Brighton & Hove City Council

Health & Wellbeing Overview & Scrutiny Committee

Title:	**Health & Wellbeing Overview & Scrutiny Committee**
Date:	**11 June 2013**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall**
Members:	**Councillors:** Rufus (Chair)C Theobald (Deputy Chair), Buckley, Cox, Marsh, Robins, Sykes and Wealls **Co-optees:** Jack Hazelgrove (OPC), Amanda Mortensen (Parent Governor Representative), Marie Ryan, Susan Thompson (Diocese of Chicester), Youth Council and Healthwatch
Contact:	**Kath Vlcek** 01273 290450 kath.vlcek@brighton-hove.gov.uk

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AGENDA

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71. Procedural Business

72. Minutes of Previous Meeting **1 - 10**

Added after the committee meeting

73. Chair's Communications **11 - 16**

Public Question from Mr Rixson attached (added after the meeting)

74. Verbal update from Cllr Marsh on PLACE assessment

75. Sexual Exploitation of Children: Response from Local Children's Safeguarding Board **17 - 30**

Report of the Head of Law (Monitoring Officer) detailing the LSCB response to HWOSC requests for information (copy attached)

Contact Officer: *Giles Rossington, Senior Scrutiny Officer* *Tel: 01273 291038*

Ward Affected: *All Wards*

76. Update on 'Talk Health' report **31 - 52**

Contact Officer: *Kath Vlcek, Scrutiny Support Officer* *Tel: 01273 290450*

Ward Affected: *All Wards*

77. A&E and Capacity Pressures at the Royal Sussex County Hospital **53 - 64**

Contact Officer: *Giles Rossington, Senior Scrutiny Officer* *Tel: 01273 291038*

Ward Affected: *All Wards*

78. Update on Dementia Services **65 - 70**

Contact Officer: *Kath Vlcek, Scrutiny Support Officer* *Tel: 01273 290450*

Ward Affected: *All Wards*

79. Mental Health Acute Beds - May 2013 Update **71 - 72**

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Date of Publication 4 June 2013

BRIGHTON & HOVE CITY COUNCIL

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE

4.00pm 23 APRIL 2013

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Rufus (Chair)

Also in attendance: Councillor C Theobald (Deputy Chair), Bowden, Cox, Marsh, Robins, Sykes and Wealls

Other Members present: Co-optees Jack Hazelgrove (OPC); Marie Ryan (Catholic Schools Service); Thomas Soud (Youth Council) and David Watkins (Healthwatch)

PART ONE

60. PROCEDURAL BUSINESS

60.1 There were no substitutes. Apologies were given from co-optees Amanda Mortenson and Susan Thompson.

This was the first meeting for new co-optee Marie Ryan (replacing David Sanders from the Catholic Schools Service). The LINk co-optee's place had ended, as LINk had ended. It has been replaced from Healthwatch, which has a co-optee place on HWOSC. David Watkins attended HWOSC as Healthwatch co-optee.

60.2 There were no declarations of interest

60.3 There was no exclusion of press and public.

61. MINUTES OF THE PREVIOUS MEETING

61.1 There were some changes submitted by the SE Ambulance Trust representative; these changes would be made and the minutes re-circulated to Committee members.

Councillor Theobald wanted the minutes to be amended to show that she had asked for a panel to be held looking at whether there could be a kitchen on the RSCH new development. She felt that it was important that patients had food that was as locally sourced and as fresh as possible. Other members commented that this issue had been discussed by HOSC previously but that Councillor Theobald's suggestion would be noted.

62. CHAIR'S COMMUNICATIONS

62.1 The Chair welcomed the new co-optees to HWOSC.

63. LETTERS FROM MEMBERS OF THE PUBLIC/ COUNCILLORS/ OTHER BODIES

63.1 Ms Jean Calder had submitted a question:

"My mother, who has dementia, was recently admitted to the RSCH with severe dehydration. She had been living in nursing homes. I believe there is a need to increase awareness of the importance of hydration in hospitals and residential care.

Can you ensure that safeguarding protocols at local hospitals are improved so that:

1. *third party complaints about hospital care of vulnerable adults are accepted and investigated and*
2. *if an elderly or vulnerable person is found to be dehydrated, social services are swiftly informed and, if the person arrived from a care or nursing home, appropriate scrutiny bodies are alerted?"*

Ms Calder then asked a supplementary question:

"My mother has lived in three different residential homes. In all 3 I have had concerns associated with hydration and when she went to hospital some of the care provided was in adequate and unsafe. The circumstances are subject to a formal complaint.

Would the Council consider leading a city wide campaign: to raise awareness of the need for hydration in elderly people, especially those with dementia; ensure appropriate training for care and nursing staff; and encourage hospitals and residential care settings to provide water and assist with drinking?

It could be called something like WaterWise or WaterWorks and homes could be accredited."

63.2 The Committee Chair thanked Ms Calder for her question. He said that the Scrutiny Committee was not in a position to give answers to Ms Calder's questions directly but that HWOSC would pass the questions on to the relevant bodies and ensure there was an answer for the next committee, and then take it further if necessary.

The Chair said that he had already had some discussions with Councillor Rob Jarrett, Chair of the Adult Care and Health Committee who was keen for his committee to look into this.

63.3 Mr Watkins said the issue of hydration and care in care homes had been on the LINk/ Healthwatch agenda for some time, and that LINk had carried out a number of reviews and reports which might be relevant. Healthwatch would be happy to take part in any ongoing work into this matter too.

64. UPDATE FROM MATTHEW KERSHAW, CHIEF EXECUTIVE OF BRIGHTON & SUSSEX UNIVERSITY HOSPITALS TRUST (BSUH)

64.1 Matthew Kershaw, the new Chief Executive of Brighton and Sussex University Hospital Trust (BSUH) gave a presentation on the situation with the emergency care system at Royal Sussex County Hospital (RSCH), which had been the subject of media attention recently due to various problems. Mr Kershaw has been in post at BSUH for three weeks, but has 22 years' experience in the health service.

64.2 Mr Kershaw began by saying that the emergency care provision at the hospital is one of his major priorities as it is a serious issue. He appreciated HWOSC inviting him to come and speak about his plans to improve the service.

64.3 Mr Kershaw presented a slide show which explained that RSCH had invited the Emergency Care Intensive Support Team (ECIST) to review the emergency care pathways. HWOSC Members had already had copies of the ECIST reports that followed these reviews.

The review concluded that there were a range of issues that were contributing to the deterioration in performance, but that more patients could be sent home directly from A&E rather than being admitted, that some patients were waiting too long for a bed, and that other patients were staying too long in hospital. The review had led to five workstreams which cut across departments, each led by a clinician. Mr Kershaw said that the work programme would take about six months to complete, but some changes had already come into place, which were having a positive effect on the service provided in the emergency department.

64.4 Mr Kershaw then answered questions from the committee members, along with Dr Christa Beesley of the Clinical Commissioning Group, and Sherree Fagge, Chief Nurse.

64.5 Members asked why there had been a deterioration in services if had changed in the hospital's systems.

Mr Kershaw said that there was no single reason, which is why the five workstreams cut across absolutely everything that the hospital provided. It was fair to say that there had been some particularly difficult days for example when it snowed, which led to higher demand for emergency services but this was not the sole reason for the deterioration in services. People had asked whether the additional regional services such as trauma and vascular services were adding to the decline in services but they are a very small percentage of the services that RSCH provides so he would not say that they added a major pressure.

There may also be issues with how A&E works with wider systems, for example discharge into the community; any delays here can have an impact.

Dr Christa Beesley for the CCG said that she agreed, it was a complex set of reasons for the problems. The CCG has been trying to get a handle on where the problems had started, so the ECIST report was welcome. The problems were ones that could be solved.

64.6 Members asked whether discharge of patients back to areas outside Brighton and Hove always happened quickly enough. Mr Kershaw said that BSUH, commissioners and providers have already carried out work to try and make this happen as quickly as possible. It is in everyone's interest for the process to work as well as possible. If problems do develop, partners will work on a case by case basis to address the situation, reviewing the system where needed. However it should be note that only a small percentage of hospital services are provided to people from out of area, and they are for specialist services.

64.7 Members said that they were shocked at the dramatic decline in the Trust's performance, it slipped by 10% in a short time. There must be more of an explanation for this deterioration. Was it a failure of one service or another?

Mr Kershaw said that there was little that he could add to the previous explanation as it was complex and multi-factoral but in summary, the flow of patients through the hospital and being discharged has slowed and not kept up with the number of patients coming into the hospital. The reason that the flow is not working is not a simple one to establish, it is due to a whole range of reasons which have been outlined. It would not be fair to say that it was a failure of one group or another; hospitals are about large teams working together, and any achievements or failings are for the whole team.

64.8 Members queried the comments in the ECIST report that said that ward rounds were not always carried out on a daily basis. Mr Kershaw clarified that there are daily rounds already, but the ECIST report refers to when a senior review is carried out; this had not always been happening on a daily basis. This will now be addressed.

64.9 Members asked about the Drop In Medical Centre close to the train station. This was open seven days a week, for extended opening hours. Members understood that the medical centre was not allowed to advertise; could this be addressed so that the centre could be used more as an alternative to A&E?

Dr Beesley responded that the medical centre was very well attended, with a high proportion of patients from out of town. The walk-in centre is already promoted as an alternative option to A&E but it also operates as a standard GP practice, and in this instance it is not allowed to advertise any more than any other GP practice.

64.10 Members asked what percentage of patients in A&E could have been treated elsewhere and what is being done to address this?

Dr Beesley said that there are definitely people at A&E who do not need to be there. Estimates are that this ranges between a third and a half of A&E patients. There are a number of processes in place to help address this. Sussex Community Trust has developed a Crisis and rapid response team to minimise A&E admissions, which will offer appointments within four hours, either in a community setting or hospital premises. SPFT has also worked with the CCG to develop a Brighton Urgent response service for people who had an urgent mental health needs, so that people could be seen face to face within 4 hours of referral from a GPs, in a community setting. This service can now also be accessed directly by patients with serious long term mental health problems and their families.

There are certain cases where A&E is definitely the most appropriate place to be, but there are other cases where this is not so. When the 111 service is more established, it is hoped that this will be a good way to direct patients to the most suitable service.

Mr Kershaw commented that there was a definite need to publicise the alternatives to A&E as much as possible.

Dr Beesley said that there was no intention to 'blame' patients for attending A&E unnecessarily but wanted to provide information on how to get to the right place in the medical system; a quick assessment as someone entered A&E could help point people in the direction of the right service.

64.11 Members asked when BSUH Trust has received the ECIST report and what recommendations have already been put into place.

Mr Kershaw said that the Trust had received the report in March, and had developed action plans which addressed every recommendation. Nothing in the report had been ignored. Some changes had already been made outside A&E, whilst in A&E, physiotherapy services have been moved forward in the process to help speed up discharge, the number of consultants has been increased, and other changes have been made. The Trust is committed to making changes sustainably and practically.

Ms Fagge said that nursing staff have a huge part to play, including ward processes and planning for discharge, working with patients and carers. There is Head of Nursing for Discharge, who gives high level input into workstream 5 in particular. Occupational Therapists and physiotherapy staff are also used to help early discharge. There has been an agreed extra investment in A&E nurses, moving from 15 to 18 trained nursing staff and from 5 to 8 untrained nurses.

64.12 Members asked whether Mr Kershaw could take more of an active role in monitoring departments personally. He confirmed that he has been visiting different wards and departments at differing times of the day and night, to see the challenges and the successes, and to meet staff, and he has committed to continue to do this.

64.13 Members also asked that, as the review showed 134 patients who were fit but who had not been discharged, would there be more doctors on duty, to help speed up timely discharge?

Mr Kershaw said that the number of consultants in A&E would be increased, with a move towards 24 hour cover, seven days a week. The hospital is very lucky that it has a motivated and dedicated group of doctors, nurses and support staff so it was important to use their skills properly

64.14 Members queried the financial circumstances that the Trust was in; it had to make significant savings so how could the additional resource be found?

Mr Kershaw said that all NHS bodies were in similar financial situations. Some elements of the action plan would have a positive effect both on patient care and on hospital finances; for example, improving flow in the hospital would be better for patients and for the hospital.

64.15 Members questioned the statement in ECIST's report that the emergency floor was now too small, what was being proposed to address this?

Mr Kershaw said that Level 5, the Emergency Floor was very tight, and changes needed to be made to how departments were arranged on the floor to help treatment and capacity issues. The 3T scheme was also a longer term plan which would help address capacity.

The Healthwatch co-optee said that he had heard concerns about pressure being put onto some patients to feel that they ought to be moving on, and that some elderly patients had said that they had been given the impression that they were nuisances and ought not to be in hospital.

Mr Kershaw said that it was a very valuable point about vulnerable people inadvertently getting the wrong impression. However, based on the staff meetings and visits that he had carried out, Mr Kershaw said that he had been universally impressed with staff commitments to their patients, especially in difficult cases.

Ms Fagge, Chief Nurse, said that she was disappointed that the lady in question had felt pressurised; it showed the importance of planning discharge in a timely and informed way.

Dr Beesley said that the opposite also happened, where patients wanted to leave sooner and could not be discharged. It was hard to balance all the demands but the system should serve the patient.

Dr Beesley also commented that the CCG would be looking for weekly and monthly improvements against the action plan, and there would be regular meetings to assess progress.

64.16 The HWOSC Chair brought this item to a close, concluding that Mr Kershaw had set out a clear action plan which he hoped would deliver concrete results. The next HWOSC would be in June; the Chair would like an update before the next meeting, so that HWOSC could assess progress. This was agreed.

65. 3T DEVELOPMENT OF ROYAL SUSSEX COUNTY HOSPITAL

65.1 Duane Passman, Director of 3Ts, BSUH, gave committee members a presentation and update on the 3Ts long-term development of the RSCH site.

It was noted that in order to commence the main development, a series of decanting and enabling moves would need to be undertaken which represented just over 20% of the existing hospital site requiring temporary, or permanent relocation.

The first of these moves, the refurbishment of the former St. Mary's Hall school, is underway and will be complete in September 2013.

Professor Passman reminded members that part of the decant project would be the relocation of the nuclear medicine department, which is already in temporary accommodation. Without this (in advance of the move to the main building), it was likely

that the service would have to be closed due to the condition of the existing buildings, which were built as temporary forty years ago.

It was noted that it had been a requirement of the former Strategic Health Authority that all the decant projects (including St. Mary's) could be demonstrated to prove value for money and intrinsic value in their own right.

In design for the new hospital buildings, care will be taken to arrange the new development in a more streamlined way, for example so that wards for general medicine and care of the elderly will be very close to the Emergency Department, where the majority of patients in these care groups are admitted to hospital from.

Professor Passman said that the 3Ts project team has learnt lessons from other hospital development schemes that have been successful in carrying out major developments without affecting other services to ensure that patient access is not affected unduly during the period of the development.

65.2 Professor Passman then answered members' questions.

65.3 Members said that several of the HWOSC committee had sat on the Planning Committee that had given planning permission for the 3Ts development, but they had not appreciated the huge time scale of the development at the time. Was it the case that the government was using delaying tactics?

Professor Passman said that planning approval had been given in January 2012; getting full planning consent had been a pre-requisite of making the business case and being able to progress approvals with the Department of Health and the Treasury. BSUH had anticipated that they would have had final approval from central government in 2012, but they are still providing more information to the decision makers.

It was frustrating that the decision has not yet been made but the prize was still there. The 3Ts scheme was one of the largest publicly funded health schemes in years, looking for £420 million of public money, so BSUH needs to assure their financial sustainability into the future. BSUH did not think that delaying tactics were being used, but that central government was assuring themselves that services were safe, sustainable and high quality and would remain so.

Mr Kershaw said that the clinical case had been accepted, and final assurances were being made. The details would be submitted by the end of May and they expected to hear a response by summer 2013. There has been no relationship between the recent problems in the Trust and a delay in the decision making.

65.4 Members asked for assurances that the development would be covering every necessary health need.

Professor Passman said that they are constantly asked to justify all decisions, and to ensure that they have met all of the needs that they can identify or are required to meet. Technology is always being developed, but having any new equipment will be an improvement on the current provision. It was always the case however, that after a new hospital building is built, within sixty years, everything will be changes at least once.

Parts of the hospital development's plans are to keep a column grid building design so that the space can be as flexible as possible.

65.5 Members asked for assurances that BSUH would not face a Mid-Staffs situation and go into special measures because of poor facilities.

Mr Kershaw said that the Mid Staffs situation occurred because the hospital was clinically and financially unsustainable; this would have happened as the end stage of a large number of monitoring reports etc. In BSUH's case, it is responding to a set of difficult financial challenges, in a similar way to other hospital trusts. It is not the same as being in an administration regime.

65.6 Members asked whether the delay in the start date will mean an ongoing rise in the end costs and a corresponding rise in savings being made.

Professor Passman said that some costs were capital and others revenue costs. He was glad that there had been no real inflation in the £420 million capital cost due to the overall slowdown in the construction sector which meant that there had been no compromise on the quality of the planned facilities. He added that this had not impacted either on the running costs.

65.7 The Chair of the HWOSC brought the item to a conclusion, thanking the Trust for the presentation and saying that HWOSC was committed to and supportive of the proposals. There were understandable concerns with regard to decanting the services, but this was a necessary part of the development and the committee would keep an eye on this as it happened.

66. SEXUAL EXPLOITATION OF CHILDREN: RESPONSE FROM LOCAL CHILDREN'S SAFEGUARDING BOARD

66.1 This item was deferred until the next committee date.

67. AUTISM - SERVICES FOR ADULTS

67.1 Anne Hagan, Head of Commissioning & Partnerships, and Mark Hendriks, Performance and Development Officer, presented a report on progress that had been made against the recommendations made in the scrutiny panel report looking at services for adults with autism.

The panel had been very helpful in informing the council's autism strategy, and significant progress had been made, with a three year action plan being put into place. There were 25 strategic objectives in the report, with a stakeholder group governing the action plan's progress.

The team had just completed the first year, which focussed on improving the diagnostic and care pathway; improvements should be operational in summer 2013.

Work has also been underway to develop an autism champions' network, with autism leads with specialist knowledge present in various services.

Years two and three would focus on transition and the local planning of services. Transition can take a number of forms, with different pathways for different conditions. The Special Educational Needs process was being revised, which will support services for young people up to the age of 25 rather than 18 which was currently the case.

67.2 Jack Norwood from the Adult ADHD Peer Support Group commented that the group was concerned that ADHD was not explicitly mentioned, would the autism strategy reflect the needs of people with ADHD? West Sussex has an ADHD nurse, would anything similar be happening in Brighton and Hove? The Adult ADHD Peer Support Group would like to be involved in any consultation that was taking place.

Ms Hagan said that it would be helpful if she met with Mr Norwood at a separate date, as there may be some risk of people falling between different services.

The Chair of HWOSC thanked Mr Norwood for his comments, and agreed that it would be helpful for Mr Norwood and Ms Hagan to meet to discuss the issues.

67.3 Members then asked questions about the autism report.

Members asked whether training would be mandatory for all staff.

Mr Hendriks said that it was not felt appropriate to make training compulsory, it was about being proportionate to need. The training offer is there and it is down to individual services to access it.

Ms Hagan added that autistic spectrum conditions were briefly mentioned in the equalities training, which was mandatory.

67.4 Members asked whether it would be possible to have details of the number of people who had had specific training. It would be good to try and test the different in people's attitudes following training.

67.5 The Chair invited Mr Steve Harmer-Strange, who had chaired the scrutiny panel, to comment. Mr Harmer-Strange welcomed the update and said that Autism Sussex was working with Jobcentre Plus in East Sussex to make staff autism-aware and help support people with autistic spectrum conditions into employment. He felt that it would be good to test whether there had been any improvements in people's experiences over the next twelve months.

67.6 The Chair said that this was a staged process and recommendations could not be rushed through, as there were many stakeholders involved. He agreed that it would be good for HWOSC to have another update in a year's time. This was agreed.

68. UPDATE ON CURRENT SCRUTINY PANELS

68.1 This was noted.

69. MENTAL HEALTH BEDS UPDATE

69.1 This was noted.

70. WORK PROGRAMME UPDATE

70.1 This was noted.

The meeting concluded at 6.40pm

Chair

Signed

Dated this day of

Tuesday 11/06/2013

Question: B&H Health & Wellbeing Overview & Scrutiny Committee

- Can the Health & Wellbeing Overview & Scrutiny Committee apply pressure to the Community Voluntary Sector Forum to accept the recommendations (and comments) of Robert Francis QC in respect of how they are developing the Brighton & Hove Healthwatch?

- The Francis Report identified many serious shortcomings of the Staffordshire Link, and made firm recommendations to be carried forward into the new Health & Social Care Watchdog to be known as Healthwatch.

- These are detailed in this separate paper, which is too long to read out now, but which I will pass forward.

- My own experiences of our local LINk and the CVSF show many parallels with Mr Francis's findings, and I am concerned that the CVSF are now developing our Brighton & Hove Healthwatch without any regard to the Francis Report recommendations.

- We are now over two months into the contract for the new HealthWatch, and there has been no Public Engagement yet. The CVSF seem to be going their own "closed shop" way.

- I shall conclude by just quoting just two examples:
    - Paragraph 1.174 (of the Francis Report) states that those with a responsibility for HealthWatch should seek the involvement of the public (as set out in the full table of recommendations).
    - Page 481 of the Francis Report is flagrantly being disregarded in which concerns are expressed about "recruiting from a small unrepresentative pool of the usual suspects". The CVSF are not inviting "fresh blood" to join them in the set-up of HealthWatch.

- So my question is:
  Can the Health & Wellbeing Overview & Scrutiny Committee apply pressure to the CVSF to accept the recommendations (and comments) of Robert Francis QC in respect of how they are developing the Brighton & Hove Healthwatch?

for further information contact
Terence.Rixon@Gmail.com

Executive Summary
Summary of Findings – Pages 46 & 47

1.22 If anything, Local Involvement Networks (LINks) were an even greater failure. The, albeit unrealised, potential for consistency represented by the Commission for Patient and Public Involvement in Health (CPPIH) was removed, leaving each local authority to devise its own working arrangements. Not surprisingly, in Stafford the squabbling that had been such a feature of the previous system continued and no constructive work was achieved at all.

1.23 Thus, the public of Stafford were left with no effective voice – other than CURE – throughout the worst crisis any district general hospital in the NHS can ever have known.

1.24 Under the new reforms, local healthwatch is intended to be the local consumer voice with a key role in influencing local commissioning decisions through representation on the local Health and Well-being Board. They will be expected to build on existing LINks functions. The responsibility for establishing Local Healthwatch will rest with the local authorities in the same way as it had for LINks. As is the position with LINks, the DH does not intend to prescribe an operational model, leaving this to local discretion. It does not prejudice local involvement in the development and maintenance of the local healthcare system for there to be consistency throughout the country in the basic structure of the organisation designed to promote and provide the channel for local involvement. Without such a framework, there is a danger of repetition of the arguments which so debilitated Staffordshire LINks.

1.168 The arrangements for public and patient involvement, and for local government scrutiny in Stafford, were a conspicuous failure.

1.171 Oversight and scrutiny committees should have power to inspect providers, using information from local patient involvement to trigger such inspections as necessary.

1.174 Those with responsibility for commissioning should also seek the involvement of the public, asset out in the full table of recommendations.

Recommendation 145: Structure of Local Healthwatch

There should be a consistent basic structure for Local Healthwatch throughout the country, in accordance with the principles set out in Chapter 6: Patient and public local involvement and scrutiny.

Chapter 6 - Patient and public local involvement and scrutiny

Key themes – Page 481
The mechanisms for patient and public involvement (Public and Patient Involvement Forums (PPIFs), Local Involvement Networks (LINks)) had raised expectations about their role which proved impractical, relying on enthusiastic but uninformed and untrained

volunteers and recruiting from a small, unrepresentative pool of the 'usual suspects'.

Patient involvement structures have relied on goodwill and insight to make them work – in Stafford this meant they quickly broke down under dysfunctional relationships and in-fighting, whilst the lack of support led to a preoccupation with constitutional arrangements rather than patient concerns. The community in Stafford was reticent in raising concerns and accepting of poor care; those who did make a complaint were not heard or given a voice.

6.120 The Inquiry received voluminous evidence containing a wide range of criticisms of individuals and their conduct in connection with the Staffordshire LINk, sometimes expressed in vitriolic terms. It is unnecessary in order to fulfil the Terms of Reference to consider each and every one, even where notionally the criticisms were relevant, and many were not. Still less has it been necessary to come to conclusions about the rights and wrongs of these criticisms. Where they are referred to in what follows, they are merely intended to describe the entirely dysfunctional nature of the LINk and for the sad light it throws on a community that became driven by the events played out in and around its local hospital.

6.149 It is clear that throughout its life LINks in Staffordshire was bedevilled by disputes over governance, personalities and other distractions which hindered it in getting on with its core task of representing the views of patients and the public at a time when this was urgently needed. Reference has already been made to the arguments about governance, but, in addition, a number of other issues took up a great deal of time at meetings and for the host.

6.160 From reviewing what was happening elsewhere, she (Jackie Owen) did not believe the problems shown here were unique to Staffordshire: "I would say it is very much not unique to Staffordshire. I think Staffordshire just hit the headlines first with it."

6.464 The DH does not intend to ring-fence the grant given to local authorities for the purpose of establishing Local Healthwatch. Mr Alexander expressed fears that this would result in the fund being diverted to other purposes in times of need.434 As was the position with LINks, the DH does not intend to prescribe an operational model, leaving this to local discretion. Mr Alexander objects to this on the grounds that it is likely to replicate the weaknesses experienced with LINks.

6.472 It is suggested that the following principles and approaches should be adopted: It is important that patients', relatives' and carers' voices are heard, and that they are consulted and listened to .....

And much much more ..... but two pages should be enough to show the parallels (albeit on a smaller scale) with our B&H LINk. If the local context is not clear in the extracts above, please ask for clarification – Terence.Rixon@Gmail.com

# HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	**Agenda Item 74** Brighton & Hove City Council

Subject:		**Sexual Exploitation of Children: Response from the Local Children's Safeguarding Board**
Date of Meeting:		**11 June 2013**
Report of:		**Head of Law/Monitoring Officer**
Contact Officer:	**Name:**	**Giles Rossington** **Tel: 29-1038**
	Email:	**Giles.rossington@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 At its December 2012 meeting, the Health & Wellbeing Overview & Scrutiny Committee (HWOSC) considered a request from Cllr Phillips to establish a scrutiny panel to examine issues relating to the sexual exploitation of children. HWOSC members agreed that, before deciding whether to set up a panel, they would request an update from the Local Children's Safeguarding Board (LSCB), the body responsible for overseeing children's safeguarding services across the city.

1.2 **Appendix 1** to this report contains the LSCB response to the HWOSC.

1.3 This report was deferred from the April HWOSC due to time constraints,

2. RECOMMENDATIONS:

2.1 That HWOSC members note the information provided by the LSCB (**Appendix 1**);

2.2 That HWOSC members agree that they are satisfied by the approach taken by the LSCB in relation to preventing the sexual exploitation of children, and do not choose at this time to establish a scrutiny panel.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 Cllr Phillips wrote to the Chair of the HWOSC requesting the establishment of a scrutiny panel to look at the issue of the sexual exploitation of children. This request was considered at the December 2012 HWOSC meeting, where members agreed that they would seek the input of the LSCB before deciding whether to establish a panel.

3.2 The LSCB brings together senior professionals from across the city to oversee and co-ordinate children's safeguarding services. The LSCB is therefore the body responsible for assuring the quality and effectiveness of services to protect children against sexual exploitation.

3.3 In light of the assurances provided by the LSCB it is recommended that members choose not to establish a scrutiny panel to look at these issues in more detail. It is clear that the LSCB has done a good deal of work on this issue, and that there is good buy-in from a range of organisations. Ultimately, of course, this is a decision for HWOSC members, bearing in mind both the other demands on members in terms of the existing programme of scrutiny panels, and the potential demands on safeguarding services that a scrutiny panel would impose.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 None directly at this stage,

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 There are no direct financial considerations for the HWOSC. Should the committee choose to establish a scrutiny panel, this would be supported within agreed Scrutiny Team budgets.

Legal Implications:

5.2 None directly – the only decision for HWOSC members is whether or not to agree to establish a scrutiny panel, which the committee is free to do under the terms of the Council's constitution.

Equalities Implications:

5.3 There is some evidence from other localities that, where there has been systemic or widespread sexual exploitation of children, the victims have been disproportionately from equalities groups or other 'vulnerable' groups, such as children from deprived communities, children in care etc. Members may wish to seek assurances that city safeguarding services are designed with these vulnerable groups in mind.

Sustainability Implications:

5.4 None identified

Crime & Disorder Implications:

5.5 There are obvious criminal implications to the sexual exploitation of children. The local police are active members of the LSCB and LSCB planning in this context is fully informed by police concerns.

Risk and Opportunity Management Implications:

5.6 Recent events in Rochdale, Derby,Oxford and elsewhere have shown that the systemic and/or widespread sexual exploitation of children can occur across a local area. Knowing this, there is an obvious risk in not taking all reasonable steps to assure that local safeguarding services are fit for purpose.

Public Health Implications:

5.7 Should sexual exploitation occur, it is bound to have a major impact upon its victims, with potentially lifelong effects upon both mental and physical wellbeing. The degree to which this impacts upon public (i.e. population) health will depend on how widespread the abuse is, but given the seriousness of its consequences, it is likely that even a relatively low level of abuse will have an adverse and measurable impact on city health and wellbeing in the longer term.

Corporate / Citywide Implications:

5.8 Safeguarding children is a core corporate responsibility. It also relates directly to the corporate priority to Tackle Inequality, and specifically to the commitments within this priority to ensure that children have the best start in life.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 This report recommends that a scrutiny panel is not established, arguing that the LSCB has provided compelling evidence that local safeguarding services for child sexual exploitation are well run and that this is a priority issue for the LSCB and its constituent partners. A scrutiny panel would therefore be relatively unlikely to lead to service improvements.

6.2 The alternative option would be for members to agree to establish a scrutiny panel, and this remains an option, if members are not satisfied with the assurances provided by the LSCB. However, members should consider where they think they might add value to the process of safeguarding children from sexual exploitation before establishing such a panel.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 HWOSC members are asked to decide whether or not to establish a scrutiny panel on the sexual exploitation of children. In this instance the recommendation is that a panel should not be established. This does not reflect the gravity or timeliness of the subject matter, but rather recognises the fact that we already

have excellent cross-partner working on this area, as demonstrated by the LSCB submissions to this report.

SUPPORTING DOCUMENTATION

Appendices:

1. Information provided by the Brighton & Hove LSCB

Documents in Members' Rooms

None

Background Documents

1. Report to December 2012 HWOSC: "Scrutiny Request: Sexual Exploitation of Children"

REPORT FROM BRIGHTON & HOVE LOCAL CHILDREN SAFEGUARDING BOARD TO HEALTH AND WELLBEING OVERVIEW & SCRUTINY COMMITTEE ON CHILD SEXUAL EXPLOITATION – 23 APRIL 2013

1. BACKGROUND

1.1. Research – 'Tipping the Iceberg' - A pan Sussex study of young people at risk of sexual exploitation and trafficking was commissioned and funded by Barnardo's and the three Sussex wide Local Safeguarding Children Boards (LSCBs) in 2005. The study was carried out by researchers from Barnardo's Policy and Research Unit between December 2005 and December 2006. The findings were produced in a final report entitled Tipping the Iceberg in September 2007.

1.2. Sussex Central YMCA – Specialist Sexual Exploitation Service Following publication of the Tipping the Iceberg research report, a project advisory group was subsequently established to consider the findings of the report. As a result of the work of the group, Sussex Central Young Man's Christian Association (YMCA) was supported to set up a specialist service for young people aged 13 - 25 in Brighton & Hove regarding Child Sexual Exploitation (CSE) issues. Nine months development funding was initially secured from the Sir Halley Stewart Trust, and later joint funding for three years was secured from Comic Relief and the former Children and Young People's Trust.

1.3. Vulnerable Young Person's (Sexual Exploitation) Development Worker - As a result of the work of the project advisory group, a jointly funded post was established within Sussex Central YMCA to take work forward. A Vulnerable Young Person's (Sexual Exploitation) Development Worker was subsequently employed from the joint funding on a three year contract from April 2010. Due to the success of the work in the city, Sussex Central YMCA has recently secured a further 3 year funding stream from Comic Relief. In addition, Sussex Police provided additional funding in 2012-13 and 2013-14 which has enabled the recruitment of a 0.5 support worker.

1.4. Sexual Exploitation Steering Group - A multi-agency Sexual Exploitation Steering Group was set up in October 2010 to support the Young People's Sexual Exploitation Project. Membership of the group was from a

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wide range of statutory and voluntary sector organisations across the city. Following a presentation by Sussex Central YMCA to the September 2011 Local Safeguarding Children Board (LSCB), the LSCB Chair and Board agreed that the work of the Sexual Exploitation Steering Group was importantly sufficient for it to become an official LSCB sub group.

2. LSCB CHILD SEXUAL EXPLOITATION SUB GROUP

2.1. LSCB CSE Sub Group - The LSCB CSE sub group meets quarterly and is currently chaired by T/Superintendent Jeremy Graves, Crime Manager, B&H Division, Sussex Police. The purpose of the city-wide multi-agency sub group is to engage all relevant agencies and promote the delivery of an enhanced service to ensure children and young people who may be sexually exploited or at risk of exploitation are identified, safeguarded and supported.

2.2. The main aims of the LSCB Sexual Exploitation Sub Group are:

- To support Community Safety Partnership/Police/LSCB Strategic plans regarding CSE
- To gain an understanding of the City Problem Profile
- Monitor ongoing prevalence and responses to CSE
- To develop and maintain an effective local strategy ensuring that there is a co-ordinated multi-agency response to CSE
- Increase understanding of CSE in both the professional and wider communities
- Address issues around Trafficking of young people for the purposes of sexual exploitation.

2.3. The CSE sub group also helps support the 'What is Sexual Exploitation (WiSE) project which is led by Sussex Central YMCA's Vulnerable Young Person's (Sexual Exploitation) Project Worker.

3. WHAT IS SEXUAL EXPLOITATION (WiSE) PROJECT

3.1. Following consultation with the Vulnerable Young Person's (Sexual Exploitation) Development Worker, the Young People's Sexual Exploitation Project was named WiSE (What is Sexual Exploitation). Key aims of the WiSE project include:

- Providing a specialist service for young women and young men aged 13 – 25 at risk of or experiencing sexual exploitation.
- Working in partnership with Sussex Police, Children's Services and the LSCB.

- Raising awareness through a young people-led eyes and ears campaign.
- Delivering a multi-agency training programme.
- Case working young people at risk and /or experiencing CSE through one-to-one and group work.

4. CARE PATHWAY

4.1. There have been significant developments within Brighton and Hove to review the care pathway for CSE, which have included the evaluation of existing meetings and forums to reform the processes by which children and young people at risk of CSE are identified. Changes have included how cases of concern are raised and discussed with key agencies, information sharing, allocations support plans, accountability and reviews.

4.2. The Missing Young People steering group is due to extend its remit from the 1st April to include any child or young person who is deemed to be vulnerable and this includes sexual exploitation. Children and young people will be referred to the steering group which will be multi-agency and the group will have responsibility to ensure the most appropriate response is given. The group will also act as an intelligence gathering forum in order to establish patterns and trends among groups of young people or possible perpetrators.

5. INFORMATION SHARING

5.1. There is an excellent working relationship between WiSE, Sussex Police and Children's Social Care, regarding CSE. WiSE is a key member of the Police's information sharing meetings and has been invited to use their intelligence systems, ESINS. This allows WiSE to inform and update Sussex Police and Children's Social Care of any intelligence gathered around both perpetrators and survivors of CSE and trends/locations of concern. This allows key statutory agencies to be linked into information that may otherwise have been unavailable.

5.2. CSE has been recognised in the job title and responsibilities of a key member of the Police Child Protection Team which is further evidence of the commitment the force is making to the work around CSE. A 'marker' is now put on Police reports to ensure that any information where CSE is mentioned gets sent to the Child Protection Team.

5.3. CSE has been added as a 'client characteristic' to the new Single Assessment document that will be replacing Children's Social Care's Initial and Core Assessments as of mid April 2013. This will enable Children's Social Care to draw upon data regarding those cases where CSE has been

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identified as an issue.

6. TRAINING

6.1. The 'Preventing and Disrupting Sexual Exploitation' multi-agency training course run by WiSE was successfully piloted on the LSCB multi-agency programme in 2011. Additional courses were run in 2011/2012 and more dates are being put on during 2013 in order to raise awareness of the project to more professionals across the city including a level two course for practitioners who want to develop their understanding of CSE.

6.2. In addition, WiSE has continued to train a large number of frontline workers from professional teams from a wide range of organisations, including Sussex Police and a large training day of 80 Social Workers and Social Work Resource Officers (SWROs) from Brighton and Hove's Children's Services Advice, Contact Assessment Service (ACAS) Duty Team.

6.3. WiSE has also delivered lectures to Brighton University Social Work Master's students. The training programme has become embedded within the training of health professionals. WiSE sessions have become part of core training for student midwives and paediatricians in the city.

6.4. Professional training has had an extremely enthusiastic response from a huge number of organisations across the city. This has led to the large increase in the numbers of young people who are at risk/being exploited being identified and referred to the project; providing evidence for successful awareness raising across the city.

6.5. The training programme has been significant in changing professional attitudes around the risky behaviours young people undertake as a result of CSE, the training has opened people's eyes and provided them with the confidence to identify abusive relationships with confidence, and an understanding of what support is available to children and young people.

7. OUTREACH WORK

7.1. WiSE has developed and maintained strong links with services across the city delivering support to young people around Housing, Sex Working, Sexual Health and within the Night- time economy. WiSE has made particularly good progress at the Claude Nicol Clinic (GUM) providing outreach during young person's drop-in sessions.

7.2. Outreach sessions increase accessibility for vulnerable children and

young people and help host providers talk about the service highlighted CSE as an issue within the service integrating the screening tool as part of their assessments.

8. MARGINALISED GROUPS

8.1. WiSE has been working with organisations in Brighton and Hove to ensure that services are available for young people who may be 'hard to reach' or not in contact with many support services.

8.2. WiSE work very closely with Independent Sexual Violence Advisers (ISVA's), meeting every two weeks to share information and refer into each others services. ISVA's from Survivors Network (a local voluntary organisation that supports female survivors of childhood sexual abuse) will also be co-delivering group work to young people in order to build capacity in both services.

8.3. The recent training of the whole ACAS team referred to in section 6.2 has led to a whole section of vulnerable young people being offered support from WiSE. ACAS were also joined by members of the Police Child Protection Team and the Police Anti Victimisation Unit on their training. The purpose of which was to develop a common language and understanding between agencies with statutory safeguarding responsibilities, in terms of identification and response.

8.4. At the beginning of the year, WiSE trained the staff team at St John's College for children and young people with learning difficulties, this was in response to the number of referrals made to the service of young people with learning disabilities.

8.5. WiSE is also working with the staff (and some of the young people) of the local Asylum Seekers support group, to train staff and raise awareness of the understanding of sexuality and relationships in the UK, based on a few incidents of cultural differences causing problems for young male asylum seekers in Brighton and Hove.

8.6. WiSE aim to work with 'Mosaic' (Children and Family Service) and B&H BME Youth Group to raise awareness of the WiSE Project with BME young people in the city.

8.7. A Practice Lead in respect of CSE has been created in both ACAS and the Police Child Protection Team. The Practice Leads are available as Specific Points of Contact to staff for the purposes of consultation in respect of identification and response to CSE. In addition the Practice Leads have taken responsibility for the dissemination of advice, training and development

within their respective teams on the issue. The Practice Leads also meet on a fortnightly basis with a WiSE representative to complete a safeguarding review in respect of children and young people who have come to the attention of services as a result of CSE.

9. WORK WITH YOUNG MEN

9.1. WiSE has recently given particular focus on how to promote the service and the support offered to young men. This has been done through linking in with 'Mankind' (a local voluntary sector organisation for providing support to male survivors of sexual assault) and Allsorts (an LGBT youth organisation offering activities and support). It is the intention of the project to fund raise for a specialist young men's worker to increase accessibility to the service.

9.2. WiSE also reviewed the content of their training sessions to include discussion about the needs of young men in order to support male referrals to WiSE.

9.3. Currently the referrals for young men at risk of CSE are 14%, 84% female and 2% transgender. As WiSE enter their fourth year of funding they plan to work with 'Mankind' to create further specific promotional material, based on the recent evaluation of a research survey produced for men in the city around attitudes and understanding of sexual assault, unhealthy relationships and SE.

10. DATA 2012-13

10.1. There were 86 referrals including those believed to be at risk of CSE and those experiencing CSE into WiSE in 2012-13. Of the 86, 63 ended up being worked with through one-one case work. The remainder were non-engaging and/or did not want the support of the service. Out of the 63 being worked with, 67% were, or had been in the care system at one time.

11. WHOLE SCHOOL APPROACH

11.1. Access to schools is essential in relation to early intervention, and WiSE has been able to build upon the links that YMCA already has in schools and the local authority to get CSE on to education agendas. WiSE has been a part of the development and design school's group-work programme entitled 'Positive Choices'.

11.2. The Positive Choices Programme will be delivered in partnership with WiSE, Survivors Network and Rise (Women's Refuge) and is being supported across the local authority through the Partnership Adviser: Health and Wellbeing who is looking to promote this as part of a whole school approach

across Brighton and Hove secondary schools. The successful pilot was completed in autumn 2012 and the partnership aims to roll out the programme to other secondary schools in the summer 2013.

11.3. The local authority Partnership Adviser: Health and Wellbeing, with support from Wise and Rise, will support and review and development of planning tools for the primary and secondary school PSHE curriculum to ensure these cover age appropriate issues related to safe touch, healthy relationships, domestic and sexual violence and sexual exploitation.

11.4. Through a Whole School Approach to Domestic Violence and Sexual Exploitation, training will be provided to schools to support the development of understanding CSE.

12. PAN SUSSEX CONFERENCE

12.1. A Sussex wide conference regarding Child Sexual Exploitation, Trafficking and Missing Children was held in October 2012 to further raise awareness and increase understanding for practitioners and managers across the county. The conference was very well attended with over 100 multi-agency partners from a range of agencies.

12.2. Key note speakers included Sheila Taylor, the Director of the National Working Group for Sexually Exploited Children and a live theatre performance called 'Chelsea's Choice' by Alter Ego Theatre Company. Participative workshops included: best practice and legislation for health care professionals around confidentiality and sharing information; group work sessions based on activities and exercises that are normally undertaken with young victims of CSE; Identifying and Safeguarding Trafficked Young People and Operation Newbridge; on-line CSE and examination of the latest national and local data with regard to the types of online sexual behaviours that young people engage in on the internet and other connectable devices and identifying and reducing missing young people from local authority care and from the community.

13. NATIONAL WORKING GROUP FOR TACKLING CSE

13.1. The National Working Group (NWG) for tackling CSE is the main national forum where practice issues and learning is exchanged amongst professionals working on CSE Projects. Sussex Central YMCA is a member of the National Working Group on CSE and has tools published on the NWG website. YMCA staff have participated in practitioner forums and has fed into the development of the University of Bedfordshire data management tool.

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13.2. The LSCB Business Manager has also attended NWG network meetings to share information and best practice examples with other LSCBs.

14. OFFICE OF THE CHILDREN'S COMMISSIONERS' TWO-YEAR INQUIRY INTO CSE IN GANGS AND GROUPS

14.1. WiSE has supported all the calls for evidence in relation to the inquiry and has been interviewed by the Office of Children's Commissioners (OCC), the project has regular contact with Sue Berelowitz (Deputy Children's Commissioner) exchanging information and providing learning from the work in Brighton & Hove.

14.2. The LSCB has also been actively involved with the OCC Inquiry. The previous chair of the LSCB (Alan Bedford) was interviewed as part of the evidence gathering process in year one of the inquiry and the LSCB has recently completed the OCC dataset request required for year two.

15. UNIVERSITY OF BEDFORDSHIRE RESEARCH

15.1. Sussex Central YMCA took part in the University of Bedfordshire's research project, supported by Comic Relief, exploring the extent and nature of the response LSCBs to the 2009 Government guidance on safeguarding children and young people from sexual exploitation on behalf of Brighton & Hove LSCB. The research is referenced in the Government's action plan on tackling child sexual exploitation.

16. CONCLUSION

16.1. It is fair to say that Brighton & Hove has well supported multi agency processes in place and is making good progress compared to other areas where high profile CSE cases have not been triggered. Nonetheless, there is still further work to be done in terms of capacity, understanding networks of perpetrators and recognising the national drive. LSCB partners will therefore continue to work as jointly as possible in order to address such issues.

16.2. In summary, the overarching achievement over the past three years is that the sexual exploitation of children and young people in the city of Brighton and Hove is being recognised by statutory services as a safeguarding issue in which a lot of joint work has been put in place. Furthermore, key achievements over the last three years include the following:

- WiSE steering group adopted as a sub-group of Brighton & Hove LSCB with excellent multi-agency membership which is now chaired by Sussex Police.

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- Referral pathway embedded amongst professionals including connection with SARC, health, social care partner agencies.
- Adoption of CSE screening tool
- Missing Persons Panel changed to Vulnerable Young People's Panel to reflect inclusive of missing children and CSE.
- Information-sharing protocol with Sussex Police developed fortnightly meetings with ACAS and Police with WiSE.
- Police Missing Persons lead has CSE formally recognised and integrated into their role.
- Marker put on Police reports to ensure that any information where CSE is mentioned gets sent to the Child Protection Team – (process tested via mystery shopper and verified as working accurately)
- Citywide training of professionals being included within B&H Children's Workforce development and LSCB multi-agency training programme.
- Increased numbers of young people supported to reduce risk taking behaviours, minimise harm and exit sexually exploitative relationships.
- Changes to PSHE curriculum in schools to include CSE.
- Development of a whole schools training package with WiSE, Survivors Network and RiSE
- Close working links with the National Working Group, Office of Children's Commissioner and University of Bedfordshire (academic lead for CSE in country).
- Young people's participation in the development of posters, leaflets and DV.
- Established cross border relations with neighbouring LSCB's including regular meetings between Business Managers and pan-Sussex conference on CSE
- WiSE project is very well-regarded by funders Comic Relief and has been re-funded for another three years plus years funding from Police to provide a part time case worker due to an increasing demand on case load.

Sharon Healy
LSCB Business Manager
April 2013

# HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	**Agenda Item 75** Brighton & Hove City Council

Subject:		**Update on the Talk Health report**		
Date of Meeting:		**11 June 2013**		
Report of:		**Monitoring Officer**		
Contact Officer:	**Name:**	**Kath Vlcek**	**Tel:**	**29-0450**
	Email:	**Kath.vlcek@brighton-hove.gov.uk**		
Ward(s) affected:		**All**		

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 In September 2012, HWOSC agreed to champion the Talk Health report produced by the Parent Carers' Council and Amaze, a report on the city's health services for children with complex needs.

1.2 HWOSC asked the Parent Carers' Council to return with an update so that they could see progress towards the recommendations.

2. RECOMMENDATIONS:

2.1 That HWOSC members note progress against the recommendations made in the 'Talk Health' report, and

2.2 That members determine whether to champion the report further.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 In September 2012, HWOSC members heard from the Parent Carers' Council and Amaze about their 'Talk Health' report, which gave parent carers' views on health services in Brighton and Hove for children with disabilities, complex needs or long-term conditions.

3.2 The report recognised that good work was being carried out in many areas but made a number of recommendations across a variety of work areas; the three headline recommendations were to improve parent participation, to increase resources for services and to improve communication and transparency.

3.3 HWOSC members agreed to champion the report and its recommendations, and to table it at all commissioning bodies. HWOSC asked the Parent Carers' Council to return to HWOSC with an update on how recommendations were progressing.

3.4 The Parent Carers' Council met senior officers from BSUH, Seaside View, the Clinical Commissioners and the Royal Alexandra Children's Hospital (RACH) to discuss the recommendations. In March 2013, Amaze held a follow up event, inviting RACH, Seaside View, CAMHS (Child & Adolescent Mental Health Services) and the GPs to come back and tell parent carers about changes that had been made. A summary of the developments are included at **Appendix 1**, with a more detailed feedback summary at **Appendix 2**.

3.5 The Parent Carers' Council have expressed their gratitude and thanks for HWOSC's championing of the report but feel that there is still work to be done and would like HWOSC's continued support in this regard.

3.6 They have detailed the areas and ongoing concerns that still require work (the section in italics below is a direct quote from the Parent Carer's Council) :

Royal Alexandra Children's Hospital

- *The car parking issue is certainly being addressed for families who have a blue badge but many of the families that we deal with do not have a disabled badge in their car. This means that they still have to wait in the long queue and are not able to get priority access to the car park. Their children have similar difficulties in waiting as do children who have the blue badge. We would like to see how all families with a disabled child can be given priority to the car park.*
- *There needs to be more involvement of young people with more complex needs and challenging behaviour in the service development at the RACH.*
- *Children with additional needs do need to be prioritised when attending the hospital. Is there any way that their additional needs could be identified on the computer system so that when the appointments are allocated this can be considered?*
- *Children who spend long periods of time in hospital need support from other agencies such as PRESENS. Will the hospital be able to provide this support for children during their stay?*

Seaside View

- *Children with lower levels of need do not have the relationship with SSV that children with more complex needs have. How can they be supported when their level of need is not always being met?*

Children and Adolescent Mental Health Service

- *Throughout all the engagement work done since the report it has been more difficult to work in partnership with the CAMHS service than the other three*

services. There has been a change of personnel in the delivery of the service and this has not helped the engagement with CAMHS.

- *Families who have lower levels of need but still real problems do not get the support from CAMHS they need and have to wait until a crisis happens. The service is not active in its prevention work and still appears to be 'fire fighting'.*
- *The feedback from the CYPOSC survey has not been made known to parents.*
- *There still seems to be a disjointed service between the mainstream CAMHS service and the LD CAMHS service. Many families access both and would like to see a more joined up approach.*

GPs

- *There still needs to be more commitment from GPs to undergo training in the parent journey to understand the challenges that families with a child or young person with additional needs face.*
- *A greater commitment to prioritise the families of children with any additional need is needed from all GPs.*

It would be nice for HWOSC to hold to account all the services to ensure that these unanswered questions are addressed. On a more strategic level we would like HWOSC to champion the inclusion of parents on the Health and Wellbeing Board, the Children's Committee and the new Healthwatch board so that parent carers are not just consulted with but are partners in the future design of services.'

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 None for this cover report, although the 'Talk Health' report is based on community engagement and consultation, and consultation has been ongoing to progress the recommendations. Details of their consultation process can be found in the Talk Health report.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 None to this cover report.

Legal Implications:

5.2 None to this cover report

Equalities Implications:

5.3 None to this cover report, but the Talk Health report is aimed at addressing health inequalities for children and young people with complex health needs.

Sustainability Implications:

5.4 None to this report.

Crime & Disorder Implications:

5.5 None to this report.

Risk and Opportunity Management Implications:

5.6 None to this report.

Public Health Implications:

5.7 The Talk Health report aims to address issues within the local health economy for parent carers of young people with complex health needs.

Corporate / Citywide Implications:

5.8 None to this report for information.

SUPPORTING DOCUMENTATION

Appendices:

1. Talk Health follow up

2. Talk Health recommendations update, March 2013.

Talk Health follow up (for Parents and Carers)

On March 20th we invited representatives from the RACH, SSV, CAMHS and the GPs to come back and tell parents what changes they had made since the PaCC's 'Talk Health' report was written last summer. See the Amaze website for the full report and the full set of notes for the day

Rather than go into great detail about all the changes that have been implemented we have included a brief summary of the exciting new developments that each of the services have made as a result of our report. .

RACH

- New **car parking** arrangements are now in place to prioritise families who have blue badges. If you are in a long queue it is now possible to ring the security guard in the car park and get permission to jump to the beginning of the queue. Details of this will be sent out in your appointment letters but if not ring the hospital switchboard and ask to be put through to the Car Park Security team
- Staff from Seaside View have been training up staff from the RACH in **disability awareness and parent journey training** so they have a better sense of your family's needs
- A new **Health Passport** is now available which gives every day details about children with complex needs. These can be down loaded from the council website for parents to fill in. (More details in Alain Glenn's article)
- A new **specialist epilepsy nurse** is going to be funded to work with children who have complex epilepsy in the community.

Seaside View

- **Physiotherapy technical instructor** is now in post to help support the work of physiotherapists in schools.
- Parents will be told how long the **therapy appointment waiting list** is when they receive a letter from the therapist.
- **New early years groups** have been re launched following feedback from families and are better attended
- **New leaflets** explaining about each service and eligibility criteria have been written with the help of the PaCC to ensure they are parent-friendly.
- Children with complex needs in mainstream schools will soon be getting a **new health care plan** which outlines their individual requirements.

CAMHS

- Are in the process of developing **new leaflets** explaining more about the different tiers within the service and eligibility criteria.
- A **simpler referral process** will hopefully ensure young people are referred to the correct service more quickly.
- **Greater transparency about waiting times** is being provided by better information at the point of referral
- **Clearer ASC pathways** have been developed in each tier.
- Work with schools and the parenting team in the council is looking at a **behaviour management strategy** for young people with challenging behaviour.
- **New Psychologist post at the RACH** has been introduced to help support children and young people with long term health conditions that don't meet

the criteria for direct CAMHS support. They do however need emotional support to help them cope with their health condition and keep up with the treatment.

GPs

- **New website** for GPs is being developed and the designers will be working with PaCC to ensure that the section on young people with disabilities is appropriate.
- GPs will be receiving **training in the parent journey** in their protected learning schemes during the year.
- GPs will be urged to give children with additional needs **priority when booking appointments and if possible a quieter area to wait in**

Amaze and the PaCC will continue to work closely with the service managers and commissioners in these health services to deliver improvements. Please tell us if you notice any improvements in these services (or not) by emailing debbie@amazebrighton.org.uk

1) RACH	Feedback given by Lorraine Tinker, specialist nurse	
Talk Health Recommendations	**Update from professionals**	**On-going / follow up questions**
? Parking priority should be given to those with a disabled badge allowing them to queue jump	This has been a massive problem for the hospital. Longer term plan to build more car parks. In short term, parent carers can be told to ring the hospital and ask to be put through to the parking security. Parents who have blue badges will be allowed to jump the queue.	
? Parent carer involvement in regular groups	Various hospitals around the country have successful children/ young people user groups and they are planning on learning from these models.	Marion asked how they were ensuring CYP with SLD/very challenging behaviour can be included in service development? Lorraine will be looking at this and asking Amaze/PaCC advice on this. Jenny mentioned there is the AHA group who could be used to feed into RACH decisions
? Parent journey training for all	SSV staff are doing regular bespoke sessions within the Alex e.g. communications. Open to all members of staff	Consultants/medical staff attending training/
? 'All About Me' Documents	The specialist nursing team has been looking at this in more detail – working with Clear Communication Company. Developed own Health Passport in conjunction with PaCC. Based on model used in Bristol. Can be used in various places e.g. health appointments, respite, trips etc. The health passport Is available to be downloaded from Amaze website, Council website. The parent/carer can fill it in and take it into hospital. In adult wards it is put on the end of hospital beds – will try to do same in RACH. One of the team will be introducing it in RACH next week. Encourage people to use it. Working on communications handbook – tips/resources for communicating with CYP with limited communication	**What plans are in place to help CYP move from the RACH to adult hospital care?** We have plans for transitioning all young people to adult services in each speciality, this is on an individualised basis for some specialities and work extremely well in some services eg: respiratory, diabetes, oncology, where there are joint clinics for patients being transitioned and there are CNS able to assist in both children's and adult services. **When a young person with complex needs moves to adult hospital care can the hospital communicate more directly with the parents**

1) RACH	Feedback given by Lorraine Tinker, specialist nurse	
Talk Health Recommendations	**Update from professionals**	**On-going / follow up questions**
	(makaton/PECS/symbols etc) which will be available soon.	**so that they can explain procedures to him and support him?** This is to be addressed by the adult teams and requested, during transition of the young person this should also be highlighted to the paediatrician when transition commences. The adult services also have a Hospital Liaison Nurse for Learning Disabilities - Mary Woods at Royal Sussex County Hospital Sussex Partnership NHS Foundation Trust *Tel: Brighton 01273 664975, email: mary.woods@sussexpartnership.nhs.uk* who may be a useful link for families **Is the health care in neurology adequate given the needs of the LD population of young people especially when they are about to transfer to adult care?** This maybe more of a question for primary care to assist with as it . Children and young people with epilepsy and LD are looked after by Dr Tounce at the Alex and are transitioned in the usual way. There is often community paediatricians involved in children's care if they have LD and epilepsy
? Disabled children given priority	Future appointments will be sent out with parking instructions. Consultants have been reminded about appointments starting on time. Will try to cluster appointments on same day where possible.	Why are SEND children not given priority e.g. ASC – no flags waved at RACH out patient. Waiting is a major problem for ASC kids.

1) RACH	Feedback given by Lorraine Tinker, specialist nurse	
Talk Health Recommendations	**Update from professionals**	**On-going / follow up questions**
	Parents/carers to ask for this too. Surgical lists are harder to influence. Small babies/CYP with diabetes need to go first. CYP with additional needs can be flagged up and moved up the list. If attending level 7 for operations parents can ask for a quiet area to take child. Can ask to see play therapist to help explain what will happen.	Trying to see how these kids can be prioritised. Lorraine will take back again. Will look at if they can be flagged on IT system. **Can children with additional needs be offered more support when they are in hospital e.g. visited by a member of the PRESENS staff? This happens in the some of the London hospitals.** We would be happy to learn more about PRESENS and the integration with hospitals. Education is provided by the local authority but we would be more than happy for PRESENS staff to come into the Alex and work with children and are open to this idea.
? Specialist disability liaison nurses	Kings College Hospital example given. Task would involve more than just RACH. Sussex Nursing group has been set up – but is still in the early stages. Needs to be worked on across Sussex. Focus will be on epilepsy and Children's Community Nursing	

2) Seaside View	Feedback given by Jenny Brickell team manager, Tracey Young, specialist nurse consultant, Jo Lord, Physiotherapy team manager and Bridget Morden, OT team manager	
Talk Health Recommendations	**Update from professionals**	**On-going / follow up questions**
? Trial innovative approaches to reduce waiting times e.g. Therapy Assistants	Physiotherapy does have a technical instructor – supporting physios in schools. Additional admin support means that qualified physios can be used in more hands on delivery. There are no more resources so it is a juggling act re. professional/qualified staff and admin/support staff. O.T. and SLT services have both spent time in training up class room assistants which is having a better impact in schools.	
? Transparency about waiting times and eligibility and provision of exercises/advice whilst waiting	Working on improving local authority's website – Amaze has done some analysis against the SE7 websites and suggested lots of recommendations. They are committed to having web info as good as that on Amaze website. Parents will soon start to see improvements. Trying to improve the process of how referral process works – can be quite complicated. There is a tight process now on referrals which are tracked closely to minimise waiting times. They have a commitment when writing to parents that they will give an indication of how long they may have to wait for an appointment. Commissioners expect a performance analysis so they can work out how long people are having to wait for different appointments/clinics. Data managers receive can help identify patterns and potentially clear hold ups in the system.	Will there be protected budgets for therapy services, given how critical therapies are for these children? As budgets stand for 2013/4 NHS budgets not massively different that for this current year. However, have to balance budget for all therapies e.g. community nursing, therapists, No cuts from family's point of view during 2013/4. Amaze/PaCC needs to work to ensure this remains the same for 2014/5 as this budget year will be even harder. **Is the SLT service confident that it is meeting the needs of CYP with SLCN? Is there a full and up to date audit of need for each**

2) Seaside View	Feedback given by Jenny Brickell team manager, Tracey Young, specialist nurse consultant, Jo Lord, Physiotherapy team manager and Bridget Morden, OT team manager	
Talk Health Recommendations	**Update from professionals**	**On-going / follow up questions**
		disability group and is the current provision in line with the needs of each specific profile? Is this available to parents? We are confident that we meet the aims of our service " to provide equitable and needs based support and intervention for all children with speech, language, communication and swallowing difficulties from 0 – 19yrs across universal, targeted and specialist tiers of provision". We do not provide a service based on the child's disability, but on their level of speech, language, communication or swallowing need. There is no specific profile for each disability group, but a profile of speech, language, communication or swallowing need for each individual child which is provided to the child's family. **For services with long waiting lists are there strategies for families with acute difficulties, that are not life threatening, to be doing with their children whilst waiting?** We do have information sheets for some specific conditions but I will raise this at our next senior managers meeting in a month or so that I can be clearer what the current position is and also see if this is an area we should develop Waiting time for SLT is currently 5 – 6 weeks.

2) Seaside View	Feedback given by Jenny Brickell team manager, Tracey Young, specialist nurse consultant, Jo Lord, Physiotherapy team manager and Bridget Morden, OT team manager	
Talk Health Recommendations	**Update from professionals**	**On-going / follow up questions**
		Services need to think about the specific needs of low level service users who often receive less support and don't have relationships to help with on going difficulties. These families still have a great level of need which needs to be taken into consideration. Following an assessment or review, each family will receive written advice about the child's difficulties, and activities to support those needs. We encourage parents to contact us if they need further advice. Those with low level needs can still access on going advice and support if they are open to the service. It would be helpful to better understand what would be helpful or where the gap is. For preschool children families can speak to their health visitor and for older children there is obviously the GP
? Information at Seaside View is good but could be better	All services put a lot of effort into new leaflets – identifying eligibility, what the service offers and are now written in a parent friendly language. All services now assessed by the Partnership Charter.	
Review of groups at SSV	Pre school nursery nurse groups had been running in same shape/form for years. Parents were voting with feet as not well attended. Nursery nurses did a review of what parents wanted. So far new groups are much better attended. Trying to link to mainstream services.	

2) Seaside View	Feedback given by Jenny Brickell team manager, Tracey Young, specialist nurse consultant, Jo Lord, Physiotherapy team manager and Bridget Morden, OT team manager	
Talk Health Recommendations	**Update from professionals**	**On-going / follow up questions**
	Trying to change make up of groups from diagnosis to needs-led. List of groups is available	
CYP with complex health needs e.g. cerebral palsy	Looking to develop a health action plan for children/ young people in mainstream school – similar to the IEP. The health action plan will identify what is needed/happening re. therapy etc These children are all high users of health services. Appointments to have these done are being made	
		How do you see the new EHC plans working in practice and how can they improve health provision for our children? Jenny updated that all professionals are working together to trial new format for EHC plans in SEN Pathfinder. However if a child has lots of different plans there needs to be better co-ordination around the review process. Social care reviews can happen every four months. e.g. Health planning for complex needs CYP in mainstream schools. Don't know yet how it will work if very complex needs – how will work in practice, may not get to just one planning/review process. Feel parents will experience the SEN process in more positive way, more joined up between

2) Seaside View	Feedback given by Jenny Brickell team manager, Tracey Young, specialist nurse consultant, Jo Lord, Physiotherapy team manager and Bridget Morden, OT team manager	
Talk Health Recommendations	**Update from professionals**	**On-going / follow up questions**
		EHC, less adversarial. Aspiration of C&F Bill is to develop a plan as a joint/team approach, greater emphasis that the plan is jointly agreed together. Alison made point that Draft Children & Families Bill is currently only being applied for CYP with SEN not disabilities without SEN. Rachel responded that Amaze/PaCC (and other major organisations) are trying to lobby to ensure legislation changed to include this group. Ed Timpson – saying Code of Practice is up for consultation – the devil will be in detail.

3) CAMHS	Feedback given by Fran Boulter, service manager, Matt Stone and Paul Goodwin	
Talk Health Recommendations	**Update from professionals**	**On-going / follow up questions**
? Better information	All referrals from GPs, schools or the parent/carer are at a single point of entry – Aldrington Centre. Here they then decide what service is the most appropriate. **Guidelines for referrals** –first draft on Council website which is due for review over the summer. This includes a referral process diagram **Developing leaflets** for Tier 2&3 – this is a work in progress and needs more development. They are starting to give out these leaflets at events Two routes **on line** – Council website is now up to date showing contact telephone numbers etc. There is more work to be done on Sussex Partnership NHS website. Someone has been identified to support CAMHS in Sussex to look at quality of website information. Work in progess Trying to put other info of who else can help e.g. national organisations. This will hopefully help families go to the right service initially. Developed **new leaflet for Tier 3** for parents – what to expect, how long have to wait, what will happen at first appointment, menu of options might happen after, types of professionals might see. Developing more **leaflets about type of interventions** e.g. mindfulness to increase understanding.	**Why are referrals not proactive but often made when families are at crisis point?** **Who is leading on local offer?** **Can put on Amaze website?** **When? Needs to be in place for Local Offer** **When? Needs to be in place for Local Offer** **Can put on Amaze website** **When? Needs to be in place for Local Offer**

3) CAMHS	Feedback given by Fran Boulter, service manager, Matt Stone and Paul Goodwin	
Talk Health Recommendations	**Update from professionals**	**On-going / follow up questions**
	Right Here are developing a leaflet for parents in the same format as the leaflet that was designed for young people.	
? Extend the CYPOSC user satisfaction survey	On-going process. Parents/ carers/ and young people are asked for feedback at end of each intervention	**Please can parents have feedback from the survey carried out by CYPOSC?**
? Transparency about pathways of care and waiting times.	Tier 3 - If a young person is new to service they will be seen within 4 weeks however if felt at risk/need they will be prioritised and seen quicker. If they are coming back to the service and need more help then they will be contacted in 7 days to explore the issues. Tier 2 – They will endeavour to see all within 8 weeks but are currently not reaching this in all cases due to extremely high demand. Trying to address with commissioners. Hopefully will get it down within few months.	**What are current average waiting times for tier 2 & 3?** Would it be possible for mainstream CAMHS and the Learning Disability CAMHS to work better together for families having to access both services? Fran acknowledged there was sometimes some cross over and that they would take this on board when trying to improve and develop the care pathways. However each part of CAMHS works differently and there would be the need to look at the interventions from each pathway acknowledging that some CYP need them from different pathways. **For services with long waiting lists are there strategies for families with acute difficulties, that are not life threatening, to be doing with their children whilst waiting?** **Services need to think about the specific needs of low level service users who often receive less support and don't have relationships to help with on going**

3) CAMHS	Feedback given by Fran Boulter, service manager, Matt Stone and Paul Goodwin	
Talk Health Recommendations	**Update from professionals**	**On-going / follow up questions**
		difficulties. These families still have a great level of need which needs to be taken into consideration.
? Training for psychiatrists in the parent journey	Fran fed back this issue at consultant meeting in November – helpful reflection to think about how the parent/CYP experience CAMHS for all CAMHS staff. Considering **joint training** with Amaze. Rachel to follow up PaCC Rep been able to sit on interview panel – great input making more inclusive/collaborative process. Induction process – considering how staff can meet people from Amaze to hear about family's perspective. Will try to include existing psychiatrists in this too. Tier 2 also using parents for recruitment – will try to use a parent or young person on an on-going basis.	
? Autism specialist needed	Brenda Davis, clinical psychologist, is developing autism services locally. Stage 1&2 care pathway has been developed. **No specifically employed autism specialist** – but feel existing skills mix is covered/can be provided	**Will CAMHS be seeking accreditation for their work in ASC from one of the independent bodies e.g. The Autism Education Trust?** **Pls confirm this is the case – some concern from parents about this.**
? Behaviour network for children with severe behavioural difficulties	CAMHS working with the Council's parenting team (Triple P courses) and schools to help deliver on this one. Needs further development but they are utilising existing resources, targeting behaviour management strategies in partnership.	
		Why are there not more early interventions services for anxiety disorders/phobias? Paul

3) CAMHS	Feedback given by Fran Boulter, service manager, Matt Stone and Paul Goodwin	
Talk Health Recommendations	**Update from professionals**	**On-going / follow up questions**
		reported there are a range of services via schools in Tier 2. Parents should contact the school and ask for a pre-referral to XXX service. Alison mentioned there are other CVS organisations out there in the city www.wheretogofor interactive map for YP mental health and emotional well-being
Alternative Help		Diana asked if a YP hasn't been taken on as a referral are parents advised who else is out there – why are there not the right people to help and where else can they go. Tier 2 said they sometimes signpost to other agencies and explain why that service might be better – but acknowledges they could get better at this. Tier 2 suggested often schools make the referral (maybe to start a family CAF) rather than the GP as the school is more likely to know the CYP better.

4) GPs	Feedback given by Kathy Felton, commissioner for Women's and Children's Health	
Talk Health Recommendations	**Update from professionals**	**On-going / follow up questions**
	Recent changes from PCT to CCGs are complex. There are 7 layers of commissioning for children's services and a national commissioning board too. One constant thing is that parents/CYP – need to be held at centre of all decisions. The answer is not always straightforward.	
? Consistency of how families are treated – Partnership Charter for GPs	Kathy urged parents to build relationships with their local GP practice encouraging their GP to understand their child's issues better. GPs are independent contractors and to get all of the different GP practices across the city on board to work consistently together will be a challenge. Want to keep getting feedback/solutions from parents – via PaCC – to keep informing planning/development.	
? A route map of services available. Want more information. Hard to find info on line	GPs agreed they needed a route map as not all felt understood all services available out there and routes to Contact a Family has produced some resources for GPs about how to make GP surgery more accessible. Amaze Through the Maze – too big Need to develop short summary for GPs Developing website for all CCG/GPs – will ensure strong section on CYP and will work with PaCC to ensure CYP with SEND material is appropriate.	

4) GPs	Feedback given by Kathy Felton, commissioner for Women's and Children's Health	
Talk Health Recommendations	**Update from professionals**	**On-going / follow up questions**
? Home visits given routinely to children with disabilities	GPs are nervous about committing to home visits as the equipment they need is often in the surgery. They accept that sometimes it is appropriate and would help offer this where they felt it was possible/needed.	
? Training for GPs on power of attorney/mental capacity act and responsibilities when young person turns 18.		At 18 GPs take on responsibility for co-ordinating a young person's care from SSV (paediatric consultant to GP) – what is happening to ensure they are ready? This is a priority area in adult services e.g. health assessment tools. Cameron Brown to circulate what's being done about this. We are considering using the Health Passport Form developed by Seaside view with GPs. This could be particularly valuable at this point of transition. Need to train up GPs in Mental Capacity Act – they have a responsibility to do annual health reviews etc. Ruby asked about the availability of physiotherapy when they move into adult services. Jo said there might be a drop off as the YP moves into adult services. No overall co-ordination role. Where a young person has been receiving physio services at the Alex I would expect them to have a transition plan into the Adult Team.

4) GPs	Feedback given by Kathy Felton, commissioner for Women's and Children's Health	
Talk Health Recommendations	**Update from professionals**	**On-going / follow up questions**
		Jenny mentioned the roll out of the new EHC plan which will go up to 25 so should help secure input as move into adult services.
? Training for GPs and families/needs of CYP with SEND	GPs need to be skilled up/more expert in some child's care. All GPs attend Protected Learning Schemes training sessions 4 times per year. Agreed to run an adapted Parent Carer Journey training at one of these sessions – bring to life with case studies.	
? A holistic approach needed by all GPs		
? Eligibility for referrals needs to be clearly explained and all communication routinely copied to parents		
? Amaze and the PaCC can represent parent carer views on a city-wide basis (unlikely to participate in PPGs)		
Prioritise appointments for families with CYP with additional/complex needs	GP Localities meeting agreed to help prioritise CYP with complex needs by offering first appointment and separate room to wait if not.	Kathy agreed waiting for GPs for CYP and SEND especially CYP with ASC is not at all acceptable – will keep trying to find solutions. I have a slot to talk about this at the Practice

4) GPs	Feedback given by Kathy Felton, commissioner for Women's and Children's Health	
Talk Health Recommendations	**Update from professionals**	**On-going / follow up questions**
		Managers forum on 30th May.

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 76 Brighton & Hove City Council

Subject:		**A&E and Capacity Pressures at the Royal Sussex County Hospital - Update**
Date of Meeting:		**11 June 2013**
Report of:		**Monitoring Officer**
Contact Officer:	**Name:**	**Kath Vlcek** **Tel: 29-0450**
	Email:	**Kath.vlcek@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The April 2013 HWOSC heard a report and update from Brighton &Sussex University Hospital (BSUH) NHS Trust on the various workstreams that had been organised to address the problems causing capacity pressures in A&E at Royal Sussex County Hospital.

1.2 HWOSC members asked for an update to come to the June committee meeting so that they could assess progress against the workstreams.

2. RECOMMENDATIONS:

2.1 That HWOSC members note progress on the different workstreams and

2.2 That HWOSC members ask for further progress updates as necessary.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 Following severe and prolonged pressures on A&E services and breaches of the four hour waiting time target, BSUH invited the Department of Health's Emergency Care Intensive Support Team to assess services and produce a report. After the report was received, the Hospital Board compiled and committed to an action plan that addressed all of the issues that had been raised.

3.2 The work programme is due to last for six months, with a period of eight weeks gaining immediate improvements and then a further 18 weeks embedding the changes.

3.3 There are two appendices to this cover report, the first from BSUH with an update on the work programme (**Appendix 1**) and the second from the Clinical Commissioning Group, which updates on work to support improvements in the urgent care system (**Appendix 2**). The two appendices are designed to complement one another.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 None to this cover report.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 None to this cover report

Legal Implications:

5.2 None to this cover report.

Equalities Implications:

5.3 None to this cover report.

Sustainability Implications:

5.4 None to this cover report.

Crime & Disorder Implications:

5.5 None to this cover report.

Risk and Opportunity Management Implications:

5.6 None to this cover report.

Public Health Implications:

5.7 The emergency service is a key public health service for the city.

Corporate / Citywide Implications:

5.8 None to this cover report.

SUPPORTING DOCUMENTATION

Appendices:

1. BSUH update May 2013
2. CCG Update May 2013.

Brighton and Sussex University Hospitals NHS Trust

Emergency and Unscheduled Care - **Right patient, right place, first time**

Briefing paper for HWOSC

1. Purpose of the Paper

1.1. This paper updates the HWOSC regarding work currently underway to improve the overall experience for patients attending our Emergency Department and who may also require admission. The HWOSC received an initial briefing on this work at their meeting on 23rd April 2013.

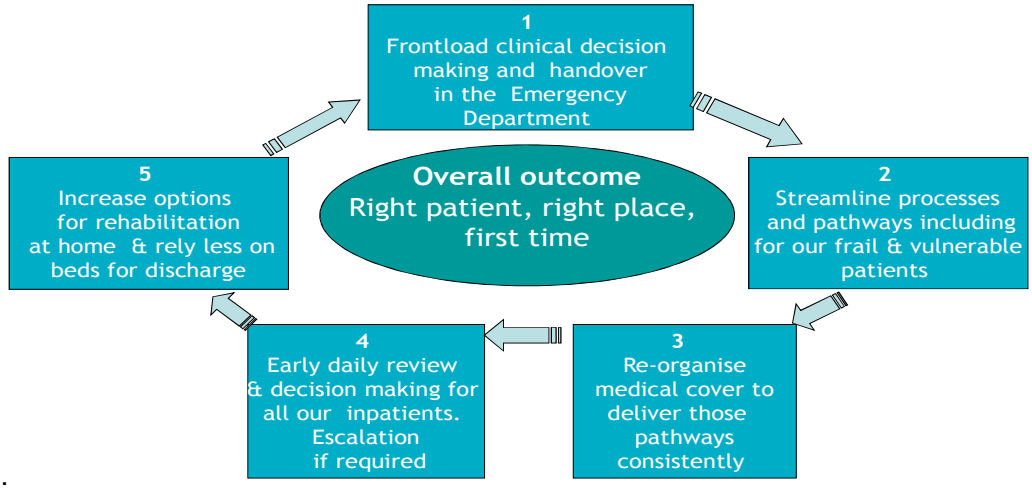
1.2. Following a marked increase in the time patients were spending in our Emergency Department at the Royal Sussex County Hospital (RSCH), BSUH invited the Emergency Care Intensive Support Team (ECIST) to review our emergency care pathways. Their report and our own assessment confirmed that our deterioration in performance could not be put down to one issue but:

- we could be sending more patients home from the Emergency Department (ED) with the right support rather than admitting them
- our patients needing admission were waiting too long for a bed and this was causing delays for patients in our ED
- our patients stayed too long in hospital.

1.3. We committed to a 6 month work programme with 5 key work streams. The programme is in two parts: measures to secure an immediate improvement in service (8 weeks) and further system changes for us to sustain our improvement (18 weeks). This paper updates on progress and work to follow within BSUH. It should be read in conjunction with the CCG/Partner update. Our work streams designed to integrate with the wider systems work. Without this integration and close working BSUH will be unable to deliver and sustain the safety and quality of service required.

2. Progress to date

2.1. Our last presentation to HWOSC described the work that was being undertaken by BSUH across five work streams:



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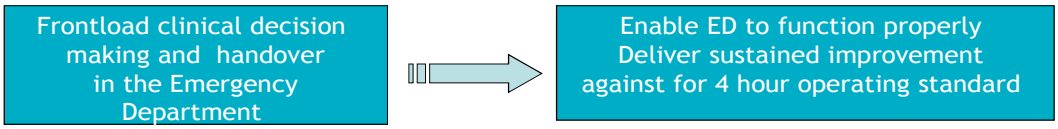
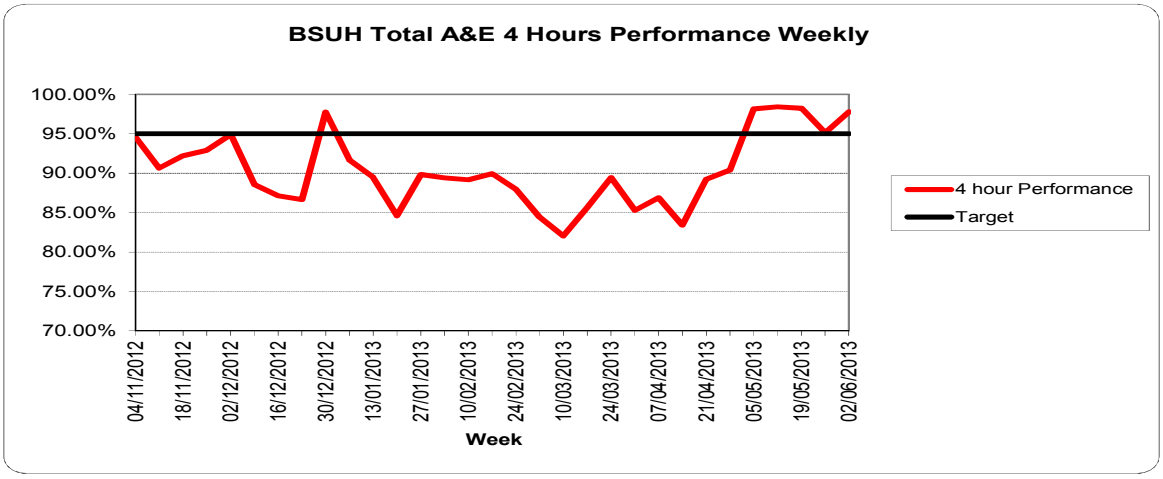
Overall we have seen an overall improvement in performance. All of the ECIST suggestions in their original report are in hand, with nine already completed. The rest of this section summarises the progress to date.

2.2. WORK STREAM ONE

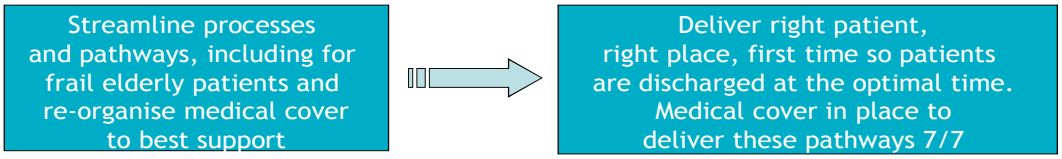


There has been a significant improvement on performance against the 4 hour operating standard. Performance was at 82% in the March against the 95% standard but has exceeded target performance for the past five weeks :



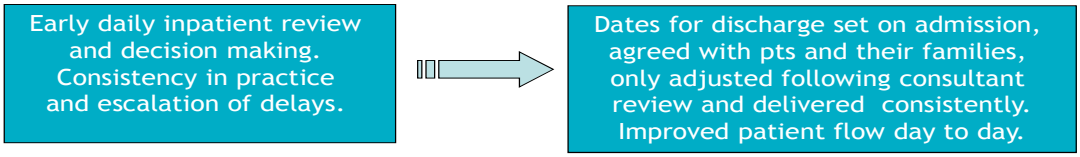
This is because we have seen some immediate benefits from work streams 4-5 but there is more to be done to ensure that we can sustain this performance. Meanwhile, the ED is working to ensure a seamless handover of patient from ED to our hospital speciality teams and best use of clinical resource and space.

2.3. WORK STREAMS TWO AND THREE



We are currently appointing three additional acute physicians and will be changing the medical cover rotas on their appointment in order to ensure early senior clinical review so we maximise the number of patients who can be safely managed without admission or admitted and discharged within 2-3 days. In the meantime the clinical teams are working closely with the Hospital Rapid Discharge Team (HRDT) in order to maximise the number of patients who can be managed without admission (see 2.5 below) and have strengthened senior decision making at weekends.

2.4. WORK STREAM FOUR



Work is underway on our care of the elderly wards at RSCH to ensure:

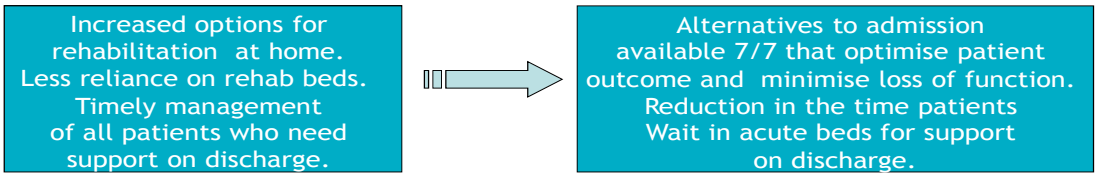
- Everything is ready for patients being discharged the following day
- All patients who have been in hospital for more than seven days are reviewed so we do all we can to ensure their safe and timely discharge.

We have also introduced:

- Electronic whiteboards on all our wards so we can see where each patient is on their pathway at a glance and easily identify and deal with potential delays. These have been very well received.

- Monitoring of discharges by day of the week and time of day. This will continue so we can monitor progress as we standardise our approach to discharge across all our wards.

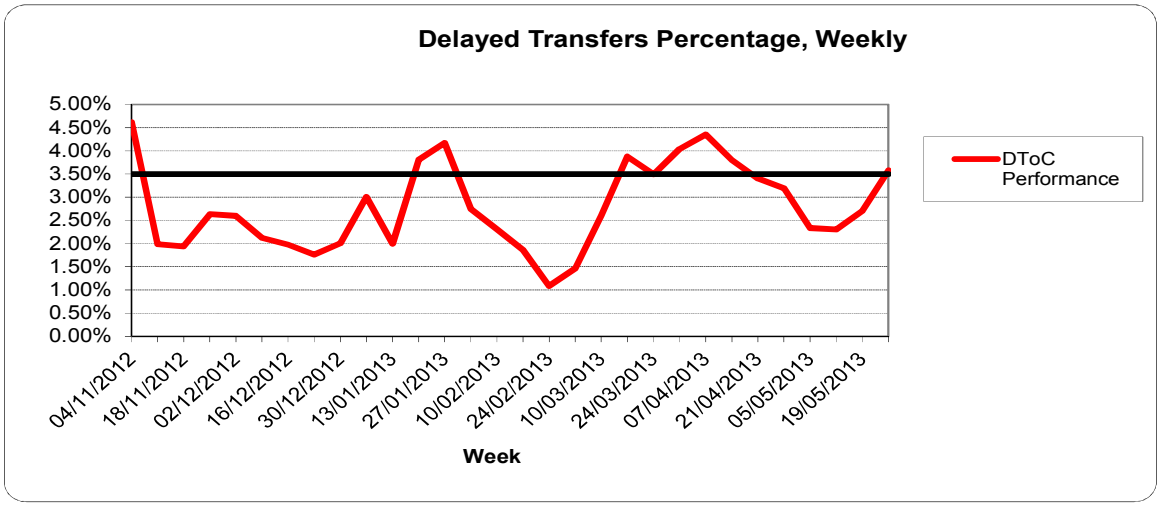
2.5. WORK STREAM FIVE



We have already seen two significant improvements from this work stream:

- There have been recent changes in the working arrangements of the Hospital Rapid Discharge Team (HRDT) which is funded by our commissioners team as part of a trial to further reduce avoidable admissions. HRDT has been based in ED majors with the aim of identifying patients suitable for discharge with support. Initial data suggests a threefold increase in avoided admissions per week (from 20 to 60). We will be working with CCG and partner organisations to ensure that this service is available at the weekend and after 6pm.

- There have been decreases in the number of patients awaiting packages of care before they can be discharged safely and this needs to be sustained:



3. Next steps

3.1. This work will continue at pace and alongside our other initiatives to improve quality, safety and dignity. notably:

- COMFORT rounds
- Quality review visits on all wards
- Nursing metrics
- Friends and family test
- Patient Voice.

3.2. A dashboard of performance and process monitors is in place and high level extracts are being used to provide assurance around our progress to the wider system.

4. Conclusion

4.1. The overall action plan is not a ‘quick fix’. This is week 11 of a 26 week programme. There is still a lot of work for BSUH to do but this is in hand. Our Implementation Board met weekly for the first 8 weeks but is now moving to fortnightly to give more time for the work stream leads to implement the required changes.

4.2. Our work streams are all clinically led but designed to integrate with the wider systems work. This relationship is key. Without this integration and close working BSUH will be unable to deliver the safety and quality of service required. We are fully committed to this and working closely with our CCG and partners weekly and tracking our progress through the governance framework agreed.

4.3. This work will continue to run alongside our other initiatives to improve quality, safety and dignity.

Updated 3 June 2013

Appendix 2

Brighton and Hove
Clinical Commissioning Group

Update for HWOSC – May 2013

The purpose of this paper is to provide an update to the HWOSC regarding work currently underway to support improvements in the local urgent care system. In particular, it describes progress in the workstreams delivered by the wider system partners and is intended to be complimentary to the update provided by BSUH.

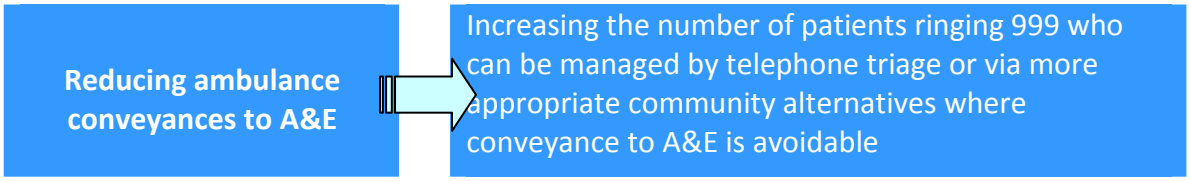
The wider system workstreams focus on 4 key areas:

Anticipatory Care → Primary and community care working together to provide coordinated and structured preventive care for older people and people with complex needs.

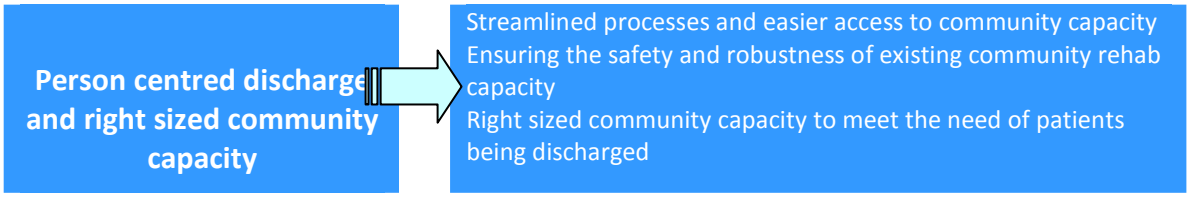
- The new end of life service started in April with single point of access, a greater focus on proactive care, 7 day a week community support and 24/7 access to consultant advice
- 12 extra posts have been agreed for the Integrated Primary Care Teams which provide care for older people and those with long term conditions around 11 groups of practices withtin the city
- Improved links have been made with mental health services and IPCTs including direct referral pathways and training and education for IPCT staff
- A standardised approach to joint IPCT/GP practice meetings is being developed including use a computer based risk stratification tool which identified which patients are at the highest risk of admission to hospital

Preventing admission in crisis → To prevent avoidable admissions to hospital and facilitate discharge from A&E through rapid assessment, diagnosis and intervention in the community .

- Activity levels are increasing for community services that prevent admission e.g. Community Rapid Response Service (CRRS) and Rapid Access Clinic for Older People
- An agreement is in place to the fund additional staffing to enable the transfer of IV/catheter activity from the IPCTs to the CRRS team
- The Professional Support Line (for GP urgent referrals - previously HERMES) is functioning well following the transfer to NHS 111 and is now available to BSUH clinicians to support discharge
- The Hospital Rapid Discharge Team (HRDT) now has dedicated capacity in A&E to prevent avoidable admissions – an estimated 65 possible admissions are being prevented in A&E per week



- The number of patients being managed by telephone triage e.g. hear and treat above expected levels at 14%
- Further work is required to increase use of alternative pathways but there has not been an increase locally in conveyances to A&E due to NHS 111
- An improvement plan is being agreed with SECAMB which includes:
  - A GP in the control room to support crews on the ground to use alternative community services
  - Additional support for care homes to access alternatives to ringing 999
  - The roll out of proactive care plans for key patient groups who are are frequent callers of 999 and at risk of admission to hospital



- There has been a significant drop in the number of patients whose discharge is delayed from BSUH (as of 08/05/13 only 3 Brighton and Hove patients were delayed transfers of care in BSUH)

- There has also been a drop in the number of patients waiting to be discharged from BSUH and admitted to community rehabilitation beds e.g. there are currently 2 patients waiting as opposed to 16 on the 16th April
- Additional homecare capacity has been secured to enable more patients to receive rehabilitation in their own home
- We have seen an increased number of patients going home with support rather than to bed based rehabilitation (this is linked to Workstream 5 in the BSUH report and the result of additional resource in the hospital rapid discharge team (HRDT) in A&E, fewer admissions and better discharge planning on admission to BSUH)
- Knoll House, one of sites from which community rehabilitation beds are delivered, remains partially closed but an improvement plan is well underway

A range of community system measures have been developed which sit alongside those produced by BSUH to provide assurance regarding delivery of the improvement plan.

The CCG Chief of Clinical Leadership, Dr Naz Khan has also established an Urgent Care Clinical Forum which will bring together senior clinicians and practitioners from primary, secondary and community services and adult social responsible for delivering urgent care services.

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 77 Brighton & Hove City Council

Subject:		**Update on Dementia Services**	
Date of Meeting:		**11 June 2013**	
Report of:		**Monitoring Officer**	
Contact Officer:	**Name:**	**Kath Vlcek**	**Tel: 29-**
	Email:	**Kath.vlcek@brighton-hove.gov.uk**	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The purpose of the report is to provide HWOSC with an update on further developments in dementia services in Brighton and Hove since the last report provided to the HWOSC in December 2012.

2. RECOMMENDATIONS:

2.1 That HWOSC members consider the information in the report, assessing progress in line with the National Dementia Strategy.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 HWOSC members heard a report about local work in dementia services in December 2012.They were very interested to hear about the work taking place and asked for an update after six months.

3.2 Brighton and Hove has a Joint Dementia Plan. It was developed in 2012 and sets out the Brighton and Hove strategic vision for improving care and support to people with dementia and their carers. The central aim of the plan is to increase awareness of the condition, ensuring early diagnosis and intervention as well as improving the quality of care for people with dementia and their carers.

3.3 The Health and Wellbeing Board has identified dementia as a priority for the city and is included in the City's first Joint Health and Wellbeing Strategy. There are plans to develop a Brighton and Hove Dementia Partnership Board to lead the strategic development of dementia services and oversee the implementation plan.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 None to this cover report.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 None to this cover report.

Legal Implications:

5.2 None to this cover report.

Equalities Implications:

5.3 None to this cover report.

Sustainability Implications:

5.4 None to this cover report.

Crime & Disorder Implications:

5.5 None to this cover report.

Risk and Opportunity Management Implications:

5.6 None to this cover report.

Public Health Implications:

5.7 Dementia is a key health issue for the city and has been identified as one of Health and Wellbeing Board's highest priorities.

Corporate / Citywide Implications:

5.8 None to this cover report.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 None to this cover report.

SUPPORTING DOCUMENTATION

Appendices:

1. Update from the CCG

HWOSC Update – May 2013
Dementia

1. Purpose of the Report

The purpose of the report is to provide HWOSC with an update on further developments in dementia services in Brighton and Hove since the last report provided to the HWOSC in December 2012.

2. Local Context

Brighton and Hove have a Joint Dementia Plan which was developed in 2012 sets out the Brighton and Hove strategic vision for improving care and support to people with dementia and their carers. The central aim of the plan is to increase awareness of the condition, ensuring early diagnosis and intervention as well as improving the quality of care for people with dementia and their carers.

The Health and Wellbeing Board has identified dementia as a priority for the city and is included in the City's first Joint Health and Wellbeing Strategy.

There are plans to develop a Brighton and Hove Dementia Partnership Board to lead the strategic development of dementia services and oversee the implementation plan.

3. Updates Since the Last HWOSC Report (December 2012)

3.1 New Memory Assessment Service.

- A new memory assessment service will start on 1 June. This service will be provided from three local GP surgeries in Portslade, Patcham and Saltdean as well as in patients' homes. It aims to increase the number of people diagnosed with dementia and provide improved support to people suffering from dementia as well as their carers. Patients can be referred to this service by their GP. There will also be an option for self-referrals that can be made via a well-publicised telephone number, which will go through to specifically trained Patient Care Advisors. Publicity of this phone number will commence by 31 August. Patients will be offered advice and an assessment by a Dementia Adviser.

- Alongside this the CCG has worked with SPFT on the dementia pathway for people with complex needs to ensure there is a clear pathway into specialist dementia services from the new memory assessment service.

3.2 Improved support to people with dementia admitted to general hospitals

- A dementia champion post is based at the Royal Sussex County Hospital and is driving forward improved services for people with dementia across the hospital. In additional a Specialist Dementia nurse role to support the champion has been funded and is now being recruited to. A dementia pathway has been developed in the hospital and is being rolled out across the hospital. 90% of people who are over the age of 75 and are in hospital for 72 hours or more have received a memory screen. The Trust is performing well against this target.

- The hospital has adopted the Butterfly scheme, and it will be launched on June 4th on the Sussex County site and June 5th at Princess Royal. The Butterfly scheme currently operates in 50 hospitals across the UK and provides a framework for rolling out education and an approach to caring for patients with dementia trust wide.

- Additional resource has been allocated to the older people **mental health liaison** service at the County Hospital to help reduce length of stay and this is now being reviewed for effectiveness.

3.3 Crisis Support

Additional resource has been put into the **Community Rapid Response Service** (CRRS), to enable more people with dementia to be supported at home and avoid unnecessary admissions to hospital. This service has also employed a mental health liaison nurse. We are continuing to review the current crisis pathway for older people who have both physical health care needs and dementia to ensure services provide a holistic response to an individuals needs.

3.4 Care Homes

- The Care home in-reach service has been reviewed and the service is now permanently funded with a change in staff mix to provide additional occupational therapy.

- A new large care eighty bedded care home has recently opened in city and another care home with over a hundred beds is on schedule to open shortly. A third is currently being built. All of these care homes are expected to have capacity to admit patients with dementia. This will improve the potential for local residents to be cared for within the City. The usage of these new Care Homes will be closely monitored.

3.5 Younger Onset Dementia

- Engagement work was carried out on day services for people with **young onset dementia** and we are currently supporting the service to move to new premises and have identified funding to improve the support available.

3.6 End of Life

- The regional funded Sussex End of Life (EoL) dementia project has been used to develop a care pathway for people with dementia at the **end of life**. Specialist resource for EoL including the "This is me bag" has been developed and in addition a range of training for professionals to support professionals has been rolled out.

3.7 **Dementia Friendly Environment Bid**

A £1million Capital funding application to support improving the environment of care for people with dementia has been submitted and successfully reached the second round of bidding. This is a partnership bid which aims to adapt the environment in a number of settings that people with dementia access. This includes GP surgeries, hospitals, day centres and residential care homes. It is anticipated we will know the outcome of this bid in June.

3.8 **Dementia Challenge Fund**

Brighton and Hove has received funding from the National Dementia Challenge Fund and is being used to employ a community development project worker for one year to support voluntary and community groups in making the city a more dementia friendly community

Mental Health Acute Beds

HWOSC Update - May 2013

1. Purpose of the Paper

The purpose of this paper is to update the HWOSC regarding the investment in community mental health services to support the acute bed reductions programme.

2. Background

Previous papers have described the rationale for the proposals. The last report to the HWOSC was in April 2013.

3. Update on Investment in Community Services

3.1 **Crisis Resolution Home Treatment Team**. All additional posts have been filled and the Clinical Review Group is monitoring the impact of the additional resources in terms of ability to provide more care in the community.

3.2 **Investment in Additional Care Co-ordinators.** Five out of the seven additional posts have been filled. The two posts that are still vacant will be re-advertised in the near future.

3.3 Enhanced Brighton Urgent Response Service. This new service providing a 24/7 urgent response started on 14 January. A full evaluation of the service will be carried out in the summer.

3.4 New Accommodation Support Services

The CCG has awarded two new contracts to provide accommodation support for people with mental health needs. A total of 50 units of accommodation will be provided by Brighton Housing Trust and Sanctuary Housing Association and it is anticipated that this increased capacity will help prevent unnecessary delays in terms of discharge from hospital.

3.5 **New Day Centre for People with Personality Disorder**. The Lighthouse Day Centre based in Hove is planned to open on 20 May. This new day centre will provide intensive support in the community that is anticipated will help prevent unnecessary admissions to hospital.

4. **Update on Performance - Access to Acute Mental Health Beds**.

The latest data (January to March 2013) shows that 94% of people have been able to access a bed within the City which is very near the 95% target. Performance has been at this level for the last two quarters. Due

to the relatively small numbers of admissions, fluctuations in terms of numbers of Brighton and Hove residents admitted out of area occur on a weekly basis. Over the last year the range has been from zero to 12 residents.

5. Summary

The beds have been closed on a temporary basis for 16 months (since January 2012). The system has on the whole managed well with less beds and the overall position in terms of people being able to access beds in the City was 94% over the most recent quarter. It should be noted that this improvement has been made prior to the additional community investment taking effect and this provides confidence that the once the new services associated with the investment are fully in place the system will be able to operate safely and effectively. The Clinical Review Group will closely monitor the impact of the new investment on the agreed metrics, and will also review qualitative feedback from clinicians and patients. We anticipate being able to bring a full report recommending whether the system is safe for the beds to be closed on a permanent basis to the July HWOSC meeting.