Brighton & Hove City Council

Overview & Scrutiny

Title:	**Health Overview & Scrutiny Committee**
Date:	**28 September 2011**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall**
Members:	**Councillors:** Rufus (Chair), Barnett, Bennett, Follett, Turton, Marsh, C Theobald (Deputy Chair), Phillips, Brown (Non-Voting Co-Optee) and Hazelgrove (Non-Voting Co-Optee)
Contact:	**Giles Rossington** **Senior Scrutiny Officer** 29-1038 Giles.rossington@brighton-hove.gov.uk

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HEALTH OVERVIEW & SCRUTINY COMMITTEE

AGENDA

Part One **Page**

26. PROCEDURAL BUSINESS **1 - 2**

(copy attached)

27. MINUTES OF THE PREVIOUS MEETING **3 - 8**

Draft minutes of the meeting held on 27 July 2011 (copy attached)

28. CHAIR'S COMMUNICATIONS

29. PUBLIC QUESTIONS

No public questions have been received

30. NOTICES OF MOTION REFERRED FROM COUNCIL

No Notices of Motion have been received

31. WRITTEN QUESTIONS FROM COUNCILLORS

No questions have been received

32. '3T' DEVELOPMENT OF THE ROYAL SUSSEX COUNTY HOSPITAL **9 - 12**

Update from Brighton & Sussex University Hospitals Trust (BSUHT) on the trust's '3T' plans to develop the Royal Sussex County Hospital site. This will be presented by Duncan Selbie, Chief Executive, and Duane Passman, 3T Director, BSUHT (copy attached)

33. CARE QUALITY COMMISSION INSPECTION OF THE ROYAL SUSSEX COUNTY HOSPITAL **13 - 14**

Update on the recent Care Quality Commission (CQC) inspection of the Royal Sussex County Hospital (copy attached)

34. CITY GP SERVICES: PERFORMANCE **15 - 38**

Update on comparative performance of city GP practices (copy attached)

35. MENTAL HEALTH ACUTE BEDS IN BRIGHTON & HOVE **39 - 50**

Report of the Strategic Director, Resources, on plans to improve Brighton & Hove mental health services/reduce city reliance on acute mental health beds (copy attached)

36. UPDATE ON LOCAL PROGRESS TOWARDS LOCAL IMPLEMENTATION OF ELEMENTS OF THE HEALTH & SOCIAL CARE BILL 2011

(verbal update)

37. HOSC WORK PROGRAMME 2011-12 **51 - 54**

HOSC work programme 2011-12 (copy attached)

38. ITEMS TO GO FORWARD TO CABINET OR THE RELEVANT CABINET MEMBER MEETING

To consider items to be submitted to the next available Cabinet or Cabinet Member meeting

39. ITEMS TO GO FORWARD TO COUNCIL

To consider items to be submitted to the next Council meeting for information

The City Council actively welcomes members of the public and the press to attend its meetings and holds as many of its meetings as possible in public. Provision is also made on the agendas for public questions to committees and details of how questions can be raised can be found on the website and/or on agendas for the meetings.

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Meeting papers can be provided, on request, in large print, in Braille, on audio tape or on disc, or translated into any other language as requested.

For further details and general enquiries about this meeting contact Giles Rossington, 01273 29-1038, email giles.rossington@brighton-hove.gov.uk) or email scrutiny@brighton-hove.gov.uk

Date of Publication - Tuesday, 20 September 2011

Agenda Item 26

To consider the following Procedural Business:

A. Declaration of Substitutes

Where a Member of the Committee is unable to attend a meeting for whatever reason, a substitute Member (who is not a Cabinet Member) may attend and speak and vote in their place for that meeting. Substitutes are not allowed on Scrutiny Select Committees or Scrutiny Panels.

The substitute Member shall be a Member of the Council drawn from the same political group as the Member who is unable to attend the meeting, and must not already be a Member of the Committee. The substitute Member must declare themselves as a substitute, and be minuted as such, at the beginning of the meeting or as soon as they arrive.

B. Declarations of Interest

(1) To seek declarations of any personal or personal & prejudicial interests under Part 2 of the Code of Conduct for Members in relation to matters on the Agenda. Members who do declare such interests are required to clearly describe the nature of the interest.

(2) A Member of the Overview and Scrutiny Commission, an Overview and Scrutiny Committee or a Select Committee has a prejudicial interest in any business at a meeting of that Committee where –

(a) that business relates to a decision made (whether implemented or not) or action taken by the Executive or another of the Council's committees, sub-committees, joint committees or joint sub-committees; and

(b) at the time the decision was made or action was taken the Member was

(i) a Member of the Executive or that committee, sub-committee, joint committee or joint sub-committee and

(ii) was present when the decision was made or action taken.

(3) If the interest is a prejudicial interest, the Code requires the Member concerned:

(a) to leave the room or chamber where the meeting takes place while the item in respect of which the declaration is made is under consideration. [There are three exceptions to this rule which are set out at paragraph (4) below].

(b) not to exercise executive functions in relation to that business and

(c) not to seek improperly to influence a decision about that business.

(4) The circumstances in which a Member who has declared a prejudicial interest is permitted to remain while the item in respect of which the interest has been declared is under consideration are:

(a) for the purpose of making representations, answering questions or giving evidence relating to the item, provided that the public are also allowed to attend the meeting for the same purpose, whether under a statutory right or otherwise, BUT the Member must leave immediately after he/she has made the representations, answered the questions, or given the evidence;

(b) if the Member has obtained a dispensation from the Standards Committee; or

(c) if the Member is the Leader or a Cabinet Member and has been required to attend before an Overview and Scrutiny Committee or Sub-Committee to answer questions.

C. Declaration of Party Whip

To seek declarations of the existence and nature of any party whip in relation to any matter on the Agenda as set out at paragraph 8 of the Overview and Scrutiny Ways of Working.

D. Exclusion of Press and Public

To consider whether, in view of the nature of the business to be transacted, or the nature of the proceedings, the press and public should be excluded from the meeting when any of the following items are under consideration.

NOTE: Any item appearing in Part 2 of the Agenda states in its heading the category under which the information disclosed in the report is confidential and therefore not available to the public.

A list and description of the exempt categories is available for public inspection at Brighton and Hove Town Halls.

Agenda item 27

BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00PM 27 JULY 2011

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillors Rufus (Chair); Bennett, Turton, Marsh, C Theobald (Deputy Chair), Phillips and Wealls

Co-opted Members: Hazelgrove (Older People's Council) (Non-Voting Co-Optee)

PART ONE

16. PROCEDURAL BUSINESS

16A Declarations of Substitutes

16.1 Cllr Andrew Wealls attended the meeting as substitute for Cllr Dawn Barnett

16B Declarations of Interest

16.2 Cllr Turton declared that he chairs the hospital liaison group in relation to any work programme items concerning Brighton & Sussex University Hospitals Trust.

16C Declarations of Party Whip

16.3 There were none.

16D Exclusion of Press and Public

16.4 In accordance with section 100A(4) of the Local Government Act 1972, it was considered whether the press and public should be excluded from the meeting during the consideration of any items contained in the agenda, having regard to the nature of the business to be transacted and the nature of the proceedings and the likelihood as to whether, if members of the press and public were present, there would be disclosure to them of confidential or exempt information as defined in section 100I (1) of the said Act.

16.5 RESOLVED – That the Press and Public be not excluded from the meeting.

17. MINUTES OF THE PREVIOUS MEETING

17.1 The Chair told members that he planned to have further conversations with the Director of Public Health regarding HOSC involvement in the public health agenda, particularly in terms of issues relating to the misuse of alcohol.

17.2 RESOLVED – That the minutes of the meeting held on 15 June 2011 be approved and signed by the Chair.

18. CHAIR'S COMMUNICATIONS

18.1 The Chair welcomed Denise D'Souza, Director of Adult Social Care and Lead Commissioner, People. Ms D'Souza addressed the committee on the issue of the failure of Southern Cross care homes.

18.2 Members were informed that:

- There are two Southern Cross care homes in the city (Bon Accord and Downs Christian), and another in West Sussex to which the city council regularly refers (Birchgrove).

- The council is still referring to two of these three homes. We are currently not placing people in the Bon Accord home while some quality issues are addressed, but do plan to place again in the future. Ceasing to place people in these homes would undermine their future viability.

- Currently it is the council's view that all three homes are commercially viable, but there are contingency plans in place (working in partnership with NHS Brighton & Hove) to deal with any eventuality.

- The council is currently seeking to identify and negotiate with the landlords of these care homes. One landlord is definitely a care provider, so should be able to take over management of the home.

18.3 In answer to a question from Mr Brown about pressure being placed on Sussex Partnership NHS Foundation Trust by this crisis, members were told that there was potentially an issue with availability of 'EMI' beds for people with mental health/capacity issues (particularly given the recent closure of the 'Swallows' home in the city), but there was confidence that this could be managed.

18.4 In response to a question from Cllr Theobald on how the council assessed the commercial viability of care providers, the committee was told that this was a tricky issue, as independent providers were not necessarily obliged to provide financial details of the operations. However, the council works closely with providers to share information

on an informal basis and has a generally good relationship with the sector in the city. Many providers in Brighton & Hove are relatively small scale businesses, and might be thought inherently less stable than larger concerns, although the failure of Southern Cross demonstrated both that large providers could fail and that the impact of their failure could be much greater than that of smaller organisations. There is an ongoing debate at a national level on how much financial information the independent sector should provide to social care commissioners.

18.5 In answer to a question from Cllr Theobald about care home residents having to be returned home to be cared for, the committee was told that this would not happen unless it reflected the express wishes of residents and their families. However, it might be that the council has to look at placing some people outside city boundaries, and talks are already underway with local providers to gauge their willingness to broaden their client range (e.g. to encourage more providers to offer Mental Health placements where it would be appropriate to do so).

18.6 In response to a question from Mr Brown as to whether the council would look kindly on local providers engaging in equity release schemes in the same way that Southern Cross had, the committee was told that this would depend entirely on the business models of individual providers: for some providers this might be a sensible mood; for others less so.

18.7 The Chair thanked Ms D'Souza for her contribution and invited her to return to provide an update in the Autumn.

19. PUBLIC QUESTIONS

19.1 There were none.

20. NOTICES OF MOTION REFERRED FROM COUNCIL

20.1 There were none.

21. WRITTEN QUESTIONS FROM COUNCILLORS

21.1 There were none.

22. HOSC WORK PROGRAMME 2011-12

22.1 Members considered a report detailing a number of potential work programme items and agreed a set of work programme priorities for the next 12 months and beyond.

22.2 It was agreed that these would include:

Workshop sessions on the NHS Brighton & Hove Annual Operating Plan 2012-13; End of Life Care; Quality across local healthcare providers

- Ongoing issues including the 3T development of the Royal Sussex County Hospital; local NHS trust applications for Foundation Trust status; development of Sussex Community Trust; mental health commissioning and bed use; and breast screening

- Reports on progress of the Health & Social Care Bill, including measures to be implemented by the city council (such as Health and Wellbeing Boards)

- Maternity services in the city, continuity of care for people coming out of prison, air quality, and short term services

- Issues relating to the misuse of alcohol

22.3 The Chair agreed to write to the Chair of the Overview & Scrutiny Commission (OSC) and to the relevant cabinet members to ensure that any HOSC work on alcohol issues complemented the ongoing Intelligent Commissioning Pilot initiative.

22.4 The Chair pointed out to members that no HOSC work programme could be definitive: there were bound to be in-year referrals of topical issues from NHS partners, the LINk etc.

22.5 RESOLVED – That a work programme be drawn up reflecting the opinions expressed by members and presented for information at subsequent HOSC meetings.

23. BRIGHTON & HOVE LINK: RECENT REPORTS

23.1 This item was introduced by Claire Stevens, LINK Host manager, and Mick Lister, LINK Steering Group member who informed members about recent LINk reports focusing on car parking at the Royal Sussex County Hospital (RSCH) and health services for the local Polish community.

23.2 Members and the LINk representatives agreed that Brighton & Sussex University Hospitals Trust (BSUHT) and city partners would need to look very carefully at parking options, particularly in the context of additional pressures during the proposed 3T development of the RSCH site. These should include the possibility of a park and ride scheme for visitors and/or for hospital staff, the offer on concessionary bus fares etc.

23.3 In answer to a members' question regarding the apparent fecundity of Polish women living in Brighton & Hove in comparison to women living in Poland, members were told that the LINk had approached an academic expert to explain this survey finding and had been told that there might be a number of explanations including relatively high UK pay rates, job security, benefit levels and free at point of use healthcare which would explain the difference.

23.4 The Chair thanked Mr Lister and Ms Stevens for their contributions.

24. IMPLEMENTATION OF THE HEALTH & SOCIAL CARE BILL

24.1 Members received a verbal update on progress towards the implementation of elements of the Health and Social Care Bill currently progressing through the legislature.

24.2 Members agreed to receive further updates as this work progressed.

25. ITEMS TO GO FORWARD TO CABINET OR THE RELEVANT CABINET MEMBER MEETING

25.1 There were none.

26. ITEMS TO GO FORWARD TO COUNCIL

26.1 There were none.

The meeting concluded at Time Not Specified

Signed Chair

Dated this day of

Brighton and Sussex University Hospitals NHS Trust

Brighton & Hove City Council Health Overview and Scrutiny Committee

Update from Brighton & Sussex University Hospitals NHS Trust: The 3Ts Programme

Introduction

1. The purpose of this report is to update the Health Overview and Scrutiny Committee of Brighton & Hove City Council on progress with regard to the 3Ts Programme.

Areas Covered within the Report

2. The following key areas are covered within this report:

- Overview of the Programme and Key Points;
- Overall Progress and Approvals;
- Engagement and Consultation;
- Links to the Trust's Foundation Trust Application.

Overview of the Programme and Key Points

Overview

3. The HOSC will be aware that the overall objectives of the programme to develop a leading teaching, trauma and tertiary care centre (the 3Ts Programme) at Brighton and Sussex University Hospitals NHS Trust (BSUH) are to:

- Replace the outdated Barry and Jubilee Buildings with modern, fit for purpose accommodation. These buildings provide inpatient facilities for some of the most vulnerable patients from Brighton & Hove that the Trust cares for. The Barry Building was completed 20 years before Florence Nightingale became a nurse and have very low numbers of single rooms and sanitary provision;
- Relocate the Regional Neurosciences Centre from Hurstwood Park in Haywards Heath to the Royal Sussex County Hospital (RSCH) campus and expand it so that it is able to treat patients from across Sussex. Many patients from Brighton & Hove and across Sussex currently have to travel into London for treatment;
- Become the Major Trauma Centre for the region, with full capacity and capability available once neurosciences is transferred to the RSCH;

- Rebuild and expand the Sussex Cancer Centre to ensure that patients do not have to travel outside Sussex for their treatment;

- Develop teaching, training and research facilities in partnership with Brighton & Sussex Medical School and Kent, Surrey and Sussex Deanery. The Medical School was recently voted top in the country for student satisfaction after less than 10 years in existence and more can be done to develop it to provide continued and growing benefits to patient care and the quality of clinical staff trained locally.

Preferred Option

4. The Trust's preferred option is to develop the south half of the RSCH campus in three main stages:

    - Stage 1 will comprise the replacement for the Barry Building wards and departments (including the hospital's main x-ray department) including the expansion of critical care facilities, the relocation and expansion of the regional neurosciences service and specialist facilities for the treatment and multiple major trauma. This will be complete in late 2017;

    - Stage 2 will comprise specialist facilities for the relocation and expansion of the Sussex Cancer Centre and for the Medical School. Stage 2 will also have a roof garden for patients, visitors and staff. This will be complete in late 2020;

    - Stage 3 will provide a logistics centre for the site, with the entire development completing in late 2021.

5. The development will provide an average of 65% of inpatient accommodation in single rooms with en-suite toilet facilities.

6. A helipad is proposed to be put in place on the existing Thomas Kemp Tower for the transfer of trauma patients by early 2014.

Transport and Travel

7. The Trust already operates a Green Travel Plan and participates in the Brighton & Hove Workplace Travel Plan Partnership.

8. The Trust's existing plan was adopted in 2006 and has operated successfully since then.

9. The Trust has a contract with a bus company to operate the 40X bus which runs between the RSCH and Princess Royal Hospital sites. Patients can travel for free on production of a Trust appointment letter. The Trust offers a salary sacrifice scheme for staff to purchase discounted bus season tickets and bicycles and offers cycle mileage for work purposes.

10. As part of the Travel Plan associated with the new development there will be discounts on car parking permits for staff who drive to work based on their car CO2 emissions and a guaranteed ride home for staff in case of emergency if they choose not to drive to work. The Trust is also piloting a personalised journey planner for patients with outpatient appointments to highlight the public transport alternatives to driving.

11. As reported at a previous HOSC, the Trust currently manages 508 car parking spaces on and around the RSCH site and also has 285 cycle spaces.

12. Of the 508 car parking spaces, 19% are dedicated for staff, 9% dedicated for patients and visitors, 7% for disabled drivers (34 spaces) and 65% are shared between patients, visitors and staff.

13. It is proposed to provide an additional 312 car parking spaces (95% of the SPG4 provision) as part of the development, taking the overall allocation to 820. It is proposed that within this, there will be an increase to 39 disabled spaces, and then 49% will be for patients and 46% for staff in dedicated areas. The patient spaces will be in the new underground car parks provided as part of the 3Ts development.

14. Cycle spaces will be increased from 285 currently to 387 and motorcycle spaces from 27 to 54.

Decanting

15. It is one of the Trust's key objectives to ensure that patient access to services are maintained through the proposed construction period. In order to deliver this, the Trust is planning to put in place temporary facilities on the RSCH and Brighton General Hospital sites whilst the construction of Stage 1 of the 3Ts development is underway. It is planned to have these in place and operational before demolition work is undertaken.

16. The majority of clinical facilities displaced by the construction work will stay on the RSCH site whilst construction is underway (nuclear medicine, ENT, audiology, speech and language therapy etc). The only exceptions will be physiotherapy and Rheumatology outpatient facilities which will transfer to Brighton General until Stage 1 is complete.

17. Office accommodation on the site will relocate to the refurbished St. Mary's Hall.

18. A full programme of communication and information will be provided to patients well in advance of the relocation of services.

Sustainability

19. The Trust is proposing that the 3Ts development is BREEAM "Excellent" and is planning to cut the carbon emissions for the whole site by the introduction of combined chilling, heat and power energy generation. The 3Ts development will also have solar energy generation included with the potential to add more as the economics of the renewable improves.

20. The development also provides a roof garden on Stage 2 as an amenity on the site and to provide a facility for greater biodiversity and to play a part in reducing the urban heat island effect.

Overall Progress and Approvals

21. The Trust is planning to submit its Full Planning Application for the development to Brighton & Hove City Council on 23 September.

22. Once a Full Planning Consent is in place, this will allow the Trust to seek final approval of the Outline Business Case for the development from the Government. This will allow the decanting programme to be implemented and final detailed development of the building to be completed. At this stage, the Trust will submit a Full Business Case for final approval of the scheme overall.

23. The importance of the Outline Business Case stage cannot be stressed sufficiently as this locks the scheme into the Government's capital programme allocations.

Engagement and Consultation

24. Over the last three years, the Trust undertaken almost 100 different presentations, meetings and events for the people of Brighton & Hove and across Sussex to consult and engage on, and provide information about, the emerging proposals. These have included:

    - Re-establishment of the Hospital Liaison Group for local residents within 0.25 miles of the hospital site;
    - Exhibitions;
    - Establishment of a Patient and Public Design Panel to test detailed elements of the planning of the interior of the building;
    - A video explaining the key points of the development;
    - A Facebook page dedicated to the development;
    - Articles in the Argus and other traditional media.

Links to the Trust's Foundation Trust Application

25. The 3Ts development is a central part of the Trust's Foundation Trust application. The Trust has recently revised its application date for FT status until April 2013.

Duane Passman
3Ts Programme Director
September 2011

Brighton and Hove Health Overview and Scrutiny Committee Care Quality Commission (CQC) Report September 2011	Brighton and Sussex University Hospitals NHS Trust

Introduction

The Care Quality Commission commits to visit organisations every two years as a planned visit. This visit would involve reviewing the 16 clinical outcomes of the Essential Standards for Quality and Safety to ensure compliance.

On occasion, the CQC will visit an organisation as part of a responsive visit. This may result from information the CQC gathers about the organisation which may include complaints, clinical incidents and information from external agencies. This visit is unannounced and would seek to review compliance for the outcomes where concerns have been raised. The focus of the visit involves people who use the services, observing care provided at the location and may also involve reviewing the records for the people who use the services to assess their outcomes.

The visit usually lasts for one day and will depend on the concerns raised. The visit may last longer if more information is sought. The visit will usually involve a team of inspectors. The CQC would determine whether the organisation is compliant or needs to improve the standards that the organisations patients receive.

The CQC publish the report on their website following the visit with any recommendations.

Care Quality Commission Visit

The CQC carried out a visit to the Royal Sussex County Hospital on 5 July 2011 because concerns were identified in relation to seven outcomes:

* Respecting and involving people who use services
* Consent to care and treatment
* Care and welfare of people who use services
* Meeting nutritional needs
* Cleanliness and infection control
* Management of medicines
* Safety and suitability of premises

All the information held about the organisation was reviewed prior to the visit. Seven assessors visited and surveyed people who use services, observed how people were being cared for, talked with people who use services and staff, checked the Trusts records, and looked at records of people who use services. The CQC recommended minor improvement actions on five of the outcomes.

The CQC were satisfied that the Royal Sussex County Hospital were compliant for cleanliness and infection control and the management of medicines.

A report was sent by the CQC on 18th July to the Chief Executive. It was checked for factual accuracy. An action plan has been agreed with the CQC and discussed by the Trust Quality and Safety Committee on 1st September. The action plan identifies the initiatives and measures the Trust will use to ensure that the recommendations made by the CQC are addressed. It will be presented to the Trust Board on 26th September 2011.

The Trust will monitor progress quarterly at the Trust Quality and Safety Committee and provide evidence to the CQC as part of regular reports. The CQC may visit again unannounced to ensure they are satisfied with the progress by the trust.

The full report can be accessed on the CQC website:
http://caredirectory.cqc.org.uk/_db/_documents/RXH_Brighton_and_Sussex_University_Hospitals_NHS_Trust_RXH01_Royal_Sussex_County_Hospital_RoC_201107.pdf

Sherree Fagge, Chief Nurse, Brighton and Sussex University Hospital

September 2011.

Report to: Health Overview and Scrutiny Committee

Regarding: Primary Medical Services (General Practice)

Date: 28th September 2011

By: Elizabeth Tinley, GP Services Lead, Brighton and Hove City

Sussex Commissioning Support Unit (CSU), NHS Sussex

Purpose: The HOSC requested an update on primary medical services, with a focus on access and performance data.

1 Background and Update on Primary Medical Service Provision:

Primary medical services are provided by a range of clinical staff including General Practitioners (GPs), Practice Nurses (PNs), Nurse Practitioners (NPs), Health Care Assistants (HCAs), counsellors and other professionals such as phlebotomists and physiotherapists. In Brighton and Hove, primary care medical services are commissioned from 47 surgeries across the city.

Forty of the surgeries provide medical services under General Medical Services (GMS) which is a nationally negotiated contract. Of these GMS practices, 35 are run by GP partnerships and five are individual medical practitioners contracts. In 2010, one single-handed practice closed (St James St surgery) and the practice list of approximately 1700 was dispersed to local practices.

There are also five surgeries providing primary medical services under Personal Medical Services (PMS) contracts. These are locally negotiated contracts, which provide standard services, but are also tailored to local and specific needs, for example providing care for homeless patients. During 2010 one of the six surgeries working under a PMS contract reverted to a GMS contract. The other five surgeries are held under one PMS contract, which includes four practices in areas of higher deprivation and the Brighton Homeless Healthcare practice.

The remaining practices are contracted under Alternative Providers of Medical Services (APMS), which are time-limited and can be subject to Key Performance Indicators (KPIs) which link elements of payment to achievement of quality targets. Brighton Station Health Centre, the GP-led Health Centre, is commissioned under a 5 year APMS contract from Care UK, and New Larchwood surgery provides services at Coldean under an APMS contract held by a local GP partnership. Elm Grove Surgery, which provided services on a short term contract, terminated at the end of 2010 and the patient list of just under 2,000 was dispersed to local practices, including a practice that had relocated to newly converted, larger premises.

2 Access

GMS and PMS contracts require GP's to provide essential services within core hours, ie from 8am to 6.30pm weekdays except Good Friday, Christmas Day or bank holidays. These services must meet the reasonable needs of patients, and there must be arrangements for patients to access these services throughout core hours in case of emergency. Patients who require medical assistance outside the core hours can be seen by the Out-of-Hours service, which is commissioned from South East Health.

Brighton and Hove is committed to increasing patients' access to appointments with a GP, including appointments outside current contracted hours, with the aim to significantly improve satisfaction with opening hours whilst maintaining standards of access and availability during core hours.

Extended Hours

To facilitate this, Extended Hours are offered under a Local Enhanced Service, where practices provide additional opening hours during which patients can be seen by either GPs and/or Practice Nurses.

The extended hours are set according to the number of patients on its list, with a minimum additional opening time of an additional 30 minutes per 1,000 registered patients.

Practices must give consideration to the needs and wishes of the patients, and should take into account the results from the GP Patient Survey (http://www.gp-patient.co.uk/results/weighted/pct/search/?code=5LQ) and any other local surveys or patient feedback received, when deciding on the additional hours to provide.
These results show whether patients have a preference for their surgery to offer extended hours during the week and/or to open on Saturday mornings.

Thirty three practices in Brighton and Hove offer Extended Hours of between one hour and eight hours and fifteen minutes, according to their list size, and provide a variety of sessions from early mornings starting at 7am, to late evenings from 6.30pm to 8.30pm and Saturday mornings.

The chart attached at Appendix 1, compares performance on satisfaction with opening hours with the provision of extended hours, and illustrates that there is generally a higher level of satisfaction with those practices offering extended hours, although other factors will also affect this.

Other results from the Patient Survey show that practices in Brighton and Hove compares well to national data on overall satisfaction achieving 88% satisfaction compared to 90% in England, and matching the ease of getting through on the phone (69%) although work is still required to increase levels of satisfaction in opening hours (Brighton 76% compared to England at 80%).

Additional support for improved access was made available through the Access and Responsiveness Local Enhanced Service, which provided incentives to encourage further improvements in patient satisfaction with access. Amongst the initiatives introduced, practices developed and improved services by updating telephone systems, introduced computerised booking systems and redesigned reception areas This two-year scheme finished at the end of March 2011, and the success of the outcomes of these schemes have yet to be seen.

Brighton Station Health Centre

Brighton Station Health Centre provided an additional facility in the city which has increased access to primary medical care. Situated centrally by Brighton railway station, the centre is open from 8.00am to 8.00pm daily, 365 days per year. Patients from anywhere within the Brighton and Hove boundary can register with the practice, and access the same core services as are offered at other GP practices. In addition, Brighton Station Health Centre offers a walk-in service which is available to anyone, irrespective of whether they are a Brighton and Hove resident or are registered with another GP practice. This resource has proved to be very successful, and meets the contracted volumes for both new registrations and for walk-in appointments as shown in the attached graphs (see Appendix 2).

3 Performance

The performance of practices within Brighton and Hove is monitored by three mechanisms:

The **Quality Outcomes Framework** (QOF) is a voluntary system, introduced nationally to reward practices for achieving high quality standards, and which all practices within Brighton and Hove participate in. Each year practices submit written evidence to provide assurance that standards are maintained, clinical data is collected and a three year rolling programme of inspection visits is also carried out. The submitted evidence and visits examine three areas – clinical, organisational and additional services - with practices receiving financial rewards that are aligned to the performance achieved.

Contract Regulations are also assessed during the QOF visit, and comprise of a number of statutory contractual regulations (see Appendix 3 for list of regulations). Practices which fail to fulfil any of the regulations are required to rectify the situation within a specified time period.

The third mechanism for monitoring performance is the **GP Scorecard** which was introduced as a pilot project by NHS Brighton and Hove during 2009-10. Central to this is the production of a balanced scorecard which measures performance in a number of different areas. The information is gathered from a number of sources, including patient surveys, the Department of Health and from the practice itself, to show how individual GP practices provide services

and how the performance of each practice compares with national targets and local achievement. The scorecard provides an opportunity to look more closely at the services provided by each practice and to highlighted areas of good practice and concerns and included information about:

- Accessibility and availability of services
- QOF results
- Prescribing information
- Public Health promotion

The practice profile which accompanied the scorecard provided background information to enable practices to engage with those specific services which would be beneficial to their patient population.

The scorecard was rolled out to all practices between December 2010 and March 2011. At the visits clinicians and Practice Managers from the practices and clinicians, commissioners and public health representatives from the PCT discussed the scorecards (see Appendix 4i, 4ii and 4iii for templates). The outcome of the visit was a Development Plan, containing agreed actions on performance over the next year and a summary review of the learning from the practice improvement plans.

The attached spreadsheet (Appendix 4iv) summarises how each practice performed on each element and indicates those that perform well or unsatisfactorily. In addition, it also provides NHS Brighton with a record of the areas of performance requiring specific attention.

NHS Brighton and Hove have published Balanced Scorecard information on each of the practices on the public website at http://www.brightonandhove.nhs.uk/localservices/gp/NHSBrightonandHove-GPbalancedscorecard.asp. This enables patients to view how their practice is performing and see how it compares to other practices in the city, and also nationally.

4 Moving Forward

Evidence of improvements in access is slow to be realised, but with continued scrutiny of the Patient Survey and with new initiatives, practices and NHS Brighton and Hove can focus on improvements in the areas which remain a challenge.

The importance of patient participation has been recognised as a vital element to the continued improvement of access and performance, and the Patient Participation Enhanced Service, introduced in April 2011, will help to address this. By introducing, or further developing, patient groups who are representative of the practice's specific population, the practice will develop an action plan to address areas of priority which could include convenience of access, patients' experience of the treatment and service they receive or other issues specific to that surgery. The outcome will be to develop an action plan to address the areas of access and performance to be published on the practice website.

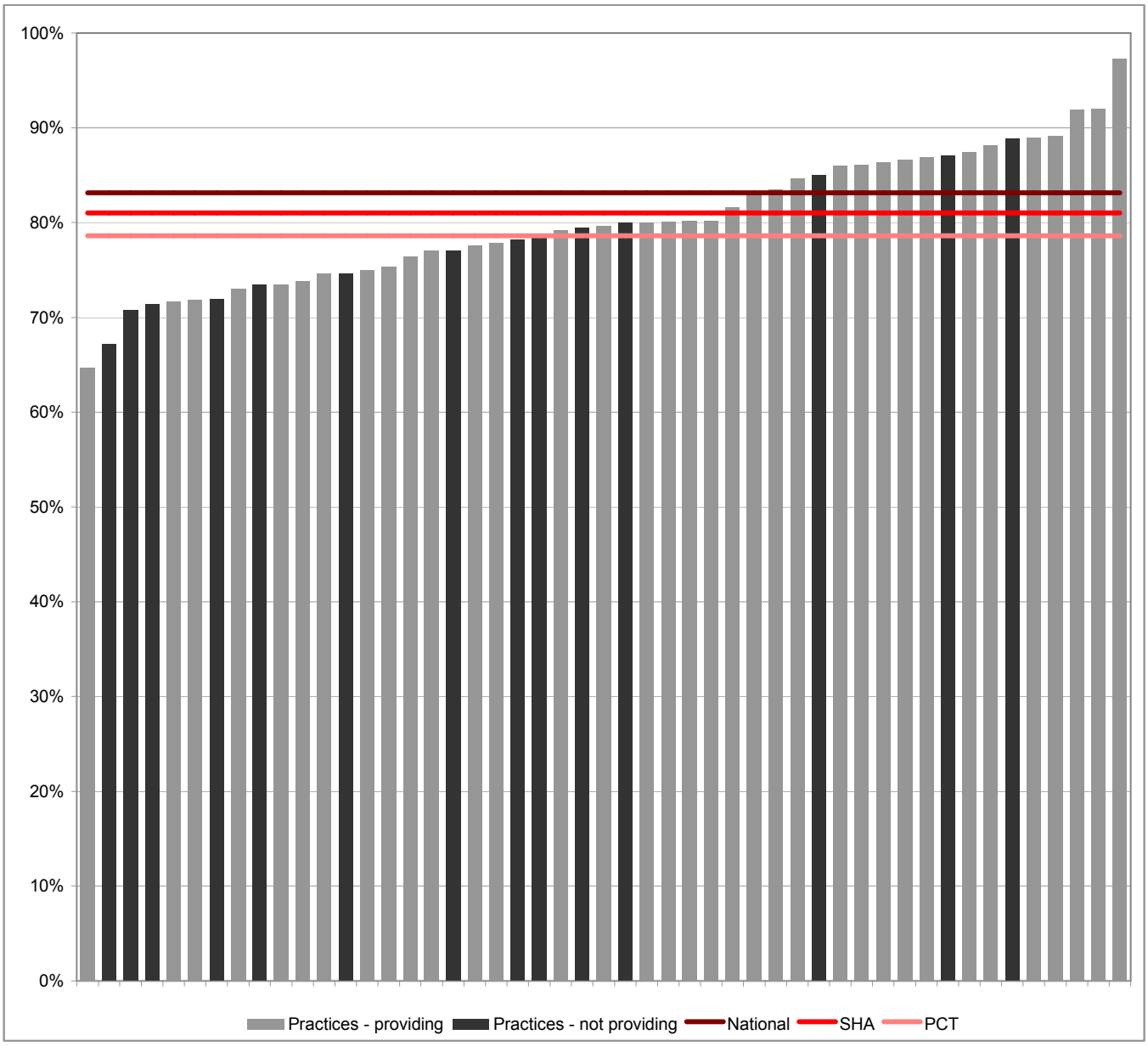
With the combined efforts of the patients, practices and NHS Brighton focusing on the challenging areas of access and performance, quality in these areas can be improved.

Appendices

Appendix 1	Satisfaction with Opening Hours and the provision of Extended Hours
Appendix 2	Brighton Station Health Centre performance
Appendix 3	Contract Regulations
Appendix 4i	Balanced Scorecard Profile
Appendix 4ii	Balanced Scorecard
Appendix 4iii	Balanced Scorecard Exception Report
Appendix 4iv	Balanced Scorecard Summary of Performance

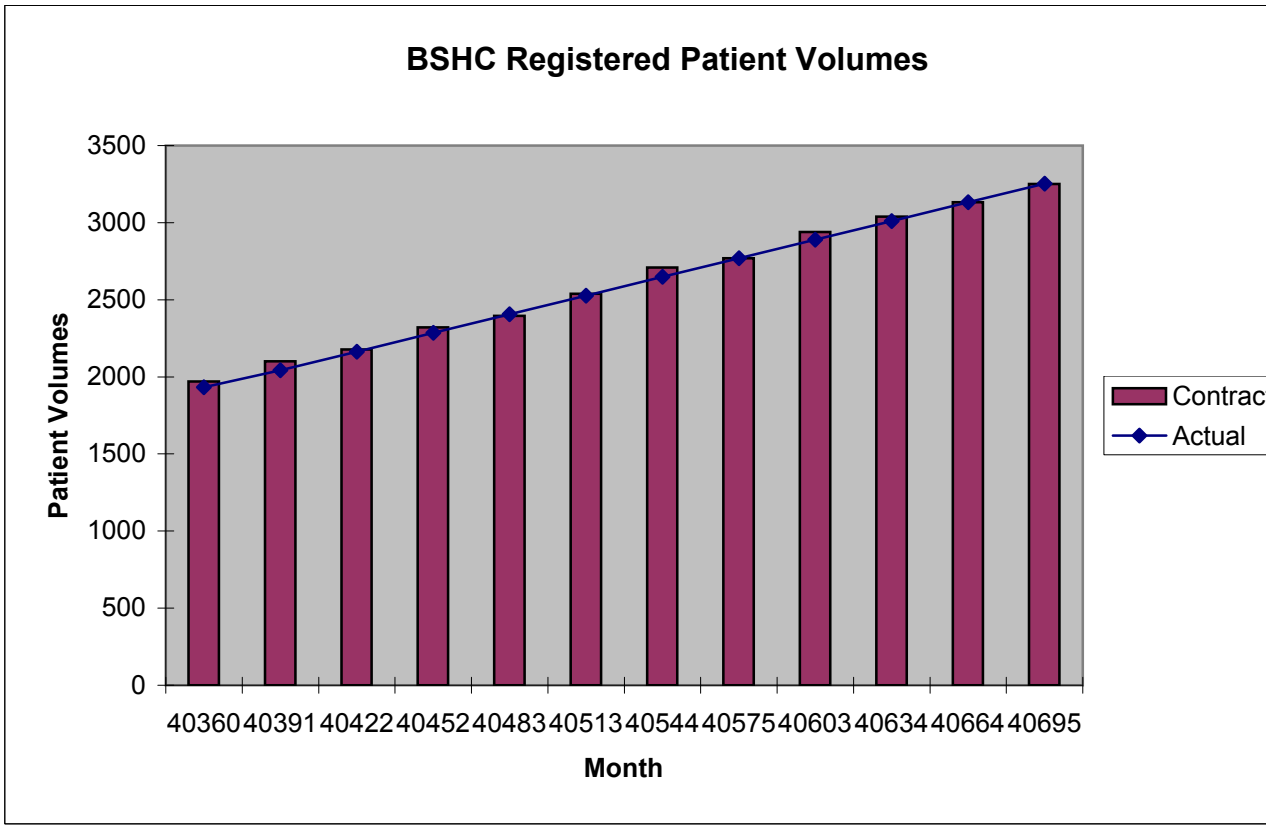
Appendix 1

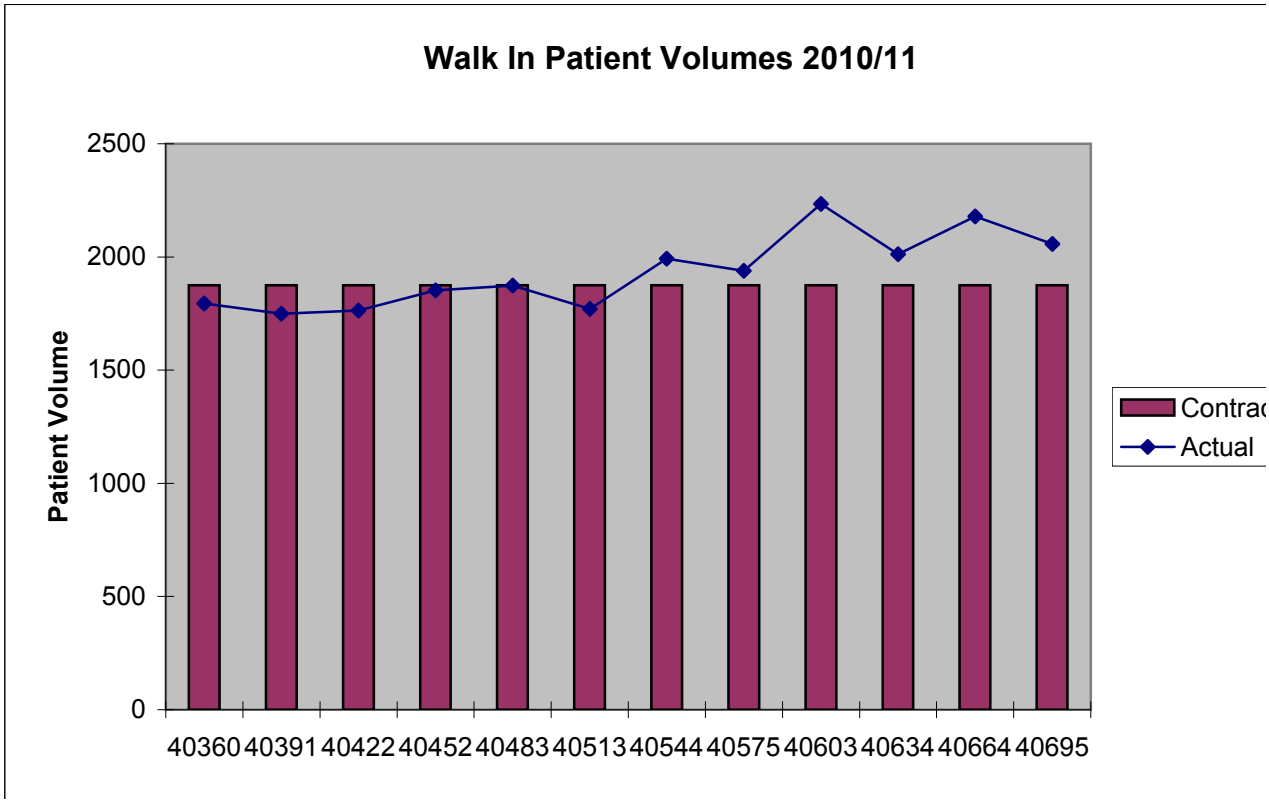
Satisfaction with opening hours - comparison with provision of extended hours (GP Patient Survey Q4 2011/12)



Brighton Station Health Centre - Patient Access

Appendix 1





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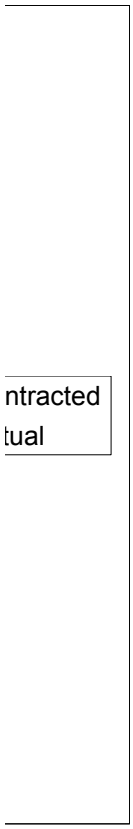
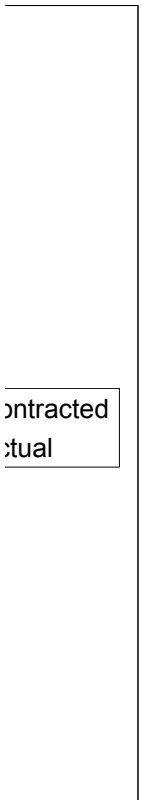




Appendix 3: Contractual and statutory requirements

CONTRACTUAL and STATUTORY REQUIREMENTS		GMS contract clause number
1	The practice provides patients with a leaflet which is available to patients and includes: • practice opening hours • whether an appointments system is operated by the practice for doctor and nurse appointments • how to access a doctor or nurse • a description of the services provided by all members of the team and how patients can obtain them • how to obtain repeat prescriptions • how to make a complaint or comment on the provision of service • a description of patients' rights and responsibilities • how the practice uses personal health information	Schedule 3
2	The practice has an agreed procedure for handling patients' complaints which complies with the NHS complaints procedure and is advertised to the patients.	500
3	Where patients are requesting to join the practice list, the practice does not discriminate on the grounds of: 1. race, gender, social class, age, religion, sexual orientation or appearance 2. disability or medical condition	181
4	The practice adheres to the requirements of the Medicines Act for the storage, prescribing, dispensing, recording and disposal of drugs including controlled drugs.	499
5	Batch numbers are recorded for all vaccines administered.	72.4.2
6	The practice has a policy for consent to the treatment of children that conforms to the current Children's Act or equivalent legislation.	499
7	The premises, equipment and arrangements for infection control and decontamination meet the minimum national standards.	41
8	The practice ensures that all healthcare professionals who are employed by the practice are currently registered with the relevant professional body on the appropriate part(s) of its Register(s) and that any employed general practitioner is a member of a recognised medical defence organisation and registered on a primary care performers list (or equivalent).	340.1, 342
9	All professionals working in the practice are covered by appropriate indemnity insurance.	489
10	All doctors have an annual appraisal.	368.1
11	The practice has a system to allow patients access to their records on request in accordance with current legislation.	499
12	There is a designated individual (data controller) responsible for confidentiality.	437
13	If the records are computerised there are mechanisms to ensure that the data are transferred when patients leave the practice.	499
14	If the team uses a computer, it is registered under, and conforms to the provisions of the Data Protection Act.	499

15	The practice has a written procedure for the electronic transmission of patient data which is in line with national policy.	499
16	The practice complies with current legislation on employment rights and discrimination.	499
17	All staff have written terms and conditions of employment conforming to or exceeding the statutory minimum.	499
18	The practice meets the statutory requirements of the Health & Safety at Work Act and complies with the current Approved Code of Practice in Management of Health and Safety at Work Regulations.	499
19	Vaccines are stored in accordance with manufacturers' instructions.	40.1
20	Individual healthcare professionals should be able to demonstrate that they comply with the national child protection guidance, and should provide at least one critical event analysis regarding concerns about a child's welfare if appropriate.	499
21	All practices have in place systems of clinical governance which enable quality assurance of its services and promote quality improvement and enhanced patient safety. The underpinning structures within the practice, which will assure embedding of clinical governance through a nominated clinical governance lead.	488
22	For minor surgery, patients consent to any surgical procedures including wart cautery and joint injections is recorded.	82
23	For vaccination and immunisation, consent to immunisation, or contraindications if they exist, are recorded in the records.	72.4.1
24	For vaccination and immunisation, fridges in which vaccines are stored have a maximum thermometer daily readings take place on working days.	40.2
25	For vaccination and immunisation, staff involved in administering vaccines are trained in the recognition of anaphylaxis and able to administer appropriate first-line treatment when it occurs.	73

Profile 2010/11, [Practice Name]

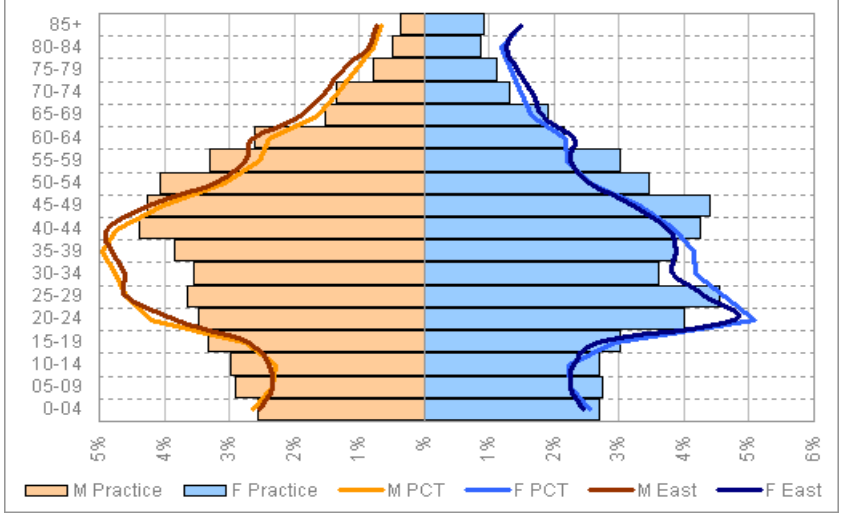
NHS Brighton and Hove

[Locality] [Code]

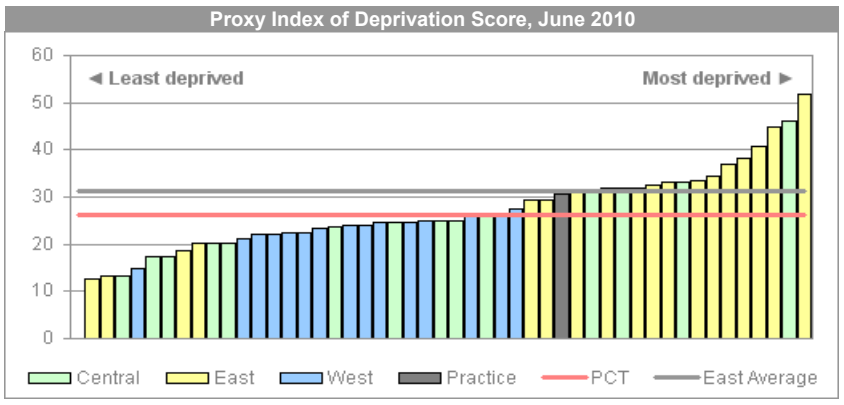
1 Practice Profile and Demographics

	Practice	Locality	PCT	National
Overall list size	11,000	5,015	6,135	
Weighted list size	11,000	5,196	5,922	
% males	49.4%	51.8%	50.7%	
% females	50.6%	48.2%	49.3%	
% patients aged less than 5	5.3%	5.0%	5.2%	
% patients aged 65 or over	10.7%	14.0%	12.6%	
Patients in nursing homes (per 1,000 patients)	0.8	3.9	4.6	
% in full-time or part-time employment	53.5%	47.6%	52.8%	49.6%
% in full-time education (aged 18+)	1.2%	2.4%	2.4%	1.9%
% unemployed	7.0%	4.3%	4.0%	4.4%
% permanently sick / disabled	11.0%	7.2%	5.6%	5.6%
% employed unable to take time off to see GP	21.3%	29.5%	27.5%	28.5%
% reporting being in "poor" health	10.6%	7.1%	5.8%	5.8%
% with carer responsibilities	8.0%	9.2%	7.3%	8.6%
Proxy Index of Deprivation score (higher = more deprived)	30.61	31.29	26.13	
Patient movers (per 1,000 patients)	6.4	12.0	9.1	
Clinical system	ISoft Synergy			
Training practice	Yes			

List Size by Age and Sex



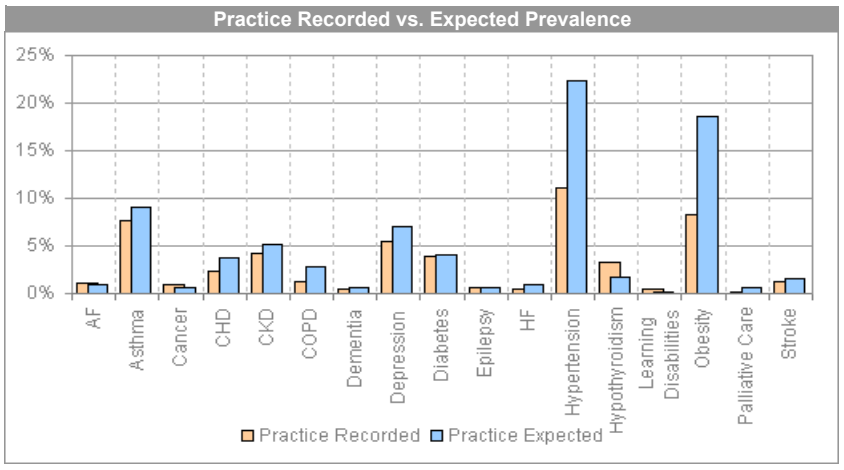
Proxy Index of Deprivation Score, June 2010



2 Recorded vs. Expected Prevalence

	Recorded Practice	*Recorded* Locality	*Recorded* PCT	*Expected* Practice
AF	1.1%	1.2%	1.2%	1.0%
Asthma	7.7%	5.8%	5.6%	9.1%
Cancer	0.9%	1.3%	1.2%	0.7%
CHD	2.3%	2.7%	2.4%	3.7%
CKD	4.3%	2.7%	2.7%	5.2%
COPD	1.3%	1.4%	1.1%	2.8%
Dementia	0.4%	0.3%	0.3%	0.7%
Depression	5.4%	5.6%	4.9%	7.1%
Diabetes	3.8%	3.5%	3.0%	4.1%
Epilepsy	0.7%	0.6%	0.5%	0.7%
HF	0.5%	0.6%	0.5%	1.0%
Hypertension	11.0%	10.6%	9.8%	22.3%
Hypothyroidism	3.3%	3.0%	2.8%	1.8%
Learning Disabilities	0.4%	0.3%	0.3%	0.2%
Obesity	8.2%	6.1%	5.9%	18.6%
Palliative Care	0.2%	0.1%	0.1%	0.7%
Stroke	1.3%	1.4%	1.3%	1.6%

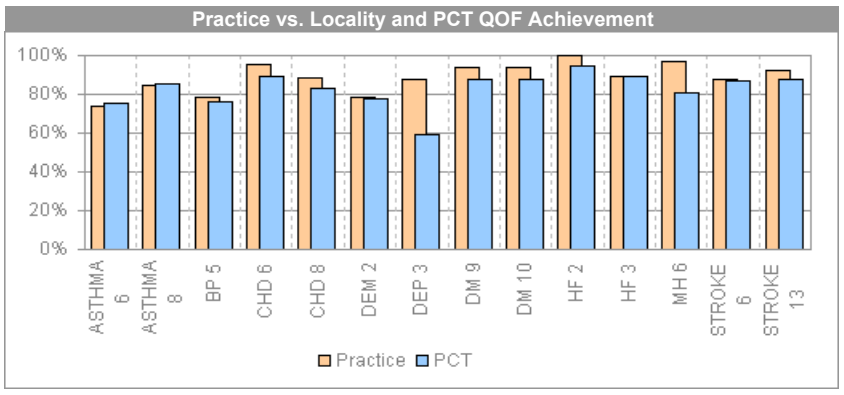
Practice Recorded vs. Expected Prevalence



3 QOF Achievement

	Practice	Locality	PCT	National
ASTHMA 6	73.9%	73.0%	75.4%	78.0%
ASTHMA 8	84.7%	82.9%	85.1%	87.6%
BP 5	78.3%	79.0%	76.3%	78.7%
CHD 6	95.5%	90.4%	89.4%	89.8%
CHD 8	88.6%	83.5%	82.9%	82.1%
DEM 2	78.3%	80.3%	77.9%	79.3%
DEP 3	87.6%	49.2%	59.3%	70.1%
DM 9	93.7%	84.9%	87.6%	91.1%
DM 10	93.9%	84.9%	88.0%	90.8%
HF 2	100.0%	93.2%	94.7%	95.9%
HF 3	89.5%	87.8%	89.3%	90.0%
MH 6	97.0%	71.6%	81.0%	88.9%
STROKE 6	87.5%	88.5%	86.9%	88.1%
STROKE 13	92.3%	87.1%	87.4%	90.2%

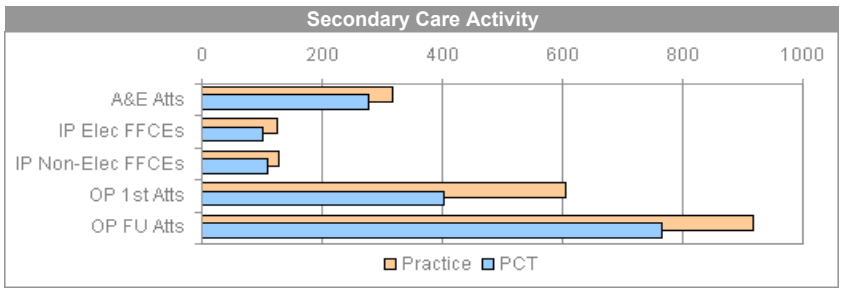
Practice vs. Locality and PCT QOF Achievement



4 Secondary Care Activity

NB: below are all per 1,000 patients	Practice	Locality	PCT
A&E attendances	317.5	324.4	278.0
Inpatient elective first finished consultant episodes	126.2	103.9	100.0
Inpatient non-elective first finished consultant episodes	129.2	120.0	110.7
Outpatient first attendances	605.1	385.0	401.9
Outpatient follow-up attendances	917.6	809.5	765.4

Secondary Care Activity



5 GMS Spend

	Practice	Locality	PCT
Global sum	£x	£x	£x
Correction factor	£x	£x	£x
Total spend (Global sum + Correction factor)	£x	£x	£x
Spend per patient	£x	£x	£x
Spend per weighted patient	£x	£x	£x

Non-GMS Spend

	Practice	Locality	PCT
Baseline contract value	N/A		
Spend per patient	N/A		
Spend per weighted patient	N/A		

GP Scorecard 2010/11, [Practice Name]

Overall Band: B (78 out of 114, 68.4%) [Locality] [Code]

1 Contractual Requirements & Premises

		A	B	C	Score	Band	Rank	Previous		Locality		PCT		National	
1.1	Compliance with GMS Contractual and Statutory Requirements	Fully compliant		Not fully compliant	Fully compliant	A	N/A	Fully compliant	=	N/A		41		N/A	
1.2	Business Continuity Plan (BCP)	Approved BCP		No approved BCP	Approved BCP	A	N/A	N/A		N/A		47		N/A	
1.3	Compliance with GMS minimum premises standards	Fully compliant	<10 changes needed	≥10 changes needed	16	A	=37	N/A		N/A		N/A		N/A	

2 Priority Standards & Services

		A	B	C	Score	Band	Rank	Previous		Locality		PCT		National	
2.1	Electronic Patient Records (EPR)	Using EPR	Working towards EPR	Not using EPR	Using EPR	A	N/A	N/A		N/A		N/A		N/A	
2.2	Information Governance Toolkit	Submitted, all ≥ level 2	Submitted, not all ≥ level 2	Not submitted	Submitted, not all ≥ level 2	B	N/A	N/A		N/A		N/A		N/A	
2.3	Priority Enhanced Services	≥ 90%	60% to 90%	< 60%	78.6%	B	=19	78.6%	=	74.6%	▲	76.5%	▲	N/A	
2.4	PBC locality agreement	Signed up		Not signed up	Signed up	A	N/A	N/A		N/A		48		N/A	

3 Access

		A	B	C	Score	Band	Rank	Previous		Locality		PCT		National	
3.1	Ease of access to building	≥ National (97.3%)	Top 50% of those below	Bottom 50% of those below	98.2%	A	19	97.8%	▲	96.8%	▲	97.0%	▲	97.3%	▲
3.2	Telephone access 1	≥ National (75.8%)	Top 50% of those below	Bottom 50% of those below	45.0%	C	48	55.7%	▼	69.7%	▼	75.0%	▼	75.8%	▼
3.3	GP appointment within 2 days 1	≥ National (79.8%)	Top 50% of those below	Bottom 50% of those below	77.3%	B	40	81.5%	▼	83.4%	▼	81.9%	▼	79.8%	▼
3.4	GP appointment 2+ days 1	≥ National (73.4%)	Top 50% of those below	Bottom 50% of those below	69.9%	B	36	52.6%	▲	75.3%	▼	74.4%	▼	73.4%	▼
3.5	Satisfaction with opening hours 1	≥ National (83.6%)	Top 50% of those below	Bottom 50% of those below	77.0%	B	33	77.3%	▼	79.7%	▼	79.2%	▼	83.6%	▼
3.6	Ability to see preferred GP 1	≥ National (74.7%)	Top 50% of those below	Bottom 50% of those below	74.1%	B	31	79.0%	▼	76.3%	▼	78.0%	▼	74.7%	▼
3.7	Extended hours 1	Providing		Not providing	Providing	A	N/A	N/A		N/A		33		N/A	

4 Patient Experience

		A	B	C	Score	Band	Rank	Previous		Locality		PCT		National	
4.1	Cleanliness of building	≥ National (98.6%)	Top 50% of those below	Bottom 50% of those below	99.1%	A	32	99.1%	▼	99.2%	▼	98.6%	▲	98.6%	▲
4.2	Helpfulness of reception staff	≥ National (93%)	Top 50% of those below	Bottom 50% of those below	90.1%	C	41	91.1%	▼	93.1%	▼	92.6%	▼	93.0%	▼
4.3	Experience with doctor	≥ National (95.4%)	Top 50% of those below	Bottom 50% of those below	95.9%	A	20	96.6%	▼	94.9%	▲	94.6%	▲	95.4%	▲
4.4	Experience with practice nurse	≥ National (97.6%)	Top 50% of those below	Bottom 50% of those below	95.8%	C	40	98.2%	▼	96.3%	▼	96.8%	▼	97.6%	▼
4.5	Patients told they have a care plan	≥ ONS cluster (12.5%)	Top 50% of those below	Bottom 50% of those below	8.5%	B	27	N/A		8.8%	▼	9.5%	▼	11.9%	▼
4.6	Overall satisfaction with care 1	≥ National (90%)	Top 50% of those below	Bottom 50% of those below	89.1%	B	33	91.3%	▼	89.5%	▼	88.5%	▲	90.0%	▼

GP Scorecard 2010/11, [Practice Name]

Overall Band: B (78 out of 114, 68.4%) [Locality] [Code]

5 QOF

Part 1: General		A	B	C	Score	Band	Rank	Previous		Locality		PCT		National	
5.1 Overall QOF score	2	≥ National (93.7%)	Top 50% of those below	Bottom 50% of those below	95.7%	A	14	95.6%	▲	87.4%	▲	89.3%	▲	93.7%	▲
5.2 Patient Experience domain score		≥ National (71.5%)	Top 50% of those below	Bottom 50% of those below	53.0%	C	41	70.2%	▼	70.5%	▼	72.0%	▼	71.5%	▼
5.3 Additional Services domain score		≥ National (95.3%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	88.4%	▲	88.3%	▲	95.3%	▲
5.4 Overall exception reporting rate		≤ National (5.4%)	Bottom 50% of those above	Top 50% of those above	6.6%	B	22	6.9%	▼	6.9%	▼	7.2%	▼	5.4%	▲
Part 2: Clinical Domain															
5.5 Overall Clinical domain score	2	≥ National (95.9%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	89.0%	▲	92.1%	▲	95.9%	▲
5.6 Asthma		≥ National (98.1%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	90.4%	▲	93.6%	▲	98.1%	▲
5.7 Chronic Kidney Disease		≥ National (94.7%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	88.5%	▲	92.0%	▲	94.7%	▲
5.8 COPD		≥ National (95.8%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	80.0%	▲	87.8%	▲	95.8%	▲
5.9 Dementia		≥ National (97.5%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	81.1%	▲	92.3%	▲	97.5%	▲
5.10 Depression		≥ National (81.7%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	69.5%	▲	68.6%	▲	81.7%	▲
5.11 Diabetes		≥ National (95.2%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	90.1%	▲	93.2%	▲	95.2%	▲
5.12 Hypertension		≥ National (98.9%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	96.2%	▲	96.8%	▲	98.9%	▲
5.13 Learning Disabilities		≥ National (98.6%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	93.8%	▲	98.0%	▲	98.6%	▲
5.14 Mental Health		≥ National (94.5%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	86.5%	▲	89.4%	▲	94.5%	▲
5.15 Obesity		≥ National (100%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	100.0%	=	100.0%	=	100.0%	▲
5.16 Palliative Care		≥ National (89.3%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	75.0%	▲	83.7%	▲	89.3%	▲
5.17 Smoking		≥ National (99%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	93.6%	▲	96.1%	▲	99.0%	▲
Part 3: Organisational Domain															
5.18 Overall Organisational domain score	2	≥ National (99%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	93.6%	▲	96.1%	▲		
5.19 Records and Information		≥ National (95.8%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	92.4%	▲	87.7%	▲		
5.20 Information for Patients		≥ National (98.6%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	95.8%	▲	93.9%	▲		
5.21 Education and Training		≥ National (95.9%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	83.0%	▲	84.8%	▲		
5.22 Practice Management		≥ National (97.9%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	84.0%	▲	89.4%	▲		
5.23 Medicines Management		≥ National (97.2%)	Top 50% of those below	Bottom 50% of those below	100.0%	A	=1	100.0%	=	89.4%	▲	88.4%	▲		

GP Scorecard 2010/11, [Practice Name]

Overall Band: B (78 out of 114, 68.4%) [Locality] [Code]

6 Public Health

		A	B	C	Score	Band	Rank	Previous		Locality		PCT		National	
6.1	Cervical screening (National Screening Programme)	≥ 80%	75% to 80%	< 75%	81.8%	A	5	80.8%	▲	74.5%	▲	75.8%	▲	N/A	
6.2	Cervical screening (QOF CS1)	≥ 80%	75% to 80%	< 75%	82.9%	A	23	83.1%	▼	83.6%	▼	83.0%	▼	N/A	
6.3	Childhood imms: DTaP/IPV/Hib 1 yr olds [1]	≥ 95%	≥ PCT (91.6%)	< PCT (91.6%)	87.9%	C	=38	N/A		89.5%	▼	91.6%	▼	N/A	
6.4	Childhood imms: MMR for 2 yr olds (1st dose) [1]	≥ 90%	≥ PCT (86.5%)	< PCT (86.5%)	85.9%	C	31	83.9%	▲	85.4%	▲	86.5%	▼	N/A	
6.5	Childhood imms: MMR for 5 yr olds (2nd dose) [1]	≥ 90%	≥ PCT (77.2%)	< PCT (77.2%)	82.2%	B	19	N/A		77.7%	▲	77.2%	▲	N/A	
6.6	Childhood imms: pre-school booster for 5 yr olds [1]	≥ 90%	≥ PCT (80.6%)	< PCT (80.6%)	87.1%	B	17	72.0%	▲	81.5%	▲	80.6%	▲	N/A	
6.7	Flu imms, 65+	≥ 70%	≥ PCT (68.1%)	< PCT (68.1%)	73.2%	A	12	76.8%	▼	68.0%	▲	68.1%	▲	72.4%	▲
6.8	Pneumococcal imms, 65+	≥ 80%	≥ PCT (69.8%)	< PCT (69.8%)	77.0%	B	11	47.0%	▲	71.2%	▲	69.8%	▲	N/A	
6.9	Smoking status recording (QOF Records 23)	Top quartile (≥ 84.5%)	Middle quartiles	Bottom quartile (< 75.9%)	90.8%	A	4	90.5%	▲	82.2%	▲	80.9%	▲	89.4%	▲
6.10	Smoking status recording (Omnibus) [1]	≥ 90%	70% to 90%	< 70%	76.2%	B	5	72.5%	▲	67.2%	▲	66.3%	▲	N/A	
6.11	Hypertension management [1]	≥ 75%	70% to 75%	< 70%	73.3%	B	24	74.7%	▼	72.1%	▲	71.7%	▲	N/A	
6.12	Chlamydia screening, 15-24 yr olds	≥ 50%	25% to 50%	< 25%	2.5%	C	25	N/A		5.3%	▼	4.3%	▼	N/A	

7 Prescribing

		A	B	C	Score	Band	Rank	Previous		Locality		PCT		National	
7.1	Renin-angiotensins	≥ 74%		< 74%	70.3%	C	30	60.8%	▲	70.6%	▼	70.7%	▼	N/A	
7.2	High risk antibiotics	≤ 25%		> 25%	16.7%	A	16	18.8%	▼	19.7%	▼	19.8%	▼	N/A	
7.3	Low cost PPIs	≥ 91%		< 91%	89.6%	C	27	83.7%	▲	88.6%	▲	89.4%	▲	N/A	
7.4	Statin prescribing	≥ 75%		< 75%	70.1%	C	45	71.0%	▼	77.5%	▼	79.7%	▼	N/A	
7.5	Seretide 250 evohaler	≤ 25%		> 25%	48.7%	C	44	N/A		34.4%	▲	30.7%	▲	N/A	

1 Indicators to which the PCT is held to account; mostly Vital Signs, but also 6.10, for which we submit data via the Omnibus return
2 These indicators do not count towards a practice's overall or banding

GP Scorecard 2010/11, [Practice Name]

NHS Brighton and Hove

Overall Band: B (78 out of 114, 68.4%)

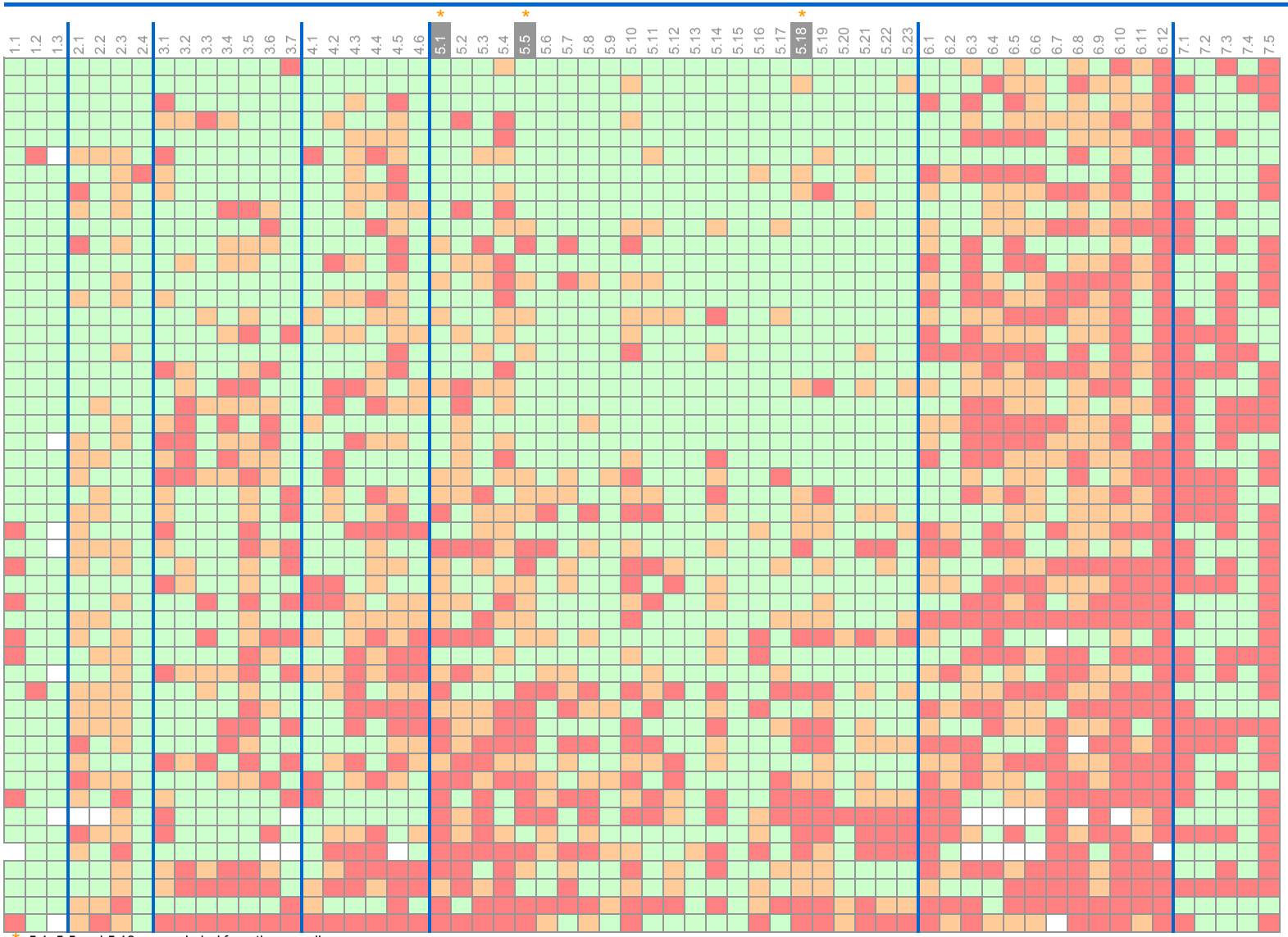
[Locality] [Code]

Appendix: QOF Exception Reporting

Part 1: General	Total	Rank	Locality		PCT		National	
5.1 Overall QOF score								
5.2 Patient Experience domain score								
5.3 Additional Services domain score								
5.4 Overall exception reporting rate								
Part 2: Clinical Domain								
5.5 Overall Clinical domain score								
5.6 Asthma	1.60%	37	8.18%	▼	7.52%	▼	5.24%	▼
5.7 Chronic Kidney Disease	7.79%	17	6.35%	▲	5.52%	▲	4.28%	▲
5.8 COPD	7.97%	37	14.34%	▼	15.80%	▼	12.65%	▼
5.9 Dementia	22.22%	7	10.47%	▲	10.12%	▲	7.07%	▲
5.10 Depression	4.87%	33	10.37%	▼	8.52%	▼	6.05%	▼
5.11 Diabetes	7.55%	32	8.84%	▼	8.91%	▼	6.44%	▲
5.12 Hypertension	4.31%	22	3.58%	▲	4.07%	▲	2.57%	▲
5.13 Learning Disabilities								
5.14 Mental Health	3.53%	43	17.20%	▼	16.48%	▼	10.80%	▼
5.15 Obesity								
5.16 Palliative Care								
5.17 Smoking	0.50%	37	0.89%	▼	0.87%	▼	0.71%	▼
Part 3: Organisational Domain								
5.18 Overall Organisational domain score								
5.19 Records and Information								
5.20 Information for Patients								
5.21 Education and Training								
5.22 Practice Management								
5.23 Medicines Management								

GP Balanced Scorecard 2010/11

NHS Brighton and Hove



Band	Rank	09/10
	1	
	2	
	3	
	4	
	5	
	6	
	=7	
	=7	
	=7	
	10	
	11	
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	35	
	36	
	37	
	38	
	39	
	40	
	=41	
	=41	
	43	
	44	
	45	N/A
	46	
	47	
	48	
	49	

* 5.1, 5.5 and 5.18 are excluded from the overall score

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

Subject:		**Improving Mental Health Services in Brighton & Hove (Reducing Acute Bed Capacity)**		
Date of Meeting:		**28 September 2011**		
Report of:		**The Strategic Director, Resources**		
Contact Officer:	Name:	Giles Rossington	Tel:	29-1038
	E-mail:	Giles.rossington@brighton-hove.gov.uk		
Wards Affected:	All			

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 In instances where local NHS bodies intend to make changes to health services, Health Overview & Scrutiny Committees (HOSCs) are charged with assessing whether their plans constitute a "substantial variation" in service provision; and if they do, whether: a) there has been sufficient consultation in regard to the plans; and, b) whether the plans will lead to improved outcomes for local people.

1.2 If a HOSC finds that a planned change would be detrimental to the local population, or has been introduced without adequate consultation, then it may, under powers granted by the 2001 Health & Social Care Act, refer the matter to the independent regulator of NHS foundation trusts for adjudication. No such referral should be made lightly or without compelling evidence.

1.3 Sussex Partnership NHS Foundation Trust (SPFT) has recently announced plans to significantly reconfigure local mental health services, reducing the number of city acute beds, whilst at the same time improving aspects of its community services. Details of these plans are included as **Appendix 1** to this report. These plans are supported by NHS Brighton & Hove and the emerging Brighton & Hove Clinical Commissioning Group (CCG).

1.4 The HOSC will need to decide whether the plans outlined in **Appendix 1** constitute a 'significant variation' in local services; and, if they do, whether SPFT has provided sufficient assurances that they have consulted on their intentions and that the end result of the initiative will be improved health outcomes for local people.

1.5 While the information provided by SPFT may serve to assure members that the plans have undergone robust consultation and will lead to better health outcomes for local people, it would not be advisable for the HOSC to make a decision to refer based solely on this information: referrals to the independent regulator must be thoroughly evidenced. Therefore, should members be unwilling to support the plans, they should request further information rather than referring these issues.

2. RECOMMENDATIONS:

2.1 That members:

(1) Determine whether the plans to reconfigure local mental health provision (**Appendix 1**) constitute a 'substantial variation' in services;

And, if they do view the plans as significant:

(2) Determine whether they require additional information before deciding whether or not to support the reconfiguration plans;

And, if members feel they have sufficient information to make a decision at this point:

(3) Agree to support the planned changes.

3. BACKGROUND INFORMATION

3.1 Regulations made under the Health & Social Care Act (2001) require NHS bodies to consult with local HOSCs when planning to make 'substantial variations' in health services, and grants HOSCs the power to refer these plans to the independent regulator of NHS trusts if they have evidence of inadequate consultation or of a likely negative health impact on local people.

3.2 There is no statutory definition of 'substantial variations'. However, SPFT plans involve the closure of 19 city mental health beds, or around 20% of the city bed capacity. It is difficult to see how such a change could be regarded as anything other than significant. This is therefore an issue that the HOSC should address, and one which it might potentially seek to refer to the Secretary of State.

3.3 However, in order to refer a matter to the Secretary of State, a HOSC must have compelling evidence to support its referral. Moreover, all implementation of plans must be suspended while a referral is being

considered, which may have major cost implications for the local health economy. For these reasons, a referral would typically only be made after an intensive period of gathering and examining evidence – e.g. via a scrutiny panel.

3.4 Members must therefore decide whether: a) they support the plans detailed in **Appendix 1**, accepting SPFT's assurances that bed spaces will not be reduced until it is evident that they are no longer required; or b) they require further detail on some elements of SPFT's plans, and therefore choose to defer any decision on whether to support the plans until they have had the opportunity to study the proposals in greater depth.

4. CONSULTATION

4.1 None has been undertaken in preparing this report. **Appendix 1** has been supplied by SPFT

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 None directly to this report.

Legal Implications:

5.2 The requirement for SPFT to consult HOSC about its proposal is provided for by regulation 4A of the Local Authority (Overview & Scrutiny Committees Health Scrutiny Functions) Regulations 2002.

Having been consulted, HOSC may make comments on the Trust's proposal by such date as may be specified by the Trust.

Where HOSC is not satisfied that the Trust's consultation about its proposal has been adequate in relation to content or time allowed, it may report to the regulator of NHS foundation trusts in writing, and the regulator may require the Trust to carry out such consultation, or such further consultation with HOSC, as it considers appropriate.

Where HOSC considers that the proposal would not be in the interests of the health service in Brighton & Hove, it may report to the regulator in writing, and the regulator shall have regard to the report.

Lawyer consulted: Oliver Dixon Date: 19/09/11

Equalities Implications:

5.3 People with mental health problems are amongst the most vulnerable in our society, and are typically over-represented in terms of deprivation, having general health problems, having substance misuse issues etc. Any plans to significantly alter mental health services must therefore aim to reduce inequalities by improving outcomes for people with mental illness. In the context of these specific plans, which, crudely speaking, involve a shift of emphasis from in-patient treatment to support in the community, members may wish to receive assurances that no group of people is likely to be disproportionately affected by such a move (i.e. that it is not more difficult to support certain groups of people in the community than others; or if it is, that sufficient ameliorative measures are in place).

Sustainability Implications:

5.4 None.

Crime & Disorder Implications:

5.5 People with severe mental health problems are disproportionately likely to be victims of crime and may, on average, also be disproportionately involved in some types of crime and disorder. Members may wish to receive assurances that a greater emphasis on treating people in the community will not increase crime and disorder

Risk and Opportunity Management Implications:

5.6 Poor mental health has a very wide impact upon individuals, families and communities, and high rates of mental illness are associated with high rates of worklessness, poverty, physical poor health, crime, substance misuse etc. Having effective mental health services is therefore a key driver to improving city performance in a number of areas, including both health and income inequalities, and any significant re-design of city services will offer substantial opportunities/risks.

Corporate / Citywide Implications:

5.7 Having effective mental health services is a key factor in tackling health and income inequalities across the city.

SUPPORTING DOCUMENTATION

Appendices:

1. Information provided by Sussex Partnership NHS Foundation Trust and Brighton & Hove Emerging Clinical Commissioning Group

Documents in Members' Rooms:

None

Background Documents:

1. Health & Social Care Bill (2001)

Sussex Partnership NHS Foundation Trust
Brighton and Hove Health Overview Scrutiny Committee
28th September 2011
By: Dr. Richard Ford & Geraldine Hoban

UPDATE ON IMPROVING MENTAL HEALTH SERVICES IN BRIGHTON AND HOVE AND OUR PLANS TO REDUCE ACUTE MENTAL HEALTH BED CAPACITY

1.0 Executive Summary

1.1 In 2009 the 4 Sussex Primary Care Trusts commissioned "Whole Systems Strategies" to review acute mental health bed provision in a whole system context across Sussex.

1.2 The review found that when benchmarking Brighton and Hove against other similar areas nationally there are higher than expected average lengths of stay, higher than expected admission rates for older people and delayed discharges contributing to longer lengths of stays than necessary in hospitals.

1.3 The review therefore highlighted the opportunity to redesign mental health services to provide better quality care through providing more services in the community that can help prevent admission in the first place and facilitate earlier discharge from hospital. The key recommendation of the review was that if services could be redesigned the overall number of acute mental health beds in Brighton and Hove can be reduced from 95 to 76 - a total reduction of 19.

1.4 The expected benefits of the service redesign and reduction in inpatient capacity are improved support close to people's home to help them stay at work and participate in their local communities.

1.5 The case for the reduction in bed capacity by January 2012 has been considered by the PCT and has been approved as a key service improvement. Approval from the PCT is subject to the review of evidence and key measures that support the development of sufficient high quality community services and demonstrate a reduced need for bed capacity in line with the recommendations from the review.

1.6 Whilst good progress is being made to redesign the services and achieve the required improvement work continues on actions to reduce the numbers of delayed discharges and reduce the length of stay. The impact the service redesign and development work is having is being actively monitored, this includes the numbers of admissions to inpatient units outside of Brighton and Hove.

1.7 **The aim of this paper is to provide an update for the Health Overview Scrutiny Committee (HOSC) on the progress in Brighton and Hove to enhance and develop adult (18 and over) community services and reduce the mental health bed capacity in Brighton and Hove by 19 beds.**

1.8 The HOSC is asked to note the progress on improvements to community mental health services and support the plan to reduce inpatient capacity by 1st January 2012 subject to a year end report that demonstrates the current bed capacity at Mill View and Neville Hospital is no longer required

2. Background and context

2.1 Sussex Partnership NHS Foundation Trust and NHS Brighton and Hove have presented the development plans for local mental health services at the HOSC on a number of occasions over the past year. The plans presented support the implementation of the City wide "Commissioning Mental Health Services for Adults Strategy – Transforming Mental Health" and the Sussex Partnership Better by Design Strategy.

2.2 The Commissioning Strategy reflects the demand for more mental health treatment and care to be available in community settings. Better by Design is the Sussex Partnership five year strategic programme to develop and improve the specialist community and inpatient mental health services across Sussex. The adult programme of work as part of this strategy is called Under One Roof (U1R).

2.3 In 2009 Professor Keith Wilson from "Whole System Strategies" undertook an independent review on the spend and bed usage on community and acute mental health services across Sussex. The key recommendation was that if services could be redesigned the overall number of acute mental health beds could be reduced from 95 to 76 - a reduction of 19 beds.

2.4 The expected benefits of the redesign are:

- Improved support close to people's home helping them to stay at work and participate in their local communities
- Financial savings of up to £1.2 which would provide an opportunity to re-investment in community mental health services

2.5 In August 2010 the PCT approved plans to reduce the number of beds on the condition that there was assurance of sufficient evidence of changes to community mental health services to support this system change. The underpinning principles are:

- service users with mental health needs should not be admitted to a hospital environment unless it is essential

- length of stay in hospital should be the minimum time required to address the problem for which the service user was admitted.

2.6 As a result of the review Sussex Partnership NHS Foundation Trust and NHS Brighton and Hove agreed it was appropriate to plan to reduce the adult acute mental health inpatient capacity and develop community services.

2.7 Sussex Partnership held a workshop where clinical and PCT staff were asked to identify those developments which would deliver the improvements and support the reduction in bed capacity. NHS Brighton and Hove and Sussex Partnership together agreed a set of High Impact Changes to support the reduction of inpatient capacity. These are the most important improvements and developments required to reduce the bed capacity. These became the "high impact changes".

2.8 The plan to reduce bed capacity by 19 across Mill View and the Nevill Hospitals in January 2012 equates to a reduction of 12 Adult Acute Admission beds, 4 Older persons "functional admission beds" and 3 Dementia assessment beds. NHS Brighton and Hove

and Sussex Partnership have focused on improving community mental health services and the acute inpatient care pathway.

2.9 The measures to monitor the reduced demand for inpatient care include length of stay, admissions to inpatient units outside Brighton and Hove, numbers of delayed discharges, and bed occupancy rates for Mill View and the Nevill Hospitals.

3. Progress Update on the High Impact Changes

3.1 **A refreshed Crisis Resolution Home Treatment Service (CRHT) to ensure these services are working in accordance with the national guidelines. Should support all adults over 18, including those over 65.**

Complete: The CRHT has undergone recent development and is now operating as an ageless service and a new manager has been appointed. Training was provided to working age adult staff to prepare them to work with older people in crisis with a functional mental health problem. The Operational Policy has been revised to reflect the changes and a small resource has been identified to supplement the CRHT to expand the scope of delivery.

3.2 **7 days a week community services and extended hours within the working week.**

In progress: The Better by Design Project has been running across Sussex Partnership for the last year. Clinicians have developed a revised service model. The proposed model referred to as "Under One Roof" (U1R), provides an adult Assessment and Treatment Centre with a Recovery and Wellbeing pathway for people with more complex presentation who require care coordination.

An operational policy to support implementation of the new service model has recently been published. Working with the City Council, Sussex Partnership is undertaking an extensive consultant with staff working in the existing services on the changes and how these affect them. The Operational Policy is included in this consultation and has also been shared with NHS Brighton and Hove Clinical Commissioners and will be amended to reflect the feedback being received on it. The supporting project management structure has been developed to reflect the next stage of the programme through consultation and implementation. A Service and Clinical Director have been assigned to lead the implementation for Brighton and Hove.

Further action: Complete Consultation October 2011
Phased implementation December 2011 – April 2012

3.3 **Redevelopment and implementation of 4 priority clinical pathways to manage people's needs in the community. The priority pathways are: Psychosis, Personality Disorder, Dementia, Depression.**

In progress: Clinical pathway development groups are set up and each is chaired by a Lead Clinician. These groups have been developing the care pathways with the aim of presenting them on "map of medicine". Progress has varied across each of the groups with the first pathway; Depression expected to be launched in October. The Psychosis pathway was presented to the Clinical Reference Group (CRG) in May and it will be published in October following final CRG review.

The independent review identified a cohort of patients with personality disorder that could more appropriately be cared for in the community. Sussex Partnership has developed community alternatives including a specialist psychological programme. The CRG will

review the Personality Disorder Pathway at the October meeting. The Clinical Commissioning Group is reviewing the potential dementia service models in September and following agreement of the preferred model the dementia pathways will be developed.

Other condition based pathways are in varying stages of development some of which are quite well advanced. These include; Obsessional Compulsive Disorder, Post Traumatic Stress Disorder, Physical Health, Neuro-behavioural disorders, Bi-Polar disorder and Eating Disorder.

Further action: Complete and publish 4 priority pathways December 2011 (subject to dementia model agreed)
Develop a plan for community cased personality disorder services building on existing services as an alternative to admission - October 2011

3.4 **Extended care management for people in recovery services.**

In progress: The revised clinical model for community services includes an integrated Recovery and Wellbeing pathway which has a discrete specialist function within the service model. This redefines the role of the Care Coordinator and the relationship with the Service User. In addition to the ongoing development of the Care Programme Approach Policy and improvements in performance, Sussex Partnership has worked with South West London and St Georges to develop a local Self Management Toolkit which has been published and launched.

Further action: Publish revised CPA practice guidelines – December 2011

3.5 **Improved rapid response service including the Out of Hours response and use of A&E (BURS).**

Complete: Improving access to services for people in urgent need and crisis is one of our shared primary objectives. Key amongst this is providing a response to people who need have a face to face assessment within four hours of referral. As a result of collaboration across Primary and Secondary care, the Brighton Urgent Response Service (BURS) was formally launched on 23 May. This provides 0800 – 2000 urgent response service which runs from Monday to Friday. Whilst initially established to provide a service to people aged 18 – 65 we are planning to extend this to over 65's too.

3.6 **Sussex Partnership operational managers in Brighton and Hove will identify the small number of complex patients who are frequent users of the inpatient beds and develop a plan for working with this group of people. This will be part of the new case management.**

Complete: It has been recognised that a small number of service users utilise a disproportionate amount of time and resource. A high level review suggested that a common theme is that these individuals do not sit easily in any particular service. Having seen the potential in the "Family Pathfinder" work, it was agreed that a similar approach be taken to this client group with the agencies involved contributing to a personalised approach to intensive care management. The Recovery Services General Manager has led a small group which has undertaken a review of case loads against a set of agreed criteria and identified a priority group across Working Age and Older Persons services to work with.

3.7 **The range of intermediate or step up and step down beds to be appropriate to demand.**

In progress: Having examined the cause of delays in discharge from Mill View and Nevill Hospitals it was suggested that whilst there are a range of housing and accommodation options across the city, the system does not always operate smoothly and blockages can appear upstream resulting in limited access and service users remaining in the wrong level of accommodation. This can result in problems for the service user involved as well as others who are effective denied access.

A local review of the Residential Rehabilitation Services provided by Sussex Partnership has been completed which has informed a revised service strategy. A multi-agency Housing and Accommodation group led by NHS Brighton and Hove has been established to move this initiative forward. Sussex Partnership was successful with its bid to the Strategic Health Authority for a project to investigate the needs of the acute inpatient and the residential care population. This piece of work complements the wider strategic programme.

3.8 **Improve Acute Care Pathway**

In progress: The 2010 Independent Review of Mill View Hospital highlighted a compartmentalised system which can result in delays in repetition in the system which can impact in terms of longer than necessary length of stay. A new acute care pathway has been developed and has been implemented at Mill View Hospital. The pathway was presented to the Clinical Reference Group in September and is in place at Mill View Hospital along with a number of other improvements.

The acute care pathway supports work to reduce the length of stay at Mill View Hospital in line with national best practice benchmarks. The pathway sets out the standards and expectations relating to assessment, treatment and discharge and places particular emphasis on the standards of care for the first seven days of admission. The new care pathway is designed to support a reduction in the average length of stay.

Sussex Partnership has recently started monitoring the median (or middle) length of stay for patients at Mill View Hospital. This measures the length of stay in a given week for patients who have stayed in the ward at any time in the period. The length of stay is calculated from the start of the patients stay in hospital and is showing a reduction in the length of stay for patients. This improvement is a direct result of the development work undertaken on the acute care pathway. Sussex Partnership is also reporting a reduction in bed occupancy levels for Brighton and Hove residents.

Whilst the numbers of admissions outside of Brighton and Hove increased temporarily earlier this year during the refurbishment of Pavillion Ward (intensive care unit) these have significantly reduced and will continued to be monitored. There is a daily trust wide conference call to manage beds. There are no current issues of Brighton and Hove patients having to be cared for out of area except through choice.

The bed numbers will reduce by 1st January 2012 in line with the plan if the length of stay and occupancy rates demonstrate the capacity is no longer required as it will effectively be redundant. This is supported by the Sussex Partnership commitment that a bed will always be found for everyone who has a clinical need for admission to hospital.

Further action: Continue to monitor the use of inpatient services against the following agreed measures admissions

- admissions outside of Brighton and Hove
- bed occupancy
- length of stay

Progress development of the changes including the plan for community based services for people with personality disorder as an alternative to admission**.**

4. Stakeholder Engagement

4.1 Stakeholders have been engaged in a variety of ways e.g. HOSC meetings, LiVE sessions, Foundation Trust members meetings and formal meetings. Sussex Partnership and NHS Brighton and Hove will continue to work closely together to ensure service users and carers are involved and engaged in the ongoing work in relation to the implementation of the High Impact Changes.

5. Recommendations

5.1 The HOSC is asked to support the plan to reduce inpatient capacity at Mill View Hospital and Neville Hospitals by 1st January 2012 subject to a year end report to the HOSC that demonstrates the current bed capacity at Mill View Hospital is no longer required.

HOSC Work Programme 2011/12

Issue	Date to be considered	Referred/Requested By?	Reason for Referral	Progress and Date	Notes
3T development of the Royal Sussex	Sep 2011	BSUHT	Ongoing monitoring of major project to re-design RSCH		
GP practice quality	Sep 11	HOSC	Monitoring relative performance of city GPs		
City MH beds	Sep 11	SPFT/PCT	NHS plans to reconfigure city MH beds		
PCT annual operating plan	TBA	PCT	Scrutinise PCT strategic commissioning plans for coming year		workshop
BSUHT Foundation Trust application	Sep 11	BSUHT	Ongoing – update on progress of trust FT application		Will be addressed as part of 3T update
SECamb FT application	TBA	SECamb	Ongoing – update on progress of trust FT application		

Issue	Date to be considered	Referred By?	Reason for Referral	Progress and Date	Notes
Sussex Community Trust - merger	TBA	SCT	Update on progress of trust following merger with WSX community		
MH re-commissioning	TBA	PCT	Update on re-commissioning of MH access services		
Screening	Nov 2011	HOSC	Update on city screening programmes (inc. breast and cervical screening + pilot on co-rectal screening)		
Health & Social Care Bill	Sep 11, Nov 11 and ongoing	HOSC	Ongoing update on progress of Health Bill, focusing on elements requiring local implementation		Nov 11 – HOSC to be consulted on model for local Health and Wellbeing Board
Continuity of care for people with MH problems leaving prison	TBC	Cllr Deane	Worries about quality/continuity of care for people leaving prison (esp transfer of information between prison services and GPs)		To be scoped before deciding on course of action
Maternity	TBC	Cllr Buckley	Look at performance of city maternity services – to include info on a city midwife led service		

Issue	**Date to be considered**	**Referred By?**	**Reason for Referral**	**Progress and Date**	**Notes**
End of Life Care	TBC	Cllr Wealls	Look at city strategies for EoL care and what providers do to guarantee dignity/quality		Workshop event
Alcohol issues	TBC	Cllrs Duncan and Powell	Look at issues re the negative impacts of alcohol on city health		Chair to liaise with executive to identify which aspects of this issue can best be taken forward by HOSC
NHS Provider Quality	TBC	PCT/BSUH	Examine quality of healthcare provision across city inc. annual patient survey		Workshop event
Short term services	Jan 2012	ASC	Look at revised short term services strategy	To include 'delayed discharge'	Due to be agreed by JCB Nov 11

Issue	**Date to be considered**	**Referred By?**	**Reason for Referral**	**Progress and Date**	**Notes**
Air Quality	TBC	Cllr Rufus	Examine health impact of poor air quality		Liaise with ECSOSC to discuss best way to progress this