Brighton & Hove City Council

Overview & Scrutiny

Title:	**Health Overview & Scrutiny Committee**
Date:	**9 May 2012**
Time:	**4.00pm**
Venue	**Banqueting Suite, 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**

82. PROCEDURAL BUSINESS **1 - 2**

(copy attached)

83. MINUTES OF THE PREVIOUS MEETING **3 - 10**

Draft minutes of the meeting held on 21 March 2012 (copy attached)

84. CHAIR'S COMMUNICATIONS

85. PUBLIC QUESTIONS

No public questions have been received

86. NOTICES OF MOTION REFERRED FROM COUNCIL

No Notices of Motion have been received

87. WRITTEN QUESTIONS FROM COUNCILLORS

No questions have been received

88. COMPARATIVE HOSPITAL MORTALITY RATES FOR WEEKEND AND WEEK DAY ADMISSIONS **11 - 18**

Report of the Strategic Director, Resources, on comparative mortality rates at the Royal Sussex County Hospital for weekend and week day admissions (copy attached)

89. RE-COMMISSIONING OF ADULT HEARING SERVICES **19 - 24**

Report of the Strategic Director, Resources, on NHS Brighton & Hove plans to re-commission adult hearing services (copy attached)

90. RE-COMMISSIONING MENTAL HEALTH COMMUNITY SERVICES **25 - 30**

Report of the Strategic Director, Resources, on implementation of NHS Brighton & Hove plans to re-commission aspects of local mental health community services (copy attached)

91. MENTAL HEALTH: ACUTE BEDS

Update on plans to reduce acute bed capacity at Mill View hospital (verbal)

92. LETTERS TO THE CHAIR **31 - 36**

A letter has been received from Sussex Community Trust, describing the implementation of changes to Short Term Services agreed at a recent HOSC meeting (copy attached)

93. 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

94. 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 - Monday, 30 April 2012

Agenda Item 82

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 83

BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00PM 21 MARCH 2012

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillors Rufus (Chair); Barnett, Bennett, Follett, Marsh, C Theobald (Deputy Chair), Summers and Pissaridou

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

PART ONE

69. PROCEDURAL BUSINESS

69A Declarations of Substitutes

69.1 Cllr Summers attended as substitute member for Cllr Phillips

Cllr Pissaridou attended as substitute member for Cllr Turton

69B Declarations of Interest

69.2 There were none.

69C Declarations of Party Whip

69.3 There were none.

69D Exclusion of Press and Public

69.4 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.

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

70. MINUTES OF THE PREVIOUS MEETING

70.1 RESOLVED – That the minutes of the meeting held on 25 January 2012 be approved and signed by the Chairman.

71. CHAIR'S COMMUNICATIONS

71.1 The Chair informed members that, in response to a request from Brighton & Sussex University Hospitals Trust (BSUHT), he had written a letter to the trust confirming that the HOSC supported the 3T plans to develop the Royal Sussex County Hospital site. Its general support for the programme notwithstanding, the HOSC reserves the right to scrutinise aspects of the development.

72. PUBLIC QUESTIONS

72.1 There were none.

73. NOTICES OF MOTION REFERRED FROM COUNCIL

73.1 There were none.

74. WRITTEN QUESTIONS FROM COUNCILLORS

74.1 There were none.

75. LONG TERM CONDITIONS

75.1 This item was introduced by Jo Matthews, Brighton & Hove Transitional Clinical Commissioning Group (CCG) Commissioner for Long Term Conditions, and by Geraldine Hoban, CCG Chief Operating Officer.

75.2 Members were told that long Term Conditions (LTC) were a CCG priority. Previously services for people had been good in parts, but there was too much variation in the quality and type of services available across the city. In response to this, LTC services were being re-oriented around primary care teams based at the level of clusters of GP practices –3-5 local GP practices with similar demographics in each cluster. Each team would have a broad range of skills, including, but not limited to nursing. Teams will be very closely linked to their GP practices and will regularly discuss admission and discharge information with the relevant GPs. Early feedback on the introduction of this model was largely positive, although there had been some issues with ensuring that team/GP meetings took place as scheduled, and with some unanticipated impacts on other services. It was expected that there would be these types of pressure emerging,

and it was always intended that the current year of operation would be used to fine-tune the system in preparation for going to procurement in the following year.

75.3 In response to a question from Cllr Marsh on the definition of LTC, members were told that there was no precise definition, but in essence the term LTC was used locally to identify people who were unable to travel to their GP practices, and who therefore required treatment delivered to their homes.

75.4 In answer to a question from Cllr Marsh on co-working with adult social care (ASC) services, the committee was informed that the LTC initiative has been developed in consultation with ASC. ASC will have a formal role in line-managing carer support managers who will work very closely with the LTC teams.

75.5 In response to a question from Cllr Marsh on the use of care-co-ordinators, members were told that, in some instances service users might choose not to have a care co-ordinator appointed, preferring to co-ordinate their own care, have their carer do so etc.

75.6 In answer to a query from Mr Hazelgrove regarding evaluation of the LTC programme, members were informed that formal evaluation would start in October 2012 and would draw on experiences of service users, GPs, and Sussex Community Trust. As well as soliciting views on the new service, the evaluation would seek to identify measurable improvements in patients' lives, possibly using the well-established methodology of PROMs – Patient Recorded Outcomes Measures.

75.7 In response to a question from Cllr C Theobald about resource implications of this initiative, the committee was told that the introduction of practice-based teams would lead to a small reduction in nursing staff requirement – 3 FTE posts. Other savings would arise from the use of more appropriate staffing – currently, too many service users were supported by inappropriately senior staff (e.g. nurses providing non-nursing services).

75.8 In answer to a question from Cllr Pissaridou regarding how the practice teams would be alerted to patients being admitted to/discharged from hospital, members were told that the hospital activity data would be electronically uploaded onto the Urgent Care Clinical Dashboard every 24 hours and automatically shared with relevant GPs. In addition, the hospital discharge team should liaise directly with GPs for every discharge.

75.9 In response to a query from Mr Brown asking whether the local LTC programme was co-ordinated with national developments and whether it was designed to save money, the committee was told that, locally at least, the programme was driven by the need to improve the quality of services. In terms of co-ordination with national developments, the Brighton & Hove programme pre-dates national moves to improve LTC care. However, the two approaches tally closely, and Brighton & Hove is very much at the forefront of delivering these improvements.

75.10 Mr Brown told members that the LINk had been consulted at every stage of the development of an LTC programme, and LINk concerns had all been addressed. The LINk will continue to monitor the implementation of the programme.

75.11 The Chair thanked Ms Matthews and Ms Hoban for their contributions and requested an update on implementation of the LTC programme in Autumn 2012.

75.12 RESOLVED – That the report be noted and a further updated requested in Autumn 2012.

76. SUSSEX TOGETHER

76.1 This item was introduced by Amanda Philpott, Director of Strategy and Provider Development, NHS Sussex. Ms Philpott told members that the NHS spend across Sussex was approximately £2.6 billion per annum. Given that government funding is likely, at best, to flat-line for the foreseeable future, and that health sector inflation, even in the context of a public sector pay freeze, is predicted to run at around 4% pa, some £440 million additional funding would be needed by 2013 to continue to meet increasing population health need through the current configuration of Sussex services. Since this extra money will not be available, the challenge for the local NHS is to make significant efficiencies. In addition, the Foundation Trust (FT) programme should see all NHS provider trusts becoming FTs by 2014. To become an FT a trust must prove that it is financially viable – i.e. capable of making a sustainable annual profit from its activities.

76.2 The process via which these efficiencies will be found is called 'Sussex Together' and will be co-ordinated by NHS Sussex. However, the initiative will be clinically led – by both GP commissioners and provider clinicians – as well as having input from adult social care professionals, services representing the wider determinants of health (e.g. housing) and LINks.

76.3 Sussex Together has initially identified four main priority areas: frail elderly, unscheduled care, planned care and 'other' (focusing particularly on medicine management, paediatrics and maternity). The aim is to establish best practice within Sussex, and then ensure that local services and pathways demonstrate a consistent approach in line with this best practice. It will be for individual Clinical Commissioning Groups (CCGs) to implement this at a local level.

76.4 Thus far, Sussex Together has identified £160 million of potential savings. This is a fairly urgent process, as the more quickly savings can be identified and enacted, the bigger the budgetary impact. Providers have responded very positively to the challenge, even though they compete with one another for custom. A Sussex Clinical Senate has been established, bringing together clinicians from across the county and building on the successes of existing clinical networks.

76.5 Ms Philpott assured members that lessons had been learnt from previous attempts to reconfigure the Sussex health economy, and that there was no agenda to shut hospitals. Hospital trusts recognised that these were difficult financial times and that they had to work together – with each other and with GP commissioners – in order to remain sustainable. The boards of all Sussex NHS trusts are signing up to the principles of Sussex Together.

76.6 In response to a question from Cllr Follett regarding the Sussex Clinical Senate, members were told that it was hoped the Senate would enable provider clinicians to contribute to commissioning decisions at a remove – sharing their knowledge without

inappropriately influencing commissioner choices. The Senate would effectively be a continuous clinical summit, and should cost relatively little (most clinicians involved will already be paid for service-planning so will not expect additional reimbursement).

76.7 In answer to a question from Cllr Marsh as to why this type of planning could not be left to CCGs, the committee was told that CCGs were still at a nascent stage of development, and in addition there are benefits from sharing best practice across Sussex. CCGs are at the heart of the Sussex Together initiative.

76.8 In response to a question from Cllr C Theobald on maternity/paediatrics, members were told that this was likely to be a very significant issue going forward, with the need to balance people's reasonable expectations of locally accessible services with a configuration of services that accords with guidance from the Royal Colleges on optimum unit size.

76.9 The Chair thanked Ms Philpott for her contribution and requested a further update in Autumn 2012.

77. IMPLEMENTATION OF THE HEALTH & SOCIAL CARE BILL: UPDATE

77.1 This item was introduced by Terry Parkin, Strategic Director, People.

77.2 Mr Parkin told members that the local Clinical Commissioning Group (CCG) was performing well on all indicators and was well-prepared for the authorisation process. The CCG has successfully resisted some pressure to increase its boundaries beyond that of the city, which is to be welcomed, as the co-terminosity of the CCG and the city council provides significant benefits to the city.

77.3 The city Public Health team have now moved into council premises and are working alongside council commissioners. At a national level, the spilt of responsibilities between Public Health England and local Public Health services is still being worked out, but an indicative budget for local areas has been published and work is underway to match this budget against city needs.

77.4 Plans for a local Health & Wellbeing Board (HWB) have now been approved by Governance Committee, Cabinet and Full Council, having in the process been amended to include greater member-representation. The success of the HWB will depend upon it maintaining a tight focus on high-level outcomes via the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy (as specified in the HWB Terms of Reference agreed by Full Council).

77.5 In terms of Healthwatch (HW), Mr Parkin told members that there was still considerable uncertainty about HW, particularly around children's services. Current plans envisage local HW organisations working closely with a national organisation, Healthwatch England, which will sit within the Care Quality Commission (CQC), the NHS and social care watchdog. However, CQC has no remit to oversee children's services, which fall within the remit of Ofsted, so it is unclear how HW would be able to represent young people's views without recourse to escalating its concerns via Healthwatch England/CQC. This lack of clarity regarding HW's roles is one of the reasons that the

local HWB will include a young person from the Brighton & Hove Youth Council, ensuring that local young people have a voice in HWB decisions.

77.6 In response to a question from the Chair on a possible clash of interest with HW taking part in HWB decisions but also potentially scrutinising the implementation of HWB strategies, members were told that the Department of Health had issued guidance on this issue. All the members of the HWB are champions for particular constituencies, so HW is not unique in this respect.

77.7 RESOLVED – That the report be noted.

78. MENTAL HEALTH: ACUTE BEDS

78.1 This item was introduced by Geraldine Hoban, Chief Operating Officer, Brighton & Hove Transitional Clinical Commissioning Group (CCG); Sam Allen, Service Director, Sussex Partnership NHS Foundation Trust (SPFT); and Anne Foster, CCG Lead Commissioner, Mental Health.

78.2 The committee was told that the Clinical Taskforce examining the planned Mill View bed reductions had met twice to agree the set of metrics they would use to determine whether beds should be permanently reduced and to begin to apply these metrics to the data on activity at Mill View. The Clinical Taskforce was being Chaired by Dr Becky Jarvis, CCG Clinical Lead on Mental Health.

78.3 The key metric was the percentage of Brighton & Hove patients seeking admission at Mill View being placed in the hospital, with a target of 95%. SPFT was not currently meeting this target, although it was performing at 92-93%. The Taskforce identified the lack of a local specialist service for Personality Disorder and a paucity of suitable supported housing to accommodate people being discharged from hospital as the key areas that required improvement if the target was to be reached.

78.4 In response to a question from the Chair as to how the 95% target was agreed, members were told that it was not feasible (or desirable) to set a target of 100%; 95% represents a challenging but achievable goal and will ensure that almost all local people receive treatment locally. SPFT would have to show it could attain the target level of services for three consecutive months before the Taskforce would agree to permanent closure of beds. In addition, there were other metrics being considered, looking at bed occupancy rates, user complaints, re-admission rates and seasonal variation.

78.5 In answer to a query from Mr Hazelgrove on the problems associated with supported housing in the city, members were told that there was historically a lack of housing at all levels of support need. There were also wide variations in quality and cost of supported housing across the city and a general lack of 'move-on' in the system – e.g. people no longer requiring high levels of support being moved on to lower support housing. A good deal of work has been undertaken in this area, and local providers are confident they can increase capacity.

78.6 The Chair thanked Ms Hoban, Ms Allen and Ms Foster for their contributions, noting that the committee was very happy with the way the process had been handled to date, and would welcome more updates at future meetings.

79. LETTERS TO THE CHAIR

79.1 Members discussed a letter from NHS Sussex alerting the committee to a change in the management of the Sussex Orthopaedic Treatment Centre.

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

80.1 There were none.

81. ITEMS TO GO FORWARD TO COUNCIL

81.1 There were none

The meeting concluded at 6.30pm

Signed Chair

Dated this day of

HEALTH OVERVIEW AND SCRUTINY COMMITTEE	Agenda Item 88 Brighton & Hove City Council

Subject:		**Comparative Mortality Rates for Hospital Admissions on Weekends and Week Days**		
Date of Meeting:		**May 09 2012**		
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 Brighton & Hove HOSC members recently requested information on the performance of the Royal Sussex County Hospital in terms of the comparative outcomes for patients admitted to hospital during the week Vs those admitted at the weekend.

1.2 Brighton & Sussex University Hospitals Trust (BSUHT) has kindly provided information on comparative performance, which is included as **Appendix 1** to this report.

2. RECOMMENDATIONS:

2.1 That members:

Note the contents of this report and its appendix.

3. BACKGROUND INFORMATION

3.1 It is a well established fact that outcomes for people admitted to hospital with emergency conditions may vary significantly depending on when they are admitted – e.g. whether admissions are in normal working hours when the hospital is fully staffed, or out of hours (i.e. at night or on weekends), when fewer senior clinicians are working and some services may be unavailable.

3.2 Information on comparative performance across English hospitals is annually collated and published by the 'Dr Foster' organisation. Data for 2011 is available at: http://drfosterintelligence.co.uk/wp-content/uploads/2011/11/Hospital_Guide_2011.pdf

3.3 Without significant additional funding it may be inevitable that there remains some variation between outcomes for patients admitted to hospital in or out of hours: it is simply not possible to provide the same level of service 24/7 with current hospital funding. However, it is definitely not the case that nothing can be done to improve out of hours outcomes. The Dr Foster data shows, for example, considerable variations in performance between hospitals, and also demonstrates that hospitals which manage to have senior clinicians on-site out of hours typically out-perform hospitals which do not.

3.4 This issue of comparative performance is not limited to patient mortality, but effects all types of clinical outcomes. However, mortality is a relatively simple outcome to measure, and is therefore used as a proxy by Dr Foster. BSUHT were asked to provide data on mortality and to do so for week days Vs weekends, as these were, relatively speaking, the easiest categories to research.

4. CONSULTATION

4.1 This report has been prepared in consultation with Brighton & Sussex University Hospitals Trust, and Appendix 1 to this report was provided by the trust.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 None to this report for information.

Legal Implications:

5.2 None to this report for information.

Equalities Implications:

5.3 None to this report for information.

Sustainability Implications:

5.4 None to this report for information.

Crime & Disorder Implications:

5.5 None to this report for information.

Risk and Opportunity Management Implications:

5.6 None to this report for information.

Corporate / Citywide Implications:

5.7 None to this report for information.

SUPPORTING DOCUMENTATION

Appendices:

1 Information provided by Brighton & Sussex University Hospitals Trust

Documents in Members' Rooms:

Background Documents:

"Inside Your Hospital": Dr Foster Hospital Guide 2011

Report on Hospital Mortality for Days of the Week
for Brighton and Sussex University Hospital
Brighton and Hove Health Overview and Scrutiny Committee
May 2012

Introduction

Brighton and Sussex University Hospital (BSUH) subscribe to Dr Foster Intelligence. This is a web based tool which allows the Trust to monitor its performance and benchmark against that of other Trusts. Dr Foster data is refreshed on a monthly basis. The latest report published by Dr Foster 'Inside your hospital, 2001-2011' reports '*being admitted to hospital at weekends is risky. Patients are less likely to get treated promptly and more likely to die. The chances of survival are better in hospitals that have more senior doctors on site. But some hospitals with A&E departments have very few senior doctors in hospital at weekends or overnight.'* The report then goes on to name nine hospitals where the mortality rate is much higher than expected at the weekend. In general, there was, on average, a seven per cent higher mortality rate for these patients compared with people admitted between Monday and Friday. Overall in terms of mortality Brighton and Sussex University hospital is in the 'top' quartile and so patients have a better outcome when compared to the rest of the country. Our mortality relative risk is at 84.3 for April – January 2011/12. The average nationally for this time period is 91.1.

There are a number of modules within the reporting systems. The 'Real Time Monitoring' (RTM) module alerts Trusts when performance falls outside of that expected (based on the performance of our peers). RTM alerts are produced for mortality, readmissions, length of stay or day-case rates, they can be either positive (green) or negative (red).

The Patient Safety Team review Mortality Alerts and Patient Safety Indicators on a monthly basis. Where Trust performance is found to be significantly below that which is 'expected' by Dr Foster, the Deputy Chief of Safety for the area is notified and a review initiated to identify the causes of the alert. The investigation is coordinated by the Patient Safety Team and involves a systematic review of coding, case mix and quality of care by appropriate senior clinicians and nursing staff together with input from the coding team.

Brighton and Sussex University Hospital

The tables below shows mortality figures for patients admitted on the respective day of the week for the HSMR basket of diagnoses. This covers the main diagnoses that make up 80% of hospital deaths. This is used by Dr Foster when they report on mortality. The figures show the relative risk figure. This is the measure used by Dr Foster. A figure of 100, reflects the number of deaths expected based on the national average for the case mix of patients seen. A figure below the average means that the trust is scoring better than expected. There are also confidence limits applied by Dr Foster. This table shows that for emergency admissions, BSUH performs within the expected performance indicators. The other trusts within our peer selected group include some London teaching hospitals and several outside London hospitals in the South.

Table 1: Relative risk of hospital mortality for non-elective patients by day of admission.

Non-Elective

Peer (Elected Peer Group)	Sunday	Monday	Tuesday	Wed	Thursday	Friday	Saturday
BSUH	91	81.2	101.3	78.6	87.8	89.3	97.1
Trust A	88.5	78.4	59.8	68.7	64.4	66.1	94.3
Trust B	67.9	59.8	65.2	65.1	72.9	68.4	78.7
Trust C	78.2	79.3	74.3	68.2	78.8	71.1	74.9
Trust D	96.1	101	94.2	94	99.9	95.3	99.3
Trust E	89.9	70.3	74.1	68.5	63.5	82.5	85.1
Trust F	97	103.6	87.1	89.4	97.1	92.1	97.5

There are a number of reasons which may contribute to a higher mortality rates at weekends. Patients who may have been seen by a GP during the weekdays and cared for at home, will access the hospital services at weekends when cover in primary care is less readily available, staffing levels may vary at the weekends and out-of hours especially senior staff and support services maybe less available at weekends.

The data for elective admissions is as follows:

Table 2: Relative risk of hospital admissions for elective patients by day of admission

Elective

Peer (Elected Peer Group)	Sunday	Monday	Tuesday	Wed	Thursday	Friday	Saturday
BSUH	483.8	136.8	120.8	104.6	97	32	78.7
Trust A	66.7	78.9	49.2	56	70.9	47	30.1
Trust B	80.6	98.4	103.7	72.7	65.6	118.9	132.4
Trust C	36.5	110.7	73.3	105.7	99.2	179.7	51.8
Trust D	95.6	64.1	98.6	113	22.2	75	253.2
Trust E	65.2	74.1	66.3	60	84.5	62.4	0
Trust F	125.1	112.3	87.1	85.1	89.9	144	0

The data for Brighton indicates that Sundays have a much higher relative risk (RR) at 483.8 and this is significant enough to cause an alert – however, the numbers (n) are very low. The RR of 483.8 is based on all elective Sunday admissions, n=192 and the number of patients who died was 7. Saturdays have a RR 78.7, n=185 and the number of deaths was 1. Of the 7 patients, five were cardiac surgical patients admitted for surgery on a later date one renal and one amputation of leg.

How is BSUH improving service provision?

BSUH recognises the importance of running a 24 hour and seven day a week service with senior input at all times. Services across the organisation have been developing to ensure that they are able to operate effectively and provide comprehensive services across the week. These include:

- 7 day week medical specialist review which has been introduced since November 2011and ensures that senior clinicians are involved in the patients care much closer to their point of admission.
- Enhanced Acute Physician Service
- Resident consultant Emergency Department staff 24/7
- Surgical and Gynaecology Assessment Units

A number of other initiatives have been introduced which include, acute oncology, neurosepsis hotline and extending the pharmacy service to improve the provision and advice for clinicians on medicines for in patients and for patients on discharge.

Enhancing quality programme.
Mortality figures are reviewed in the trust for four pathways within the enhancing quality programme. The pathways currently being reviewed are acute myocardial infarction (heart attack), heart failure, pneumonia and hip and knee operations. In the future, the pathways to be reviewed will include dementia and acute kidney injury.

There are of 5 outcome measures which are used as part of the programme which include; length of stay, admission, readmission, mortality and complications.

Author
Dr Stephen Holmberg
Medical Director
April 2012.

Reference
http://drfosterintelligence.co.uk/wp-content/uploads/2011/11/Hospital_Guide_2011.pdf

HEALTH OVERVIEW AND SCRUTINY COMMITTEE	**Agenda Item 89** Brighton & Hove City Council

Subject:		**Re-Commissioning Adult Hearing Services**		
Date of Meeting:		**May 09 2012**		
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 NHS Brighton & Hove has recently announced that it intends to re-commission local Adult Hearing Services (e.g. hearing aid services for the over-55s), moving away from the current single provider model to an 'Any Qualified Provider' model.

1.2 Any Qualified Provider (AQP) allows service users to choose from a range of providers – in essence any body that has registered an interest in providing a service and is able to deliver services in accordance with the service specification. Providers are 'pre-qualified' – that is, they will already have been assessed by the Department of Health as competent in delivering particular kinds of service, although the commissioning PCT will still need to assure itself that they can meet the specific demands of the service being commissioned. Details of how NHS Brighton & Hove intends to undertake this assurance process are included in **Appendices 1** and **2**).

1.3 AQP is explicitly intended to encourage a plurality of providers, which may include NHS trusts, private sector organisations or the voluntary/community sector. In essence, any provider which can demonstrate its competence and is willing to work to the service specification and at standard NHS pay rates may become a qualified provider for a given service.

2. RECOMMENDATIONS:

2.1 That members:

(1) Agree to support the proposed model for adult hearing services, and

(2) Agree to support the process outlined the appendices to this report for reaching a definitive decision on the selection of Any Qualified Provider.

3. BACKGROUND INFORMATION

3.1 The Health & Social Care Act (2012) contains measures to both abolish Primary Care Trusts (PCTs) and establish Clinical Commissioning Groups (CCGs). Until these measures come into force (April 2013 for PCT abolition; from April 2013 for CCG authorisation), formal responsibility for commissioning the bulk of NHS services rests with local PCTs rather than emerging CCGs or sub-regional PCT clusters. Hence these plans are being taken forward under the aegis of NHS Brighton & Hove rather than that of the Brighton & Hove Transitional CCG or NHS Sussex, although they represent the intentions of all the commissioning organisations.

3.2 Additional information provided by NHS Brighton & Hove on adult hearing services, and the planned change to an AQP model is included as **Appendix 1** to this report. NHS Brighton & Hove's draft service specification for a re-commissioned hearing services is included as **Appendix 2**.

4. CONSULTATION

4.1 This report has been prepared in consultation with NHS Brighton & Hove.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 None for the city council – these are NHS funded health services and there is no shared budget with the council.

Legal Implications:

5.2 Under regulation 4 of the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002, NHS Brighton and Hove must consult the council's Health Overview & Scrutiny Committee whenever it is proposing a substantial variation in the provision of the health service in the city.

Although there is no statutory definition of "substantial variation", the intention to increase the range of Adult Hearing Service providers could be regarded as "substantial" as it would bring about a change in the market place for such services and offer the public wider choice.

This report and the meeting of HOSC to consider its contents will satisfy the said obligation to consult.

Under regulation 7 of the 2002 Regulations, should HOSC consider that the proposal would not be in the interests of the local health service, it may report to the Secretary of State, who may make a final decision on the proposal and require NHS Brighton and Hove to take such action, or desist from taking such action, as he may direct.

Lawyer consulted: Oliver Dixon *Date: 27 April 2012*

Equalities Implications:

5.3 NHS Brighton & Hove avers that: "The new model for Any Qualified Provider of Adult Hearing Services will improve equality, providing a comprehensive patient-centred direct access adult hearing service for age related hearing loss in line with national guidance and local requirements."

Sustainability Implications:

5.4 NHS Brighton & Hove states that: "Tendering and procurement processes will address sustainability implications which will be a key factor in the decision regarding procurement."

Crime & Disorder Implications:

5.5 None

Risk and Opportunity Management Implications:

5.6 NHS Brighton & Hove states that: "The implementation of the new service model following successful procurement will ensure the ongoing safety of patients."

Corporate / Citywide Implications:

5.7 NHS Brighton & Hove states that: “The proposed service will have a positive impact on all wards of the city, reducing inequalities and improving patient access, outcomes and experience.”

SUPPORTING DOCUMENTATION

Appendices:

1 Information provided by NHS Brighton & Hove

2 Draft Service Specification provided by NHS Brighton & Hove

Documents in Members’ Rooms:

Background Documents:
Health & Social Care Act (2012)

Appendix 1

Re-commissioning Hearing Services for Adults

1 Introduction

This paper describes the proposed model for the future of adult hearing services for those aged over 55 years with age-related hearing loss in Brighton and Hove.

DoH Operational Guidance published in July 2011 set out plans for a phased implementation of the extension of patient choice to Any Qualified Provider, treating 2012/13 as a transitional year and starting with a limited set of community and mental health services.

When a service is opened up to choice of 'Any Qualified Provider', patients can choose from a range of providers all of whom meet NHS standards and price. Patients will choose based on quality and individual preferences such as geographical convenience. Money will follow patients' choices. Competition will be on quality not price and Providers must pass a standard qualification process to ensure they meet the appropriate quality requirements.

Commissioners will own the service specification and will confirm if the provider can deliver that specification. Because providers are qualified, commissioners know that a range of safe, good quality and affordable providers are available to whom they can refer their patients without the cost and effort of competitive tendering.

Primary Care Trust (PCT) Clusters, supported by pathfinder clinical commissioning groups, have been offered a menu of services from which to choose a service which would best meet local requirements. NHS Brighton and Hove have selected Adult Hearing Services.

2 Hearing Services for Adults

The ageing population means that demand for both hearing assessment and treatment services is set to rise substantially over the coming years. However, a significant proportion of this client group will have routine problems that do not require referral for an Ear, Nose and Throat (ENT) out-patient appointment prior to assessment. These patients would benefit from direct access to adult hearing care services with a referral being made directly from their GP, enabling timely diagnosis and treatment.

The aim is to provide a comprehensive patient-centred direct access adult hearing service for age related hearing loss in line with national guidance and local requirements. The vision for people with age related hearing problems is for them to receive high quality, efficient services delivered closer to home,

with short waiting times and high responsiveness to the needs of local communities, not unlike an optician service, and free at the point of access.

The Direct Access Adult Hearing Service is aimed at adults over the age of 55 experiencing difficulties with their hearing and communication who feel they might benefit from hearing assessment and care, including the option of trying hearing aids to reduce these difficulties. It is not appropriate for all hearing loss and there will still be scope for those with other medical conditions which may affect their hearing to receive appropriate treatment elsewhere, as at present.

Timetable. Advertising for potential bidders will take place in late May 2012, following which there will be a period of evaluation to determine suitable providers. It is expected that providers will be approved by August 2012 with a view to implementing the new service from September 2012.

Service Specification. The Commissioners have worked with the Clinical Commissioning Group to set an outcome-based specification that encourages providers to deliver high quality services, based on national exemplars, and published guidance where available. The service specification is largely based on the draft SHA Clinical Leads Audiology Network (CLaN) specification and is in line with national guidance, but has been adapted to take into account local circumstances and reflect the breadth of needs of local patients.

Monitoring of Providers. Regular performance reviews will be undertaken as part of normal contract monitoring, including patient feedback, and the Commissioners will take action where they receive information signalling the quality of services may not be meeting the contractual standards.

Information provided by NHS Brighton & Hove

HEALTH OVERVIEW AND SCRUTINY COMMITTEE	**Agenda Item 90** Brighton & Hove City Council

Subject:		**Re-commissioning of Community Mental Health Services**		
Date of Meeting:		**May 09 2012**		
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 At its March 2011 meeting the HOSC received a report from NHS Brighton & Hove outlining the PCT's intentions to re-commission aspects of community mental health services. The attached paper (**Appendix 1**) from NHS Brighton & Hove provides an update on progress in regard to this initiative.

2. RECOMMENDATIONS:

2.1 That members note the contents of this report and the information provided by NHS Brighton & Hove (**Appendix 1**).

3. BACKGROUND INFORMATION

3.1 See information supplied by NHS Brighton & Hove (Appendix 1)

4. CONSULTATION

4.1 None undertaken

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 None to this report for information

Legal Implications:

5.2 None to this report for information

Equalities Implications:

5.3 None to this report for information

Sustainability Implications:

5.4 None to this report for information

Crime & Disorder Implications:

5.5 None to this report for information

Risk and Opportunity Management Implications:

5.6 None to this report for information

Corporate / Citywide Implications:

5.7 None to this report for information

SUPPORTING DOCUMENTATION

Appendices:

1 Information on community mental health re-commissioning provided by NHS Brighton & Hove

Documents in Members' Rooms:

None

Background Documents:

None

Community Mental Health Services Review
Update for May HOSC Meeting

Background

As reported to the January HOSC Meeting, formal consultation on proposals to improve the provision of Community Mental Health Services in Brighton & Hove ended on 16th January 2012. This exercise was led by the Brighton & Hove Clinical Commissioning Group's joint mental health commissioning team on behalf of the Local Authority and PCT.

The services involved in this consultation were:-

- Advice & Information
- Outreach Support
- One to One & Group Support
- Day Services
- Employment Support

Outlined below is the information taken to the 20th February meeting of the Joint Commissioning Board, where approval was given to proceed with the following:-

- Extend all existing contracts within the framework of the review to 31st March 2013 (at which point they will terminate)
- Develop specifications and outcome-based performance indicators for new services
- Agree the preferred route to obtaining new services (e.g. by procurement or grants process or a mixture of both)

February JCB papers can be found at:
http://present.brighton-hove.gov.uk/ieAgenda.aspx?A=3311

A further paper was presented to the Joint Commissioning Board on 23rd April where approval was given to the following:-

- New services to be commissioned via the prospectus route
- Draft specifications (provided in the report) to be developed for use in the prospectus

March JCB papers can be found at:-
http://present.brighton-hove.gov.uk/ieListDocuments.aspx?MId=3312&x=1

Consultation

A large number of people from a cross-section of the community took the opportunity to engage with the consultation process, including around 450 responses via the online and hard-copy survey/questionnaire.

It was evident from the feedback received that community mental health support services are highly valued by the local community but there was a recognition that improvements could be made to the way that some services worked individually as well as together as part of whole system.

Commissioning Intentions

As a result of our findings, we intend to commission services which will deliver the following:-

Information & Advice

- Face to face mental health information in a greater range of community settings.
- An on-line mental health information facility.

One to one and group support

- One to One & Group Support that will provide psycho social support to help build community and individual resilience to manage mental health difficulties and improve wellbeing.
  The services will:
  - Have a clear pathway into the new Primary Care Mental Health service
  - Include an integral out-reach function

Outreach Support

- Outreach services for the most excluded groups. The top 5 groups identified through the consultation were:
  - Men with a high risk of poor mental health
  - Homeless/rough sleepers
  - LGBT communities
  - Older people
  - Refugees/asylum seekers
- Outreach services that are integrated with other mental health services including one to one and group services.

Day Services

- Two Mental Health Day Centres in Brighton and Hove.
- Day service activities which will be provided in a range of other community settings such as community halls to enable more choice for people.
- Day services where a key function will be to provide social, creative and educational activities to help people in their recovery from their mental illness as well as enabling those with more enduring problems to maintain stability by providing a safe and supportive space.

Employment Support

- Employment support that helps people stay in work as well as find work.
- Employment support as an integral part of other services (e.g. Day Services)

Procurement v. prospectus

We investigated the potential advantages of using a prospectus approach rather than the full procurement process. This is the direction of travel within the Brighton & Hove Local Authority and has been used successfully to commission voluntary and community services by other joint commissioning organisations (e.g. East Sussex). This system results in the award of 'Funding Agreements' containing terms and conditions which mirror those of normal contracts; performance indicators are based on desired outcomes measured in terms of Quality, Cost and Social Capital. The process of bidding is less onerous than with full procurement (both for commissioners and providers) and will, therefore, not discourage or preclude smaller organisations from taking part. It also allows greater innovation from prospective service providers and more input into shaping new services. Formal discussion with current community voluntary sector providers suggests that they too favour of this approach.

Service User Involvement

Service users have been kept informed of our intentions and progress over the last few months and we have received favourable feedback.

A key message is that changes will not happen immediately; all current services will continue until 31st March 2013. Where changes do take place, there will be a transition phase of several months when service users will be helped to start using the new services with minimum disruption to their existing routine and level of support.

Service users and carers will be involved in the evaluation of the Social Capital Element of bids. Participation is being sought through our existing 3rd Sector Service User Group, the MIND Voluntary Sector Engagement Service (LIVE) and the Equalities and Engagement Forum.

High Level Milestone Plan

Activity	End Date
Prospectus launched	May 2012
Bids evaluated	September 2012
CCG/Council approval of new providers	October 2012
New Funding Agreements in place	November 2012
Handover/transition plans in place	December 2012
New services begin	April 2013

Sussex Community NHS
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29/03/2012

Dear Sven,

Re: Update on short term services review in Brighton & Hove

I am writing to inform you that phase one of the short-term services review has started to be implemented this week at Sussex Community NHS Trust (SCT).

As previously advised by Geraldine Hoban, Chief Operating Officer, Brighton & Hove Emerging Clinical Commissioning Group, at the January 2012 HOSC meeting, we are moving current bed provision away from Newhaven Rehabilitation Centre (NRC) and investing in our intermediate care services (ICS). By 23rd April, 16 beds will be moved from NRC to support 16 more patients within their own homes in Brighton & Hove. A flexible approach by the multidisciplinary team (MDT) is being applied to match the care needs of patients.

With this focus on providing more care in patient's homes, the current staff skills mix at Knoll House is being reviewed. This is to enable consistency of care delivery. Managers at SCT and adult social care at Brighton & Hove City Council (BHCC) are working together to develop a consistent model for the ICS beds at both Knoll House and Craven Vale. Some staff will be transferring to ICS to enhance this service in order to support patients in home settings.

Please find attached a copy of the short term services briefing paper, put together by NHS Brighton & Hove, Brighton & Hove City Council and Sussex Community NHS Trust. This gives an overview for the change and outlines the changes as they are due to take place, in three distinct phases.

Keeping you informed
We will keep you updated on the progress of these changes as they happen. If in the meantime you have any queries, please do not hesitate to contact Janet Heath, Deputy Head of Locality Brighton & Hove, by telephone: **01273 267588** ext **7582**, mobile: **07771 860266** or email: **janet.heath@nhs.net**.

Yours sincerely

Louise Mayer
Head of Locality Brighton & Hove

SHORT TERM SERVICES BRIEFING PAPER – MARCH 2012

CONTEXT

Currently there are a mix of community and bed based services providing support to Brighton and Hove patients for a short period of time to avoid admission to hospital or following discharge from hospital. We currently have 92 beds and 110 intermediate care community places (patients who are treated in their own homes). A variety of payments arrangements exist for the beds - sometimes patients pay, sometimes the NHS pays, sometimes the local authority pays and sometimes a combination of these happens. There is little consistency and the system is sometimes inequitable. We also know from audits that have been done and national benchmarking that we have more beds than we need given our demographics. In addition we have a rich supply of community services and community clinicians who could work differently to support more patients in their own homes.

PROCESS

A review of short term services has been underway since January 2010. Regular project board meetings have taken place and the LINK was represented on this group, a stakeholder event was held and throughout the whole process there has been significant engagement with clinical and council colleagues. The model has now been approved by the Brighton and Hove Clinical Commissioning Group, NHS Sussex and the Joint Commissioning Board. We are now ready to start delivering these changes.

RECOMMENDATIONS

- That everyone who is assessed as needing the service should receive free care for an initial period up to a maximum of 6 weeks – regardless of income.
- That we will reduce the bed stock from 92 to 67 and locate as many as possible at one venue/location.
- That we will increase the number of community places to 135 so more patients can be supported in their own homes.
- That a single point of access, supported by a single assessment process for patients will be developed.
- That we will have a fully integrated service so patient care will be joined up and allow for more tailored and flexible support as patients needs change.
- Clinical leadership will be embedded within the service.
- That there will be an integrated rapid response service that will brought together into one virtual team, including the functions of the out of hours (OOH) district nursing service, the roving GP, the community rapid response service and the crisis service provide by Age UK.

WHAT IS GOING TO HAPPEN?

The changes are happening in 3 separate phases

Phase 1

Phase 1 Summary

- 16 beds at Newhaven Rehab Centre (NRC) re-provided
- Total ICS (intermediate care services) and transitional beds in system = 76
- ICS at home capacity increased to manage additional 16 patients
- Skill mix review at Knoll House

From mid April 2012, 16 of the beds at NRC will be closed and there will be additional investment in Intermediate Care Services (ICS) community service to enable it to support 16 more patients in their own homes. A flexible approach by the multidisciplinary team (MDT) will be applied to match the care needs of patients.

In addition the skill mix of the staff at Knoll House is being reviewed – staff are currently being consulted about proposals. This will enable consistency of care delivery in all the community beds. Managers in Sussex Community Trust and Adult Social Care will be working together to develop a consistent model for the ICS beds across both Knoll House and Craven Vale

Phase 2

Phase 2 Summary

- Remaining 16 beds at NRC re-provided
- 7 ICS beds moved to Craven Vale
- 7 transitional beds at Craven Vale relocated
- Total beds, including transitional beds = 67
- ICS at home capacity increased to manage additional 9 patients

By the end of September 2012 the remaining 16 beds at NRC will be closed. 7 of these beds will be transferred to Craven Vale and additional investment will be made in ICS to enable it to support an additional 9 patients in a community setting. Craven Vale will have a total of 24 ICS beds, and the 7 respite beds there will remain. To accommodate the 7 ICS beds at Craven Vale, the 7 current transitional beds will need to be reprovided - a suitable provider is currently being sourced.

Phase 3

Phase 3 Summary

- Implementation of new integrated service model
- 7 interim transitional beds closed
- Co-location of as many as possible of remaining community beds

The final phase is about co-locating all the ICS beds in as few locations as possible. At this stage the total number of ICS beds will not change. Final decisions about the location of these beds have not yet been made. At the present time, commissioners are considering a range of options. Until final decisions about the location of the beds has been made the ICS beds at Victoria Highgrove will remain.

Medical cover

Until March 2013 medical cover to the beds will continue to be provided by the roving GP and by the community geriatricians. And patients in their own homes will continue to be supported by their own GPs with the support of the community geriatrician and Roving GP if required.

During 2012/13 South East Health, Sussex Community NHS Trust and Brighton & Hove City Council will be working together to put in place the changes to ensure that the new integrated service operates according to the specification that is developed by the Clinical Commissioning Group (CCG). It will be the responsibility of the providers to put in place the model and to demonstrate that they can operate as a single unit and provide a seamless service to patients.

Part of the provider's responsibility will be to develop the optimal arrangements for medical cover to support the patients being supported by intermediate care and the integrated rapid response service. This will include working with the community geriatricians at Brighton and Sussex University Hospitals (BSUH) to agree how intermediate care and the integrated rapid response service will work with Rapid Assessment Clinic for Older People (RACOP). These changes will need to be implemented by 31 March 2013

KEY MESSAGES

Our priority throughout the review has been to improve services for patients. These changes will do just that by:

- Introducing equity into the charging regime.
- Providing more enhanced care in patient's homes.
- Locating all the bed based care in Brighton and Hove.
- Developing a more streamlined access and assessment process with patients receiving care in the best environment matched to their care need.
- Delivering a more joined up service for patients with the service adapting as the needs of the patient change.

For staff the changes will mean:

- That more of the bed based patient care will be in fewer locations – reducing travel time for staff that work across sites and enabling staff to spend more time with patients.
- That there will be increased opportunities to work as part of a bigger multi disciplinary virtual team with more clinical support.
- Closer partnership working.
- Opportunities for staff to develop and gain experience across all short term services.

For the system as a whole this will mean:

- Fewer beds but much more enhanced community provision including increased night sitting, roving nurse to support bed based services and more support for carers.
- There will be no overall loss of capacity within the system – 67 beds and 135 community places.
- Services will be easier to access - referrers will no longer have to deal with multiple entry points, assessments and referral criteria.
- All bed based services will continue to take hospital discharges as well as admissions from the community.
- There will be no change in the level of dependency the services are able to take.

Further updates will be sent to stakeholders as work progresses through the phases of the review.