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