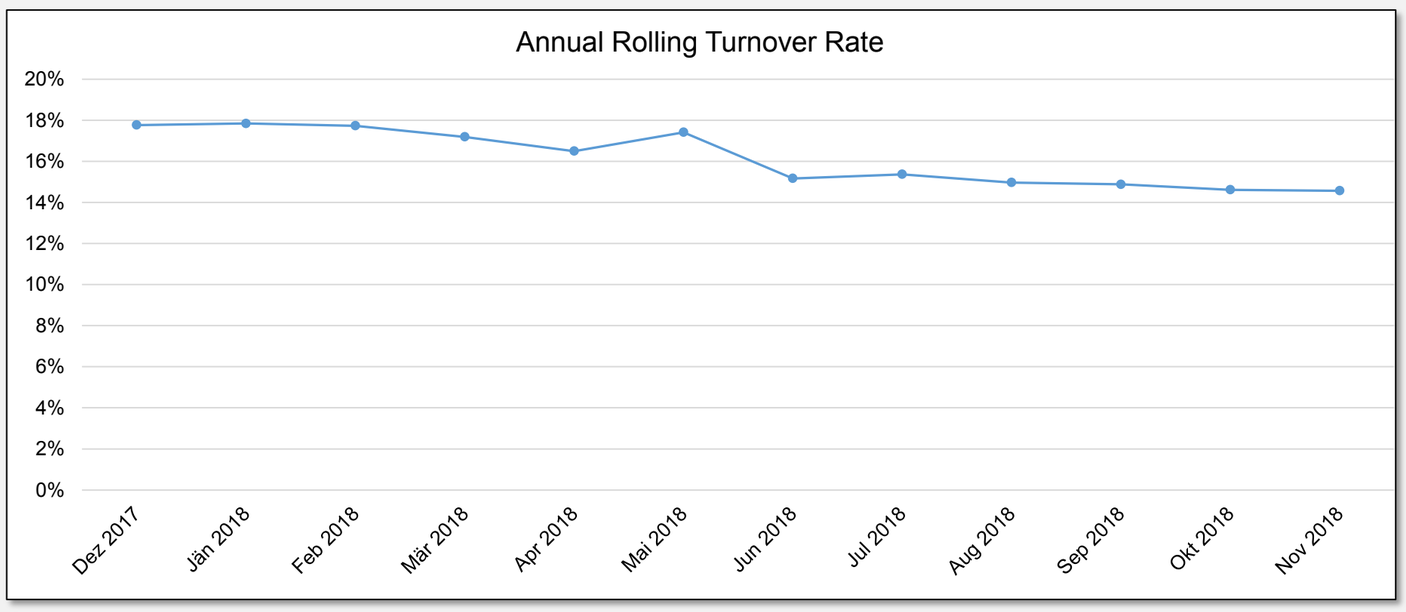
In November we recruited 102 new staff into the Trust. Our adjusted vacancy rate increased slightly to 7.3%

We have 21 EMAs due to start in December and have filled the pipeline of EMAs for West up until February 2019. We have a talent pool of candidates for West. Our focus is on East EOC recruitment.

We had 34 new ECSW start in November. Our pipeline for ECSW is currently 38 new joiners for January



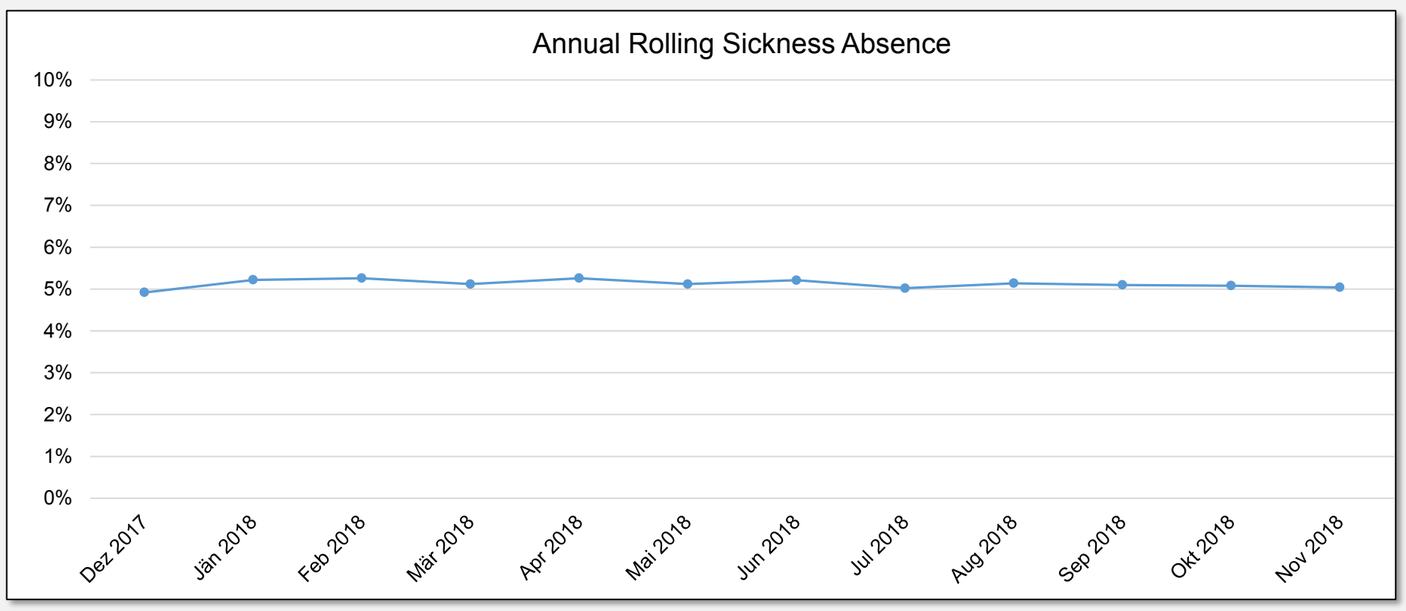
There is a continued increase in appraisals being published which shows activity in some areas of the organisation. The appraisal percentage has increased to 48.09% from 36.73%, from the previous month. However this representation is only for published appraisals on the performance management system and we need to view the combined activity of appraisals which are in-progress as well. This reflects an actual figure of 63.74%, which at this time last year we are on target to achieve our target, at the projected rate of 10% each month.



We can now report a clear downward trend in our annual rolling turnover rate, which is excellent news. Turnover now stands at 14.6% compared to 18.05% a year ago.

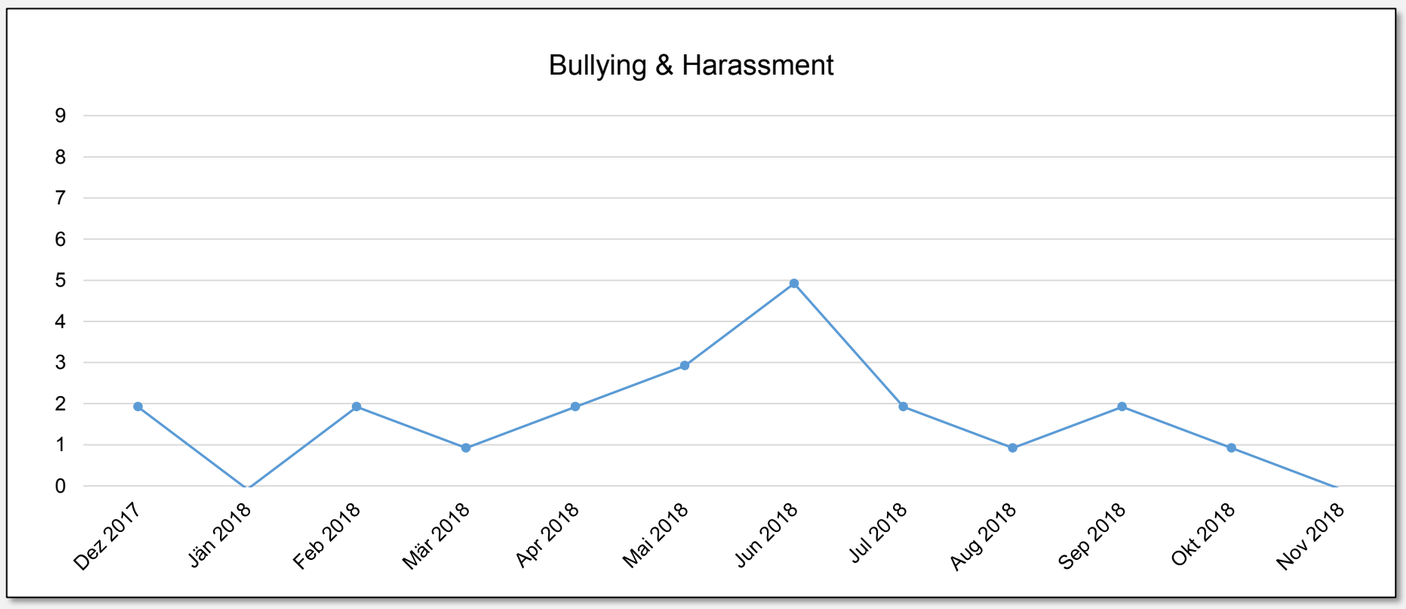
November has seen the lowest turnover of the last 12 months.

We continue to focus on the two Emergency Operations Centres (EOC's) and 111 over the next 3-months should enable a continued downward trend in turnover.



Sickness absence hit target (5.0%)for the first time in 11 months which is excellent news.

Sickness Absence Management continues to be a key focus on the HR Advisors and the Line Managers they support.

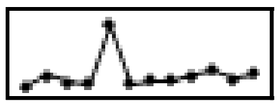


There was no reported cases of Bullying and Harassment (B&H) in November bringing the rolling total to 25 cases.
There has been a number of very complex cases which has taken a significant amount of time to investigate, complicated by suspensions and sickness.
HR Advisors and HR Business Partners spent a significant amount of time bringing our ER Tracker System up to date and we have now introduced a rolling monthly review meeting with the Director of HR and OD
We are in the next stages of our plan to eradicate Bullying and Harassment in SECAmb which we hope to have completed for a New Year launch
On January 9th 2019 we held a workshop for Senior Leaders and Executives with our employment lawyers.

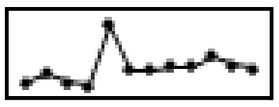
Our Enablers

SECAmb Finance Performance Scorecard

Income

	Sep-18	Oct-18	Nov-18	12 Months
Actual £	£ 17,589	£18,398	£20,453	
Previous Year £	£ 16,716	£16,329	£16,493	
Plan £	£ 17,226	£18,034	£ 18,051	

Expenditure

	Sep-18	Oct-18	Nov-18	12 Months
Actual £	£ 18,402	£ 18,029	£ 20,344	
Previous Year £	£ 17,319	£ 16,623	£ 16,501	
Plan £	£ 18,055	£ 17,674	£ 17,951	

Capital Expenditure

	Sep-18	Oct-18	Nov-18	12 Months
Actual £	£ 555	£ 598	£ 405	
Previous Year £	£ 450	£ 375	£ 554	
Plan £	£ 501	£ 308	£ 551	
Actual Cumulative £	£ 3,617	£ 4,215	£ 4,215	
Plan Cumulative £	£ 3,920	£ 4,228	£ 4,779	

Cost Improvement Programme (CIP)

	Sep-18	Oct-18	Nov-18	12 Months
Actual £	£ 1,242	£ 965	£ 961	
Previous Year £	£ 1,330	£ 1,304	£ 1,459	
Plan £	£ 1,223	£ 947	£ 947	
Actual Cumulative £	£ 4,179	£ 5,144	£ 6,105	
Plan Cumulative £	£ 4,087	£ 5,034	£ 5,981	

CQUIN (Quarterly)

	Q1 18/19	Q2 18/19	Q3 18/19
Actual £	£ 871	£ 870	£ 1,161
Previous Year £	£ 850	£ 846	£ 855
Plan £	£ 870	£ 870	£ 870

*The Trust anticipates that it will achieve the planned level of CQUIN

Surplus/(Deficit)

	Sep-18	Oct-18	Nov-18	12 Months
Actual £	-£ 813	£ 369	£ 109	
Actual YTD £	-£ 3,610	-£ 3,241	-£ 3,241	
Plan £	-£ 829	£ 360	£ 100	
Plan YTD £	-£ 3,734	-£ 3,374	-£ 3,274	

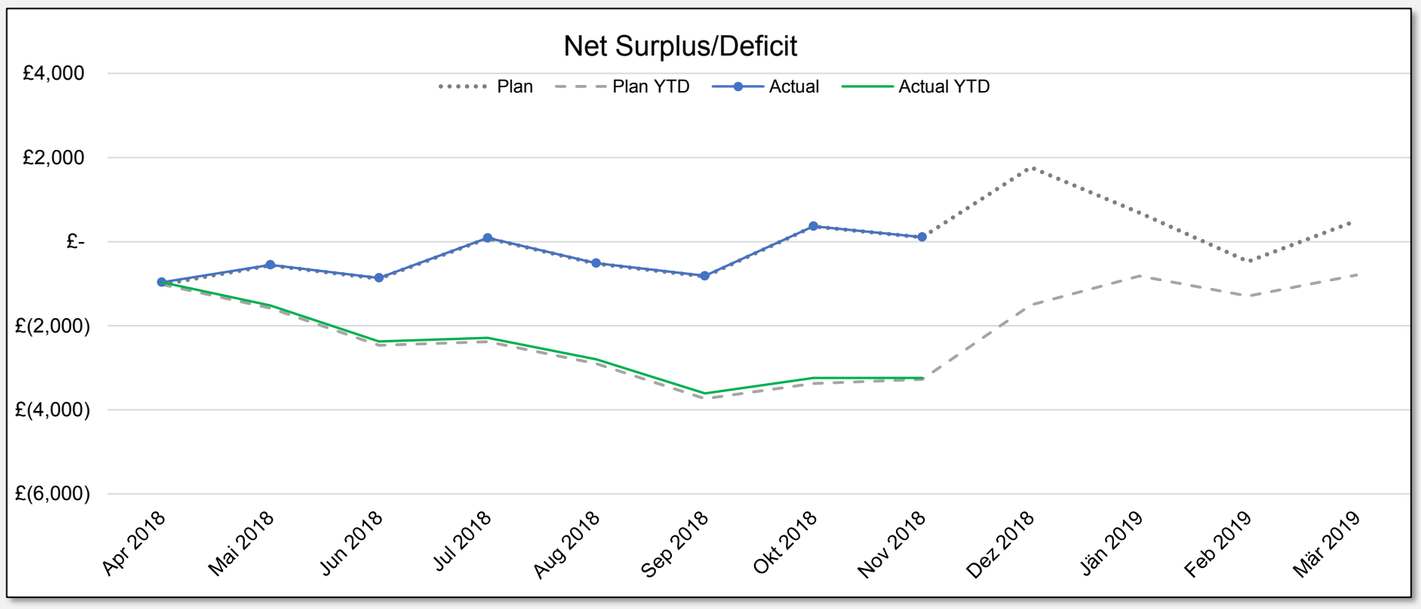
Cash Position

	Sep-18	Oct-18	Nov-18	12 Months
Actual £	£ 22,032	£ 21,971	£ 26,656	
Minimum £	£ 10,000	£ 10,000	£ 10,000	
Plan £	£ 14,749	£ 14,693	£ 14,402	

Agency Spend

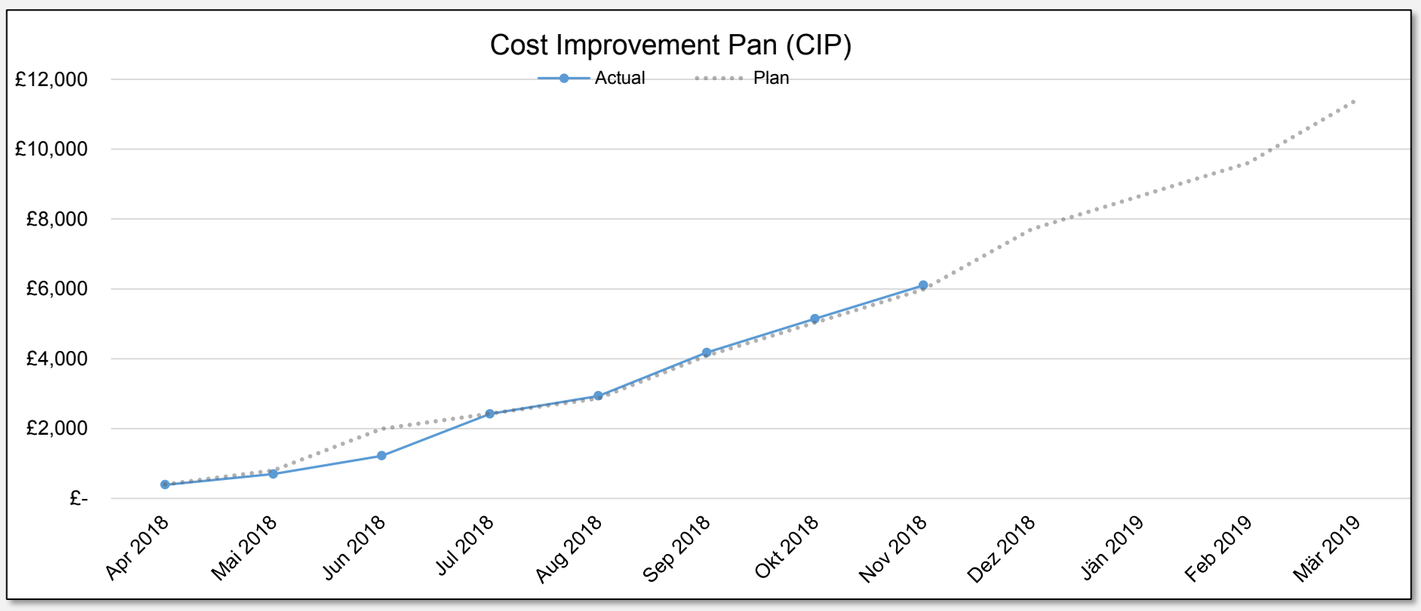
	Sep-18	Oct-18	Nov-18	12 Months
Actual £	£ 322	£ 357	£ 430	
Plan £	£ 222	£ 218	£ 215	

SECAmb Finance Performance Charts



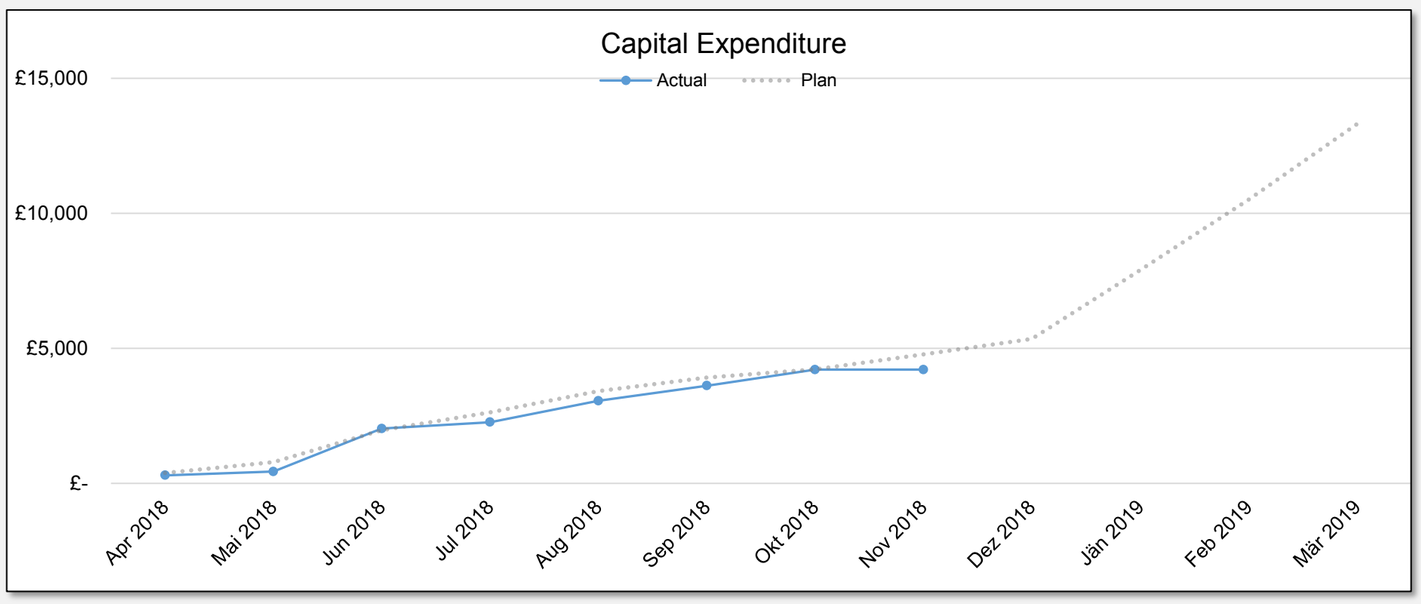
The Trust's I&E position in Month 8 was a surplus of £0.1m, in line with plan.

This reduced the cumulative deficit to £3.1m, which is a £0.1m improvement above plan



CIPs to the value of £1.0m were achieved in the month, as planned. Achievement to date is £6.1m, which is slightly ahead of plan.

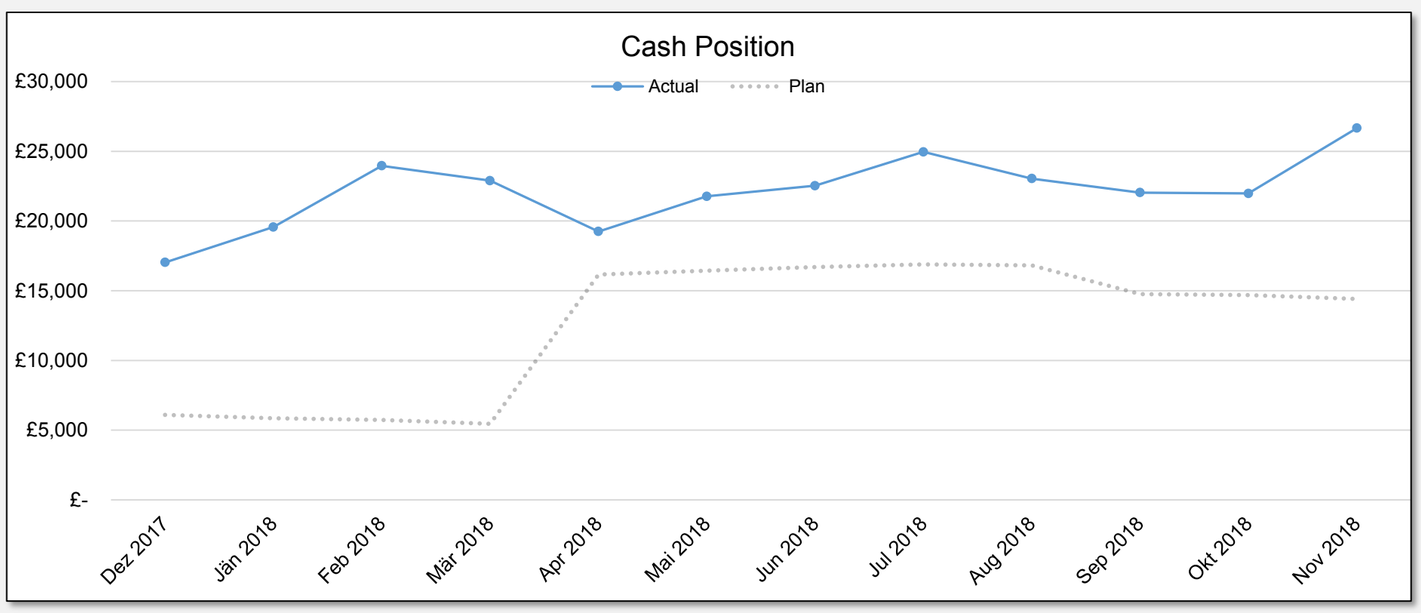
It is projected that the full year target of £11.4m will be met, but there remain challenges to achieving this. £10.3m of schemes were fully validated, with a total of £13.9m identified schemes on the pipeline tracker as at month 8



Capital expenditure in the month was £0.4m and cumulative spend is just £0.2m behind plan. The forecast for the year is a spend of £12.9m against a plan of £13.3m, the shortfall is due to the delay in the delivery of some of the 43 Mercedes box chassis beyond 31 March and spend on the new ePCR, partly offset by the substitution of 111 implementation.

In November it was announced that £12.3m of capital funding has been awarded to the Trust for 3 make ready centres in Brighton, Medway and Worthing. A further £6.7m has also been recently awarded for developments at the Nexus House Headquarters. The Trust has been unsuccessful with a bid for new ambulances.

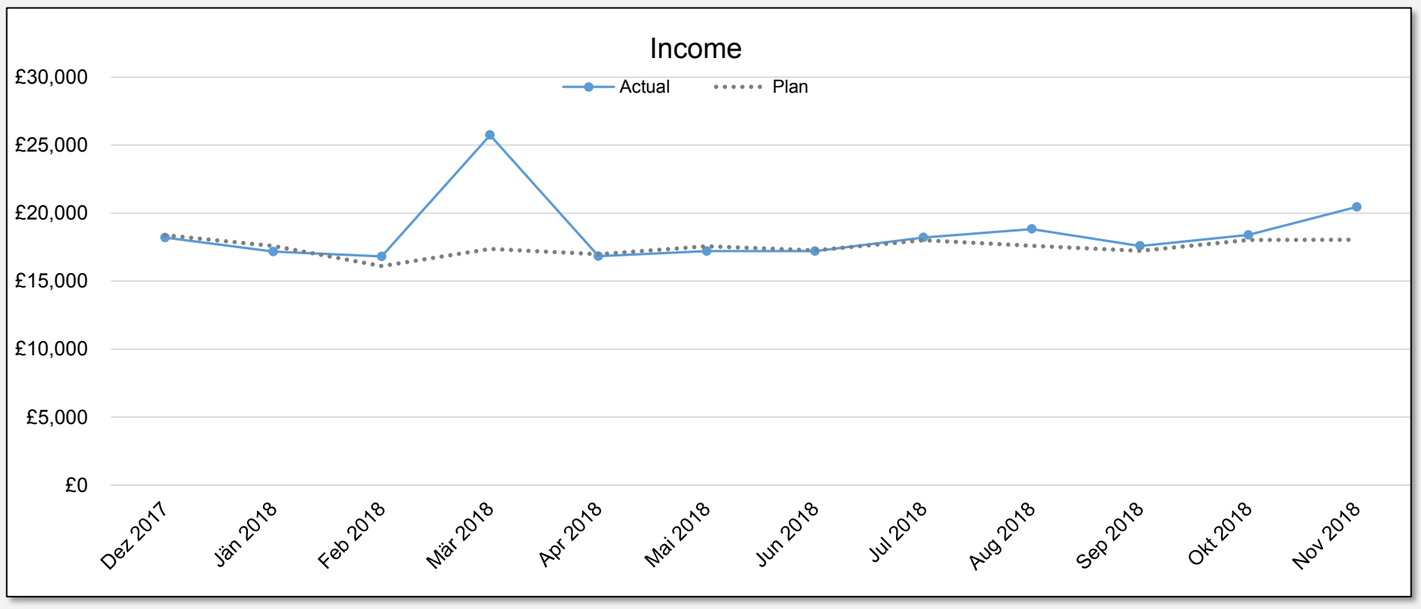
The above funding is subject to formal approval of a business case and recommendation to DHSC (Department of Health and Social Care) by NHSI.



The cash position at 30 November increased to £26.7m. This is £12.3m better than plan and £3.8m above the balance at 31 March. The main cause for the increase in month is receipt of funds following the 999 contract variation.

In line with good practice, the Trust produces cash forecasts for a three-year period. The latest projection shows, based on forecast capital requirements and I&E performance, cash could fall to below £15.0m by June 2020. This reflects the Trust's investment plans for the estate and frontline vehicles, any impact from the capital bids will be included once business cases have been fully approved.

Performance against the 'Better Payment Practice Code' for payment of suppliers declined slightly this month, falling year to date to 93.3% by value, against a target of 95.0%.



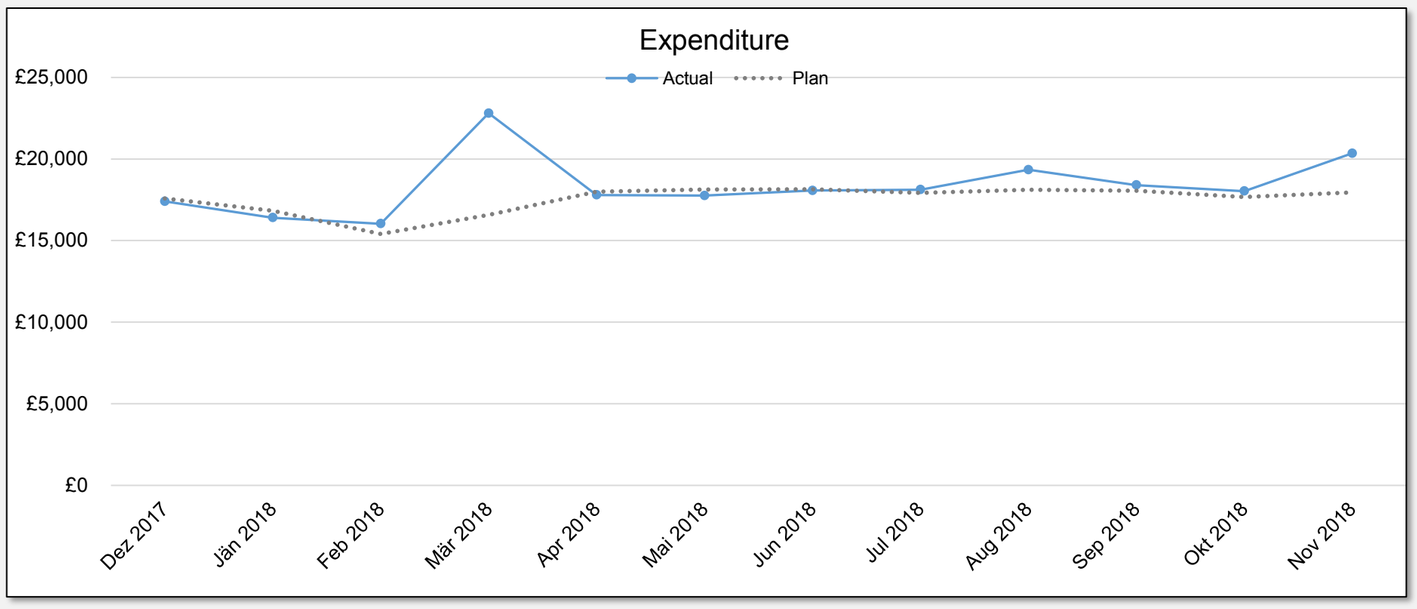
Total Income in the month was £20.4m, which was £2.4m better than plan.

This resulted in a cumulative favourable variance against plan of £4.0m.

The main reason for the improvement in the month was the recognition of £2.0m from the 999 contract variation arising from the successful conclusion of the demand and capacity agreement with commissioners. This includes an additional £0.4m for the Helicopter Emergency Medical Service (HEMS). A further £0.1m represents the impact of the new contract variation for 111 and £0.5m funding for the new pay deal.

The Trust has assumed full achievement of planned core PSF income in the first eight months at £1.0m. The full year value is £1.8m, funding being weighted towards the latter part of the year. Receipt of this funding is contingent on meeting I&E trajectories on a quarterly basis. Funding of £0.6m for quarters one and two has been confirmed

SECAmb Finance Performance Charts



Total Expenditure exceeded plan by £2.4m in month

Cumulatively expenditure is £3.9 above plan.

Pay costs in the month were above plan by £1.3m, moving the cumulative position to a £2.1 overspend. The main reason for this is the £0.5m impact of the new pay deal, £0.2m in Operations due to the respective recognition of the approved re-banding uplift for Technicians and increasing hours over plan, £0.5m transfer from reserves to support approved business cases.

Non-pay costs were £1.1m above plan in the month, bringing cumulative costs to £1.3m overspent. The main area of overspend was for £0.4m HEMS support (reflecting the additional income reported above), £0.2m uniforms and £0.2m for estates improvements.

Non-operating costs were £0.1m greater than plan in month.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	145/18

Name of meeting	Trust Board
Date	24th January 2019
Name of paper	Responding to Category 1 patients ensuring patient safety when there are delays.
Responsible Executive	Joe Garcia – Executive Director of Operations
Author	Mark Bailey – EOC Operations Unit Manager Hilary Parsons – Business Support Manager
Synopsis	This paper provides confirmation on the management of Category 1 calls.
Recommendations, decisions or actions sought	The Board is asked to note the contents of this paper.

Does this paper, or the subject of this paper, require an equality impact analysis ('EIA')? (EIAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	**No**

1. Introduction

1.1. This response paper is to provide confirmation on how Category 1 calls are managed when there is a delay in response.

2. Incident Resourcing, Deployment & Management Standard Operating Procedure

2.1. The embedded document below provides the full procedure for the process for the deployment of resources to all categories of 999, Urgent and appropriate routine calls during normal working arrangements.

2.2. The overriding consideration of these procedures and protocols is to promote patient safety and clinical excellence, and to ensure that best practise is delivered at all times.

Incident
Resourcing Deployn

3. The 10 Principles of Dispatch

3.1. There are 10 Emergency Dispatch Principles which the Dispatchers must follow at all times and these are the core dispatching rules of engagement. These are listed below;

1. Ensure that all resources are booked on and set up correctly in the CAD including confirmation and set up of appropriate staff, shift and meal break times. Late sign-ons escalate to the Dispatch Team Leader.

2. Check that all First Responders (including all types of Community Responders) are booked on correctly on the CAD if they are available and are showing their dispatch point positions accurately.

3. Allocate the nearest available resource/s to all Category 1 Incidents.

4. Monitor all other emergency calls on the dispatch stack and assign a suitable resource when;

    - The time exceeds 240 seconds and the incident remains uncategorised.
    - The incident has been coded (the incident line will change colour to reflect the response level).

5. Divert resources from other lower priority calls as necessary.

6. Ensure the most appropriate and nearest CFR is assigned to the emergency if applicable (in accordance with the incident type and/or location) and confirm they are mobile.

7. Consider and respond other suitable additional resources to the emergency if appropriate and in accordance with incident type and/or location e.g. Helicopter Emergency Medical Service (HEMS), Hazardous Area Response Team (HART), Critical Care Paramedic (CCP), Paramedic Practitioner (PP), Operational Manager etc.

8. DCA must respond to SRV back up requests.

9. **Guidance On Running Calls:** If a crew are flagged down or come across a running call whilst transporting a patient to hospital, they should be expected to contact control to advise a running call and request back up whilst rending aid to the patient/s.

10. If appropriate contact a solo responder who is on scene with a DCA crew to check if they can respond to another incident as the nearest and quickest response.

3.2. General Broadcasts via Airwave group call should be undertaken by dispatchers in the following circumstances:

- All Category 1 incidents irrespective of ETA for assigned
- All grade one back up requests from SRVs

4. Responding and Resourcing to Incidents

4.1. On receiving an incident, the personnel crewing the vehicle, will proceed to the vehicle without delay. Mobilisation will be measured by the time it takes a vehicle to physically move once allocated.

4.2. Crews are expected to proceed to any incident under emergency conditions until the exact nature of the call is established.

4.3. Resourcing to category of incidents 1 – 4 should be based on the clinical needs of the patient ensuring that response time standards are also adhered to.

4.4. Calls will be responded to as follows:

Category	**Default Response**	**Ideal Resource Type**	**Response Time Standards**
Category 1	Full Emergency Conditions	Nearest Resource Including Closet DCA, If not initial assigned.	Initial Response & Transport **7** Minutes
Category 2	Full Emergency Conditions	DCA (Consider SRV)	Initial Response & Transport **18** Minutes
Category 3	Full Emergency Conditions	SRV/DCA (Consider Specialist Resource)	Transport Must Arrive In **120** Minutes

5. Responding to Category 1 Calls

5.1. Cardiac Arrest Calls require significant attention to detail. Every effort will be made to ensure the timeliest response possible is achieved. For every minute the patient remains in cardiac arrest, the chance of survival reduces by 10%.

5.2. Due to the nature of cardiac arrest calls, careful resourcing is required. Too few resources will compromise care (due to rescuer fatigue etc.), however, it is possible to over-resource these calls which may cause scene management issues, which also compromises care.

5.3. The Trust operates the “pit stop” model in its approach to delivering advanced life support and as such staffing levels should be as a guide four pairs of hands.

5.4. An Airwave general broadcast will be carried out for every category 1 call.

5.5. The nearest resource, regardless of grade, will be sent to every category 1 via automated dispatch function via CAD.

5.6. The Dispatcher will also check to see which resource/s are being sent to the incident and review other resources that could be deployed, for example any managers, community first responders (CFRs), Co-Responders or HART resources nearer to the incident.

5.7. A Double Crewed Ambulance (DCA) must be deployed to each category 1 incident.

5.8. The Incident Command Hub will review all Cardiac Arrest calls to ensure optimum ratio and skill mix has been deployed. Consideration for CCP to attend will also be considered.

5.9. Following cardiac arrest, crews should be offered a welfare check after the event and if required offered support from the duty operational commander.

6. Emergency Operations Centre (EOC) Call Handling Procedure

6.1. This procedure provides a full process to ensure that the Trust’s EOCs manage calls received appropriately and that the patient’s safety and welfare needs are met.

6.2. This procedure will ensure all calls handled by the EOC are matched to a disposition which will provide recommendation for the most appropriate clinical care, dependant on the needs of the individual patient in line with national and local performance standards. The full copy of the procedure is embedded below.

EOC Call Handling Procedure V1.00.pdf

7. Staying on the Line

7.1. The Emergency Medical Advisor (EMA) should only remain on the line under the following criteria, as any time spent on the phone unnecessarily impacts on the EOCs ability to answer other waiting 999 calls. Under the Trust's Operational Instruction 236, there is an expectation that the EMA will Stay on the Line for;

- Cardiac of peri arrests
- Unconscious / fitting if there is no-one on scene who knows how to deal with the patient
- Imminent births
- Child callers

7.2. The EMA should stay on the line where in line care advice is being provided, or where there is a concern on the management of the patient's airway in an unconscious patient.

8. "Tail Management" Patient Welfare Procedure

8.1. A paper was submitted at the Trust Board Meeting on 29 November 2018, which provided an update on the progress and management of the "tail" to ensure patient safety. A copy of this paper is embedded below as a reference;

130.18 Clinical Safety - EOC Tail Ma

8.2. This report provides full detail on how the "tail" is managed and the controls in place to ensure that patient safety and welfare is maintained. For the purposes of this paper the 'tail' is identified as incidents within the Trust pending dispatch CAD queue who are experiencing delays in resource arrival.

8.3. Under the Trust's Welfare Call Procedure, any incident subject to welfare calls are specified as below;

ARP Response Category	Time of Initial Welfare Call	Time of Subsequent Welfare Call
Category 1	7 minutes	7 minutes
Category 2	18 minutes	30 minutes
Category 3	120 minutes	60 minutes
Category 4	180 minutes	60 minutes
Category 5	180 minutes	60 minutes
HCP 60	180 minutes	60 minutes
HCP 120	180 minutes	60 minutes
HCP 180	180 minutes	60 minutes

8.4. Latest performance figures for Category 1 Response calls for December 2018 are;

C1		Mean
England		00:07:06
1	London	00:06:17
2	North East	00:06:29
3	West Midlands	00:06:48
4	South Western	00:06:49
5	South Central	00:06:55
6	Yorkshire	00:07:03
7	East of England	00:07:31
8	North West	00:07:41
9	South East Coast	00:07:44
10	East Midlands	00:07:45
11	Isle of Wight	00:09:40

C1		90th
England		00:12:24
1	London	00:10:29
2	North East	00:11:17
3	West Midlands	00:11:49
4	Yorkshire	00:12:15
5	South Western	00:12:18
6	South Central	00:12:26
7	North West	00:12:55
8	East of England	00:13:42
9	East Midlands	00:13:50
10	South East Coast	00:14:13
11	Isle of Wight	00:18:34

C1T		Mean
England		00:10:56
1	North East	00:07:43
2	West Midlands	00:07:45
3	Yorkshire	00:09:02
4	South Central	00:09:58
5	South East Coast	00:10:01
6	North West	00:10:29
7	Isle of Wight	00:10:42
8	London	00:11:02
9	South Western	00:11:02
10	East of England	00:11:33
11	East Midlands	00:17:32

C1T		90th
England		00:20:28
1	West Midlands	00:13:33
2	North East	00:13:56
3	Yorkshire	00:16:33
4	North West	00:17:52
5	South East Coast	00:18:44
6	South Central	00:18:46
7	London	00:19:05
8	Isle of Wight	00:20:34
9	South Western	00:20:41
10	East of England	00:20:53
11	East Midlands	00:41:10

9. Managing Category 1 Delays

9.1. The nature of each incident will vary depending on the call, however the concept for managing C1 calls remains dynamic and will follow the procedures as highlighted above.

9.2. Any delays to C1 responses that exceed the 7-minute target time are recorded on the CAD and the EOCMs must review and sign off these responses ensuring reasons are documented.

9.3. The longest C1 response each day is explained by the EOCM on the daily Teams E conference call. This allows any risks to be discussed and the Strategic Commander to be fully sighted on issues.

9.4. It should be noted that many of the longest delays recorded are not actually delays but rather upgrades from lower acuity calls C2, C3, C4 and HCP. This is due to the fact that on upgrade the clock does not restart.

9.5. The EOC Clinical Team, review the C1 incidents as part of the Tail Audits, as detailed in the earlier embedded document and previously presented to the Trust Board in November 2018.

10. Conclusion

10.1. This paper has sought to set out the fundamental requirements for the management of Category 1 calls and the priority that these calls are given from both the EOC and Field Operations.

10.2. The Trust is asked to note the contents of this paper as further supporting information to the paper 130.18 Clinical Safety – EOC Tail Management and CAT 1 Assurance.

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Operational review of Christmas and New Year period – 2018/19

1. Introduction

1.1 The aim of this document is to provide a brief summary of the performance of South East Coast Ambulance Service's (SECAmb's) 999 service during the Christmas 2018 and New Year 2019 period. For clarity, this paper will focus on the period 24 December 2018 to 6 January 2019.

1.2 Separate papers provide a detailed operational look-back for the NHS 111 service in our region during the same period, as well as a detailed review of the Emergency Operations Centres (EOCs).

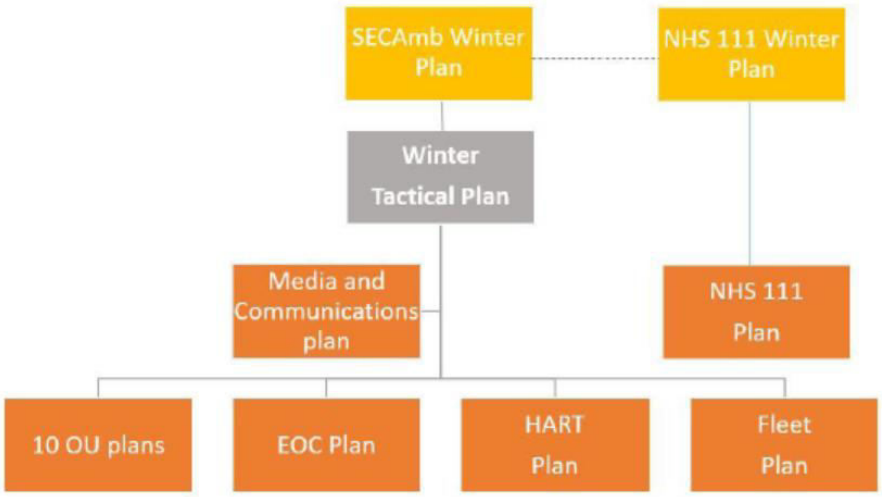
2. Planning and preparation for the Christmas and New Year period

2.1 Learning lessons from previous years, SECAmb worked hard this year to ensure the Trust was in the best position possible to respond to the anticipated high levels of demand over the festive period.

2.2 A ***Winter Capacity Plan*** to cover the period 1 November 2018 to 31 March 2019 was developed by the Trust and can be found at Appendix A.

2.3 This Plan draws on the experiences of past winters and integrates NHS England recommendations, guidance and criteria for winter capacity planning. It concentrates on a number of year round processes and key seasonal initiatives that will deliver real resilience during the winter period and ensure engagement with local health systems.

2.4 It also serves as an overarching plan to bring together the arrangements detailed in the individual Operating Unit, Emergency Operations Centre winter plans and the NHS111 Winter Plan, as shown below:



2.5 The Winter Capacity Plan was developed to deliver the following:

Strategic Intentions:

- Maintain a clinically safe service to all our patients
- Mitigate and minimise the impact to the wider NHS
- Inform the public and maintain public confidence
- Ensure sufficient assets are available to manage the event to maintain service delivery to national standards
- Ensure a swift return to normality in the event of an incident

Tactical Intentions:

- To ensure patient safety is at the centre of our actions
- To have a pre-defined Command and Control Structure in place to ensure the operational demand is managed effectively
- To maintain core services through the effective use of escalatory framework
- To ensure that staff welfare is considered by providing refreshments and adequate breaks within the constraints of the demands being placed on the service
- To work with partners to mitigate demands and limit the impact on the wider NHS

2.6 Underpinning our planning assumptions to deliver the above intentions were the following key drivers:

- Maximising staffing on the road and in the control rooms by:
    - Closely managing staff abstraction
    - Incentivising key operational shifts between 24 December 2018 and 6 January 2019
    - Developing individual operational plans for each local Operational Unit, including detailed local staffing plans
    - Maximising support from volunteer CFRs and Co-Responder schemes
    - Utilising operationally-capable managers to provide additional resources
    - Working closely, in advance, with our Private Ambulance Providers (PAPs) to ensure maximum availability of resources
    - Identification of clinically-trained staff, not working in patient-facing roles, who were able to provide additional support at peak times
    - Close, on-going monitoring of resource levels, including conference calls three times per week (in addition to the business as usual, daily 'Teams E' call)
- High-level on-site support from senior managers and Executive Directors on key dates during this period, including Christmas Day, Boxing Day, New Year's Eve and New Year's Day
- Maximising availability of key support functions, including Fleet, Logistics and Make Ready
- Establishment of the Strategic Command Hub at EOC West:
    - Stood up from 26 December 2018 to 3 January 2019

    - To provide additional strategic oversight, on-site from 0700 to 2300 hours and on-call overnight, utilising the same methodology as for a Major Incident
- Close working as part of the broader NHS & Social Care system:
    - Ensuring our plans took full account of the guidance circulated in July 2017 by NHS England and NHS Improvement regarding planning for winter 2017/18
    - In line with this guidance and the operational priorities set out by the NHS England Board on 30 November 2017 for 2018/19, the Trust continued to engage with the wider NHS through the CCGs and A&E Delivery Boards to deliver local initiatives
    - Hosting of the NHS England 'Winter South' Team on a number of days across the period
    - Daily up-date calls with the NHS England 'Winter South' Team to identify and share challenges in the region
- Detailed analysis of activity data from preceding years, to identify potential 'hot spots'

2.7 This year, as part of the delivery of the early phases of the Service Transformation and Delivery Programme (STAD), the Trust also benefited from the extensive recruitment of front-line staff, which had taken place during Quarter Three. Including internal transferees, by January 2019 we saw a total of 389 extra staff working operationally to support patients.

2.8 Ahead of the winter period, the Trust had also revised its Surge Management Plan (SMP), to ensure it was as responsive and effective as possible and the revised version went live on 3 December 2018, following in-put from a range of internal and external stakeholders.

2.9 The SMP is utilised by the EOC in situations of surges in call volume, which result in the supply of ambulance service resources being insufficient to meet the clinical demand of patients. The more flexible and immediate nature of this plan will often mean that it provides an effective and expedient response to surges in demand that are likely to be for short durations.

2.10 The SMP is subject to an on-going cycle of review and improvement. Following feedback from its use during the festive period, it is currently under review, with a further revised version likely to go live in February 2019.

3. 999 Performance

3.1 As anticipated, SECAmb experienced sustained and significant pressure across the festive period, although we did not experience poor weather conditions during this time in our region.

3.2 As the information below shows, we performed well overall with some particular areas of improved performance. However, there remain a number of areas where we need to see improvement and on which we continue to focus.

3.3 The tables below show activity levels and performance for the individual periods week commencing 24 December and week commencing 1 January and compared to the same periods last year:

999 Activity levels

w/c 24 December	2017/18	2018/19	Difference
Number of 999 calls answered	17,246	14,664	Decrease of 15%
Number of incidents with a response	14,358	13,542	Decrease of 6%
Number of transports	9,346	8,947	Decrease of 4%

w/c 31 December	2017/18	2018/19	Difference
Number of 999 calls answered	15,011	14,974	Decrease of 0.25%
Number of incidents with a response	13,956	14,413	Increase of 3%
Number of transports	8,923	9,436	Increase of 6%

999 call answer performance

w/c 24 December	2017/18	2018/19
Number of 999 calls answered	17,246	14,664
Average answer time (seconds)	64	5
95th centile (seconds)	236	19

w/c 31 December	2017/18	2018/19
Number of 999 calls answered	15,011	14,974
Average answer time (seconds)	80	3
95th centile (seconds)	362	3

Performance against ARP standards

w/c 24 December	2017/18		2018/19	
	Mean Response Time	90th centile	Mean Response Time	90th centile
Category 1 - these will be responded to in a mean average time of seven minutes and at least 9 out of 10 times before 15 minutes	00:08:32	00:15:17	00:06:57	00:12:45
Category 2 - these will be responded to in a mean average time of 18 minutes	00:20:03	00:38:38	00:20:05	00:38:11

and at least 9 out of 10 times before 40 minutes				
Category 3 - these types of calls will be responded to at least 9 out of 10 times before 120 minutes	01:52:08	04:17:42	01:38:32	03:56:24
Category 4 - these less urgent calls will be responded to at least 9 out of 10 times before 180 minutes	03:01:11	06:35:55	02:02:35	04:20:57

w/c 31 December	**2017/18**		**2018/19**	
	Mean Response Time	**90th centile**	**Mean Response Time**	**90th centile**
Category 1 - these will be responded to in a mean average time of seven minutes and at least 9 out of 10 times before 15 minutes	00:08:09	00:14:15		
Category 2 - these will be responded to in a mean average time of 18 minutes and at least 9 out of 10 times before 40 minutes	00:17:08	00:32:17		
Category 3 - these types of calls will be responded to at least 9 out of 10 times before 120 minutes	01:07:55	02:36:23		
Category 4 - these less urgent calls will be responded to at least 9 out of 10 times before 180 minutes	01:41:14	04:15:38		

3.4 As can be seen from the tables above, activity levels for both periods were down compared to last year, which is likely to be explained by the reasonably mild weather conditions experienced during this period.

3.5 A decrease overall in the number of 999 calls can also potentially be explained by the Trust providing an improved service to waiting patients i.e. with the increased number of resources we have available, patients are waiting less time overall for a response, meaning they do not have to make repeat 999 calls.

3.6 It is also interesting to note that, despite a small decrease in the number of 999 calls received for the week commencing 31 December compared to the previous year, the number of incidents that received an ambulance response increased by 3% and the number of patients transported by 6%. Although specific

analytical comparison is difficult, these increases were potentially caused by an increase in the acuity of patients phoning 999.

3.7 As the figures also show, a number of performance areas saw improvement compared to the same period last year:

- Considerable improved performance in both Category 1 measures for both time periods compared to the previous year
- Improved performance in all call categories for week commencing 24 December including a reduction of almost an hour in our mean response to Category 4 patients
- Significant improvement in 999 call answer times for both time periods

3.8 I am pleased to see sustained improvements such as this during a busy and pressurised period and am extremely proud of the efforts of staff and volunteers, both ahead of and during this period, which has seen us provide an improved service to our patients.

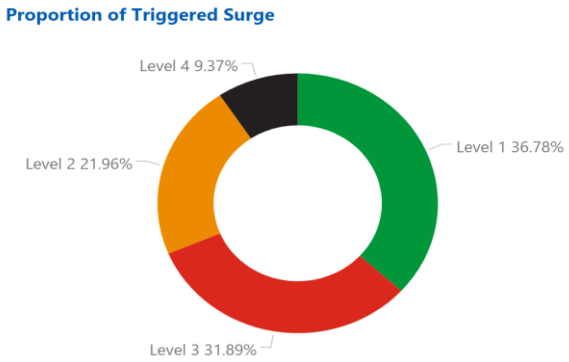
3.9 However, I also recognise that there is still more to do to sustain the improvements we have seen and also improve performance in a number of areas, especially in our response to Category 2 and Category 3 patients.

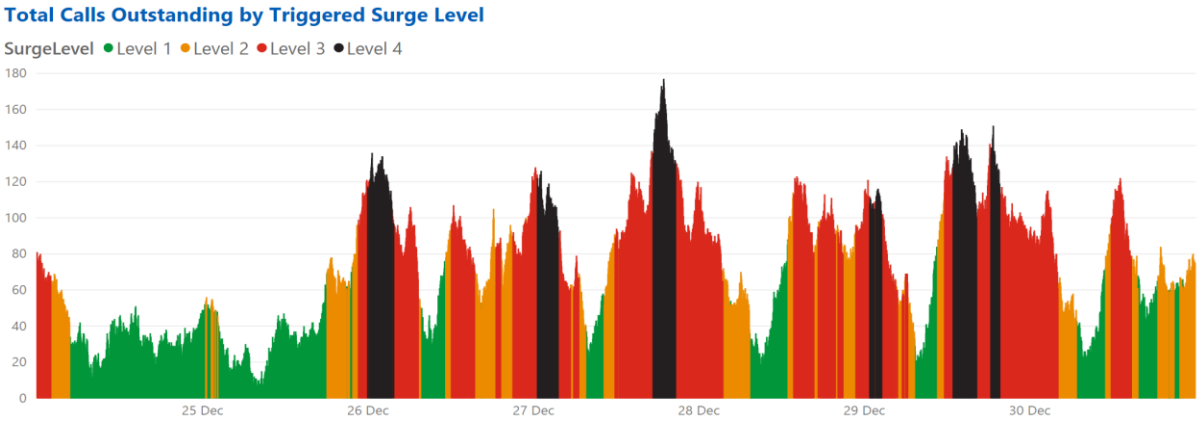
4. Escalation levels

4.1 As explained in 2.9 above, the Trust's Surge Management Plan (SMP) provides a framework for managing escalation. It contains levels of surge linked to specific triggers, from Level 1 (business as usual) to Level 4 (major pressure which prevents the Trust from delivering a comprehensive service to patients).

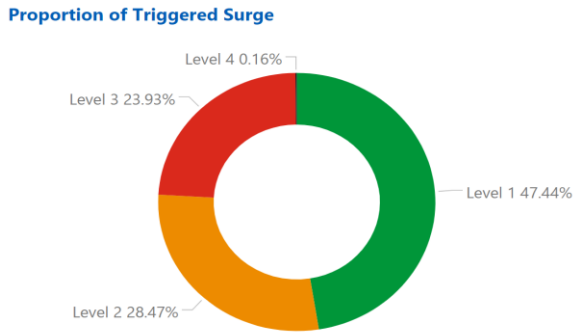
4.2 Analysis of the percentage of time spent at the different levels of surge during this period provides a good indication of the level of pressure experienced by the Trust, taken alongside performance indicators. (Comparison with the previous year is not possible, as surge levels have only been constantly recorded and available to run as a report since July 2018).

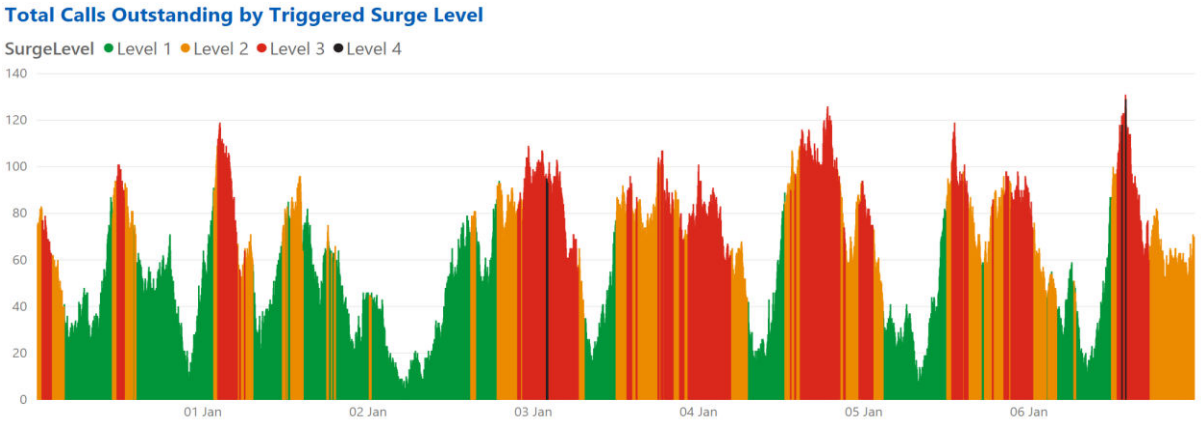
Surge Profile – w/c 24 December 2018





Surge Profile - w/c 31 December 2018





5. Communications

5.1 As shown in 2.4 above, the Trust developed and delivered a Winter Media & Communications Plan during this period, to ensure that key stakeholders were kept up-dated on challenges and key issues and, importantly, that public messages were delivered as needed to support operational delivery during periods of escalation.

5.2 A key strand of this year's Plan was the in-house development of a range of bespoke infographics to support the communication of key messages on-line and on various social media platforms:

5.3 Whilst the objectives contained in the Plan will continue into Q1 of 2019, a significant number of winter and demand-specific proactive media releases were

issued during December and into early January, utilising a range of communication mechanisms.

5.4 Following evaluation, key achievements so far include:

- A significant reduction in the number of reactive media statements issued in relation to long response times. This could be down to overall improved response times and a greater understanding of the public of the new response standards, thanks to, in part, communications messaging
- Positive broadcast media coverage, including coverage on ITV including interviews with EOC staff and coverage by BBC South East on the Trust's Hazardous Area Response Team (HART) alongside figures for number of calls handled by the Trust on New Year's Eve
- Significant coverage of Trust messages on social media including:
    - Figure 1 as shown above at 5.2 was estimated by Facebook to have reached more than 400,000 people and was shared more than 5,000 times after it was posted on 4 December 2018
    - Other posts, including Figure 3 above, regularly reached in excess of 50,000 people on Facebook

5.5 While these are estimates and should only be used as a guide, it is worth noting that these figures are far in excess of the reach of many regional newspapers weekly sales. While regional newspapers remain an extremely worthwhile medium in which to achieve coverage of the Trust's key messages, especially given their own online presence and reach, the Trust's own reach via social media, linking to its own website and utilising bespoke media, should not be under estimated.

6. Patient experience, staff & safety indicators

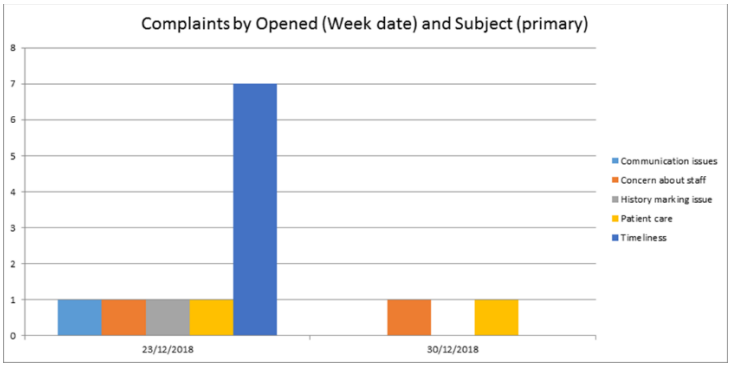
6.1 Alongside 999 performance measures, it is useful to consider a range of other indicators when assessing the Trust's performance during Q3. However, due to the long lag on performance reporting, we will be unable to consider performance against our clinical indicators for a number of months.

6.2 To date, two Serious Incidents (SIs) have been reported, relating to incidents occurring during this period. This compares to ten SIs reported during the same period last year:

- 28.12.18 - (999) call received from Police about a patient who was not breathing. Delay in locating incident as Police unable to provide an accurate location and EMA struggled to find anything with the information given. EMA finished call but did not make a call back to scene to give CPR advice
- 03.01.19 - received a call from care line, regarding an elderly female with slurred speech. After initial care line contact, no further response from patient. This was categorized as Cat 3 (respond within 2 hours). At 12:00 3 x welfare calls were attempted with no answer. Crew arrived on scene to find patient deceased

6.3 These are currently being investigated as part of the SI process.

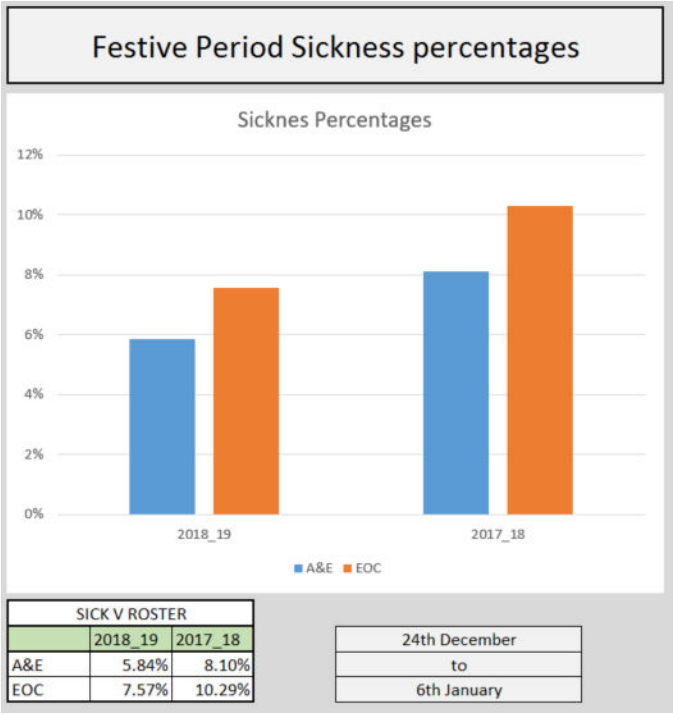
6.4 A review of the number and themes of complaints received relating to incidents during this period is as below:



6.5 When compared to the numbers of complaints received for these periods last year, we saw a reduction in overall numbers for both periods:

w/c 24 December	2017/18	2018/19	Difference
Number of complaints received	22	11	Decrease of 50%
w/c 31 December	**2017/18**	**2018/19**	**Difference**
Number of complaints received	14	2	Decrease of 79%

6.6 Another key indicator to consider for this period is staff sickness levels and, as the table below shows, sickness levels for both A&E and EOC staff were down compared to the previous year for this period.



7. Issues

7.1 The only key issue that the Trust experienced during this period, which impacted on our ability to respond to patients, was hospital handover delays.

7.2 During the past year, the Trust has been working as part of a system-wide programme to reduce hospital handover delay experienced by ambulance crews when handing over patients at acute hospital sites.

7.3 Good progress has been made in many areas and as the tables below show, the total number of hours lost to delays during this period was considerably lower than last year.

w/c 24 December	2017/18	2018/19	Difference
Number of handovers	7,790	7,646	Decrease of 2%
Hours lost over 30 minutes	710	325	Decrease of 54%
Number of handovers over 60 minutes	430	205	Decrease of 52%
Proportion of handovers over 60 minutes	5.5%	2.7%	Decrease of 2.8%

w/c 31 December	2017/18	2018/19	Difference
Number of handovers	7,383	8,079	Increase of 9%
Hours lost over 30 minutes	894	411	Decrease of 54%
Number of handovers over 60 minutes	580	233	Decrease of 60%
Proportion of handovers over 60 minutes	7.9%	2.9%	Decrease of 5%

7.4 It is worth noting however that, despite the improvement in figures for the region at a whole, delays were experienced at individual sites during this period, which in turn had a considerable impact on our local response to patients.

8. Conclusion

8.1 As part of our on-going improvement methodology, we are continuing to review performance in all areas for this period and to identify lessons learned for future years.

8.2 I am also conscious that, we may still experience low temperatures and bad weather across our region, which would increase demand for our services and create a number of logistical challenges. We are continuing to plan for this scenario and monitoring the medium range weather forecasts carefully.

8.3 Finally, I would like to thank all of our staff and volunteers for everything they did to help our patients during this period and throughout the year. Notwithstanding the improvements we need to make, I am immensely proud of the dedication of every colleague within the Trust and the achievements we have made.

Joe Garcia, Executive Director of Operations

16 January 2019

SECAMB Board

Summary Report on the Workforce and Wellbeing Committee Meeting of 18 January 2019

Date of meeting	**18 January 2019**
Overview of issues/areas covered at the meeting:	The key areas covered in this meeting related to Diversity & Inclusion, the Wellbeing Hub, Brexit HR Risks, and updates on Service Transformation & Delivery (STAD) and HR Transformation.
Diversity and Inclusion	The WWC received a comprehensive report from Asmina Islam Chowdhury, the Trust's Inclusion Advisor, which demonstrated that the Trust has a highly motivated and competent focus on Diversity and Inclusion. The report covered 4 key areas: • **Compliance with Public Sector Equality Duties:** the report provided **Assurance** that the Trust was meeting its obligations. • **The Workforce Race Equality Standard (WRES):** the report provided **Assurance** that the Trust is engaged in and is monitoring progress against the WRES and its 9 key indicators. The Executive, on behalf of the Trust had identified an overarching Equality objective: "The Trust will improve the diversity of the workforce to make it more representative of the population we serve." This is supported by an action plan. Overall, WWC was **Partially Assured** - the issues were understood and were being co-ordinated appropriately, but, similar to other Ambulance Trusts, we fall short of the standard in a number of areas. More comparative information was being received and the WWC asked that a summary be brought to the Board. • **Pay Gap Reporting – Gender and Ethnicity:** the report provided **Assurance** that the Trust was recording Gender and Ethnicity Pay Gap data, but highlighted that the mean/median gaps had widened between Mar 17 and Mar 18 and further analysis is required to understand the reason(s) for this. In discussion a number of anecdotal examples of lack of awareness of diversity and inclusion requirements during recruitment and advancement processes had been observed. It was agreed that a particular focus must be paid to championing of the WRES and Diversity & Inclusion agenda at all levels, including Board, and that more work and focus was needed to integrate its principles into all the Trusts policies, planning and processes. It was discussed that this would be further supported by the appointment of a Non-Executive Board Champion alongside the Executive Board Champion for Diversity and Inclusion.
Wellbeing Hub	WWC received a comprehensive report from Angela Rayner which gave **Assurance** that the Wellbeing Hub initiative was being well managed. WWC thanked Angela and her team, on behalf of the Board, for their commitment and progress with this initiative. • The report provided qualitative and quantitative evidence that the hub is providing a very positive contribution to the wellbeing of our workforce as well as delivering a number of efficiencies and improvements. • However, it was noted the current usage of the Hub's facilities and services is placing a heavy demand on the existing staff. This was being assessed and a forthcoming business case makes the case referred to EMB to consider any recommendation for

	an uplift in Wellbeing Hub staffing. • An NHS Employers Health and Wellbeing self-assessment had been completed which is to be submitted to NHSI, demonstrating that the Trust is well placed in its approach to Wellbeing. It also highlighted potential areas for improvement, including training, the frequency and nature of reporting to the Board, and the opportunity for increased championing by Board/Exec members. • WWC asked that the completed self-assessment together with appropriate Board dashboard Wellbeing information be brought to the Board.
BREXIT	WWC **noted** that sensible HR considerations were being included in the Trust wide management of risks associated with BREXIT.
STAD	Discussion focussed on the considerable progress made to date in increasing recruitment, especially for EOCs and of ECSWs. WWC congratulated a hard pressed resourcing team on progress to date. **Partial Assurance** was provided with a number of specific concerns: • Continuing challenges with obtaining C1 driving licences and getting new recruits into the front line due to the availability of vehicles were openly and thoughtfully raised. These were slowing "on-boarding" but were being addressed. • The challenge of managing a workforce with a higher proportion of new recruits was highlighted. This was placing additional pressures on OUs, EOCs etc as well as adding to the pressure on HR specialist staff. • A workforce presentation demonstrated the great potential of Power BI for analysing workforce data to improve planning and make adjustments. WWC asked to review the presentation outside the meeting as it appeared to show **a significant step forward** in capturing workforce planning interdependencies. It was felt that this might form the basis of a long-awaited "Workforce Plan" which would argue not only "what" we need to do to meet D&CR workforce projections, but "how" and "why". • WWC noted that an expected briefing on the Trust's intended approach to improving retention had been delayed. Anecdotal examples were offered and the committee asked that a substantial discussion was brought to the next WWC.
HR Transformation Programme	WWC was **Partially Assured** by a brief on HR Transformation: • Whilst a new approach to work on "Culture" was being captured in a mandate and plan (due Feb 19) this was running in parallel with other direction emerging from a Board Development group. WWC asked that the 2 strands be brought together with urgency. • Process Improvement had now mapped and analysed most "as-is" processes. Recommendations would be brought to the Board (and committees) (by March tbc) supported by business cases as required. • The progress of a People Strategy had been slowed. A draft had yet to be reviewed by EMB, by WWC (out of committee initially so as not to delay) and the Board.
Workforce/HR Dashboard	The WWC heard that a proposed revision of the Workforce/HR dashboard had been delayed but offered guidance that the focus should be on a small number of additional reports to capture KPIs for STAD, workforce development and HR transformation. WWC noted a

	number of positive trends and a number of concerns: • Progress towards at least 80% completion of Appraisals and Objective Setting by 31 Mar 19 had slowed putting the target at risk unless the Board, Exec and senior managers all stressed the importance of prioritising this important aspect of staff engagement and morale. • Notwithstanding the great progress with ECSW recruitment the WWC noted the continuing (anticipated) high vacancy rates for Dispatchers (c22-25%), Paramedics (inc NQP) (21%, CCP (22%) and PP (41%). The plan for recovery from these figures towards a new clinical workforce structure must be central to the new Workforce Plan. • WWC noted high levels of employee relations casework, grievances and appeals and the potential impact these were having in a number of cases on industrial relations.
Review of Risks and Policies	The paper was received, but discussion was deferred due to time constraints.

SECAMB Board

QPS Committee Escalation report to the Board

Date of meetings	06 December 2018 & 18 January 2019
Section 1 **Overview of issues/areas covered at the meeting:**	The committee has met twice since the last Board meeting. This report therefore covers some of the key issues (not every areas covered during the two meetings). Firstly, the committee considered a number of ***Management Responses*** (*response to previous items scrutinised by the committee)*, including: **Internal Safeguarding (DBS checks) (Partially Assured)** In December the executive was assured with the significant progress made; all staff confirmed to have an initial DBS check. It noted the Trust policy is to undertake checks again after 3 years, and that there is significantly reduced backlog of less than 30 staff. However, in January an issue was raised by the executive which highlighted that the controls still require embedding. Therefore it could not be fully assured and has added DBS checks to its annual cycle and will seek assurance on the controls during 2019/20. **NRLS reporting** The Committee has examined the issue of classification of deaths (SECamb responsibility vs not SECAmb) and potential over reporting of numbers. This management response provided further detail on the actual numbers. It was noted that the classification of the Sis went through the process in place at the time. Given that this process has been significantly improved it was agreed that 5 cases should be reviewed again against the current process. The Committee also heard that there may be other cases under the old system that require review. A piece of work is currently being completed by CQC and this will inform what we do. **999 NHS Pathways (Not Assured)** The committee noted the steps taken by management to ensure robust management of pathways audits to ensure 100% compliance. It was able to determine at the January meeting that the underlying risk to compliance is the capacity of staff. As a consequence of the prioritisation of completing audits, we don't have a system of learning. Detailed questioning also revealed some current 999 auditors do not meet the standards required for the role (still need to take a set number of calls themselves). The overall compliance and issues are subject to an action plan but are of concern. The committee escalated this to the executive management board – see section 4 below. **Mobilisation of Kent and Sussex 111 (Assured)** The committee was assured by the level of work going on to ensure the mobilisation is well managed. It will review the Go Live criteria in February, to ensure the relevant patient safety considerations are sufficiently met. The meetings also considered a number of ***Scrutiny Items*** *(where the committee*

	scrutinises that the design and effectiveness of the Trust's system of internal control for different areas), including; **PAPs (Partially Assured)** The committee has looked at this issue at both meetings to reach a decision it was partially assured by the governance in place to ensure safe use of private providers. The Committee looked in more detail at the clinical rationale for continuing to use SSG despite it being placed in special measures. It received evidence to demonstrate the decision was based on a robust consideration of the risks and our own governance processes, in particular, our PIN system. SECAmb is the only ambulance trust using a PIN login system for private providers so we are assured that all SSG staff working SECAmb shifts are suitably trained and meet our standards. A robust improvement plan is in progress and is closely monitored. A further management response has been requested to provide more clinical data, further assurance on meds management, key actions and dates. **Infection Prevention and Control (Partially Assured)** In December there was scrutiny of how we are doing against the plan and the strategy launched earlier this year. The plan is on track but there was concern about one area of non-compliance, in particular; vehicle cleanliness. In January the management response set out the main cause being the pressure of vehicle turnaround, which is linked to the increase in front line staff hours. Management explained the balance of risk considered by operational leaders, which the committee acknowledged. Some comfort was gained by confirmation that there have been no related issues to date from swab testing results. The committee also noted the planned arrival of more vehicles, which would improve the situation. **Non Registered Clinicians Scope of Practice (Partially Assured)** The paper set out the different roles and scope of practice for the non-registered clinicians. There is clearly some lack of clarity among the workforce in part due to some legacy issues HR issues. The paper helpfully laid out the complexity and the proposed actions to ensure all roles are clear, safe and understood. The committee explored how the scope of practice is followed and the related risks and mitigations. It was helpful to get this clarity and the stated recommendations were supported by the committee. It will monitor the action plan. It was noted that a recent patient safety and leadership walkabout had identified exactly the issues described in the paper. This item is returning to QPS in 3 months. **EOC Clinical Safety (Partially Assured)** Pre-Christmas, the committee explored the clinical support available in the EOC over the Christmas / New Year period, and the different steps being taken to ensure this would be sufficient. It noted all the various steps being taken, which reflected a much better position this year than last year. The committee thanked management for a clear and honest appraisal of the positon. Pre-Christmas, there were still a number of issues to resolve to ensure sufficient staff and so the committee asked for an update by email and then confirmation in January

	of the extent to which the gap was closed. The look back took place in January where the positive impact of the clinical navigator was highlighted. The Committee noted that although staffing levels we not at the level ideally required, they were above the levels expected. The Committee asked for details of incidents and was informed there were serious incidents in relation to lack of welfare calls but the number of incidents did not spike in the same way as in 2017. The Committee will look at the Sis as part of its ongoing assurance of incident management. **CFR (Partially Assured)** The committee agreed that progress continues to be made and reviewed evidence on a range of developments and improvements. However the Committee challenged how the progress was perceived by CFRs. Concerns remain about the way we monitor CFR performance and quality measures, how CFRs are supported at a local level and how we can ensure compliance with instructions. The committee challenged management to be clearer about what it wanted from CFRs now and in the future. The committee will seek this clarification at its April meeting, together with a clear set of actions and time line. The committee also asked that further work is completed to provide clarity on the CFR strategy, separately from any wider community and volunteer engagement/strategy. **Internal audit – medical gases** The Committee received the internal audit report covering this topic which had been under considerable scrutiny over the past months at QPS. The Committee was concerned to learn of a new issue regarding the tagging of equipment and a historical decision to alter the service dates. The Committee has asked for a response detailing what happened and why so it can be assured on learning and authorisation processes. The committee also received a number of reports: ▪ **Clinical Audit Quarterly Re**port – this showed an improving picture especially on care bundles. The committee was assured the plan is on track. ▪ **Medicines Governance Quarterly Inspections** – the results were reviewed and the committee was assured that management is aware of the issues and have corrective actions in place. ▪ **Mortality and Morbidity Bi-Annual Review** – there have been two deep dive reviews in the period relating to delays and calls from care line. The committee challenged the executive to include more of the learning in future reports to reflect all the work we are doing.
Section 2 **Reports *not* received as per the annual work plan and action required**	The committee asked for an update over Christmas confirming the extent to which the gaps in clinicians was being closed. This was not provided, in the way it was requested.
Section 3 **Changes to significant risk profile of the**	N/A

trust identified and actions required	
Section 4 **Weaknesses in the design or effectiveness of the system of internal control identified and action required**	**Learning from Pathways Audits** There is no systemic process of learning from pathways audits, save for that arising from incidents and complaints. Acknowledging that a business case is being developed to improve staff (audit) capacity in EOC, the committee has asked EMB to ensure immediate action is taken in the meantime, to ensure a system of learning from pathways audits and that auditors meet the required standard..
Section 5 **Any other matters the Committee wishes to escalate to the Board**	**R&D Strategy** The committee considered the strategy and recommends it to the Trust Board (agenda item 147-18). In exploring the various elements, the committee noted that externally, the Trust is well recognised in terms of research, but yet this is somewhat less visible internally. The Committee noted and supported, the development of a business case to strengthen R&D. **Learning from deaths** The committee is receiving a deep dive presentation in February.

SECAMB Board

Summary Report on the Audit & Risk Committee (AUC) Meeting of 3rd December 2018

Date of meeting	**3 December 2018**
Overview of issues/areas covered at the meeting:	This Meeting of The Committee was observed by Felicity Dennis on behalf of the Board of Governors. The key areas covered in this meeting were • Progress with outstanding Internal Audit actions • Audit Reports on Duty of Candour and the Medical Asset Register • A Local Counter Fraud Report • KPMG External Audit Plan for the year ending 31 March 2019 • Discussion as to the linkages between AUC and other Board Committees • Proposals in respect of Governance & Assurance Framework • Declarations of Interest In general, and subject to the minutes of the meeting and the commentary below, AUC observed good progress
Internal Audit	AUC was pleased to note continuing good progress with outstanding Audit actions. **Duty of Candour Audit (partial assurance)** AUC scrutinized the report in detail and in particular the effectiveness of Datix. AUC emphasised the importance of building staff confidence and trust in the system through appropriate training. **Medical Asset Register Audit (partial assurance).** The main themes were clarity on procedures and decision making, particularly in respect of servicing. AUC was assured that the agreed actions on governance and authority would be scrutinised by the Board QPS Committee Linkage between AUC and other committees was discussed. AUC took the view that the inclusion of the Chairs of other committees within AUC was sufficient; however, AUC encouraged the Executive and/or Internal Audit to discuss findings with other Board Committees directly if/as appropriate
Risk Update Report **Governance & Assurance Framework Proposal**	AUC reviewed the risk update paper. Whilst some good direction was noted, the Committee asked for more focus on emerging themes, specific risks and deep dives. AUC considered a paper which described a proposed framework that the Board could use to help assure sustainable and quality provision of service. Detailed discussion and guidance to the executive followed. A revised draft will be presented to AUC and/or the Full Board in due course.

Declarations of Interest Policy	Subject to amendments discussed at the meeting, The Committee was assured
Counter Fraud Report	AUC noted and was assured by the good work undertaken.
External Audit	KPMG presented their plan in respect of the year ending on 31 March 2019. Following detailed discussion, the Committee was assured. KPMG noted AUC sensitivity surrounding Value for Money

SECAMB Board

Summary of the Finance and Investment Committee (FIC) Meeting of 17th January 2019

Date of meeting	**17 January 2019**
Overview of issues/areas covered at the meeting:	The key areas covered in this meeting related to Conduct of FIC, 111, Operational Performance, Financial Performance, Brexit contingency and Business Cases for approval.
Business Cases	Whilst FIC is prepared to consider urgent one-off businesses case on an exceptional basis, the committee re-iterated its expectation that future business cases would normally be expected to consider their impact on longer term financial projections. Currently FIC has no formal approval powers, so the word "approval" below should be understood to mean "FIC recommends to the full Board that the project be approved" • Increase in Call Handling Capacity. This was approved • CCP/PP Re-banding. This was approved.
Financial Performance **Operational Performance**	The Committee was assured following discussion and challenge of a full report on month 8 /year to date financial performance. The committee noted with pleasure our best performance over the Christmas/New Year period for at least three years and acknowledged: • the hard work and planning throughout this year that has enabled and delivered such performance. • The additional financial contributions (following the Demand and Capacity review) that have enabled SECAmb to field additional vehicles and staff. The Committee/Executive agreed that the trust should continue to be creative with shifts/rostering to enable/enhance staff motivation and better retention.
Financial Planning	The Executive is on track to present a financial plan (consistent with previous FIC guidance) to the next meeting of FIC, possibly preceded by informal discussion with members.
Fleet Strategy	The Executive is on track to present a Fleet Strategy proposal to the next meeting of FIC. The forthcoming (shorter) paper will focus on key strategic principles and will be set in the context of the Carter Review.
Conduct of FIC	The Committee agreed to move to 6 meetings a year (in alternate months to AuC) to better support the trust during the Service Transformation program. Key points were • Service Transformation update at each ordinary FIC meeting • A plan for regular "deep dive" reviews of Finance Dept, Fleet, Procurement, Estates,

	IT and Other Corporate services on a rolling cycle • Benefits realisation reviews should take place for at least FIC approved projects and be presented to AuC
Brexit	The Committee received a verbal update on preparations for Brexit
111	The Committee received an update on the 12-month 111 extension program. The Executive are confident that the financial envelope will eventually settle within existing Board guidance, but there is some risk. The Committee noted that the existing guidance/red-lines expressed by the Board might relax a little following publication of the new 10 -ear NHS Strategy
IT	The Committee received and was generally assured by an update paper on IT, subject to comments and recommendations made
Estates Update	The Committee is grateful to colleagues and government for success with GBP19m of Capital bids; however, detailed business cases must be approved by NHSI before works can commence – this may be an issue with urgent projects such as the Brighton MRC build Whilst much work is underway/planned, the Committee was concerned that the paper did not give a comprehensive picture of the standard of all parts of the Estate. A further paper will be brought to the next FIC.